



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-866-449-6495. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-866-449-6495 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>Network</u> : EE Only \$3,000; EE+ Family \$6,000. <u>Out-of-Network</u> : EE Only \$3,000; EE+ Family \$6,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	<u>Network</u> : EE Only \$6,000; EE+ Family \$12,000. <u>Out-of-Network</u> : EE Only \$6,000; EE+ Family \$12,000.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-866-449-6495 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Specialist visit</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Preventive care /screening /immunization</u>	No charge	No charge	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. Age and frequency schedules may apply.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition	Generic drugs	30% <u>coinsurance</u> .	30% <u>coinsurance</u> .	Mail Order: 30% <u>coinsurance</u> .
	Preferred brand drugs	30% <u>coinsurance</u> .	30% <u>coinsurance</u> .	Mail Order: 30% <u>coinsurance</u> .
	Non-preferred brand drugs	30% <u>coinsurance</u>	30% <u>coinsurance</u> .	Mail Order: 30% <u>coinsurance</u> .
	<u>Specialty drugs</u>	Covered at Preferred or Non-Preferred brand drug <u>coinsurance</u> as applicable	Not covered	None
More information about prescription drug coverage is available at www.caremark.com				
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Urgent care</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
	Physician/surgeon fees	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 30% <u>coinsurance</u>	Office & other outpatient services: 30% <u>coinsurance</u>	None
	Inpatient services	30% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
If you are pregnant	Office visits	No charge	No charge	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) <u>Pre-authorization</u> required for out-of-network care.
	Childbirth/delivery professional services	30% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	40 visits/calendar year combined with private-duty nursing. <u>Pre-authorization</u> required for out-of-network care.
	<u>Rehabilitation services</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Habilitation services</u>	Not covered	Not covered	Not covered.
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	60 days/calendar year. <u>Pre-authorization</u> required for out-of-network care.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care - 35 visits/calendar year.
- Hearing aids
- Infertility treatment
- Private-duty nursing - 40 visits/calendar year combined with home health care.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-866-449-6495.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-866-449-6495.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan Meet Minimum Value Standard? Yes.

If your plan doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a plan through the **Marketplace**.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this **plan** might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the **cost sharing** amounts (**deductibles**, **copayments** and **coinsurance**) and **excluded services** under the **plan**. Use this information to compare the portion of costs you might pay under different health **plans**. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The **plan's** overall **deductible** \$3,000
- **Specialist coinsurance** 30%
- **Hospital (facility) coinsurance** 30%
- **Other coinsurance** 30%

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$2,900

<i>What isn't covered</i>	
Limits or exclusions	\$600

The total Peg would pay is	\$5,960
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Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The **plan's** overall **deductible** \$3,000
- **Specialist coinsurance** 30%
- **Hospital (facility) coinsurance** 30%
- **Other coinsurance** 30%

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$1,300

<i>What isn't covered</i>	
Limits or exclusions	\$60

The total Joe would pay is	\$4,360
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Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The **plan's** overall **deductible** \$3,000
- **Specialist coinsurance** 30%
- **Hospital (facility) coinsurance** 30%
- **Other coinsurance** 30%

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$0

The total Mia would pay is	\$1,900
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Note: If your **plan** has a wellness program and you choose to participate, you may be able to reduce your costs.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-449-6495.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705),

Email: CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-866-449-6495. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - हनिदी में भाषा सहायता के लिए, 1-866-449-6495 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-866-449-6495.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-866-449-6495 na akwụghị ụgwọ ọ bụla
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-449-6495 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-866-449-6495.
- Japanese - 日本語で援助をご希望の方は、1-866-449-6495 まで無料でお電話ください。
- Karen - လာဝတ်စာတော်ကတိတ်ကျိတ်အင်္ဂါ ကျိတ် ကိ: 1-866-449-6495 လာဝတ်အိတ်ဒီးတော်လာတ်ဘူတ်လာတ်စုဘူတ်
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-449-6495번으로 전화해 주십시오.
- Kru-Bassa - Ɓe m'ké gbo-kpá-kpá dyé pidiyi dé Ɓašwó-wuḍuün wɛɛ, dǎ 1-866-449-6495
- Kurdish - برای راهنمایی به زبان فارسی با شماره 1-866-449-6495 به خورایی یه یومندی بکن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-866-449-6495 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-866-449-6495 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-866-449-6495 ilo ejjelok wōnān.
- Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-449-6495 ni sohte isais.
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទទេលកាន់លេខ 1-866-449-6495 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shík'a a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-449-6495
- Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-866-449-6495 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tën kuwoony ë thok ë Thuonjäng col 1-866-449-6495 kec'in ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-866-449-6495 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-866-449-6495 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hilfe in Deutsch, ruf: 1-866-449-6495 aa. Es Aaruf koschtet nix.
- Persian - برای راهنمایی به زبان فارسی با شماره 1-866-449-6495 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
- Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-866-449-6495.

- Portuguese - Para obter assistência linguística em português ligue para o 1-866-449-6495 gratuitamente.
- Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-866-449-6495
- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-449-6495.
- Samoaan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-866-449-6495 e aunoa ma se totogi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-866-449-6495.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-866-449-6495.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-866-449-6495. Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-866-449-6495 bila malipo.
- Syriac - ܟܠ ܥܡܟܢ ܟܠ ܗܝ ܡܨܝܝܬܝܢ ܥܠܝܟܟܡ ܟܠ ܗܝ ܝܘܡܝܟܡ ܟܠ ܗܝ ܝܘܡܝܟܡ ܟܠ ܗܝ ܝܘܡܝܟܡ 1-866-449-6495 ܗܝܢܝܢ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-449-6495 nang walang bayad.
- Telugu - భాషలో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-866-449-6495 కు కాల్ చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-866-449-6495 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-866-449-6495 'o 'ikai hā ʻōtōngi.
- Trukese - Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-866-449-6495 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedен 1-866-449-6495.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-866-449-6495.
- Urdu - اریکال گفتفم رپ 1-866-449-6495 عیلم یکتن و اع مین لیل ریم ودر
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-866-449-6495.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-866-449-6495 פאר פון אפצאל.
- Yoruba - Fún ìrànጂwọ nípa èdè (Yorùbá) pe 1-866-449-6495 láí san owó kankan rárá.