



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 1-866-276-5125. 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 1-866-276-5125 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	In- <u>Network</u> : EE Only \$1,650; EE+ 1 or more \$3,300. Out-of-Network: EE Only \$3,300; EE+ 1 or more \$6,600.	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. A Health Reimbursement Arrangement (HRA) is available that works with your medical <u>plan</u> , as described in your employer's Summary Plan Description.
Are there services covered before you meet your <u>deductible</u>?	Yes. In- <u>network</u> <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 <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	In- <u>Network</u> : EE Only \$3,300; EE+ 1 or more \$6,600. Out-of-Network: EE Only \$6,600; EE+ 1 or more \$13,200.	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> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	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 <u>network provider</u>?	Yes. See www.aetna.com/docfind or call 1-866-276-5125 for a list of in- <u>network</u> <u>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 <u>referral</u> to see a <u>specialist</u>?	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
		In-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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	40% <u>coinsurance</u> , except no charge for immunizations	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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aetnapharmacy.com/advancedcontrol	Generic drugs	<u>Copay/prescription</u> : 20% (retail & mail order)	20% <u>coinsurance</u> after <u>copay/prescription</u> : 20% (retail)	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your <u>formulary</u> for prescriptions requiring step therapy for coverage. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written; cost difference penalty doesn't apply to <u>deductible</u> or <u>out-of-pocket limit</u> . Maintenance drugs- after two retail fills, you are required to fill a 90-day supply at a participating mail service pharmacy or at selected participating retail <u>providers</u> . <u>Deductible</u> doesn't apply to certain preventive medications.
	Preferred brand drugs	<u>Copay/prescription</u> : 20% (retail & mail order)	20% <u>coinsurance</u> after <u>copay/prescription</u> : 20% (retail)	
	Non-preferred brand drugs	<u>Copay/prescription</u> : 20% (retail & mail order)	20% <u>coinsurance</u> after <u>copay/prescription</u> : 20% (retail)	
	<u>Specialty drugs</u>	Applicable cost as noted above for generic or brand drugs	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . No coverage for non-emergency use. Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except if pre-authorized.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$750 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 40% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$750 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge	40% <u>coinsurance</u>	<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). Penalty of \$750 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	120 visits/calendar year combined with private-duty nursing. Penalty of \$750 for failure to obtain <u>pre-authorization</u> for out-of-network care. 90 visits/calendar year for Physical, Occupational, Speech & Cognitive Therapy combined, including outpatient hospital services. None 90 days/calendar year. Penalty of \$750 for failure to obtain <u>pre-authorization</u> for out-of-network care. Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	0% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$750 for failure to obtain <u>pre-authorization</u> 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.)

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

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

- Acupuncture - 20 visits/calendar year.
- Chiropractic care - 20 visits/calendar year.
- Hearing aids - \$3,000 maximum/24 months.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, including artificial insemination.
- Private-duty nursing - Included as part of 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 1-866-276-5125.
- 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 <http://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 on how 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:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-866-276-5125. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://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.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet Minimum Value Standards? 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 \$1,650
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,650
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,650
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,360

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,650
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

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

Total Example Cost	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,650
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,470

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,650
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,650
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,850

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-276-5125.

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 unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide 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: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), 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).

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TTY: 711

Language Assistance:

To access language services at no cost to you, call 1-866-276-5125.

- Albanian - Për shërbime përkthimi falas për ju, telefononi 1-866-276-5125.
- Amharic - የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-866-276-5125 ይደውሉ።
- Arabic - للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-866-276-5125
- Armenian - Անվճար լեզվալեզան ծառայություններից օգտվելու համար զանգահարեք 1-866-276-5125 հեռախոսահամարով:
- Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-866-276-5125 tanpa dikenakan biaya.
- Bantu-Kirundi - Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-866-276-5125.
- Bengali-Bangala - আপনাকে বিনামূল্যে ভাষা পবিকষা পপকে হকয এই নম্বকি পেবযক ান েরন: 1-866-276-5125 ।
- Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-866-276-5125.
- Burmese - သငှ်အေအ်ဖှ်ဖှ် အေေဖှ်ကေးေငြ် မေးရပဲ ဘာသာစကေးေန့ေဆာငှ်မား ရရှိဖှ်ငှ်န့ 1-866-276-5125 သိုငှ် ဖှ်န့ေးေခငှ်ဆိုဝါ။
- Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-866-276-5125.
- Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-866-276-5125.
- Cherokee - ႠႃႆႠ ႡႣႆႠႆႠ ႡႣႆႠႆႠ Ⴀ ႠႆႠ ႡႠႆႠႆႠ ႡႣ, ႡႣႆႠႆႠ 1-866-276-5125.
- Chinese - 如欲使用免費語言服務，請致電 1-866-276-5125.
- Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-866-276-5125.
- Cushite - Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-866-276-5125.
- Dutch - Voor gratis toegang tot taaldiensten, bell 1-866-276-5125.
- French - Afin d'accéder aux services langagiers sans frais, composez le 1-866-276-5125.
- French Creole - Pou jwenn sèvis lang gratis, rele 1-866-276-5125.
- German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-866-276-5125 an.
- Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-866-276-5125.
- Gujarati - તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેવિઓની પહોર માટે, કોલ કરો1-866-276-5125.

- Hawaiian - No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-866-276-5125. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए,1-866-276-5125 पर कॉल करें।
- Hmong - Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-866-276-5125.
- Igbo - Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-866-276-5125
- Ilocano - Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-866-276-5125.
- Indonesian - Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-866-276-5125.
- Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-866-276-5125.
- Japanese - 言語サービスを無料でご利用いただくには、1-866-276-5125 までお電話ください。
- Karen - လၢတၢ်ကမၤန့ၢ်ကိၣ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အီၤအဂီၢ်ဘၣ်န့ၣ် ကိး 1-866-276-5125 တက့ၢ်.
- Korean - 무료 언어 서비스를 이용하려면 1-866-276-5125 번으로 전화해 주십시오.
- Kru-Bassa - M̄ dyi wuḍu-dù kà kò ḍò bě dyi m̄oú n̄ ní Pídyi ní, níí, ḍá nòbà nià ke: 1-866-276-5125
- Kurdish - 1-866-276-5125 بۆ دەسپێر اگه‌شتن به خزمه‌تگوزاری زمان به‌ی تێچوون بۆ تو، په‌یوه‌ندی بکه به ژماره‌ی
- Laotian - ຕຳແໜ່ງໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໃບຫາເບີ 1-866-276-5125
- Marathi - कोणत्याही शक्ृकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-866-276-5125 वर फोन करा.
- Marshallese - Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-866-276-5125.
- Micronesian - Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-866-276-5125.
- Pohnpeyan - 1-866-276-5125 ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ
- Mon-Khmer, Cambodian - 1-866-276-5125 ។
- Navajo - T'áá ni nizaad k'ehjí bee níká a'doowoł doo bą́ąh ílínígóó kobjí' hólne' 1-866-276-5125.
- Nepali - निःशुल्क भाषा सेवा प्राप्त गर्न 1-866-276-5125 मा टेलिफोन गर्नुहोस् ।
- Nilotic-Dinka - Të koor yin wëër de thokic ke cïn wëu kør keek tënəŋ yin. Ke cəl koc ye koc kuony ne nomba 1-866-276-5125.
- Norwegian - For tilgang til kostnadsfri språktjenester, ring 1-866-276-5125.
- Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-866-276-5125.
- Persian - برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-866-276-5125 تماس بگیرید .
- Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-866-276-5125.
- Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-866-276-5125.

