



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](http://www.HealthReformPlanSBC.com) or by calling 1-833-821-0849. 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 1-833-821-0849 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	For each <u>Plan</u> Year, In- <u>Network</u> : Individual \$0 / Family \$0.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
<b>Are there services covered before you meet your deductible?</b>	No.	You do not have to meet a <u>deductible</u> before services are covered under this plan, but a <u>copayment</u> may apply.
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	In- <u>Network</u> Medical: Individual \$4,500 / Family \$9,000. In- <u>Network</u> Prescription drugs: Individual \$2,100 / Family \$4,200. Out-of- <u>Network</u> : Not applicable.	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.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, <u>copayments</u> & <u>coinsurance</u> on certain services & penalties for failure to obtain precertification.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-833-821-0849 for a list of <u>in-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.
<b>Do you need a referral to see a specialist?</b>	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</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	\$15 <u>copay</u> /visit	Not covered	None
	<u>Specialist</u> visit	\$25 <u>copay</u> /visit	Not covered	<u>Referrals</u> are required for most <u>specialist</u> visits. If you don't get <u>referral</u> , benefits will be denied.
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	Not covered	Age and frequency limits may apply. 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)	X-ray: \$50 <u>copay</u> /visit for hospital facility & No charge for freestanding facility; Laboratory: \$50 <u>copay</u> /visit except \$10 <u>copay</u> /visit for Quest Diagnostics/Labcorp	Not covered	Preferred laboratories: Quest Diagnostic or Labcorp.
	Imaging (CT/PET scans, MRIs)	\$100 <u>copay</u> /visit for hospital; no charge for non-hospital freestanding facility	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.

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)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.aetnapharmacy.com">www.aetnapharmacy.com</a></p> <p><u>Aetna Standard Plan Formulary</u></p>	Generic drugs	\$10 <u>copay</u> /prescription for 30-day supply (retail or mail order); \$20 <u>copay</u> /prescription for 90-day supply (participating retail or mail order)	Not covered	Up to 30-day fills at retail or mail order for non-maintenance drugs; 90-day fills for maintenance drugs available at participating pharmacies or mail order only, maintenance drugs filled as 30-day supply incur penalty at fourth fill; under Choice Program, you pay applicable copay plus difference between generic and brand when preferred generic equivalent is available. Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. Qualified members ages 40 - 75 receive generic low to moderate dose statins at no cost. No charge for preferred generic FDA-approved women's contraceptives in-network.
	Preferred brand drugs	\$32 <u>copay</u> /prescription for 30-day supply (retail or mail order); \$64 <u>copay</u> /prescription for 90-day supply (participating retail or mail order)	Not covered	
	Non-preferred brand drugs	\$60 <u>copay</u> /prescription for 30-day supply (retail or mail order); \$120 <u>copay</u> /prescription for 90-day supply (participating retail or mail order)	Not covered	

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)	
	<u>Specialty drugs</u>	No charge if enrolled in the PrudentRx program; 30% <u>coinsurance</u> if not enrolled in the PrudentRx program	Not covered	<u>Specialty drugs</u> must be filled by CVS Specialty Pharmacy.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$150 <u>copay</u> /visit for hospital facility; except \$50 <u>copay</u> /visit for freestanding facility	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied. Additional benefits for non-emergency, planned surgeries are available through Lantern.
	Physician/surgeon fees	No charge	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$200 <u>copay</u> /visit	\$200 <u>copay</u> /visit	<u>Out-of-network</u> emergency use paid the same as <u>in-network</u> . No coverage for non-emergency use, except certain services. Refer to <u>plan</u> document for coverage details of non-emergency use.
	<u>Emergency medical transportation</u>	\$50 <u>copay</u> /trip	\$50 <u>copay</u> /trip	<u>Out-of-network</u> emergency use paid the same as <u>in-network</u> . Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$15 <u>copay</u> /visit	Not covered	No coverage for non-urgent use.

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 have a hospital stay	Facility fee (e.g., hospital room)	\$100 copay per day, maximum 2 copays per admission	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: \$15 <u>copay</u> /visit	Not covered	None
	Inpatient services	\$100 copay per day, maximum 2 copays per admission	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
If you are pregnant	Office visits	No charge; except applicable office visit copay for initial visit to confirm pregnancy	Not covered	<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). Initial visit to diagnose pregnancy will have member cost share based on where services are rendered.
	Childbirth/delivery professional services	\$25 <u>copay</u> /pregnancy	Not covered	
	Childbirth/delivery facility services	\$100 copay per day, maximum 2 copays per admission	Not covered	
If you need help recovering or have	<u>Home health care</u>	No charge	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.

		What You Will Pay		
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Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
other special health needs	<u>Rehabilitation services</u>	20% <u>coinsurance</u> or lesser of \$15 copay or 20% coinsurance per visit for mental health and substance abuse disorder diagnosis	Not covered	Limited to 45 visits per condition for physical and occupational therapy combined. No visit-limit on physical therapy for treatment of back pain. Coverage is limited to 45 visits per condition for speech therapy. Subject to medical necessity review at 25 visits. No visit limit for Physical, Occupational and Speech Therapy for mental health and substance abuse disorder diagnosis.
	<u>Habilitation services</u>	No charge	Not covered	None
	<u>Skilled nursing care</u>	No charge	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	None.
	<u>Hospice services</u>	No charge	Not covered	None
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 (Adult & Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Routine eye care (Adult)

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

- Acupuncture - 10 visits/year for disease, injury & chronic pain.
- Bariatric surgery
- Chiropractic care
- Hearing aids - 3 hearing aids per ear/36 months for children up to age 24
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Private-duty nursing

**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](http://www.dol.gov/ebsa/healthreform) at 1-833-821-0849.
- 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](http://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](http://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 1-833-821-0849. 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](http://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 \$0
- Specialist copayment \$25
- Hospital (facility) copayment \$100
- Other copayment \$0

**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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$460</b>

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

- The plan's overall deductible \$0
- Specialist copayment \$25
- Hospital (facility) copayment \$100
- Other copayment \$0

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$5,600</b>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$200
<b>The total Joe would pay is</b>	<b>\$920</b>

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

- The plan's overall deductible \$0
- Specialist copayment \$25
- Hospital (facility) copayment \$100
- Other copayment \$0

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$700</b>

### Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-833-821-0849.

### 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](mailto: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 companies, including Aetna Life Insurance Company and its affiliates (Aetna).**

TTY: 711

**Language Assistance:**

To access language services at no cost to you, call 1-833-821-0849.

- Albanian - Për shërbime përkthimi falas për ju, telefononi 1-833-821-0849.
- Amharic - የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-833-821-0849 ይደውሉ።
- Arabic - للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-833-821-0849
- Armenian - Անվճար լեզվակախ ծառայություններից օգտվելու համար զանգահարեք 1-833-821-0849 հեռախոսահամարով:
- Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-833-821-0849 tanpa dikenakan biaya.
- Bantu-Kirundi - Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-833-821-0849.
- Bengali-Bangala - আপনাকে বিনামূল্যে ভাষা পিবকিষা পপেক হকয এই ন িক েপবযক ান েংকন: 1-833-821-0849।
- Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-833-821-0849.
- Burmese - သင့်အတွက် အခမဲ့ ဝေဖမ်းရဲ့ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ဖို့ 1-833-821-0849 သို့
- Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-833-821-0849.
- Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-833-821-0849.
- Cherokee - Ⴊႃ႗ႃ Ⴑႃ႗ႃ 1-833-821-0849.
- Chinese - 如欲使用免費語言服務，請致電 1-833-821-0849.
- Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-833-821-0849.
- Cushite - Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-833-821-0849.
- Dutch - Voor gratis toegang tot taaldiensten, bell 1-833-821-0849.
- French - Afin d'accéder aux services langagiers sans frais, composez le 1-833-821-0849.
- French Creole - Pou jwenn sèvis lang gratis, rele 1-833-821-0849.
- German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-833-821-0849 an.
- Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-833-821-0849.

Gujarati -

તમારેકોઇ ક્ષતના ખચરવિના ભાષાની સેવિંાઓની પહોર માટે, કોલ કરો1-833-821-0849.



