



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 1-800-370-4526. 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 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1 Individual \$0 / Family \$0. Tier 2 In-Network: Individual \$1,500 / Family \$3,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency care; plus in-network office visits & preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Tier 1 In-Network: Individual \$2,500 / Family \$5,000. Tier 2 In-Network: Individual \$4,500 / Family \$9,000.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of Tier 1 In-Network Providerproviders.	You pay the least if you use a provider in Tier 1 In-Network Provider. You pay more if you use a provider in Tier 2 In-Network Provider. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



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
		Tier 1 In-Network Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$5 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	None
	<u>Specialist</u> visit	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	None
	<u>Preventive care /screening /immunization</u>	No charge	No charge	Not covered	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)	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply for hospital; no charge for free standing facility	20% <u>coinsurance</u> for hospital; no charge for free standing facility	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply for hospital; no charge for free standing facility	20% <u>coinsurance</u> for hospital; no charge for free standing facility	Not covered	<u>Pre-authorization</u> required for care.
If you need drugs to treat your	Generic drugs	Not covered	Not covered	Not covered	Not covered.
	Preferred brand drugs	Not covered	Not covered	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	Not covered	

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illness or condition More information about prescription drug coverage is available at www.aetna.com/pharmacy-insurance/individuals-families	<u>Specialty drugs</u>	Not covered	Not covered	Not covered	Not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 <u>copay/visit</u> , <u>deductible</u> doesn't apply	20% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay/visit</u> , <u>deductible</u> doesn't apply	\$100 <u>copay/visit</u> , <u>deductible</u> doesn't apply	\$100 <u>copay/visit</u> , <u>deductible</u> doesn't apply	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	No charge	No charge	Not covered	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>Urgent care</u>	\$15 <u>copay/visit</u> , <u>deductible</u> doesn't apply	\$30 <u>copay/visit</u> , <u>deductible</u> doesn't apply	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150 <u>copay/stay</u> , <u>deductible</u> doesn't apply	20% <u>coinsurance</u>	Not covered	<u>Pre-authorization</u> required for care.
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	Not covered	None

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		Tier 1 In-Network Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$15 <u>copay/visit</u> , <u>deductible</u> doesn't apply; other outpatient services: no charge	Office: \$30 <u>copay/visit</u> , <u>deductible</u> doesn't apply; other outpatient services: no charge	Not covered	None
	Inpatient services	No charge	20% <u>coinsurance</u>	Not covered	None
If you are pregnant	Office visits	No charge	No charge	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).
	Childbirth/delivery professional services	No charge	20% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	No charge	20% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	Not applicable	\$5 <u>copay/visit</u> , <u>deductible</u> doesn't apply	Not covered	None
	<u>Rehabilitation services</u>	<u>Deductible</u> doesn't apply: \$5 <u>copay/visit</u> (office), \$15 <u>copay/visit</u> (outpatient facility)	\$20 <u>copay/visit</u> , <u>deductible</u> doesn't apply; except 20% <u>coinsurance</u> for outpatient hospital facility	Not covered	30 visits/calendar year for Physical, Occupational & Speech Therapy, including outpatient hospital services. <u>Pre-authorization</u> required for care.
	<u>Habilitation services</u>	<u>Deductible</u> doesn't apply: \$15 <u>copay/visit</u> , except \$5 <u>copay/visit</u> for outpatient hospital facility	\$30 <u>copay/visit</u> , <u>deductible</u> doesn't apply; except 20% <u>coinsurance</u> for outpatient hospital facility	Not covered	None
	<u>Skilled nursing care</u>	\$150 <u>copay/stay</u> , <u>deductible</u> doesn't apply	20% <u>coinsurance</u>	Not covered	100 days/calendar year. <u>Pre-authorization</u> required for care.
	<u>Durable medical equipment</u>	Not applicable	No charge	Not covered	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.

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		Tier 1 In-Network Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	<u>Hospice services</u>	No charge	\$150 <u>copay/stay</u> , <u>deductible</u> doesn't apply for inpatient; no charge for outpatient	Not covered	<u>Pre-authorization</u> required for care.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Not covered	1 routine eye exam/calendar year.
	Children's glasses	Not covered	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Bariatric surgery
- Chiropractic care - 25 visits/calendar year.
- Hearing aids - 1 hearing aid to \$2,500 maximum per ear/60 months.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Private-duty nursing
- Routine eye care (Adult) - 1 routine eye exam/calendar year.

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 1-800-370-4526.
- 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 1-800-370-4526. 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? No.

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 \$15
- Hospital (facility) copayment \$150
- 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*)

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

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$90
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Peg would pay is	\$160

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 \$15
- Hospital (facility) copayment \$150
- Other copayment \$0

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>	\$0
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,300
The total Joe would pay is	\$4,400

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

- The plan's overall deductible \$0
- Specialist copayment \$15
- Hospital (facility) copayment \$150
- 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*)

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

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Mia would pay is	\$110

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-370-4526.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

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 1-800-370-4526.

- Albanian - Për shërbime përkthimi falas për ju, telefononi 1-800-370-4526.
- Amharic - የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-800-370-4526 ይደውሉ።
- Arabic - للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-800-370-4526
- Armenian - Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-800-370-4526 հեռախոսահամարով:
- Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
- Bantu-Kirundi - Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-800-370-4526.
- Bengali-Bangala - ১৮০০ ৩৭০ ৪৫২৬ এ কল করে আপনি কোনও খরচ ছাড়াই ভাষাসেবা পাবেন।: 1-800-370-4526 ☐
- Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-800-370-4526.
- Burmese - သငှ်အေအ်ဖုခ်အေဖုကးေငြ်မေးရဲဲ ဘာသာစကးေန့ေဆာငွးမ်း ရဲဲန့်ိုငှ်န့် 1-800-370-4526 သိုငှ် ဖုန့်းေခငှ်ဆိုဝါ။
- Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-800-370-4526.
- Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-800-370-4526.
- Cherokee - ᏍᏏᏉ ᏍᏏᏉᏍᏉ ᏍᏏᏉᏍᏉ Ꮝ ᏍᏏᏉ ᏍᏏᏉᏍᏉ ᏍᏉ, ᏍᏏᏉᏍᏉ 1-800-370-4526.
- Chinese - 如欲使用免費語言服務，請致電 1-800-370-4526.
- Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-800-370-4526.
- Cushite - Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-800-370-4526.
- Dutch - Voor gratis toegang tot taaldiensten, bell 1-800-370-4526.
- French - Afin d'accéder aux services langagiers sans frais, composez le 1-800-370-4526.
- French Creole - Pou jwenn sèvis lang gratis, rele 1-800-370-4526.
- German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-370-4526 an.
- Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-800-370-4526.

- Gujarati - તમારેકોઈ જાતના ખર્ચવિના ભાષાની સેવાઓની પહોંર માટે, કોલ કરો 1-800-370-4526.
- Hawaiian - No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-800-370-4526. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-800-370-4526 पर कॉल करें।
- Hmong - Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-800-370-4526.
- Igbo - Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-800-370-4526
- Ilocano - Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-800-370-4526.
- Indonesian - Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-800-370-4526.
- Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-370-4526.
- Japanese - 言語サービスを無料でご利用いただくには、1-800-370-4526 までお電話ください。
- Karen - လၢတၢ်ကမၤန့ၢ်ကိၣ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-800-370-4526 တက့ၢ်.
- Korean - 무료 언어 서비스를 이용하려면 1-800-370-4526 번으로 전화해 주십시오.
- Kru-Bassa - Mɔ̃ dyi wuɖu-dù kà kò dɔ̀ bɛ̃ dyi mɔ́u ń nì Pidyì ní, níí, dǎ nɔ̃bà nià kɛ: 1-800-370-4526
- Kurdish - بو دەسپێرێگه‌پشتن به خزمه‌تگوزاری زمان به‌ی تێچوون بو تو، په‌یوه‌ندی بکه به ژماره‌ی 1-800-370-4526
- Laotian - ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-800-370-4526
- Marathi - कोणत्याही शक्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी, 1-800-370-4526 वर फोन करा.
- Marshallese - Nan etal nan jikan jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-800-370-4526.
- Micronesian-Pohnpeyan - Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-800-370-4526.
- Mon-Khmer,
 1-800-370-4526 ។
- Cambodian -
- Navajo - T'áá ni nizaad k'ehjí bee níká a'doowoł doo bááh ílínígóó kojí' hólne' 1-800-370-4526.
- Nepali - 1-800-370-4526
- Nilotic-Dinka - Të kɔɔr yin wɛɛr̥ de thokic ke c̥in w̥ɛu kɔr keek t̥ɛnɔŋ yin. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-800-370-4526.
- Norwegian - For tilgang til kostnadsfri språktjenester, ring 1-800-370-4526.
- Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-800-370-4526.
- Persian - برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-800-370-4526 تماس بگیرید .
- Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-800-370-4526.

