



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 1-877-858-6507. 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 1-877-858-6507 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual \$0 / Family \$0.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	Yes. This <u>plan</u> has no <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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
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?	Medical In- <u>Network</u> : Individual \$1,500 / Family \$3,000. Global In- <u>network</u> : Individual \$9,450 / Family \$18,900. (met by medical and prescription <u>copays</u> or prescription <u>copays</u> only).	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> and services 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 <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-877-858-6507 for a list of in- <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 charge</u> 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit	Not covered	Additional charges may apply for non- <u>preventive services</u> performed in the Physician's office. Additional charges may apply for non- <u>preventive services</u> performed in the Physician's office. 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.
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit	Not covered	
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	Not covered	
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	Charges for office visits may apply if services are performed in a Physician's office. Charge for office visits or Physician/professional services may also apply depending where services are received.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	
<b>If you need drugs to treat your illness or condition</b>	Generic drugs	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.
	<u>Specialty drugs</u>	Not covered	Not covered	Not covered.
More information about <b>prescription drug coverage</b> is available at <a href="http://www.aetna.com/pharmacy-insurance/individuals-families">www.aetna.com/pharmacy-insurance/individuals-families</a>				

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Charges for office visits may also apply if services are performed in any Physician's office. Prior authorization required.
	Physician/surgeon fees	No charge	Not covered	Charges for office visits may also apply if services are performed in any Physician's office. Prior authorization required.
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit	\$100 <u>copay</u> /visit	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> .
	<u>Emergency medical transportation</u>	No charge	No charge	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>	\$25 <u>copay</u> /visit	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <u>copay</u> /per admission	Not covered	Prior authorization required.
	Physician/surgeon fees	No charge	Not covered	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: \$20 <u>copay</u> /visit \$250 <u>copay</u> /per admission	Not covered	Prior authorization required.
	Inpatient services	Residential stay: no charge	Not covered	Prior authorization required.
If you are pregnant	Office visits	No charge, except \$40 <u>copay</u> 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). Prior authorization required.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$250 <u>copay</u> /per admission	Not covered	
	<u>Home health care</u>	No charge	Not covered	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 help recovering or have other special health needs	<u>Rehabilitation services</u>	\$40 <u>copay</u> /visit for physical, occupational, speech therapy, and chiropractic services	Not covered	Limited to treatment for 60 visits/condition per calendar year for Physical, Speech Therapy & Chiropractic care combined & 60 visits/condition per calendar year for Occupational Therapy, including outpatient hospital services.
	<u>Habilitation services</u>	\$20 <u>copay</u> /visit	Not covered	Habilitative occupational therapy is limited to <u>home health care</u> , hospice care, treatment of Autism Spectrum Disorder, treatment of Developmental Disabilities, and Down syndrome.
	<u>Skilled nursing care</u>	\$250 <u>copay</u> /per admission	Not covered	Limited to 60 days post- <u>hospitalization</u> care per calendar year. Prior authorization required.
	<u>Durable medical equipment</u>	No charge	Not covered	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	\$250 <u>copay</u> /per admission for inpatient; no charge for outpatient	Not covered	Limited to 210 days per lifetime.
If your child needs dental or eye care	Children's eye exam	\$20 <u>copay</u> /visit at PCP; \$40 <u>copay</u> /visit at <u>Specialist</u>	Not covered	Limited to 1 routine eye exam per calendar year.
	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.)

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

- Bariatric surgery
- Chiropractic care - 60 visits/condition per calendar year combined with physical & speech therapy.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- 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 1-877-858-6507.
- 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 1-877-858-6507. 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 \$40
- Hospital (facility) copayment \$250
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
<b>In this example, Peg would pay:</b>	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments:</u>	
Initial Pregnancy Visit	\$40
Hospital Delivery	\$250
<u>Coinsurance</u>	\$0
<b>The total Peg would pay is</b>	<b>\$290</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
- Primary care copayment \$20
- Hospital (facility) copayment \$250
- Other copayment \$0

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$5,600</b>
<b>In this example, Joe would pay:</b>	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments:</u>	
Primary Care Visit	\$20
Inpatient Hospital Stay	\$250
<u>Coinsurance</u>	\$0
<b>The total Joe would pay is</b>	<b>\$270</b>

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

- The plan's overall deductible \$0
- Specialist copayment \$40
- Emergency Room (facility) copayment \$100
- Other copayment \$0

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic test (x-ray) in Emergency Room
- Specialist visit follow-up care

<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Mia would pay:</b>	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments:</u>	
Emergency Room Visit	\$100
Specialist Follow-Up Visit	\$40
<u>Coinsurance</u>	\$0
<b>The total Mia would pay is</b>	<b>\$140</b>

The plan would be responsible for the other costs of these EXAMPLE covered services.

### Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

### 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 1-877-858-6507.

- Albanian - Për shërbime përkthimi falas për ju, telefononi 1-877-858-6507.
- Amharic - የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-877-858-6507 ይደውሉ።
- Arabic - للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-877-858-6507
- Armenian - Անվճար լեզվակալան ծառայություններից օգտվելու համար զանգահարեք 1-877-858-6507 հեռախոսահամարով:
- Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-858-6507 tanpa dikenakan biaya.
- Bantu-Kirundi - Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-877-858-6507.
- Bengali-Bangala - আপনাকে বিনামূল্যে ভাষা পবিকষা পপকে হকয এই নম্বকি পেবযক ান েরন: 1-888-982-386।
- Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-877-858-6507.
- Burmese - သငှ်အေချဖှ်အခေဖှ်ကေးြ မေးရပဲ ဘာသာစကားဝနောဆှ်းရ်း ရ်းြ်းြ်း 1-877-858-6507 သိုှ် ဖှ်းြ်းြ်းြ်း
- Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-877-858-6507.
- Chamorro - Para un hago' i setbision lengguâhi ni dibåtde para hågu, ågang 1-877-858-6507.
- Cherokee - Ⴀႃ႗ႃ Ⴁႃ႗ႃ Ⴁႃ႗ႃ Ⴁႃ႗ႃ Ⴁႃ႗ႃ Ⴁႃ႗ႃ Ⴁႃ႗ႃ Ⴁႃ႗ႃ 1-877-858-6507.
- Chinese - 如欲使用免費語言服務，請致電 1-877-858-6507.
- Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-877-858-6507.
- Cushite - Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-877-858-6507.
- Dutch - Voor gratis toegang tot taaldiensten, bell 1-877-858-6507.
- French - Afin d'accéder aux services langagiers sans frais, composez le 1-877-858-6507.
- French Creole - Pou jwenn sèvis lang gratis, rele 1-877-858-6507.
- German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-877-858-6507 an.
- Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-877-858-6507.
- Gujarati - તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેવિઓની પહોર માટે, કોલ કરો1-877-858-6507.

- Hawaiian - No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-877-858-6507. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए,1-877-858-6507 पर कॉल करें।
- Hmong - Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-877-858-6507.
- Igbo - lji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-877-858-6507
- Ilocano - Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-877-858-6507.
- Indonesian - Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-877-858-6507.
- Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-877-858-6507.
- Japanese - 言語サービスを無料でご利用いただくには、1-877-858-6507 までお電話ください。
- Karen - လာတီကမ္ဘာ့ကိရိတ်အတီမတီအတီဖံးတီမတီလတ်လတ်အိတ်ဒီးအပူလတ်ကတီဟုတ်အီအဂီကတီနုတ် ကိး 1-877-858-6507 တကုတ်.
- Korean - 무료 언어 서비스를 이용하려면 1-877-858-6507 번으로 전화해 주십시오.
- Kru-Bassa - M̈ dyi wuḍu-dù kà kò ḍò bě dyi m̈oú n̈ ní Nídyi ní, níí, ḍá nòbà n̈ià ke: 1-877-858-6507
- Kurdish - 1-877-858-6507 بۆ دەسپێر اگه‌شتن به خزمەتگوزاری زمان بەبی تێچوون بۆ تۆ، په‌یومندی بکه به ژماره‌ی
- Laotian - ຕຳແໜ່ງໃຫ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໃບຫາເບີ1-888-982-3862
- Marathi - कोणत्याही शक्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-877-858-6507 वर फोन करा.
- Marshallese - Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-877-858-6507.
- Micronesian- Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-877-858-6507.
- Pohnpeyan -
- Mon-Khmer, Cambodian - ដើម្បីទទួលបានសេវាភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-888- 982-3862។
- Navajo - T'áá ni nizaad k'ehjí bee níká a'doowoł doo báąh ílínígóó kojí' hólne' 1-877-858-6507.
- Nepali - निःशुल्क भाषा सेवा प्राप्त गर्न 1-877-858-6507 मा टेलिफोन गर्नुहोस् ।
- Nilotic-Dinka - Të koor yin wəëř de thokic ke ciin wëu kər keek tənɔŋ yin. Ke cəl kɔc ye kɔc kuɔny ne nɔmba 1-877-858-6507.
- Norwegian - For tilgang til kostnadsfri språktjenester, ring 1-877-858-6507.
- Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-877-858-6507.
- Persian - برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-877-858-6507 تماس بگیرید .
- Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-877-858-6507.
- Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-877-858-6507.

