



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, please visit www.HealthReformPlanSBC.com or call 1-866-381-8933. 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 1-866-381-8933 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	For each Calendar Year, In- <u>network</u> : Individual \$2,500 / Family \$5,000; Out-of-network: Individual \$3,500 / Family \$7,000.	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 <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>?	For each Calendar Year, In- <u>network</u> : Individual \$6,550 / Family \$13,100; Out-of-network: There is no <u>out-of-pocket limit</u> .	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, penalties for failure to obtain <u>pre-authorization</u> for services & 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 <u>network provider</u>?	Yes. See www.aetna.com/docfind or call 1-866-381-8933 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 <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
		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>	50% <u>coinsurance</u>	————— None —————
	<u>Specialist</u> visit	30% <u>coinsurance</u>	50% <u>coinsurance</u>	————— None —————
	<u>Preventive care / screening / immunization</u>	No charge	No charge for 1st \$500 in services	Age and frequency schedules may apply. <u>Plan</u> pays up to \$500 for all eligible routine Services per calendar year then <u>coinsurance</u> applies for out of network.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	————— None —————
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Precertification required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aetnapharmacy.com/value Value <u>Formulary</u>	Preferred generic drugs	30% <u>coinsurance</u>	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Includes contraceptive drugs and devices obtainable from a pharmacy.
	Preferred brand drugs	30% <u>coinsurance</u>	Not covered	
	Non-preferred brand and non-preferred generic drugs	30% <u>coinsurance</u>	Not covered	Mandatory generics required. Precertification required. Step therapy required. Does not apply for anticonvulsant drugs.
	Specialty drugs	30% <u>coinsurance</u>	Not covered	Aetna Specialty CareRx SM - First Prescription must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy [®] . After 1st fill, subsequent fills must be through Aetna Specialty Pharmacy [®] .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	————— None —————
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	————— None —————
If you need immediate medical attention	<u>Emergency room care</u>	30% <u>coinsurance</u> plus \$150 copay	30% <u>coinsurance</u> plus \$150 copay	50% <u>coinsurance</u> for non-emergency use.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	————— None —————
	<u>Urgent care</u>	30% <u>coinsurance</u>	50% <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 have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	50% <u>coinsurance</u> after \$500 <u>copay</u> /stay after <u>deductible</u>	<u>Pre-authorization</u> required for out-of-network care.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	———— None ————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	———— None ————
	Inpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u> after \$500 <u>copay</u> /stay after <u>deductible</u>	<u>Pre-authorization</u> required for out-of-network care.
If you are pregnant	Office visits	No charge	50% <u>coinsurance</u>	———— None ————
	Childbirth/delivery professional services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Includes outpatient postnatal care.
	Childbirth/delivery facility services	30% <u>coinsurance</u>	50% <u>coinsurance</u> after \$500 <u>copay</u> /stay after <u>deductible</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage is limited to 120 visits/calendar year. <u>Pre-authorization</u> required for out-of-network care.
	<u>Rehabilitation services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage is limited to 60 visits/ <u>plan</u> year for Physical, Occupational, and Speech Therapy combined.
	<u>Habilitation services</u>	Not covered	Not covered	Not covered
	Skilled nursing care	30% <u>coinsurance</u>	50% <u>coinsurance</u> after \$500 <u>copay</u> /stay after <u>deductible</u>	Coverage is limited to 60 days/calendar year. <u>Pre-authorization</u> required for out-of-network care.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	———— None ————
	<u>Hospice services</u>	30% <u>coinsurance</u>	Inpatient: 50% <u>coinsurance</u> after \$500 <u>copay</u> per stay, after <u>deductible</u> ; Outpatient: 50% <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	———— None ————
	Children's glasses	Not covered	Not covered	———— 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)	
	Children's dental check-up	Not covered	Not covered	None

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.)

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|---|---|---|
| <ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental care (Adult & Child) • Glasses (Child) | <ul style="list-style-type: none"> • Habilitation services • Hearing aids • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Routine foot care • Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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| <ul style="list-style-type: none"> • Bariatric surgery - Coverage is limited to \$10,000 maximum per lifetime. • Chiropractic care | <ul style="list-style-type: none"> • Infertility treatment - Coverage is limited to the diagnosis and treatment of underlying medical condition. • Private-duty nursing - Coverage is limited to 70 eight-hour shifts per calendar year. | <ul style="list-style-type: none"> • |
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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 1-866-381-8933.
- 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 1-866-381-8933.

- 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** \$2,500
- **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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$0
Coinsurance	\$3,000

What isn't covered

Limits or exclusions	\$60
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The total Peg would pay is	\$5,560
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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** \$2,500
- **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	\$2,500
Copayments	\$0
Coinsurance	\$1,400

What isn't covered

Limits or exclusions	\$20
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The total Joe would pay is	\$3,920
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Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The **plan's overall deductible** \$2,500
- **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

What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is	\$1,900
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Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-381-8933.

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 on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com.

California HMO/HNO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY 711, Fax 860-262-7705, CRCoordinator@aetna.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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.

TTY: 711

Language Assistance:

For language assistance in your language call 1-866-381-8933 at no cost.

- Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-866-381-8933.
- Amharic - ለቋንቋ እገዛ በ አማርኛ በ 1-866-381-8933 በነጻ ይደውሉ
- Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-866-381-8933
- Armenian - Լեզվի ցուցաբերած աջակցություն (հայերեն) զանգի 1-866-381-8933 առանց գնով:
- Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-866-381-8933 tanpa dikenakan biaya.
- Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-866-381-8933 ku busa
- Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-866-381-8933 nga walay bayad.
- Catalan - Per rebre assistència en (català), truqui al número gratuït 1-866-381-8933.
- Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-866-381-8933 sin gåstu.
- Chinese - 欲取得繁體中文語言協助，請撥打1-866-381-8933，無需付費。
- Choctaw - (Chahta) anumpa ya apela a chi l_paya hinla 1-866-381-8933.
- Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-866-381-8933 irratti bilisaan bilbilaa.
- Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-866-381-8933.
- French - Pour une assistance linguistique en français appeler le 1-866-381-8933 sans frais.
- French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-866-381-8933 gratis.
- German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-866-381-8933 an.
- Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-866-381-8933 χωρίς χρέωση.

- Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-866-381-8933. Kāki 'ole 'ia kēia kōkua nei.
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-866-381-8933.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-866-381-8933 na akwughị ugwo ọ bụla
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-381-8933 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-866-381-8933.
- Japanese - 日本語で援助をご希望の方は、1-866-381-8933 まで無料でお電話ください。
- Karen - v>w>frRp>Rw>fuwdRusd.ft*D>f usd.f ud; 1-866-381-8933 v>wtd.f'D;w>fv>mfbl.fv>mfphRb.f
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-381-8933번으로 전화해 주십시오.
- Kru-Bassa - BÉ ò ké gbo-kpá-kpá dyé pídyi dé Bäsòò-wùdùün wěε, dǎ 1-866-381-8933
- Kurdish - برای راهنمایی به زبان فارسی با شماره 1-866-381-8933 به خورایی په یومندی بکمن.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-866-381-8933 ilo ejjelok wōnān.
- Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-381-8933 ni sohte isais.
- Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínizingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-381-8933
- Nilotic-Dinka - Tën kuɔny ë thok ë Thuɔnjän ɔl 1-866-381-8933 kec'in ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-866-381-8933 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਮਹਾਇਤਾ ਲਈ, 1-866-381-8933 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hilfe in Deutsch, ruf: 1-866-381-8933 aa. Es Aaruf koschtet nix.
- Persian - برای راهنمایی به زبان فارسی با شماره 1-866-381-8933 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
- Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-866-381-8933.

- Portuguese - Para obter assistência linguística em português ligue para o 1-866-381-8933 gratuitamente.
- Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-866-381-8933
- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-381-8933.
- Samoaan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-866-381-8933 e aunoa ma se totagi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-866-381-8933.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-866-381-8933.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-866-381-8933. Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-866-381-8933 bila malipo.
- Syriac - ٩٣٣-٣٨١-٨٦٦-١ 8933-381-866-1
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-381-8933 nang walang bayad.
- Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-866-381-8933 'o 'ikai hā tōtōngi.
- Trukese - Ren ánnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-866-381-8933 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödmeden 1-866-381-8933.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-866-381-8933.
- Urdu - 1-866-381-8933 پر کال کر کے اور اردو میں مدد حاصل کریں
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-866-381-8933.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-866-381-8933 פון אפצאל.
- Yoruba - Fún ìrànlowọ nípa èdè (Yorùbá) pe 1-866-381-8933 láí san owó kankan rárá.