



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:
<u>What is the overall deductible?</u>	In-Network Designated: Individual \$1,500 / Family \$3,000. Out-of-Network/Non-Designated: Individual \$3,000 / Family \$6,000.	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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<u>Are there services covered before you meet your deductible?</u>	Yes. <u>Prescription drugs</u> ; plus <u>in-network</u> office visits & <u>preventive care</u> are 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/
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	In-Network Designated: Individual \$4,500 / Family \$9,000. Out-of-Network/Non-Designated: Individual \$22,500 / Family \$45,000.	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.
<u>What is not included in the 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 pre-authorization for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<u>Will you pay less if you use a network provider?</u>	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of In-Network Designated providers.	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.
<u>Do you need a referral to see a 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 In-Network Designated Provider (You will pay the least)	Out-of-Network/Non-Designated Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	40% <u>coinsurance</u> , except no charge for immunizations up to age 5	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)	No charge for laboratory; 10% <u>coinsurance</u> for x-ray	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.aetnapharmacy.com/advancedcontrol	Preferred generic drugs	<u>Copay/prescription</u> , <u>deductible</u> doesn't apply: \$10 (retail), \$20 (mail order)	50% <u>coinsurance</u> after <u>copay/prescription</u> , <u>deductible</u> doesn't apply: \$10 (retail), \$20 (mail order)	Covers 34 day supply (retail), 35-101 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> . Review your <u>formulary</u> for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics.
	Preferred brand drugs	<u>Copay/prescription</u> , <u>deductible</u> doesn't apply: \$30 (retail), \$60 (mail order)	50% <u>coinsurance</u> after <u>copay/prescription</u> , <u>deductible</u> doesn't apply: \$30 (retail), \$60 (mail order)	

Common Medical Event	Services You May Need	In-Network Designated Provider (You will pay the least)	Out-of-Network/Non-Designated Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Non-preferred generic/brand drugs <u>Specialty drugs</u>	<u>Copay/prescription, deductible</u> doesn't apply: \$50 (retail), \$100 (mail order) Applicable cost as noted above for generic or brand drugs	50% <u>coinsurance</u> after <u>copay/prescription, deductible</u> doesn't apply: \$50 (retail), \$100 (mail order) Not covered	All prescriptions must be filled through the Aetna Specialty Pharmacy <u>Network</u> . Prescriptions for a specialty drug will need to be filled at a designated pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	10% <u>coinsurance</u> 10% <u>coinsurance</u>	40% <u>coinsurance</u> 40% <u>coinsurance</u>	None None
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u> after \$150 <u>copay/visit</u>	10% <u>coinsurance</u> after \$150 <u>copay/visit</u>	Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$40 <u>copay/visit</u> , <u>deductible</u> doesn't apply	10% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room) Physician/surgeon fees	10% <u>coinsurance</u> 10% <u>coinsurance</u>	40% <u>coinsurance</u> 40% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care. None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$40 <u>copay/visit</u> , <u>deductible</u> doesn't apply; other outpatient services: no charge	Office & other outpatient services: 40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Designated Provider (You will pay the least)	Out-of-Network/Non-Designated Provider (You will pay the most)	
If you are pregnant	Inpatient services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Office visits Childbirth/delivery professional services	No charge 10% <u>coinsurance</u>	40% <u>coinsurance</u> 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 \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery facility services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	60 visits/calender year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Rehabilitation services</u>	\$40 <u>copay/visit</u> , <u>deductible</u> doesn't apply	40% <u>coinsurance</u>	60 visits/calender year for Physical & Occupational Therapy combined.
	<u>Habilitation services</u>	No charge	40% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	30 days/calender year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$400 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	No charge	40% <u>coinsurance</u>	1 routine eye exam/12 months.
	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 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.)

- Acupuncture - 10 visits/calendar year for disease, injury & chronic pain.
- Chiropractic care
- Hearing aids - 1 hearing aid per ear/4 years for children up to age 18.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, including artificial insemination.
- Private-duty nursing - 70- 8 hour shifts/calendar year.
- Routine eye care (Adult) - 1 routine eye exam/12 months.

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.](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 <u>plan's overall deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$40
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	10%

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
---------------------------	-----------------

In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,470

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's overall deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$40
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	10%

This EXAMPLE event includes services like:

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

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,220

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's overall deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$40
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	10%

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
---------------------------	----------------

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,740

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

146209-369472-489001

Page 7 of 7

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.

English -	To access language services at no cost to you, call 1-800-370-4526.
Amharic -	የኢትዮጵያ አገልግሎቶችን የለከናፍ ለማግኘት፡ በ 1-800-370-4526 ይደውሉ::
Arabic -	للحصول على الخدمات اللغوية دون أي تكفة، الرجاء التصال على الرقم 1-800-370-4526.
Armenian -	Անվար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-800-370-4526 հեռախոսահամարով:
Carolinian (Kapasal Falawasch) -	ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-370-4526.
Chamorro -	Para un hago' i setbision lengguâhi ni dibâtde para hâgu, âgang 1-800-370-4526.
Chinese Traditional -	如欲使用免費語言服務，請致電 1-800-370-4526.
Cushitic-Oromo	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-800-370-4526.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-800-370-4526.
French Creole (Haitian)-	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 -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સે વિના ઓની પહોંચ માટે, કોલ કરો ર 1-800-370-4526.
Hindi -	आपकेलिए बिना कक्सी कीमत के भाषा 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.
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 -	လာတုကမ္မန်ကိုယ်အတူမှစာအတိုးတို့မှတ်ဖုန်လာတဲ့အိမ်ဒီးအပ္ပါယာကဘာ့ုံးအိုးဘုံးနှင့် ကို 1-800-370-4526 တကူး။
Korean -	무료 언어 서비스를 이용하려면 1-800-370-4526 번으로 전화해 주십시오.
Laotian -	ເຜົ່າອົດເຂົ້າໃຊ້ກໍານົບນີ້ກໍານົບນີ້ໄດ້ຢູ່ເນັດຕິກັນທີ່, ໃຫ້ໃຫ້ທາງເບີ 1-800-370-4526.
Mon-Khmer, Cambodian -	ເជີ່ມື້ງຂູ້ລົບດາວເສັກມູ້ກາສາເຈັບຕະຄິຕິກິ່ງສູ່ມາປ່າເມາດມູ້ກ ສູ່ມາເບົ່ງກູ້ຮັບສັງເກົ່າການໆເລີຍ 1-800-370-4526 ວ

Navajo -	T'áá ni nizaad k'ehjí bee níká a'doowoł doo báqh ílínígóó koji' hólne' 1-800-370-4526.
Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff 1-800-370-4526.
Persian-Farsi -	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 zadzwonić 1-800-370-4526.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para 1-800-370-4526.
Punjabi -	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-800-370-4526 'ਤੇ ਫੋਨ ਕਰੋ।
Russian -	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-800-370-4526.
Samoan -	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-800-370-4526.
Serbo-Croatian -	Za besplatne prevodilačke usluge pozovite 1-800-370-4526.
Spanish -	Para acceder a los servicios de idiomas sin costo, llame al 1-800-370-4526.
Syriac-Assyrian -	جَلْ بِلْجِيَّةَ حَلَقَنْتَهُوَ، مَنْجَهُوَ 1-800-370-4526.
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-800-370-4526.
Thai -	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-800-370-4526.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-800-370-4526.
Vietnamese -	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-800-370-4526.