



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 1-800-370-4526. 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?                             | In-Network: Individual \$1,000 / Family \$2,000.<br>Out-of-Network: Individual \$1,000 / Family \$2,000.                                 | 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. 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 <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 deductibles for specific services.  |
| What is the out-of-pocket limit for this plan?              | In-Network: Individual \$4,000 / Family \$8,000.<br>Out-of-Network: Individual \$4,000 / Family \$8,000.                                 | 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 & penalties for failure to obtain pre-authorization for services. | 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 <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-800-370-4526 for a list of in-network providers.     | This plan uses a provider network. You will pay less if you use a provider in the plan's network. 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  |
|---|---|--|---|---|
|   |   | In-Network Preferred 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        | \$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply  | 40% <u>coinsurance</u>                          | None  |
|   | <u>Specialist</u> visit                                 | \$50 <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>                          | 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. |
| <b>If you have a test</b>   | <u>Diagnostic test</u> (x-ray, blood work)              | No charge for laboratory; 30% <u>coinsurance</u> for x-ray | 40% <u>coinsurance</u>                          | None  |
|   | Imaging (CT/PET scans, MRIs)                            | 30% <u>coinsurance</u>                                     | 40% <u>coinsurance</u>                          | None  |
| <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                                     |   |
|   | Non-preferred brand drugs                               | 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> |   |  |   |   |
|   | Facility fee (e.g., ambulatory surgery center)          | 30% <u>coinsurance</u>                                     | 40% <u>coinsurance</u>                          | None  |

| Common Medical Event   | Services You May Need                     | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information   |
|--|---|---|--|--|
|  |   | In-Network Preferred Provider (You will pay the least)  | Out-of-Network Provider (You will pay the most)            |  |
| <b>If you have outpatient surgery</b>  | Physician/surgeon fees                    | 30% <u>coinsurance</u>  | 40% <u>coinsurance</u>                                     | None   |
| <b>If you need immediate medical attention</b>                                   | <u>Emergency room care</u>                | 30% <u>coinsurance</u>  | 30% <u>coinsurance</u>                                     | No coverage for non-emergency use.   |
|  | <u>Emergency medical transportation</u>   | \$100 <u>copay</u> /trip, <u>deductible</u> doesn't apply                                     | \$100 <u>copay</u> /trip, <u>deductible</u> doesn't apply  | Non-emergency transport: not covered, except if pre-authorized.  |
|  | <u>Urgent care</u>                        | \$75 <u>copay</u> /visit, <u>deductible</u> doesn't apply                                     | 40% <u>coinsurance</u>                                     | No coverage for non-urgent use.  |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)        | 30% <u>coinsurance</u>  | 40% <u>coinsurance</u>                                     | Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.   |
|  | Physician/surgeon fees                    | 30% <u>coinsurance</u>  | 40% <u>coinsurance</u>                                     | None   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | Office & other outpatient services: \$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply | Office & other outpatient services: 40% <u>coinsurance</u> | None   |
|  | Inpatient services                        | 30% <u>coinsurance</u>  | 40% <u>coinsurance</u>                                     | Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.   |
| <b>If you are pregnant</b>   | Office visits                             | No charge   | 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 professional services | 30% <u>coinsurance</u>  | 40% <u>coinsurance</u>                                     |  |
|  | Childbirth/delivery facility services     | 30% <u>coinsurance</u>  | 40% <u>coinsurance</u>                                     |  |
| <b>If you need help recovering or have other special health needs</b>            | <u>Home health care</u>                   | 30% <u>coinsurance</u>  | 40% <u>coinsurance</u>                                     | 90 visits/calendar year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.  |
|  | <u>Rehabilitation services</u>            | \$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply                                     | 40% <u>coinsurance</u>                                     | 30 visits/calendar year for Physical, Occupational & Speech Therapy combined.  |

| Common Medical Event                          | Services You May Need            | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information   |
|---|----------------------------------|---|---|--|
|   |                                  | In-Network Preferred Provider (You will pay the least)    | Out-of-Network Provider (You will pay the most) |  |
|   | <u>Habilitation services</u>     | \$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply | 40% <u>coinsurance</u>                          | None   |
|   | <u>Skilled nursing care</u>      | 30% <u>coinsurance</u>                                    | 40% <u>coinsurance</u>                          | 100 days/calendar year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care. |
|   | <u>Durable medical equipment</u> | 30% <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>          | 30% <u>coinsurance</u>                                    | 40% <u>coinsurance</u>                          | Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.                         |
| <b>If your child needs dental or eye care</b> | Children's eye exam              | No charge   | Not covered                                     | 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.)**

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

- Chiropractic care - 12 visits/calendar year.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Routine eye care (Adult) - 1 routine eye exam/12 months for in-network only.

### 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](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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number 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](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? 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 \$1,000
- Specialist copayment \$50
- 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$1,000        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$2,800        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$70           |
| <b>The total Peg would pay is</b> | <b>\$3,870</b> |

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

- The plan's overall deductible \$1,000
- Specialist copayment \$50
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$0            |
| <u>Copayments</u>                 | \$300          |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$4,300        |
| <b>The total Joe would pay is</b> | <b>\$4,600</b> |

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

- The plan's overall deductible \$1,000
- Specialist copayment \$50
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$1,000        |
| <u>Copayments</u>                 | \$400          |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$10           |
| <b>The total Mia would pay is</b> | <b>\$1,410</b> |

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 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, or disability.

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).

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