



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?	\$0. Out-of-Network: Individual \$1,250/ Family \$3000.	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> .
Are there services covered before you meet your deductible?	Yes. Emergency care only; All in-Network <u>preventive care</u> , inpatient hospital services, outpatient hospital services, prescription drugs and office visits 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/
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?	In-Network: Individual \$3,000 / Family \$5,000. Out-of-Network: Individual \$4,000 / Family \$7,000. Prescription drugs: Individual \$1,800 / Family \$3,600.	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> , balance-billing charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	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 www.aetna.com/docfind or call 1-800-370-4526 for a list of <u>in-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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit	20% <u>coinsurance</u> , <u>deductible applies</u>	Includes Internist, General Physician, Family Practitioner or Pediatrician.
If you visit a health care provider's office or clinic	<u>Specialist</u> visit	\$35 <u>copay</u> /visit	20% <u>coinsurance</u> , <u>deductible applies</u>	None
If you visit a health care provider's office or clinic	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	No charge	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> (blood work)	\$50 <u>copay</u> /visit; \$25 <u>copay</u> /visit for Independent lab	20% <u>coinsurance</u> , <u>deductible applies</u> ; 20% <u>coinsurance</u> for Independent lab, <u>deductible applies</u>	None
If you have a test	<u>Imaging</u> (X-ray)	\$50 <u>copay</u> /visit; \$25 <u>copay</u> /visit for Independent lab	20% <u>coinsurance</u> , <u>deductible applies</u> ; 20% <u>coinsurance</u> for Independent lab, <u>deductible applies</u>	None
If you have a test	<u>Complex Imaging</u> (CT/PET scans, MRIs)	\$75 <u>copay</u> /visit; \$50 <u>copay</u> /visit for freestanding facility	20% <u>coinsurance</u> , <u>deductible applies</u> ; 20% <u>coinsurance</u> for freestanding facility, <u>deductible applies</u>	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 drugs to treat your illness or condition	Drug Tier 1 - includes preferred generics and some lower-cost brand products	31 Day Retail: \$10 90 Day Mail Order \$20	Not covered	Covers 31 day supply (retail), 90 day supply (mail order – Birdirx.com, 1-888-240-2211 www.Birdirx.com)
<u>Prescription drug coverage is administered by Navitus 1-866-333-2757</u>	Drug Tier 2 – includes preferred brand products and some higher-cost non-preferred generics	31 Day Retail: \$35 90 Day Mail Order: \$70	Not covered	<ul style="list-style-type: none"> • Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. • Review formulary for \$0 co-pay covered products. • Prior Authorization may be required. Step therapy may be required • Mandatory generic when available.
More information about <u>prescription drug coverage</u> is available at www.Navitus.com	Drug Tier 3 - includes non-preferred products; may include some high-cost, non-preferred generics	31 Day Retail: \$50 90 Day Mail Order: \$100	Not covered	
	Drug Tier 4 – includes specialty products available at specialty pharmacies	31 Day Specialty: \$100	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$125 <u>copay</u> /visit	20% <u>coinsurance</u> , <u>deductible</u> applies	None
If you have outpatient surgery	Physician/surgeon fees	\$35 <u>copay</u> /visit	20% <u>coinsurance</u> , <u>deductible</u> applies	None
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay</u> /visit	\$150 <u>copay</u> /visit, <u>deductible</u> doesn't apply	20% <u>coinsurance</u> for non-emergency use, <u>deductible</u> applies
If you need immediate medical attention	<u>Emergency medical transportation</u>	\$50 <u>copay</u> /trip	\$50 <u>copay</u> /trip	Non-emergency transport: not covered, except 20% <u>coinsurance</u> if pre-authorized, <u>deductible</u> 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)	
If you need immediate medical attention	<u>Urgent care</u>	\$35 <u>copay</u> /visit,	\$35 <u>copay</u> /visit, <u>deductible</u> applies	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$300 <u>copay</u> /stay	20% <u>coinsurance</u> , <u>deductible</u> applies	Penalty of \$250 (or 50% of <u>allowed amount</u>) for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you have a hospital stay	Physician/surgeon fees	\$35 <u>copay</u> /visit	20% <u>coinsurance</u> , <u>deductible</u> applies	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> /visit (office), \$25 (other outpatient services)	Office & other outpatient services: 20% <u>coinsurance</u> , <u>deductible</u> applies	None
If you need mental health, behavioral health, or substance abuse services	Inpatient services	\$300 <u>copay</u> /stay	20% <u>coinsurance</u> , <u>deductible</u> applies	Penalty of \$250 (or 50% of <u>allowed amount</u>) for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge	20% <u>coinsurance</u> , <u>deductible</u> applies	<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 \$250 (or 50% of <u>allowed amount</u>) for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
If you are pregnant	Childbirth/delivery professional services	\$25 <u>copay</u> /pregnancy	20% <u>coinsurance</u> , <u>deductible</u> applies	<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 \$250 (or 50% of <u>allowed amount</u>) for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.

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 are pregnant	Childbirth/delivery facility services	\$300 <u>copay</u> /stay	20% <u>coinsurance</u> , <u>deductible</u> applies	<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 \$250 (or 50% of <u>allowed amount</u>) for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	20% <u>coinsurance</u> , <u>deductible</u> applies	200 visits/calendar year. Penalty of \$250 (or 50% of <u>allowed amount</u>) for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	\$35 <u>copay</u> /visit	20% <u>coinsurance</u> , <u>deductible</u> applies	None
If you need help recovering or have other special health needs	<u>Habilitation services</u>	\$25 <u>copay</u> /visit	20% <u>coinsurance</u> , <u>deductible</u> applies	Limited to treatment of Autism, Developmental Delay and Pervasive Developmental Disorders (PDD)
If you need help recovering or have other special health needs	<u>Skilled nursing care</u>	\$300 <u>copay</u> /stay	20% <u>coinsurance</u> , <u>deductible</u> applies	100 days/confinement. Penalty of \$250 (or 50% of <u>allowed amount</u>) for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you need help recovering or have other special health needs	<u>Durable medical equipment</u>	10% coinsurance, up to Max of \$125	20% <u>coinsurance</u> , <u>deductible</u> applies	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.

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>Hospice services</u>	\$300 <u>copay/stay</u> , <u>deductible</u> doesn't apply for inpatient; no charge for outpatient	<u>Deductible</u> applies: 20% <u>coinsurance</u> for inpatient; 20% <u>coinsurance</u> for outpatient	Penalty of \$250 (or 50% of <u>allowed amount</u>) 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	Not covered	Not covered	Not covered.
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Not covered.
If your child needs dental or eye care	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 (Adult & Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- 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 - Limited for in-network only
- Hearing aids - \$4,000 maximum every 3 years
- Infertility treatment - Cover 3 cycles of IVF/ART treatments used in the treatment of infertility and iatrogenic infertility; covers cryopreservation of eggs, embryos and sperm for members undergoing treatment that may impact fertility
- Private-duty nursing - Limited to \$400/day.
- Mental Health – Maternal Depression coverage under infant's plan
- Teladoc – Telemedicine service made available through Aetna for 24 hour, on-demand general medical, dermatology, and behavioral health. Standard \$10 co-pay

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:

- 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>
- Navitus directly by calling the toll free number on your Prescription ID card, or by calling the general toll free number at 1-866-333-2757.
- 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? 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 \$35
- Hospital (facility) copayment \$300
- 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
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$445
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$445

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 \$35
- Hospital (facility) copayment \$300
- Other copayment \$0

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$75
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$750

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

- The plan's overall deductible \$0
- Specialist copayment \$35
- Hospital (facility) copayment \$300
- 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
In this example, Mia would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$235
<u>Coinsurance</u>	\$125
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$360

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.

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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