



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, see www.HealthReformPlanSBC.com or call 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?	For each <u>plan</u> year, \$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?	Not applicable.	This <u>plan</u> does not have an overall <u>deductible</u> .
Are there other deductibles for specific services?	Yes. Individual \$75 / Family \$150 for dental coverage (waived if <u>in-network provider</u>). There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In- <u>Network</u> : Individual \$2,000 / Family \$4,000. Out-of- <u>Network</u> : Individual \$2,500 / Family \$5,000.	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.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, & 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 1-800-370-4526 for a list of <u>in-network providers</u> . Call 1-800-234-3375 for dental <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 <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
		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	50% <u>coinsurance</u>	70% <u>coinsurance</u>	None Chiropractic care is limited to \$800 / family per calendar year. Certain routine cancer screenings, flu shots, COVID-19 testing and vaccines, and well child immunizations are covered at 100%.
	<u>Specialist</u> visit	50% <u>coinsurance</u>	70% <u>coinsurance</u>	
	<u>Preventive care /screening /immunization</u>	50% <u>coinsurance</u>	70% <u>coinsurance</u>	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	50% <u>coinsurance</u>	70% <u>coinsurance</u>	<u>Preauthorization</u> required for certain procedures.
	Imaging (CT/PET scans, MRIs)	50% <u>coinsurance</u>	70% <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/standard	Generic drugs	50% <u>coinsurance</u> (retail & mail order)	50% <u>coinsurance</u> after <u>copay</u> /prescription: 50% (retail)	Covers 30 day supply (retail), 31-90 day supply (retail at Extended Day Supply <u>Network</u> Pharmacy & participating mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written; cost difference penalty doesn't apply to <u>out-of-pocket limit</u> . Review your Aetna Extended Day Supply <u>Network provider</u> directory for a list of <u>network providers</u> . Covers 30 day supply. All prescriptions must be filled through the Aetna Specialty Performance Pharmacy <u>Network</u> . Precertification required for coverage.
	Preferred brand drugs	50% <u>coinsurance</u> (retail & mail order)	50% <u>coinsurance</u> after <u>copay</u> /prescription: 50% (retail)	
	Non-preferred brand drugs	50% <u>coinsurance</u> (retail & mail order)	50% <u>coinsurance</u> after <u>copay</u> /prescription: 50% (retail)	
	<u>Specialty drugs</u>	Applicable cost as noted above for generic or brand drugs	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% <u>coinsurance</u>	70% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	Physician/surgeon fees	50% <u>coinsurance</u>	70% <u>coinsurance</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 immediate medical attention	<u>Emergency room care</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> .
	<u>Emergency medical transportation</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> .
	<u>Urgent care</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	50% <u>coinsurance</u>	70% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	Physician/surgeon fees	50% <u>coinsurance</u>	70% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 50% <u>coinsurance</u>	Office & other outpatient services: 70% <u>coinsurance</u>	<u>Preauthorization</u> required for certain services.
	Inpatient services	50% <u>coinsurance</u>	70% <u>coinsurance</u>	<u>Preauthorization</u> required for certain services.
If you are pregnant	Office visits	50% <u>coinsurance</u>	70% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). <u>Preauthorization</u> may be required for out-of- <u>network</u> services.
	Childbirth/delivery professional services	50% <u>coinsurance</u>	70% <u>coinsurance</u>	
	Childbirth/delivery facility services	50% <u>coinsurance</u>	70% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	50% <u>coinsurance</u>	70% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	<u>Rehabilitation services</u>	50% <u>coinsurance</u>	70% <u>coinsurance</u>	90 visits per calendar year for Speech Therapy.
	<u>Habilitation services</u>	50% <u>coinsurance</u>	70% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	50% <u>coinsurance</u>	70% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	70% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	50% <u>coinsurance</u>	70% <u>coinsurance</u>	<u>Preauthorization</u> is required.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limited to \$600 / participant every two calendar years.
	Children's glasses	No charge	No charge	
	Children's dental check-up	No charge	No charge	Limited to \$1,500 / individual per calendar year. Benefits provided by Delta Dental. You are responsible for charges above the reasonable and customary charge for a check-up by an <u>out-of-network</u> provider.

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
- Hearing aids (other than bone-anchored)
- 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.)

- Chiropractic care - \$800 per family/calendar year.
- Dental care (Delta Dental)
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Routine eye care
- Private-duty nursing

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>

- 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 coinsurance 50%
- Hospital (facility) coinsurance 50%
- Other coinsurance 50%

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:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,060

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 coinsurance 50%
- Hospital (facility) coinsurance 50%
- Other coinsurance 50%

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	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,020

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

- The plan's overall deductible \$0
- Specialist coinsurance 50%
- Hospital (facility) coinsurance 50%
- Other coinsurance 50%

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

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.

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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TTY: 711

Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

- Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.
- Amharic - ለቋንቋ እገዛ በ አማርኛ በ 1-800-370-4526 በነጻ ይደውሉ
- Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526
- Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-370-4526 առանց գնով:
- Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
- Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-800-370-4526 ku busa
- Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-370-4526-তে কল করুন।
- Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
- Burmese - ငွေတန်ကျပ်ခရေမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-370-4526 ကို ခေါ်ဆိုပါ။
- Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.
- Chamorro - Para ayuda gi fino' (Chamoru), ágang 1-800-370-4526 sin gástu.
- Cherokee - ᎠᎩᎠᎵ ᎠᎩᎠᎵ ᎠᎩᎠᎵ ᎠᎩᎠᎵ ᎠᎩᎠᎵ (GWY) ᎠᎩᎠᎵ 1-800-370-4526 ᎠᎩᎠᎵ ᎠᎩᎠᎵ ᎠᎩᎠᎵ ᎠᎩᎠᎵ ᎠᎩᎠᎵ.
- Chinese - 欲取得繁體中文語言協助，請撥打 1-800-370-4526，無需付費。
- Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-800-370-4526.
- Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.
- Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.
- French - Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.
- French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.
- German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.
- Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.
- Gujarati - ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-370-4526 પર કોલ કરો.
- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ‘ole ‘ia kēia kōkua nei.

- Hindi - **हन्दिी में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ्त कॉल करें।**
- Hmong - **Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.**
- Ibo - **Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwughị ugwo ọ bụla**
- Ilocano - **Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.**
- Italian - **Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.**
- Japanese - **日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。**
- Karen - **လၢတၢ်မၤစၢၤတၢ်ကလိၤကိၣ်အကိၣ် ကိၣ်ကိၣ် 1-800-370-4526 လၢတၢ်အိၣ်ဒီးတၢ်လၢတၢ်ဂ့ၣ်လၢတၢ်စ့ၣ်**
- Korean - **한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.**
- Kru-Bassa - **Be´m`ké gbo-kpá-kpá dyé pidyi dé Baśwó`wuḍuüñ wěe, dá 1-800-370-4526**
- Kurdish - **برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خۆرایی یه یۆمندی بکهن.**
- Laotian - **ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ.**
- Marathi - **कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-800-370-4526 वर फोन करा.**
- Marshallese - **Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.**
- Micronesian-Pohnpeyan - **Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.**
- Mon-Khmer, Cambodian - **សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ដោយឥតគិតថ្លៃ។**
- Navajo - **T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíik'e hólné' 1-800-370-4526**
- Nepali - **(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस् ।**
- Nilotic-Dinka - **Tën kucony ë thok ë Thuonjjanj col 1-800-370-4526 kecin ayöc.**
- Norwegian - **For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.**
- Panjabi - **ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਮਗਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।**
- Pennsylvania Dutch - **Fer Hilfe in Deutsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.**
- Persian - **برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 بدون هیچ هزینه ای تماس بگیرید. انگلیسی**
- Polish - **Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.**
- Portuguese - **Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.**
- Romanian - **Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-370-4526**
- Russian - **Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.**

