



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>?	<u>In-Network</u> : Individual \$2,000 / Family \$4,000. <u>Out-of-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>	Telemedicine visits with a Teladoc <u>provider</u> are covered at 100%.
	<u>Specialist</u> visit	50% <u>coinsurance</u>	70% <u>coinsurance</u>	Chiropractic care is limited to \$800 / family per calendar year. Telemedicine visits with a Teladoc <u>provider</u> are covered at 100%.
	<u>Preventive care</u> / <u>screening</u> /immunization	50% <u>coinsurance</u>	70% <u>coinsurance</u>	Certain routine cancer screenings, flu shots, COVID-19 testing and vaccines, and well child immunizations are covered at 100%.
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.
	<u>Imaging</u> (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 prescription drug coverage 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 Pharmacy</u> & 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> .
	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	Covers 30 day supply. All prescriptions must be filled through the Aetna Specialty Performance Pharmacy <u>Network</u> . Precertification required for coverage.
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-network emergency use paid the same as in-network. 70% <u>coinsurance</u> for non-emergency use out-of-network.
	<u>Emergency medical transportation</u>	50% <u>coinsurance</u>	50% <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>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	70% <u>coinsurance</u> for non-urgent use out-of-network.
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. Telemedicine visits with a Teladoc <u>provider</u> are covered at 100%.
	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-network 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	

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)	
	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 out-of-network 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
- Private-duty nursing
- Routine eye care - Limited to \$600 / participant every two calendar years

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>.

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

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.

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 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:	
<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

TTY: 711

- English -** To access language services at no cost to you, call 1-800-370-4526.
- Amharic -** የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-800-370-4526 ይደውሉ።.
- Arabic -** للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-800-370-4526.
- Armenian -** Անվճար լեզվական ծառայություններից օգտվելու համար գանգահարեք 1-800-370-4526 հեռախոսահամարով:
- Carolinian (Kapasal Falawasch) -** ngere aukke ghut allis reel kapasal Falawasch au fafaingi tilifon ye 1-800-370-4526.
- Chamorro -** Para un hago' i setbision lengguahi ni dibatde para hagu, afgang 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** Tajaajiloota afaanii garuu bilisaa ati argaachuuf, bilibili 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 વહીવટ માટે, કોલ કરો 1-800-370-4526.
- Hindi -** आपकेलिए बिना ककसी कीमत केभाषा 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 -** 1-800-370-4526
- Korean -** 무료 언어 서비스를 이용하려면 1-800-370-4526 번으로 전화해 주십시오.
- Laotian -** ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໃບຫາເບີ 1-800-370-4526.
- Mon-Khmer, Cambodian -** ដើម្បីទទួលបានសេវាកម្មភាសាដោយឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ។

