
 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, call Aetna at 1-855-695-3416. 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 1-855-695-3416 to request a copy. If there is a conflict between the SBC and the plan document, the plan document determines the benefits.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$4,500 single / \$9,000 family <u>in-network</u> . \$13,500 single / \$27,000 family <u>out-of-network</u> .	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> , the overall family <u>deductible</u> must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Yes. <u>Preventive care</u> services are covered before you meet your deductible.	This plan 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 preventive services 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 ?	\$6,650 single / \$13,300 family <u>in-network</u> . \$13,500 single / \$27,000 family <u>out-of-network</u> .	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> , <u>balance-billed charges</u> , and 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 network provider ?	Yes. See www.aetna.com or call 1-855-695-3416 for a list of participating <u>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
		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	30% Coinsurance After Deductible	50% Coinsurance After Deductible	Chiropractic care maximum of 20 visits; Walk in Retail Health Clinics have 30% Coinsurance After Deductible in-network and 50% Coinsurance After Deductible out-of-network; Tele-Health Services have 30% Coinsurance After Deductible in-network and N/A out-of-network.
	Specialist visit	30% Coinsurance After Deductible	50% Coinsurance After Deductible	None
	Preventive care/screening/immunization	No charge	50% Coinsurance After Deductible	None
If you have a test	Diagnostic test (x-ray, blood work)	30% Coinsurance After Deductible	50% Coinsurance After Deductible	None
	Imaging (CT/PET scans, MRIs)	30% Coinsurance After Deductible	50% Coinsurance After Deductible	Preauthorization is required or a \$300 penalty applies
If you need drugs to help manage or treat your illness or condition More information about prescription drug coverage is available at http://www.caremark.com or 844-232-2329	Generic drugs	Retail: 30% Coinsurance After Deductible (minimum \$4, maximum \$25) Mail: 30% Coinsurance After Deductible (minimum \$10, maximum \$60)	Reimbursement is based on network-negotiated price of medication. You pay the full amount in excess of network price.	Retail and Specialty Pharmacy: Up to 30-day supply. Mail Order or CVS Pharmacy Prescription Drugs: Up to 90-day supply. Maintenance drugs: After three retail fills, you will need to fill a 90-day supply through CVS Caremark mail order, or at a CVS retail pharmacy; otherwise you will pay the full negotiated price of the prescription. Certain preventive drugs not subject to the deductible.
	Preferred brand drugs	Retail: 30% Coinsurance After Deductible (minimum \$25, maximum \$70) Mail: 30% Coinsurance After Deductible (minimum \$60, maximum \$175)		
	Non-preferred brand drugs	Retail: 30% Coinsurance After Deductible (minimum \$40, maximum \$100) Mail:		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		30% <u>Coinsurance</u> After <u>Deductible</u> (minimum \$100, maximum \$250)		
	Specialty drugs	Same as Retail <u>copayment</u> for Generic and Brand drugs above		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>Coinsurance</u> After <u>Deductible</u>	50% <u>Coinsurance</u> After <u>Deductible</u>	<u>Preauthorization</u> is required or a \$300 penalty applies
	Physician/surgeon fees	30% <u>Coinsurance</u> After <u>Deductible</u>	50% <u>Coinsurance</u> After <u>Deductible</u>	<u>Preauthorization</u> is required or a \$300 penalty applies
If you need immediate medical attention	Emergency room care	30% <u>Coinsurance</u> After <u>Deductible</u>	30% <u>Coinsurance</u> After <u>Deductible</u>	None
	Emergency medical transportation	30% <u>Coinsurance</u> After <u>Deductible</u>	30% <u>Coinsurance</u> After <u>Deductible</u>	None
	Urgent care	30% <u>Coinsurance</u> After <u>Deductible</u>	50% <u>Coinsurance</u> After <u>Deductible</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>Coinsurance</u> After <u>Deductible</u>	50% <u>Coinsurance</u> After <u>Deductible</u>	<u>Preauthorization</u> is required or a \$300 penalty applies
	Physician/surgeon fees	30% <u>Coinsurance</u> After <u>Deductible</u>	50% <u>Coinsurance</u> After <u>Deductible</u>	<u>Preauthorization</u> is required or a \$300 penalty applies
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% <u>Coinsurance</u> After <u>Deductible</u>	50% <u>Coinsurance</u> After <u>Deductible</u>	None
	Inpatient services	30% <u>Coinsurance</u> After <u>Deductible</u>	50% <u>Coinsurance</u> After <u>Deductible</u>	<u>Preauthorization</u> is required or a \$300 penalty applies
If you are pregnant	Office visits	100% coverage for pre-natal care, then 30% <u>Coinsurance</u> After <u>Deductible</u> for post-natal care	50% <u>Coinsurance</u> After <u>Deductible</u>	Cost sharing does not apply for <u>preventive</u> services. Depending on the type of services, <u>coinsurance</u> , <u>copayment</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) <u>Preauthorization</u> is required for childbirth/delivery or a \$300 penalty applies.
	Childbirth/delivery professional services	30% <u>Coinsurance</u> After <u>Deductible</u>	50% <u>Coinsurance</u> After <u>Deductible</u>	
	Childbirth/delivery facility services	30% <u>Coinsurance</u> After <u>Deductible</u>	50% <u>Coinsurance</u> After <u>Deductible</u>	
If you need help	Home health care	30% <u>Coinsurance</u> After	50% <u>Coinsurance</u> After	Up to 120 visits per calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
recovering or have other special health needs		<u>Deductible</u>	<u>Deductible</u>	<u>Preauthorization</u> is required or a \$300 penalty applies
	Rehabilitation services	30% <u>Coinsurance</u> After <u>Deductible</u>	50% <u>Coinsurance</u> After <u>Deductible</u>	Covered as medically necessary; 60 visit annual limit for occupation and physical therapy combined; 25 annual visit limit for speech therapy
	Habilitation services	30% <u>Coinsurance</u> After <u>Deductible</u>	50% <u>Coinsurance</u> After <u>Deductible</u>	Subject to carrier guidelines
	Skilled nursing care	30% <u>Coinsurance</u> After <u>Deductible</u>	50% <u>Coinsurance</u> After <u>Deductible</u>	Up to 100 days per calendar year. <u>Preauthorization</u> is required or a \$300 penalty applies
	Durable medical equipment	30% <u>Coinsurance</u> After <u>Deductible</u>	50% <u>Coinsurance</u> After <u>Deductible</u>	<u>Preauthorization</u> is required or a \$300 penalty applies
	Hospice services	30% <u>Coinsurance</u> After <u>Deductible</u>	50% <u>Coinsurance</u> After <u>Deductible</u>	<u>Preauthorization</u> is required or a \$300 penalty may apply
If your child needs dental or eye care	Children's eye exam	No charge	50% <u>Coinsurance</u> After <u>Deductible</u>	Routine eye exam is a covered benefit if performed by a licensed Ophthalmologist.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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](#).)

- Children's eye glasses and dental check-ups
- Cosmetic surgery - unless clinically eligible
- Dental care (Child and Adult) - unless due to treatment related to accidental injury within 12 months of an accident
- 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
- Bariatric surgery
- Chiropractic care – up to 20 visits per calendar year
- Habilitation Services, subject to carrier guidelines
- Hearing Aids, up to \$1,000 lifetime
- Infertility treatment, up to \$5,000 lifetime maximum (\$2,500 for medical services and \$2,500 for prescriptions)
- Private-duty nursing (if medically necessary)
- Routine eye care (Adult)

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 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 at 1-855-695-3416 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the 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](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 888-772-6372.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-772-6372.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码888-772-6372.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 888-772-6372.

————— *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	\$4,500
■ Specialist coinsurance	30%
■ 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*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$4,500
Copayments	\$0
Coinsurance	\$2,150
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$6,710

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$4,500
■ Specialist coinsurance	30%
■ 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*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$4,500
Copayments	\$0
Coinsurance	\$749
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$5,304

Mia's Simple Fracture

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

■ The plan's overall deductible	\$4,500
■ Specialist coinsurance	30%
■ 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*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.