




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 1-800-974-2873 or see [www.aetna.com](http://www.aetna.com). 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 [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-800-974-2873 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>In-Network providers</u> : \$300/individual or \$750/family <u>Out-of-Network providers</u> : \$1,250/individual or \$3,125/family	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 <u>deductible</u> ?	Yes. <u>Preventive care</u> , <u>In-Network</u> office visits, diagnostic tests, imaging, urgent care, home health care and outpatient rehabilitation services 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <u>deductibles</u> for specific services?	Yes. \$50/individual for <u>prescription drugs</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 providers</u> : \$2,750/individual or \$5,500/family Prescription drugs (In-Network): \$750/individual or \$1,500/family <u>Out-of-Network providers</u> : \$20,000/individual or \$50,000/family	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, penalties for failure to obtain <u>pre-authorization</u> for service and health care this <u>Plan</u> does not 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 <a href="http://www.aetna.com">www.aetna.com</a> 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 <u>referral</u> to see a <u>specialist</u> ?	No.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$35 <u>copay</u> /visit	\$35 <u>copay</u> /visit, then 40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit	\$50 <u>copay</u> /visit, then 40% <u>coinsurance</u>	None
	Other practitioner office visit	Acupuncture and chiropractic care: \$35 <u>copay</u> /visit	Acupuncture and chiropractic care: \$35 <u>copay</u> /visit, then 40% <u>coinsurance</u>	Acupuncture limited to 20 visits per calendar year.
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	Age and frequency limits apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	\$50 <u>copay</u>	40% <u>coinsurance</u>	None
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	Retail (30 days): \$5 <u>copay</u> /script Mail Order (90 days): \$10 <u>copay</u> /script	Not covered	ACA preventive medications, including certain over the counter drugs with a prescription, are available at no charge. No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate).
	Preferred brand drugs	Retail (30 days): \$40 <u>copay</u> /script Mail Order (90 days): \$80 <u>copay</u> /script	Not covered	
	Non-preferred brand drugs	Retail (30 days): \$55 <u>copay</u> /script Mail Order (90 days): \$100 <u>copay</u> /script	Not covered	

\* For more information about limitations and exceptions, see the plan or policy document at 1-800-974-2873.

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)	
	<u>Specialty drugs</u>	Applicable <u>copay</u> above	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Failure to pre-certify <u>out-of-network</u> services will result in a 50% reduction of benefits.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> /visit, then 20% <u>coinsurance</u>	\$200 <u>copay</u> /visit, then 20% <u>coinsurance</u>	<u>Copay</u> waived if admitted to the hospital.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Non-emergency use of <u>emergency medical transportation</u> not covered.
	<u>Urgent care</u>	\$35 <u>copay</u> /visit	\$35 <u>copay</u> /visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <u>copay</u> /visit, then 20% <u>coinsurance</u>	\$250 <u>copay</u> /visit, then 40% <u>coinsurance</u>	Failure to pre-certify <u>out-of network</u> services will result in a 50% reduction of benefits.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: \$35 <u>copay</u> /visit Other outpatient services: No charge	Office visit: \$35 <u>copay</u> /visit, then 40% <u>coinsurance</u> Other outpatient services: 40% <u>coinsurance</u>	Failure to pre-certify <u>out-of network</u> intensive outpatient and partial <u>hospitalization</u> services will result in a 50% reduction of benefits.
	Inpatient services	\$250 <u>copay</u> /visit, then 20% <u>coinsurance</u>	\$250 <u>copay</u> /visit, then 40% <u>coinsurance</u>	Failure to pre-certify <u>out-of network</u> services will result in a 50% reduction of benefits.
If you are pregnant	Office visits	No charge	40% <u>coinsurance</u>	None
	Childbirth/delivery professional services	No charge	40% <u>coinsurance</u>	Pre-certification required for <u>out-of-Network</u> stays that last longer than 48 hours for

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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)	
	Childbirth/delivery facility services	\$250 <u>copay</u> /visit, then 20% <u>coinsurance</u>	\$250 <u>copay</u> /visit, then 40% <u>coinsurance</u>	vaginal delivery or 96 hours for delivery by Cesarean section. Failure to pre-certify extended out-of- <u>Network</u> stays will result in a 50% reduction of benefits.
If you need help recovering or have other special health needs	<u>Home health care</u>	\$50 <u>copay</u> /visit, then 20% <u>coinsurance</u>	\$50 <u>copay</u> /visit, then 25% <u>coinsurance</u>	Limited to 120 visits per calendar year. Failure to pre-certify <u>out-of network</u> services will result in a 50% reduction of benefits.
	<u>Rehabilitation services</u>	Outpatient: \$35 <u>copay</u> /visit	Outpatient: \$35 <u>copay</u> /visit, then 40% <u>coinsurance</u>	Occupational, physical and speech therapies combined limited to 60 visits per calendar year.
	<u>Habilitation services</u>	Not covered	Not covered	You must pay 100% of these expenses, even <u>In-Network</u> .
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 60 days per calendar year. Failure to pre-certify <u>out-of network</u> services will result in a 50% reduction of benefits.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	None
	<u>Hospice services</u>	Inpatient: 20% <u>coinsurance</u> Outpatient: \$50 <u>copay</u> /visit, then 25% <u>coinsurance</u>	Inpatient: 40% <u>coinsurance</u> Outpatient: \$50 <u>copay</u> /visit, then 25% <u>coinsurance</u>	Failure to pre-certify out-of <u>network</u> services will result in a 50% reduction of benefits.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of these expenses, even <u>In-Network</u>
	Children's glasses	Not covered	Not covered	You must pay 100% of these expenses, even <u>In-Network</u>
	Children's dental check-up	Not covered	Not covered	You must pay 100% of these expenses, even <u>In-Network</u>

\* For more information about limitations and exceptions, see the plan or policy document at 1-800-974-2873.

### 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.)

- |                                |  |  |
|--------------------------------|--|--|
| • Cosmetic surgery             | • Hearing aids                                       | • Routine eye care (Adult)   |
| • Dental Care (Adult) (Child)  | • Long-term care                                     | • Routine foot care  |
| • Eye exam and Glasses (Child) | • Non-emergency care when traveling outside the U.S. | • Weight loss programs (except as required by the Affordable Care Act) |
| • <u>Habilitation services</u> | • Private-duty nursing                               |  |

#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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|--|---------------------|-------------------------|
| • Acupuncture (Limited to 20 visits/calendar year) | • Bariatric surgery | • Infertility treatment |
|  | • Chiropractic care |                         |

**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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](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, this notice or assistance, contact: Aetna at 1-800-974-2873. You may also 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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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 1-800-974-2873.

-----*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 \$300
- Specialist Co-payment \$50
- Hospital (facility) cost sharing \$250
- 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$340
<u>Copayments</u>	\$500
Coinsurance	\$750
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,650</b>

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

- The plan's overall deductible \$300
- Specialist Co-payment \$50
- Hospital (facility) cost sharing \$250
- Other copayment \$0

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>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$160
<u>Copayments</u>	\$1,520
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,740</b>

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

- The plan's overall deductible \$300
- Specialist Co-payment \$50
- Hospital (facility) cost sharing \$250
- 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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
<u>Copayments</u>	\$520
Coinsurance	\$230
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$750</b>