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 1-888-982-3862. 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 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: Individual $4,000 / Family $8,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network office visits, generic prescription & preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. 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 deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual $4,000 / Family $8,000.	The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out–of–pocket limits until the overall family out–of–pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-888-982-3862 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 copay/visit, deductible doesn't apply	Not covered	None
	Specialist visit	$50 copay/visit, deductible doesn't apply	Not covered	None
	Preventive care /screening /immunization	No charge	Not covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetna.com/pharmacy-insurance/individuals-families	Generic drugs	Retail: $10 copayment; no deductible Mail Order: $25; no deductible	Reimbursement based on network-negotiated price of medication, minus applicable copayment. You pay excess over reimbursement.	• Retail: Up to a 30 day supply. • Mail-Order: Up to a 90 day supply. • If you purchase a brand drug (preferred or non-preferred) when a generic is available, you will pay the generic copay plus the cost difference between the brand and generic medication. The difference will not count towards your out-of-pocket limit and will apply after deductible/out-of-pocket limit is reached. • Some drugs are subject to preauthorization rules. • Long term (maintenance) drugs are subject to higher member cost-share if purchased at retail instead of mail Certain preventive medications covered at $0 copay.
	Preferred brand drugs	0% coinsurance after deductible		
	Non-preferred brand drugs	0% coinsurance after deductible		
	Specialty drugs	Generally only covered under the Specialty Care Pharmacy program.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not covered	None
	Physician/surgeon fees	0% coinsurance	Not covered	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	Emergency room care	0% coinsurance	0% coinsurance	None
	Emergency medical transportation	0% coinsurance	0% coinsurance	Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	$50 copay/visit, deductible doesn't apply	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	None
	Physician/surgeon fees	0% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: $25 copay/visit, deductible doesn't apply	Not covered	None
	Inpatient services	0% coinsurance	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	0% coinsurance	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	0% coinsurance	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not covered	120 visits/calendar year.
	Rehabilitation services	0% coinsurance	Not covered	Medical review required after 25 visits
	Habilitation services	0% coinsurance	Not covered	Medical review required after 25 visits
	Skilled nursing care	0% coinsurance	Not covered	60 days/calendar year.
	Durable medical equipment	0% coinsurance	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	0% coinsurance	Not covered	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 your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	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.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (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.)

- Acupuncture - 20 visits/calendar year.
- Bariatric surgery
- Chiropractic care - $2,500 maximum/calendar year.
- Hearing aids - $1,000 maximum/36 months.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. Artificial insemination & ovulation induction: 6 attempts/lifetime. Advanced reproductive technology: 3 attempts/lifetime.
- Private-duty nursing - 70- 8 hour shifts/calendar year.

Your Rights to Continue Coverage: For more information on your rights to continue coverage, contact the plan at 1-888-982-3862. 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 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 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 1-888-982-3862.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform

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.

Language Access Services:
TTY: 711
For language assistance in your language call 1-888-982-3862 at no cost.

Albanian	Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.
Amharic	ለቋንቋ እገዛ በ አማርኛ በ 1-888-982-3862 በነጻ ይደውሉ
Arabic	1-888-982-3862 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني
Armenian	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով:
Bahasa Indonesia	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya
Bantu-Kirundi	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-982-3862 ku busa
Bengali-Bangala	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-888-982-3862-তে কল করুন।
Bisayan-Visayan	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
Burmese	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 ကို ခေါ်ဆိုပါ။
Catalan	Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862
Chamorro	Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gåstu.
Cherokee	ᎾᏍᎩᎾ ᏕᏯᏂᎯᏍᏗ ᏗᏂᏍᏕᏲᏍᎩ ᎾᏍᎦᎢ (ᏣᎳᎩ) ᎾᏓᎳᏅᎯᏕ 1-888-982-3862 ᎤᎾᎢ Ꮭ ᎪᎱᏍᏗ ᏧᎬᏩᎶᏗ ᏂᏢᎡᎾ.
Chinese	欲取得繁體中文語言協助，請撥打1-888-982-3862，無需付費。
Choctaw	(Chahta) anumpa ya apela a chi I paya hinla 1-888-982-3862.
Cushite	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.
Dutch	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.
French	Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.
French Creole	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.
German	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.
Greek	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.

Gujarati	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-982-3862 પર કૉલ કરો.
Hawaiian	No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi	हिन्दी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।
Hmong	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.
Ibo	Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwụghị ụgwọ ọ bụla
Ilocano	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.
Italian	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.
Japanese	日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。
Karen	လာတၢ်မၤစၢၤတၢ်ကတိၤကျိာ်အဂီၢ် ကျိာ် ကိး 1-888-982-3862 လာတအိဉ်ဒီးတၢ်လာဝ်ဘျဉ်လာဝ်စုဘဉ်
Korean	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.
Kru-Bassa	Bɛ´m`ké gbo-kpá-kpá dyé pidyi dé Baŝɔɔ̀-wuḍuùn wɛ̃ɛ, dá 1-888-982-3862
Kurdish	برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 به خۆرایی پەیوەندی بکەن.
Laotian	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-888-982-3862 वर फोन करा.
Marshallese	Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.
Micronesian Pohnpeyan	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.
Mon-Khmer Cambodian	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ដោយឥតគិតថ្លៃ។
Navajo	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862
Nepali	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस् ।
Nilotic-Dinka	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-888-982-3862 kecïn aɣöc.
Norwegian	For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
Panjabi	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch	Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.
Persian	برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.

Portuguese	Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.
Romanian	Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-888-982-3862
Russian	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862.
Samoan	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totogi.
Serbo-Croatian	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-982-3862.
Spanish	Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862.
Sudanic-Fulfude	Fii yo on heƃu balal e ko yowitii e haala Pular noddee e oo numero ƈoo 1-888-982-3862. Njodi woo fawaaki on.
Swahili	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo.
Syriac	1-888-982-3862
Tagalog	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad
Telugu	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-888-982-3862 కు కాల్ చేయండి. (తెలుగు)
Thai	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย
Tongan	Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-888-982-3862 ‘o ‘ikai hā ōtōngi.
Trukese	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk.
Turkish	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862.
Ukrainian	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.
Urdu	بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے، 1-888-982-3862 پر بات کریں۔
Vietnamese	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-982-3862
Yiddish	פריי פון אפצאל. 1-888-982-3862 פאר שפראך הילף אין אידיש רופט
Yoruba	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá.

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** **$4,000**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **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:

Cost Sharing	
Deductibles	$4,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

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

- **The plan's overall deductible** **$4,000**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$420**

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

- **The plan's overall deductible** **$4,000**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Emergency room care office visits *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,300
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,400**

The plan would be responsible for the other costs of these EXAMPLE covered services.