



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 1-877-292-2480. 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 1-877-292-2480 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>Network</u> : Individual \$100 / Family \$300. <u>Out-of-Network</u> : Individual \$450 / Family \$1,350.	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 deductible?	Yes. Emergency care & inpatient hospital services; plus in- <u>network</u> office visits, <u>prescription drugs</u> & <u>preventive care</u> 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 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?	<u>Network</u> : Individual \$2,100 / Family \$4,300. <u>Out-of-Network</u> : Individual \$3,450 / Family \$7,350. <u>Prescription drugs</u> : Individual \$1,200 / Family \$3,600.	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-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 network provider?	Yes. See www.aetna.com/docfind or call 1-877-292-2480 for a list of Aexcel designated providers.	You pay the least if you use a provider in Aexcel designated. You pay more if you use a <u>provider</u> in In- <u>Network</u> or Non-Designated. 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</u> charge 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
		Aexcel Designated Provider (You will pay the least)	In-Network Provider (You will pay more)	Aexcel Non-Designated Provider (You will pay more)	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	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> / immunization	No charge	No charge	No charge	Not covered, except 40% <u>coinsurance</u> for mammograms & gynecological exams	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Not applicable	10% <u>coinsurance</u>	Not applicable	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	Not applicable	10% <u>coinsurance</u>	Not applicable	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions & Other Important Information
		Aexcel Designated Provider (You will pay the least)	In-Network Provider (You will pay more)	Aexcel Non-Designated Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aetnapharmacy.com/premierplus Premier Plus Formulary	Generic drugs	Not applicable	30% <u>coinsurance</u> /prescription with: \$10 min & \$100 max (retail), \$20 min & \$200 max (mail order)	Not applicable	Not covered	Covers 31 day supply (retail), 32-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> .
	Preferred brand drugs	Not applicable	40% <u>coinsurance</u> /prescription with: \$10 min & \$100 max (retail), \$20 min & \$200 max (mail order)	Not applicable	Not covered	
	Non-preferred brand drugs	Not applicable	40% <u>coinsurance</u> /prescription with: \$10 min & \$100 max (retail), \$20 min & \$200 max (mail order)	Not applicable	Not covered	
	<u>Specialty drugs</u>	Not applicable	Applicable cost as noted above for generic or brand drugs	Not applicable	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not applicable	10% <u>coinsurance</u>	Not applicable	40% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	Not applicable	10% <u>coinsurance</u> after \$150 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not applicable	10% <u>coinsurance</u> after \$150 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u> after \$150 <u>copay</u> /visit for non-emergency use, <u>deductible</u> doesn't apply.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions & Other Important Information
		Aexcel Designated Provider (You will pay the least)	In-Network Provider (You will pay more)	Aexcel Non-Designated Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	<u>Emergency medical transportation</u>	Not applicable	10% <u>coinsurance</u>	Not applicable	10% <u>coinsurance</u>	<u>Pre-authorization</u> required for non-emergency use.
	<u>Urgent care</u>	Not applicable	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not applicable	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Not applicable	10% <u>coinsurance</u> after \$200 <u>copay</u> /stay, <u>deductible</u> doesn't apply	Not applicable	40% <u>coinsurance</u> after \$200 <u>copay</u> /stay, <u>deductible</u> doesn't apply	<u>Pre-authorization</u> required for out-of-network care.
	Physician/surgeon fees	10% <u>coinsurance</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not applicable	Office & other outpatient services: \$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not applicable	Office & other outpatient services: 40% <u>coinsurance</u>	None
	Inpatient services	Not applicable	10% <u>coinsurance</u> after \$200 <u>copay</u> /stay, <u>deductible</u> doesn't apply	Not applicable	40% <u>coinsurance</u> after \$200 <u>copay</u> /stay, <u>deductible</u> doesn't apply	<u>Pre-authorization</u> required for out-of-network care.
If you are pregnant	Office visits	Not applicable	No charge	Not applicable	40% <u>coinsurance</u>	<u>Cost sharing</u> doesn't apply to certain <u>preventive services</u> . Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Not applicable	10% <u>coinsurance</u> , <u>deductible</u> doesn't apply	Not applicable	40% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions & Other Important Information
		Aexcel Designated Provider (You will pay the least)	In-Network Provider (You will pay more)	Aexcel Non-Designated Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	Not applicable	10% <u>coinsurance</u> after \$200 <u>copay/stay</u> , <u>deductible</u> doesn't apply, <u>copay</u> waived for newborn hospital expenses	Not applicable	40% <u>coinsurance</u> after \$200 <u>copay/stay</u> , <u>deductible</u> doesn't apply, <u>copay</u> waived for newborn hospital expenses	
If you need help recovering or have other special health needs	<u>Home health care</u>	Not applicable	10% <u>coinsurance</u>	Not applicable	40% <u>coinsurance</u>	130 visits/calendar year. <u>Pre-authorization</u> required for out-of-network care.
	<u>Rehabilitation services</u>	Not applicable	\$15 <u>copay/visit</u> , <u>deductible</u> doesn't apply	Not applicable	40% <u>coinsurance</u>	None
	<u>Habilitation services</u>	Not applicable	\$15 <u>copay/visit</u> , <u>deductible</u> doesn't apply	Not applicable	40% <u>coinsurance</u>	Limited to treatment of developmental delays.
	<u>Skilled nursing care</u>	Not applicable	10% <u>coinsurance</u> after \$200 <u>copay/stay</u> , <u>deductible</u> doesn't apply	Not applicable	40% <u>coinsurance</u> after \$200 <u>copay/stay</u> , <u>deductible</u> doesn't apply	120 days/calendar year. <u>Pre-authorization</u> required for out-of-network care.
	<u>Durable medical equipment</u>	Not applicable	10% <u>coinsurance</u>	Not applicable	40% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	Not applicable	10% <u>coinsurance</u>	Not applicable	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	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.)

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|--|---|---|
| <ul style="list-style-type: none">• Cosmetic surgery• Dental care (Adult & Child)• Glasses (Child) | <ul style="list-style-type: none">• Long-term care• Routine eye care (Adult & Child)• Routine foot care | <ul style="list-style-type: none">• Weight loss programs - Except for required preventive services. |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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| <ul style="list-style-type: none">• Acupuncture• Bariatric surgery - Limited to Institutes of Quality contracted facility only months.• Chiropractic care - 20 visits/calendar year. | <ul style="list-style-type: none">• Hearing aids - 1 hearing aid to \$1,000 maximum per ear/36• Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.• Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none">• Private-duty nursing |
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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 1-877-292-2480.
- 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 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 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 1-877-292-2480.
- 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 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.

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 Minimum Value Standard? 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** \$100
- **Specialist copayment** \$15
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

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:

Cost Sharing

Deductibles	\$100
Copayments	\$60
Coinsurance	\$1,200

What isn't covered

Limits or exclusions	\$60
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The total Peg would pay is	\$1,420
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Managing Joe's type 2 Diabetes

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

- The **plan's overall deductible** \$100
- **Specialist copayment** \$15
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

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:

Cost Sharing

Deductibles	\$100
Copayments	\$900
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$20
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The total Joe would pay is	\$1,020
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Mia's Simple Fracture

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

- The **plan's overall deductible** \$100
- **Specialist copayment** \$15
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

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:

Cost Sharing

Deductibles	\$100
Copayments	\$80
Coinsurance	\$100

What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is	\$280
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Note: If your **plan** has a wellness program and you choose to participate, you may be able to reduce your costs.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-877-292-2480.

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 discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides 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 1-877-292-2480.

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: PO Box 24030, Fresno, CA 93779)

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705)

Email: 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).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

Language Assistance:

For language assistance in your language call 1-877-292-2480 at no cost.

- Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-877-292-2480.
- Amharic - ለቋንቋ እገዛ በ አማርኛ በ 1-877-292-2480 በነጻ ይደውሉ
- Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-877-292-2480
- Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-877-292-2480 առանց գնով:
- Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-292-2480 tanpa dikenakan biaya.
- Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-877-292-2480 ku busa
- Bengali-Bangala - ১-৮৭৭-২৯২-২৪৮০-এ (বাংলায়) ১-৮৭৭-২৯২-২৪৮০-এ (বাংলায়) ১-৮৭৭-২৯২-২৪৮০-এ
- Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-877-292-2480 nga walay bayad.
- Burmese - ၁-၈၇၇-၂၉၂-၂၄၈၀ (မြန်မာ) ၁-၈၇၇-၂၉၂-၂၄၈၀ (မြန်မာ) ၁-၈၇၇-၂၉၂-၂၄၈၀
- Catalan -Per rebre assistència en (català), truqui al número gratuït 1-877-292-2480
- Chamorro - Para ayuda gi fino' (Chamoru), âgang 1-877-292-2480 sin gâstu.
- Cherokee - ᏍᏏᏉ ᏍᏏᏉ ᏍᏏᏉ ᏍᏏᏉ (ᏍᏏᏉ) ᏍᏏᏉ ᏍᏏᏉ 1-877-292-2480 ᏍᏏᏉ ᏍᏏᏉ ᏍᏏᏉ ᏍᏏᏉ.
- Chinese - 欲取得繁體中文語言協助，請撥打 1-877-292-2480，無需付費。
- Choctaw - (Chahta) anumpa ya apela a chi l_paya hinla 1-877-292-2480.
- Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-877-292-2480 irratti bilisaan bilbilaa.
- Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-877-292-2480.
- French - Pour une assistance linguistique en français appeler le 1-877-292-2480 sans frais.
- French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-877-292-2480 gratis.
- German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-877-292-2480 an.
- Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-877-292-2480 χωρίς χρέωση.
- Gujarati - ૧-૮૭૭-૨૯૨-૨૪૮૦ (ગુજરાત) ૧-૮૭૭-૨૯૨-૨૪૮૦ (ગુજરાત) ૧-૮૭૭-૨૯૨-૨૪૮૦

