



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, <https://www.aetna.com/sbcsearch/getpolicydocs?u=081000-050020-021821> or by calling 1-855-856-0038. 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 1-855-856-0038 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>Network</u> : Individual \$500 / Family \$1,500. <u>Out-of-Network</u> : Individual \$500 / Family \$1,500.	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. <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 \$1,500 / Family \$4,500. <u>Out-of-Network</u> : Individual \$1,500 / Family \$4,500. <u>Prescription drugs</u> : Individual \$1,000 / Family \$3,000.	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 out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	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 http://www.aetna.com/docfind or call 1-855-856-0038 for a list of <u>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</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
		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	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Preventive care/ screening/ immunization</u>	No charge	No charge	You may have to pay for services that aren't preventive. 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	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.aetnapharmacy.com/p/remierplus Premier Plus <u>Formulary</u>	Generic drugs	<u>Copay/prescription, deductible</u> doesn't apply: No charge (retail), \$10 (mail order)	20% <u>coinsurance, deductible</u> doesn't apply	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> . Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written.
	Preferred brand drugs	20% <u>coinsurance</u> with minimum & maximum/prescription, <u>deductible</u> doesn't apply: \$15 minimum & \$50 maximum (retail), \$30 (mail order)	20% <u>coinsurance</u> after <u>copay/prescription, deductible</u> doesn't apply: 20% with \$15 minimum & \$50 maximum (retail)	
	Non-preferred brand drugs	30% <u>coinsurance</u> with minimum & maximum/prescription, <u>deductible</u> doesn't apply: \$30 minimum & \$75 maximum (retail), \$30 (mail order)	20% <u>coinsurance</u> after <u>copay/prescription, deductible</u> doesn't apply: 30% with \$30 minimum & \$75 maximum (retail)	
	<u>Specialty drugs</u>	Applicable cost as noted above for generic or brand drugs	Applicable cost as noted above for generic or brand drugs	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u> for hospital facility; 20% <u>coinsurance</u> for free standing facility	None
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u> for non-emergency use.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	No coverage for non-emergency transport.
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u> after \$500 <u>copay</u> /stay	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 20% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u> after \$500 <u>copay</u> /stay	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge	No charge	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u> after \$500 <u>copay</u> /stay	

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 need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to acute conditions only out-of-network.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to treatment of Autism.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> after \$500 <u>copay/stay</u>	120 days/calendar year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> after \$500 <u>copay/stay</u> for inpatient; 20% <u>coinsurance</u> for outpatient	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
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.)

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|-------------------------------|--|---|
| • Acupuncture | • Hearing aids | • Routine foot care |
| • Bariatric surgery | • Long-term care | • Weight loss programs - Except for required preventive services. |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | |
| • Dental care (Adult & Child) | • Routine eye care (Adult & Child) | |
| • Glasses (Child) | | |

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

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|---------------------|---|------------------------|
| • Chiropractic care | • Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. | • 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: Alaska Division of Insurance, (800) 467-8725, <https://www.commerce.alaska.gov/web/ins/Consumers.aspx>.

- For more information on your rights to continue coverage, contact the [plan](#) at 1-855-856-0038.
- 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 <https://www.dol.gov/agencies/ebsa>.
- 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 1-855-856-0038.
- Alaska Division of Insurance, (800) 467-8725, <https://www.commerce.alaska.gov/web/ins/Consumers.aspx>.
- 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 <https://www.dol.gov/agencies/ebsa>.
- 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.

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 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 **\$500**
- Specialist coinsurance **20%**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

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	\$500
Copayments	\$0
Coinsurance	\$2,000

What isn't covered

Limits or exclusions	\$60
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The total Peg would pay is	\$2,560
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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 **\$500**
- Specialist coinsurance **20%**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

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	\$500
Copayments	\$200
Coinsurance	\$100

What isn't covered

Limits or exclusions	\$20
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The total Joe would pay is	\$820
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Mia's Simple Fracture

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

- The plan's overall deductible **\$500**
- Specialist coinsurance **20%**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

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	\$500
Copayments	\$0
Coinsurance	\$300

What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is	\$800
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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.

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

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-855-856-0038.

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 the number on your ID card.

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.

- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-855-856-0038. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - हिन्दी में भाषा सहायता के लिए, 1-855-856-0038 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-855-856-0038.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-855-856-0038 na akwughị ugwo ọ bụla
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-855-856-0038 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-855-856-0038.
- Japanese - 日本語で援助をご希望の方は、1-855-856-0038 まで無料でお電話ください。
- Karen - လာတဝ်မၤစၢလၢကတိၤကိၣ်အဂီၢ် ကိၣ် ဂိး 1-855-856-0038 လၢတအိၣ်ဒီးတၢ်လၢကိၣ်လၢကိၣ်စၢလၢ
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-855-856-0038 번으로 전화해 주십시오.
- Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pídyi dé Bašwá-wuḍuñ wεε, dá 1-855-856-0038
- Kurdish - برای راهنمایی به زبان فارسی با شماره 1-855-856-0038 به خۆرای پهیوهندی بکەن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-855-856-0038 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - तीलभाषा(मराठी)सहाय्यासाठी 1-855-856-0038 क्रमांकावरकोणत्याहीखर्चाशवियकॉलकरा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-855-856-0038 ilo ejjelok wōnān.
- Micronesian - Pohnpeyan Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-855-856-0038 ni sohte isais.
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទទេកាន់លេខ 1-855-856-0038 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shiká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-855-856-0038
- Nepali - (नेपाली) मा नःशुल्क भाषा सहायता पाउनका लागि 1-855-856-0038 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tën kuwoony ë thok ë Thuonjäng col 1-855-856-0038 kecïn ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-855-856-0038 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਮਦਦ ਲਈ, 1-855-856-0038 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hilfe in Deutsch, ruf: 1-855-856-0038 aa. Es Aaruf koschtet nix.

- Persian - برای راهنمایی به زبان فارسی با شماره 1-855-856-0038 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
- Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-855-856-0038.
- Portuguese - Para obter assistência linguística em português ligue para o 1-855-856-0038 gratuitamente.
- Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-855-856-0038
- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-855-856-0038.
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-855-856-0038 e aunoa ma se totogi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatno broj 1-855-856-0038.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-855-856-0038.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-855-856-0038 Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-855-856-0038 bila malipo.
- Syriac - ܠܗܘܢܐ ܕܡܘܨܝܘܢܐ ܕܡܘܨܝܘܢܐ ܕܡܘܨܝܘܢܐ ܕܡܘܨܝܘܢܐ ܕܡܘܨܝܘܢܐ 1-855-856-0038 ܡܘܨܝܘܢܐ .
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-855-856-0038 nang walang bayad.
- Telugu - భషణ్ణి సాయం కిరకు ఎలంటి ఖరీచు లేకుండా 1-855-856-0038 కు కల్ చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-855-856-0038 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-855-856-0038 'o 'ikai hā tōtōngi.
- Trukese - Ren ánnisinis chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-855-856-0038 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedi 1-855-856-0038.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-855-856-0038.
- Urdu - اریکل گفتفم رپ 1-855-856-0038 میں بلل ریم ودر
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-855-856-0038.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-855-856-0038 פון אפצאל.
- Yoruba - Fún iránlọwọ nípa èdè (Yorùbá) pe 1-855-856-0038 láí san owó kankan rárá.