



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 1-866-851-0754. 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 1-866-851-0754 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In- <u>Network</u> : \$500 per Individual / \$1,000 per Family. Out-of- <u>Network</u> : \$1,000 per Individual / \$2,000 per 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 deductible?	Yes. In- <u>network</u> <u>preventive care</u> is 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. There are no other specific <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Medical and Pharmacy combined Out-of-Pocket: <u>Network</u> : \$7,350 Individual / \$14,700 Family. Out-of- <u>Network</u> : \$10,000 Individual / \$20,000 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 out-of-pocket limit?	<u>Premiums</u> , balance-billing 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. For a list of in-network providers, see www.aetnastateofkansas.com or call 1-866-851-0754.	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
		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	Deductible plus 25% coinsurance	Deductible plus 50% coinsurance	None
	Specialist visit	Deductible plus 25% coinsurance	Deductible plus 50% coinsurance	None
	Preventive care /screening /immunization	\$0 copayment	Deductible plus 50% coinsurance; no charge for child immunizations to age 6	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. Colonoscopies, Mammograms, and Pap Smears - Not limited to once per year / in network 100% regardless of diagnosis. Immunizations with Non Network providers covered in full up to age 6 only.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible plus 25% coinsurance	Deductible plus 50% coinsurance	Discount to member when using preferred labs (Quest, Stormont Vail or University of KS).
	Imaging (CT/PET scans, MRIs)	Deductible plus 25% coinsurance	Deductible plus 50% coinsurance	None
If you need drugs to treat your illness or condition Prescription drug coverage is administered by CVS Caremark More information about prescription	Generic drugs	Deductible plus 20% coinsurance (retail or mail order)	Deductible plus 20% coinsurance on the plans allowed charge	First fill is a 30 day supply at retail and mail. A 90 day supply is allowed at retail and mail for subsequent refills. Deductible: \$500 Individual /\$1,000 Family. Out-Of-Pocket Maximum: \$7,350 Individual/ \$14,700 Family Contraceptives: Covered with \$0 member coinsurance
	Preferred brand drugs	Deductible plus 40% coinsurance (retail or mail order)	Deductible plus 40% coinsurance on the plans allowed charge	Non Preferred Contraceptives: Covered subject to 65% member coinsurance. Compound medications covered only at a Network Pharmacy.
	Non-preferred brand drugs	Deductible plus 65% coinsurance (retail or mail order)	Deductible plus 65% coinsurance on the plans allowed charge	

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)	
drug coverage is available at www.caremark.com	<u>Specialty drugs</u>	Deductible plus 40% coinsurance per 30 day supply	None	All fills must be filled through CVS Caremark Specialty (1-800-237-2767)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible plus 25% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required.
	Physician/surgeon fees	Deductible plus 25% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required.
If you need immediate medical attention	<u>Emergency room care</u>	Deductible plus 25% coinsurance	Deductible plus 25% coinsurance	Must meet emergency criteria.
	<u>Emergency medical transportation</u>	Deductible plus 25% coinsurance	Deductible plus 25% coinsurance	Must meet emergency criteria.
	<u>Urgent care</u>	Deductible plus 25% coinsurance	Deductible plus 50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible plus 25% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required.
	Physician/surgeon fees	Deductible plus 25% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: Deductible plus 25% coinsurance	Office & other outpatient services: Deductible plus 50% coinsurance	None
	Inpatient services	Deductible plus 25% coinsurance	Deductible plus 50% coinsurance	Prior authorization is required for inpatient services.
If you are pregnant	Office visits	Deductible plus 25% coinsurance	Deductible plus 50% coinsurance	Cost sharing does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Prior authorization required for stays longer than 48/96 hours.
	Childbirth/delivery professional services	Deductible plus 25% coinsurance	Deductible plus 50% coinsurance	
	Childbirth/delivery facility services	Deductible plus 25% coinsurance	Deductible plus 50% coinsurance	
If you need help recovering or have	<u>Home health care</u>	Deductible plus 25% coinsurance	Deductible plus 50% coinsurance	Prior authorization may be required.

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)	
other special health needs	<u>Rehabilitation services</u>	<u>Deductible plus 25% coinsurance</u>	<u>Deductible plus 50% coinsurance</u>	Prior authorization required.
	<u>Habilitation services</u>	Not covered	Not covered	Unless under Autism rider of the policy.
	<u>Skilled nursing care</u>	Not covered	Not covered	Not covered.
	<u>Durable medical equipment</u>	<u>Deductible plus 25% coinsurance</u>	<u>Deductible plus 50% coinsurance</u>	Prior authorization required.
	<u>Hospice services</u>	<u>Deductible plus 25% coinsurance</u>	<u>Deductible plus 50% coinsurance</u>	Prior authorization may be required. Inpatient Hospice care limited to 180 days maximum/lifetime.
If your child needs dental or eye care	Children's eye exam	\$0 <u>copayment</u> for first annual visit, then <u>deductible plus 25% coinsurance</u>	<u>Deductible plus 50% coinsurance</u>	1 routine eye exam/calendar year.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered under <u>Medical Plan</u>	Not covered under <u>Medical Plan</u>	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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Habilitation services
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine foot care
- Skilled nursing
- 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.)

- Bariatric surgery - (for qualified patients)
- Chiropractic care - 30 visits/calendar year.
- Hearing Exam
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. 3 cycles/calendar year for artificial insemination & ovulation induction combined.
- Non-emergency care when traveling outside the U.S. - Most coverage provided outside of United States. See www.aetnainternational.com
- Nutritional Evaluation and Diabetes Management
- Routine eye care (Adult) - 1 routine eye exam/calendar year.

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 1-866-851-0754.
- 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 <http://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 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 1-866-851-0754.
- 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 <http://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.

[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.

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 25%
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$3,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,560

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 25%
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,620

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

- The plan's overall deductible \$500
- Specialist coinsurance 25%
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

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	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$900

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

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

We provide 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: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), 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.

- Hindi - **हन्दिी में भाषा सहायता के लएि, 1-866-851-0754 पर मुफ्त कॉल करें।**
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-866-851-0754.
- Ibo - **Maka enyemaka asụsụ na Igbo kpọọ 1-866-851-0754 na akwughị ugwo ọ bụla**
- Ilocano - **Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-851-0754 nga awan ti bayadanyo.**
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-866-851-0754.
- Japanese - **日本語で援助をご希望の方は、1-866-851-0754 まで無料でお電話ください。**
- Karen - လာဝာ်မစာလာ်ကလီာ်ကျိာ်အကို ကျိာ် ၈-866-851-0754 လာဝာ်အိာ်ဒီးလာ်ဘျာ်လာ်စုဘျာ်
- Korean - **한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-851-0754 번으로 전화해 주십시오.**
- Kru-Bassa - **Ɖé m`ké gbo-kpá-kpá dyé pídyi dé Ɖásoó`wuđuúń wěé, dá 1-866-851-0754**
- Kurdish - **برای راهنمایی به زبان فارسی با شماره 1-866-851-0754 به خورایی یه یهوندی بکن.**
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ-866-851-0754 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - **कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-866-851-0754 वर फोन करा.**
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-866-851-0754 ilo ejjelok wōnān.
- Micronesian-Pohnpeyan - **Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-851-0754 ni sohte isais.**
- Mon-Khmer, Cambodian - **សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទទួលបានការសំលេខ 1-866-851-0754 ដោយឥតគិតថ្លៃ។**
- Navajo - **T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-851-0754**
- Nepali - **(नेपाली) मा नि:शुल्क भाषा सहायता पाउनका लागि 1-866-851-0754 मा फोन गर्नुहोस् ।**
- Nilotic-Dinka - **Tën kuwoŋy è thok è Thuonjäŋ cöl 1-866-851-0754 kecīn ayōc.**
- Norwegian - **For språkassistanse på norsk, ring 1-866-851-0754 kostnadsfritt.**
- Panjabi - **ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਮਦਦ ਲਈ, 1-866-851-0754 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।**
- Pennsylvania Dutch - **Fer Hilfe in Deutsch, ruf: 1-866-851-0754 aa. Es Aaruf koschtet nix.**
- Persian - **برای راهنمایی به زبان فارسی با شماره 1-866-851-0754 بدون هیچ هزینه ای تماس بگیريد. انگلیسی**
- Polish - **Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-866-851-0754.**
- Portuguese - **Para obter assistência linguística em português ligue para o 1-866-851-0754 gratuitamente.**
- Romanian - **Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-866-851-0754**

