



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> : \$900 individual / \$1,800 family. Out-of- <u>Network</u> : \$900 individual / \$1,800 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. <u>Prescription drugs</u> , plus in- <u>network</u> office visits & <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. 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: In- <u>Network</u> : Individual \$5,250 / Family \$10,500. Out-of- <u>Network</u> : Individual \$5,250 / Family \$10,500.	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</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
		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	\$30 <u>copay</u> /visit	<u>Deductible</u> plus 50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$60 <u>copay</u> /visit	<u>Deductible</u> plus 50% <u>coinsurance</u>	None
	<u>Preventive care /screening /immunization</u>	\$0 <u>copayment</u>	<u>Deductible</u> plus 50% <u>coinsurance</u> ; no charge for child immunizations to age 6	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. Colonoscopies, Mammograms and Pap Smears - Not limited to once per year / in <u>network</u> 100% regardless of diagnosis. Immunizations with Non <u>Network providers</u> covered in full up to age 6 only.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	<u>Deductible</u> plus 20% <u>coinsurance</u>	<u>Deductible</u> plus 50% <u>coinsurance</u>	Lab services paid at 100% when using preferred labs (Quest, Stormont Vail or University of KS).
	Imaging (CT/PET scans, MRIs)	<u>Deductible</u> plus 20% <u>coinsurance</u>	<u>Deductible</u> plus 50% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition <u>Prescription drug coverage is administered by CVS Caremark</u>	Generic drugs	20% <u>coinsurance</u> (retail or mail order)	20% <u>coinsurance</u> on the <u>plans</u> 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. Diabetics and Asthma medications that are considered generic or preferred brand with the following <u>copays</u> : Generic: 10% <u>coinsurance</u> with a \$20 maximum per 30 day supply. Preferred brand: 20% <u>coinsurance</u> with a \$40 maximum per 30 day supply. Non Preferred Contraceptives: Covered subject to 65% <u>coinsurance</u> . Compound Medications covered only at a <u>Network Pharmacy</u> .
	Preferred brand drugs	35% <u>coinsurance</u> (retail or mail order)	35% <u>coinsurance</u> on the <u>plans</u> allowed charge	
	Non-preferred brand drugs	60% <u>coinsurance</u> (retail or mail order)	60% <u>coinsurance</u> on the <u>plans</u> 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)	
More information about prescription drug coverage is available at www.caremark.com	<u>Specialty drugs</u>	40% <u>coinsurance</u> (with a \$100 maximum) 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)	<u>Deductible</u> plus 20% <u>coinsurance</u>	<u>Deductible</u> plus 50% <u>coinsurance</u>	Prior Authorization is required.
	Physician/surgeon fees	<u>Deductible</u> plus 20% <u>coinsurance</u>	<u>Deductible</u> plus 50% <u>coinsurance</u>	Prior Authorization is required.
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copayment</u> plus <u>deductible</u> and 20% <u>coinsurance</u>	\$100 <u>copayment</u> plus <u>deductible</u> and 20% <u>coinsurance</u>	Must meet emergency criteria. <u>Copay</u> waived if admitted within 24 hours.
	<u>Emergency medical transportation</u>	<u>Deductible</u> plus 20% <u>coinsurance</u>	<u>Deductible</u> plus 20% <u>coinsurance</u>	Must meet emergency criteria.
	<u>Urgent care</u>	\$50 <u>copay/visit</u>	<u>Deductible</u> plus 50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	<u>Deductible</u> plus 20% <u>coinsurance</u>	<u>Deductible</u> plus 50% <u>coinsurance</u>	Prior Authorization is required.
	Physician/surgeon fees	<u>Deductible</u> plus 20% <u>coinsurance</u>	<u>Deductible</u> plus 50% <u>coinsurance</u>	Prior Authorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: \$30 <u>copay/visit</u> , <u>deductible</u> doesn't apply	Office & other outpatient services: <u>Deductible</u> plus 50% <u>coinsurance</u>	\$20 <u>copayment</u> for group therapy sessions.
	Inpatient services	<u>Deductible</u> plus 20% <u>coinsurance</u>	<u>Deductible</u> plus 50% <u>coinsurance</u>	Prior authorization is required for inpatient services.
If you are pregnant	Office visits	\$0 <u>copayment</u>	<u>Deductible</u> plus 50% <u>coinsurance</u>	<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.) Prior authorization required for stays longer than 48/96 hours.
	Childbirth/delivery professional services	<u>Deductible</u> plus 20% <u>coinsurance</u>	<u>Deductible</u> plus 50% <u>coinsurance</u>	
	Childbirth/delivery facility services	<u>Deductible</u> plus 20% <u>coinsurance</u>	<u>Deductible</u> plus 50% <u>coinsurance</u>	

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 help recovering or have other special health needs	<u>Home health care</u>	<u>Deductible plus 20% coinsurance</u>	<u>Deductible plus 50% coinsurance</u>	Prior authorization may be required.
	<u>Rehabilitation services</u>	<u>Deductible plus 20% coinsurance</u>	<u>Deductible plus 50% coinsurance</u>	Prior authorization required.
	<u>Habilitation services</u>	<u>Deductible plus 20% coinsurance</u>	<u>Deductible plus 50% coinsurance</u>	Limited to treatment of Autism.
	<u>Skilled nursing care</u>	Not covered	Not covered	Not covered.
	<u>Durable medical equipment</u>	<u>Deductible plus 20% coinsurance</u>	<u>Deductible plus 50% coinsurance</u>	Prior authorization required.
	<u>Hospice services</u>	<u>Deductible plus 20% 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 \$60 <u>copayment</u> per visit	<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	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.)

- Acupuncture
- Cosmetic surgery - (to improve appearance of normal body structure)
- Dental care (Adult & Child)
- Glasses (Child)
- 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 - Limited to in-network providers. (for qualified patients)
- Chiropractic care - 30 visits/calendar year.
- Hearing exam
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- 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 \$900
- Specialist copayment \$60
- 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	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$900
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

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

- The plan's overall deductible \$900
- Specialist copayment \$60
- 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	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$1,300
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,820

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

- The plan's overall deductible \$900
- Specialist copayment \$60
- 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	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$900
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,300

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.

- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-851-0754.
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-866-851-0754 e aunoa ma se totogi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-866-851-0754.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-866-851-0754.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-866-851-0754. Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-866-851-0754 bila malipo.
- Syriac - ܟܠ ܥܘܪܟܐ ܟܠ ܗܝ ܡܫܝܚܐ ܕܗܝ ܥܠܡܐ ܟܠ ܗܝ ܡܫܝܚܐ ܟܠ ܗܝ ܡܫܝܚܐ ܟܠ ܗܝ ܡܫܝܚܐ ܟܠ ܗܝ ܡܫܝܚܐ ܟܠ ܗܝ ܡܫܝܚܐ 1-866-851-0754 ܕܡܫܝܚܐ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-851-0754 nang walang bayad.
- Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-866-851-0754 కు కాల్ చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-866-851-0754 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-866-851-0754 ‘o ‘ikai hā ʻōtōngi.
- Trukese - Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkeéri 1-866-851-0754 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedен 1-866-851-0754.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-866-851-0754.
- Urdu - بلا قیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-866-851-0754 پر بات کریں۔
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-866-851-0754.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-866-851-0754 פון אפצאל.
- Yoruba - Fún ìrànṣọwọ nípa èdè (Yorùbá) pe 1-866-851-0754 láí san owó kankan rárá.