



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 1-877-272-6374. 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 1-877-272-6374 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	Tier 1a: \$0 person / \$0 person + 1 / \$0 family; Tier 1b: \$250 person / \$500 person + 1 / \$625 family; Tier 2: \$500 person / \$1,000 person + 1 / \$1,250 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 <u>deductible</u>?	Yes. Emergency care; plus Tier 1b & Tier 2 <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 <u>deductibles</u> for specific services?	Yes. \$50 person / \$150 family for Prescription Drugs.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Tier 1a: \$1,250 person / \$2,000 person + 1 / \$2,625 family; Tier 1b: \$1,250 person / \$2,000 person + 1 / \$2,625 family; Tier 2: \$1,750 person / \$2,500 person + 1 / \$3,250 family; Prescription Drugs: \$3,000 person / \$6,000 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 <u>out-of-pocket limit</u>?	<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 <u>network provider</u>?	Yes. See www.aetnaresource.com/n/Nuvance-Health or call (877) 272-6374 for a list of <u>in-network providers</u> .	You pay the least if you use a <u>provider</u> in Tier 1a. You pay more if you use a <u>provider</u> in Tier 1b or Tier 2. 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 <u>referral</u> to see a <u>specialist</u>?	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
		Tier 1a Provider (You will pay the least)	Tier 1b Provider (You will pay more)	Tier 2 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	No charge	0% <u>coinsurance</u> ; 20% <u>coinsurance</u> after \$100 <u>copay</u> /visit for office surgery	Not covered	Not covered	None
	<u>Specialist</u> visit	No charge	\$35 <u>copay</u> /visit; 20% <u>coinsurance</u> after \$100 <u>copay</u> /visit for office surgery	Not covered	Not covered	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	No charge	No charge	Not covered	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)	No charge	\$10 <u>copay</u> /visit for laboratory; 0% <u>coinsurance</u> for x-ray	\$10 <u>copay</u> /visit for laboratory; not covered for x-ray	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	\$75 <u>copay</u> /visit	Not covered	Not covered	None
If you need drugs to treat your illness or condition	Generic drugs	15% <u>coinsurance</u> after specific <u>deductible</u>	15% <u>coinsurance</u> after specific <u>deductible</u>	15% <u>coinsurance</u> after specific <u>deductible</u>	Not covered	Under limitations, exceptions and other important information : Covers 30 day supply
	Preferred brand drugs	15% <u>coinsurance</u> after specific <u>deductible</u>	15% <u>coinsurance</u> after specific <u>deductible</u>	15% <u>coinsurance</u> after specific <u>deductible</u>	Not covered	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1a Provider (You will pay the least)	Tier 1b Provider (You will pay more)	Tier 2 Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Non-preferred brand drugs	15% <u>coinsurance</u> after specific <u>deductible</u>	15% <u>coinsurance</u> after specific <u>deductible</u>	15% <u>coinsurance</u> after specific <u>deductible</u>	Not covered	(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 in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics.
	<u>Specialty drugs</u>	Applicable cost as noted above for generic or brand drugs	Applicable cost as noted above for generic or brand drugs	Applicable cost as noted above for generic or brand drugs	Not covered	Precertification required for coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% <u>coinsurance</u> after \$100 <u>copay/visit</u>	Not covered	Not covered	None
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	Not covered	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$50 <u>copay/visit</u> , <u>deductible</u> doesn't apply	\$50 <u>copay/visit</u> , <u>deductible</u> doesn't apply	\$50 <u>copay/visit</u> , <u>deductible</u> doesn't apply	\$50 <u>copay/visit</u> , <u>deductible</u> doesn't apply	Out-of-network emergency use paid the same as in-network.
	<u>Emergency medical transportation</u>	No charge	No charge	No charge	No charge	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1a Provider (You will pay the least)	Tier 1b Provider (You will pay more)	Tier 2 Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	<u>Urgent care</u>	No charge	\$50 <u>copay/visit</u> after specific deductible	\$50 <u>copay/visit</u> after specific deductible	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% <u>coinsurance</u> after \$500 copay/stay	Not covered	Not covered	None
	Physician/surgeon fees	No charge	<u>Deductible, then no charge</u> 0% <u>coinsurance</u>	Not covered	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: no charge	Office: \$35 <u>copay/visit</u> ; other outpatient services: no charge	Office: \$35 <u>copay/visit</u> ; other outpatient services: no charge	Not covered	None
	Inpatient services	No charge	10% <u>coinsurance</u> after \$250 copay/stay	10% <u>coinsurance</u> after \$250 copay/stay	Not covered	None
If you are pregnant	Office visits	No charge	No charge \$35 <u>copay for initial visit only then no charge</u>	Not covered	Not covered	<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.)
	Childbirth/delivery professional services	No charge	<u>Deductible, then no charge</u> 0% <u>coinsurance</u>	Not covered	Not covered	
	Childbirth/delivery facility services	No charge	20% <u>coinsurance</u> after \$500 copay/stay	Not covered	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	<u>Deductible, then no charge</u> 0% <u>coinsurance</u>	<u>Deductible, then no charge</u> 0% <u>coinsurance</u>	Not covered	200 visits/calendar year.
	<u>Rehabilitation services</u>	No charge	Not covered	Not covered	Not covered	90 visits/calendar year for Physical & Occupational Therapy combined, 60 visits/calendar year for Speech Therapy, including outpatient hospital services.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1a Provider (You will pay the least)	Tier 1b Provider (You will pay more)	Tier 2 Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	<u>Habilitation services</u>	No charge	Not covered	Not covered	Not covered	None
	<u>Skilled nursing care</u>	No charge	\$500 <u>copay/stay</u>	Not covered	Not covered	120 days/calendar year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> , <u>deductible</u> doesn't apply	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Not covered	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	No charge	<u>Deductible, then no charge</u> 0% <u>coinsurance</u>	<u>Deductible, then no charge</u> 0% <u>coinsurance</u>	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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- Bariatric surgery
- Chiropractic care
- Hearing aids - \$2,500 maximum/3 years.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.

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 1-877-272-6374.

- 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:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-877-272-6374. 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 \$0
- Specialist copayment \$0
- Hospital (facility) copayment \$0
- Other copayment \$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:	
<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$10
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$70

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

- The plan's overall deductible \$0
- Specialist copayment \$0
- Hospital (facility) copayment \$0
- Other copayment \$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:	
<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$50
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$670

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

- The plan's overall deductible \$0
- Specialist copayment \$0
- Hospital (facility) copayment \$0
- Other copayment \$0

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
In this example, Mia would pay:	
<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$10
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$60

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-877-272-6374.
 *Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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, disability, gender identity or sexual orientation.

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 1-877-272-6374.
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-877-272-6374 e aunoa ma se totogi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-877-272-6374.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-877-272-6374.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-877-272-6374. Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-877-272-6374 bila malipo.
- Syriac - ܟܠ ܘܫܬܝܢ ܟܠ ܗܝ ܡܫܝܚܝܢ ܘܗܝ ܘܠܟܝܢ ܟܠ ܘܢܝܝܢܝܢ ܟܠ ܕܝܢ ܝܘܡܝܢܝܢ ܗܝܠܟܝܢ ܕܝܢܝܢܝܢ ܕܝܢܝܢܝܢ ܕܝܢܝܢܝܢ 1-877-272-6374 ܕܝܢܝܢܝܢ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-272-6374 nang walang bayad.
- Telugu - భాషతో సాయం కోరకు ఎలాంటి ఖర్చు లేకుండా 1-877-272-6374 కు కాల్ చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-877-272-6374 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-877-272-6374 'o 'ikai hā ʻōtōngi.
- Trukese - Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-877-272-6374 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedен 1-877-272-6374.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-877-272-6374.
- Urdu - بلا قیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-877-272-6374 پر بات کریں۔
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-877-272-6374.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-877-272-6374 פון אפצאל.
- Yoruba - Fún ìrànlowọ nípa èdè (Yorùbá) pe 1-877-272-6374 láí san owó kankan rárá.