



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=082600-080020-002501> or by calling 1-800-704-7287. 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 1-800-704-7287 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each Calendar Year, In- <u>Network</u> : Individual \$4,000 / Family \$8,000.	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; 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?	For each Calendar Year, In- <u>Network</u> : Individual \$6,850 / Family \$13,700.	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 http://www.aetna.com/docfind or call 1-800-704-7287 for a list of in- <u>network providers</u> . Select Aetna Open Access® Elect Choice®.	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> doesn't apply	Not covered	No charge for in-network Virtual Primary Care telemedicine <u>provider</u> visits for certain services.
	<u>Specialist</u> visit	\$60 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	None
	<u>Preventive care</u> / <u>screening</u> /immunization	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)	20% <u>coinsurance</u>	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	Not covered	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/advancedcontrolaetna	Preferred generic drugs (Includes Tier 1A - Value Drugs and Tier 1 Preferred Generic <u>Prescription Drugs</u>)	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: Tier 1A \$3 for 30 day supply (retail), \$6 for 31-90 day supply (retail & mail order); Preferred Generic \$10 for 30 day supply (retail), \$20 for 31-90 day supply (retail & mail order)	Not covered	Covers 30 day supply (retail), 31-90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs, injectable fertility drugs for preservation of fertility due to disease only. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your <u>formulary</u> for prescriptions requiring precertification or step therapy for coverage. <u>Copay</u> /prescription for insulin, <u>deductible</u> doesn't apply: \$25 for each 30 day supply. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written.
	Preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$45 for 30 day supply (retail), \$90 for 31-90 day supply (retail & mail order)	Not covered	
	Non-preferred generic/brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$70 for 30 day supply (retail), \$140 for 31-90 day supply (retail & mail order)	Not covered	
	<u>Specialty drugs</u>	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: 30% (preferred), 50%	Not covered	All prescriptions must be filled through the Aetna Specialty Pharmacy <u>Network</u> . \$300 (preferred) and \$500 (non-preferred) maximum

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)	
		(non-preferred)		<u>copay</u> for each 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$350 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$350 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	\$350 <u>copay</u> /trip, <u>deductible</u> doesn't apply	\$350 <u>copay</u> /trip, <u>deductible</u> doesn't apply	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$85 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$60 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: no charge	Not covered	None
	Inpatient services	20% <u>coinsurance</u>	Not covered	None
If you are pregnant	Office visits	No charge	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	20% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	120 visits/calendar year.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	Not covered	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.

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)	
	<u>Habilitation services</u>	No charge	Not covered	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not covered	60 days/calendar year.
	<u>Durable medical equipment</u>	50% <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>	20% <u>coinsurance</u>	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam/12 months.
	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

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

- Acupuncture - 10 visits/calendar year for disease, injury & chronic pain.
- Chiropractic care
- Hearing aids - 1 hearing aid per ear/3 years.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, including artificial insemination.
- Private-duty nursing - 70- 8 hour shifts/calendar year.
- Routine eye care (Adult) - 1 routine eye exam/12 months.

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: Texas Department of Insurance, 1-800-252-3439 (Consumer HelpLine), (512) 676-6000 (Local), (800) 578-4677 (Toll-Free), www.tdi.texas.gov/consumer/get-help-with-an-insurance-complaint.html.

- For more information on your rights to continue coverage, contact the plan at 1-800-704-7287.
- 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 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 toll free number at 1-800-704-7287. 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.
- Texas Department of Insurance, 1-800-252-3439 (Consumer HelpLine), (512) 676-6000 (Local), (800) 578-4677 (Toll-Free), www.tdi.texas.gov/consumer/get-help-with-an-insurance-complaint.html.
- 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 Texas Department of Insurance, Consumer Protection, Mail Code 111-1A, 333 Guadalupe, P.O. Box 149091, Austin, TX 78714-9091, Phone toll-free: 1-800-252-3439, <http://www.texashealthoptions.com>, ConsumerProtection@tdi.texas.gov

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 \$4,000
- 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
In this example, Peg would pay:	
<u>Cost Sharing</u>	
Deductibles	\$4,000
Copayments	\$10
Coinsurance	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,570

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$4,000
- Specialist copayment \$60
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Primary care provider office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Diabetic supplies (*glucose meter*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
Deductibles	\$100
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,020

Mia's Simple Fracture

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

- The plan's overall deductible \$4,000
- 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
In this example, Mia would pay:	
<u>Cost Sharing</u>	
Deductibles	\$400
Copayments	\$800
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,200

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 1-800-704-7287.

[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.

English	To access language services at no cost to you, call 1-800-704-7287.
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-800-704-7287 ይደውሉ፡፡.
Arabic	للحصول على خدمات لغوية دون تكلفة، الرجاء الاتصال على الرقم 1-800-704-7287
Armenian	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-800-704-7287 հեռախոսահամարով:
Carolinian (Kapasal Falawasch)	ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-704-7287.
Chamorro	Para un hago' i setbision lengguahi ni dibatde para hagu, a'gang 1-800-704-7287.
Chinese Traditional	如欲使用免費語言服務，請致電 1-800-704-7287.
Cushitic-Oromo	Tajaajiloota afaanii garuu bilisaa ati argaachuuf, bilbili 1-800-704-7287.
French	Afin d'accéder aux services langagiers sans frais, composez le 1-800-704-7287.
French Creole (Haitian)	Pou jwenn sèvis lang gratis, rele 1-800-704-7287.
German	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-704-7287 an.
Greek	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-800-704-7287.
Gujarati	તમારે કોઇ જાતના ખર્ચ વગર ભાષાની સેવાઓની પહોંચ માટે, કોલ કરો 1-800-704-7287.
Hindi	आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-800-704-7287 पर कॉल करें।.
Hmong	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-800-704-7287.
Italian	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-704-7287.
Japanese	言語サービスを無料でご利用いただくには、1-800-704-7287 までお電話ください。
Karen	လၢတၢ်ကမၤန့ၣ် ကံၣ်စၢ အတၢ်မၤစၢၤ အတၢ်ဖဲးတၢ်မၤတဖၣ်လၢ တအံၣ်ဒီးအပၤလၢကတၢၢ်ဟ့ၣ်အၤအဂီၢ်ဘၣ်န့ၣ် ကံး 1-800-704-7287 တကၢၢ်.
Korean	무료 언어 서비스를 이용하려면 1-800-704-7287 번으로 전화해 주십시오.
Laotian	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ສຍຄ່າຕົກທ່ານ, ໃຫ້ໃບຫາບ 1-800-704-7287.
Mon-Khmer Cambodian	ដើម្បីប្រើប្រាស់សេវាភាសាដោយឥតគិតថ្លៃ ម្ចាស់សេវាស្រុក ឬម្ចាស់ទូរស័ព្ទស្រុកស្រី ត្រូវទូរស័ព្ទលេខ 1-800-704-7287 ។
Navajo	T'áá ni nizaad k'ehjí bee níká a'doowol doo bą́ąh ílínígóó kojí' hólne' 1-800-704-7287.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff 1-800-704-7287.

Persian-Farsi	مرايش اب ،نآگي ار روط ماب نابز تامدخ مب سرتسد يارب 1-800-704-7287 ديري گب سامت
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-800-704-7287.
Portuguese	Para acessar os serviços de idiomas sem custo para você, ligue para 1-800-704-7287.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਨਿੰ ਬਸਿੰ ਈਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਰਿਨ ਲਈ, 1-800-704-7287 ‘ਤੇ ਫ਼ੋਨ ਕ੍ਰਿ। .
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-800-704-7287.
Samoan	Mo le mauaina o auauunaga tau gagana e aunoa ma se totogi, vala’au le 1-800-704-7287.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite 1-800-704-7287.
Spanish	Para acceder a los servicios de idiomas sin costo, llame al 1-800-704-7287.
Syriac-Assyrian	: ܐܡܪܝܬܟܠܢ ܕܥܘܨܩܐ ܕܚܒܠܗܐ ܕܓܠܝܠܝܬܐ ܕܣܦܪܝܬܐ ܕܟܰܛܶܪܳܝܼܽܬܵܐ ܕܰܝܺܠܹܕܸܝܤܻܐ ܕܰܠܴܚܿܝܺܝܠܱܐ ܕܰܡܲܕܢܯܬܢܷܐ ܕܰܝܺܠܹܕܸܝܤܻܐ ܕܰܠܴܚܿܝܺܝܠܱܐ ܕܰܡܲܕܢܯܬܢܷܐ : 1-800-704-7287.
Tagalog	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-800-704-7287.
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-800-704-7287.
Ukrainian	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-800-704-7287.
Vietnamese	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, gọi số 1-800-704-7287.