



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=082400-090020-072537> or by calling 1-888-982-3862. 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 1-888-982-3862 to request a copy.

| Important Questions                                                 | Answers                                                                                                                                              | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                              | \$0.                                                                                                                                                 | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Are there services covered before you meet your deductible?</b>  | No.                                                                                                                                                  | You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Are there other deductibles for specific services?</b>           | No.                                                                                                                                                  | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b> | In- <u>Network</u> : Individual \$1,500 / 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.                                                                                                                                                                                                                                                                                     |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>      | <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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Will you pay less if you use a <u>network provider</u>?</b>      | Yes. See <a href="http://www.aetna.com/docfind">http://www.aetna.com/docfind</a> or call 1-888-982-3862 for a list of in- <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. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>    | Yes.                                                                                                                                                 | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</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) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                                                                             | Primary care visit to treat an injury or illness        | \$10 <u>copay</u> /visit                                     | Not covered                                     | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                           | <u>Specialist</u> visit                                 | \$10 <u>copay</u> /visit                                     | 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.                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>If you have a test</b>                                                                                                                                                                                                                                 | <u>Diagnostic test</u> (x-ray, blood work)              | No charge for laboratory; \$10 <u>copay</u> /visit for x-ray | Not covered                                     | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                           | Imaging (CT/PET scans, MRIs)                            | \$100 <u>copay</u> /visit                                    | Not covered                                     | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.aetnapharmacy.com/advancedcontrolaetna">www.aetnapharmacy.com/advancedcontrolaetna</a> | Preferred generic drugs                                 | <u>Copay</u> /prescription: \$15 (retail), \$30 (mail order) | Not covered                                     | Covers 30 day supply (retail), 31-90 day supply (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- <u>network</u> . Review your <u>formulary</u> for prescriptions requiring precertification or step therapy for coverage. <u>Copay</u> /prescription for preferred insulin: \$25 for each 30 day supply. Your cost will be higher for choosing Brand over Generics. |
|                                                                                                                                                                                                                                                           | Preferred brand drugs                                   | <u>Copay</u> /prescription: \$25 (retail), \$50 (mail order) | Not covered                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                                           | Non-preferred generic/brand drugs                       | <u>Copay</u> /prescription: \$40 (retail), \$80 (mail order) | Not covered                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                                           | <u>Specialty drugs</u>                                  | Applicable cost as noted above for generic or brand drugs    | Not covered                                     | First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy <u>Network</u> .                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                     | Facility fee (e.g., ambulatory surgery center)          | \$100 <u>copay</u> /visit                                    | Not covered                                     | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                           | Physician/surgeon fees                                  | No charge                                                    | Not covered                                     | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

| 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 immediate medical attention                                   | <u>Emergency room care</u>                | \$100 <u>copay</u> /visit                                                 | \$100 <u>copay</u> /visit                       | Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.                                                                         |
|                                                                           | <u>Emergency medical transportation</u>   | \$100 <u>copay</u> /trip                                                  | \$100 <u>copay</u> /trip                        | Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.                                            |
|                                                                           | <u>Urgent care</u>                        | \$35 <u>copay</u> /visit                                                  | Not covered                                     | No coverage for non-urgent use.                                                                                                                                      |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | \$100 <u>copay</u> /stay                                                  | Not covered                                     | None                                                                                                                                                                 |
|                                                                           | Physician/surgeon fees                    | No charge                                                                 | Not covered                                     | None                                                                                                                                                                 |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | Office: \$10 <u>copay</u> /visit;<br>other outpatient services: no charge | Not covered                                     | None                                                                                                                                                                 |
|                                                                           | Inpatient services                        | \$100 <u>copay</u> /stay                                                  | 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 | \$10 <u>copay</u> /pregnancy                                              | Not covered                                     |                                                                                                                                                                      |
|                                                                           | Childbirth/delivery facility services     | \$100 <u>copay</u> /stay                                                  | Not covered                                     |                                                                                                                                                                      |
| If you need help recovering or have other special health needs            | <u>Home health care</u>                   | No charge                                                                 | Not covered                                     | 100 visits/calendar year.                                                                                                                                            |
|                                                                           | <u>Rehabilitation services</u>            | \$10 <u>copay</u> /visit                                                  | Not covered                                     | None                                                                                                                                                                 |
|                                                                           | <u>Habilitation services</u>              | No charge                                                                 | Not covered                                     | None                                                                                                                                                                 |
|                                                                           | <u>Skilled nursing care</u>               | \$100 <u>copay</u> /stay                                                  | Not covered                                     | 100 days/calendar year.                                                                                                                                              |
|                                                                           | <u>Durable medical equipment</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>                   | \$100 <u>copay</u> /stay for inpatient; no charge for outpatient          | Not covered                                     | None                                                                                                                                                                 |

| 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) |                                                        |
| <b>If your child needs dental or eye care</b> | Children's eye exam        | No charge                                    | Not covered                                     | 1 routine eye exam/24 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.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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 - 20 visits/calendar year for disease, injury & chronic pain.
- Bariatric surgery
- Chiropractic care - 20 visits/calendar year.
- Hearing aids - 1 hearing aid per ear/60 months for children up to age 18.
- Infertility treatment - For more information & exceptions, see policy document using summary box link on page 1 or call the number on your ID card.
- Routine eye care (Adult) - 1 routine eye exam/24 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: Colorado Division of Insurance, Consumer Services, 800-930-3745 (toll-free outside the Denver Metro Area) or 303-894-7490 or Office of the Ombudsperson for Behavioral Health Access to Care, 303-866-2789, <https://doi.colorado.gov/>.

- For more information on your rights to continue coverage, contact the plan at 1-888-982-3862.
- 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](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](http://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](http://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 1-888-982-3862. 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](http://www.dol.gov/ebsa/healthreform).
- Colorado Division of Insurance, Consumer Services, 800-930-3745 (toll-free outside the Denver Metro Area) or 303-894-7490 or Office of the Ombudsperson for Behavioral Health Access to Care, 303-866-2789, <https://doi.colorado.gov/>.
- 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](http://www.cciio.cms.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 \$0
- Specialist copayment \$10
- Hospital (facility) copayment \$100
- 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>             |          |
| Deductibles                     | \$0      |
| Copayments                      | \$100    |
| Coinsurance                     | \$0      |
| <i>What isn't covered</i>       |          |
| Limits or exclusions            | \$60     |
| The total Peg would pay is      | \$160    |

**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 \$10
- Hospital (facility) copayment \$100
- Other copayment \$0

**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                     | \$0     |
| Copayments                      | \$900   |
| Coinsurance                     | \$0     |
| <i>What isn't covered</i>       |         |
| Limits or exclusions            | \$20    |
| The total Joe would pay is      | \$920   |

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

- The plan's overall deductible \$0
- Specialist copayment \$10
- Hospital (facility) copayment \$100
- 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>             |         |
| Deductibles                     | \$0     |
| Copayments                      | \$300   |
| Coinsurance                     | \$0     |
| <i>What isn't covered</i>       |         |
| Limits or exclusions            | \$0     |
| The total Mia would pay is      | \$300   |

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 1-888-982-3862.

### [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.

|                                |                                                                                                                             |
|--------------------------------|-----------------------------------------------------------------------------------------------------------------------------|
| <b>English</b>                 | <b>To access language services at no cost to you, call 1-888-982-3862.</b>                                                  |
| Amharic                        | የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-888-982-3862 ይደውሉ፡፡                                                                          |
| Arabic                         | للحصول على خدمات لغوية دون تكلفة، الرجاء الاتصال على الرقم 1-888-982-3862                                                   |
| Armenian                       | Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-888-982-3862 հեռախոսահամարով:                                 |
| Carolinian (Kapasal Falawasch) | ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-888-982-3862.                                      |
| Chamorro                       | Para un hago' i setbision lengguahi ni dibatde para hagu, a'gang 1-888-982-3862.                                            |
| Chinese Traditional            | 如欲使用免費語言服務，請致電 1-888-982-3862.                                                                                              |
| Cushitic-Oromo                 | Tajaajiloota afaanii garuu bilisaa ati argaachuuf, bilbili 1-888-982-3862.                                                  |
| French                         | Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862.                                              |
| French Creole (Haitian)        | Pou jwenn sèvis lang gratis, rele 1-888-982-3862.                                                                           |
| German                         | Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an.                                  |
| Greek                          | Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-982-3862. |
| Gujarati                       | તમારે કોઇ જાતના ખર્ચ વના ભાષાની સેવિસોની પછોડ માટે, કોલ કરો 1-888-982-3862.                                                 |
| Hindi                          | आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-888-982-3862 पर कॉल करें।.                                   |
| Hmong                          | Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-888-982-3862.                                                   |
| Italian                        | Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-982-3862.                            |
| Japanese                       | 言語サービスを無料でご利用いただくには、1-888-982-3862 までお電話ください。                                                                               |
| Karen                          | လၢတၢ်ကမၤန့ၣ် ကံၣ်စၢ အတၢ်မၤစၢၤ အတၢ်ဖဲးတၢ်မၤတဖၣ်လၢ တအံၣ်ဒီးအပၤလၢကတၢ်ဟ့ၣ်အၤအဂီၢ်ဘၣ်န့ၣ် ကံး 1-888-982-3862 တကါၤ.               |
| Korean                         | 무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오.                                                                               |
| Laotian                        | ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ສຍຄ່າຕົກຢ່າງ, ໃຫ້ໃບຫາບ 1-888-982-3862.                                                     |
| Mon-Khmer Cambodian            | ដើម្បីប្រើប្រាស់សេវាភាសាដោយឥតគិតថ្លៃ ម្ចាស់សេវាស្រុក ឬ ម្ចាស់ទូរស័ព្ទ ត្រូវទូរស័ព្ទលេខ 1-888-982-3862 ។                     |
| Navajo                         | T'áá ni nizaad k'ehjí bee níká a'doowol doo bą́ąh ílínígóó kojí' hólne' 1-888-982-3862.                                     |
| Pennsylvanian-Dutch            | Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-982-3862.                                                         |



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