



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=082200-100020-021862> or by calling 1-866-529-2517. 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 1-866-529-2517 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: Individual \$6,300 / Family \$12,600.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain office visits, preventive care and urgent care in-network.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. For prescription drug expenses - In-network: Individual \$500 / Family \$1,000. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network: Individual \$7,550 / Family \$15,100.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See http://www.aetna.com/docfind or call 1-866-529-2517 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.



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	\$75 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	Visits 1-3 <u>deductible</u> does not apply for primary care, <u>specialist</u> , other practitioners, <u>urgent care</u> , outpatient mental health and substance abuse combined.
	<u>Specialist</u> visit	\$105 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	Visits 1-3 <u>deductible</u> does not apply for primary care, <u>specialist</u> , other practitioners, <u>urgent care</u> , outpatient mental health and substance abuse combined.
	<u>Preventive care /screening /immunization</u>	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)	Lab: \$40 <u>copay</u> /visit, <u>deductible</u> does not apply; X-ray: 100% <u>coinsurance</u>	Not covered	None
	Imaging (CT/PET scans, MRIs)	100% <u>coinsurance</u>	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 drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at http://client.formularynavigator.com/Search.aspx?siteCode=4391485344	Preferred/non-preferred generic drugs (Tier 1)	100% <u>coinsurance</u> up to \$500 maximum/prescription (retail & mail order)	Not Covered	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Applicable cost share plus difference (brand minus generic cost) applies for brand when generic available. No charge for preferred generic FDA-approved women's contraceptives in-network. Precertification and step therapy for certain <u>prescription drugs</u> is required.
	Preferred brand drugs (Tier 2)	100% <u>coinsurance</u> up to \$500 maximum/prescription (retail & mail order)	Not Covered	
	Non-preferred brand drugs (Tier 3)	100% <u>coinsurance</u> up to \$500 maximum/prescription (retail & mail order)	Not Covered	
	Preferred/non-preferred <u>specialty drugs</u> (Tier 4)	100% <u>coinsurance</u> up to a \$500 maximum/prescription for up to a 30 day supply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	100% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	100% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	100% <u>coinsurance</u>	100% <u>coinsurance</u>	No coverage for non-emergency care.
	<u>Emergency medical transportation</u>	100% <u>coinsurance</u>	100% <u>coinsurance</u>	Precertification is required for certain services.
	<u>Urgent care</u>	\$75 <u>copay/visit</u> , <u>deductible</u> does not apply	Not covered	No coverage for non-urgent use. Visits 1-3 <u>deductible</u> does not apply for primary care, <u>specialist</u> , other practitioners, <u>urgent care</u> , outpatient mental health and substance abuse combined.
If you have a hospital stay	Facility fee (e.g., hospital room)	100% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	100% <u>coinsurance</u>	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 mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient office visits: \$75 <u>copay/visit</u> , <u>deductible</u> does not apply; All other outpatient services: 0% <u>coinsurance</u>	Not covered	Precertification is required for certain services.
	Inpatient services	100% <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> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	100% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	100% <u>coinsurance</u>	Not covered	Coverage is limited to 100 visits per year.
	<u>Rehabilitation services</u>	\$75 <u>copay/visit</u> , <u>deductible</u> does not apply	Not covered	None
	<u>Habilitation services</u>	\$75 <u>copay/visit</u> , <u>deductible</u> does not apply	Not covered	None
	<u>Skilled nursing care</u>	100% <u>coinsurance</u>	Not covered	Coverage is limited to 100 days per benefit period.
	<u>Durable medical equipment</u>	100% <u>coinsurance</u>	Not covered	Coverage is limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Coverage is limited up to age 19.
	Children's glasses	No charge	Not covered	Coverage is limited to 1 pair of glasses (lenses and frames) or a one-year supply of contact lenses up to age 19.
	Children's dental check-up	No charge	Not covered	Coverage is limited to 2 prophylaxis (cleanings) and 2 fluoride applications a year.

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.)

- | | | |
|-----------------------|--|----------------------------|
| • Chiropractic care | • Long-term care | • Routine eye care (Adult) |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Routine foot care |
| • Dental care (Adult) | • Private-duty nursing | • Weight loss programs |
| • Hearing aids | | |

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

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|---------------|---------------------|--|
| • Acupuncture | • Bariatric surgery | • Infertility treatment - Benefit limitations may apply. |
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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: California Department of Managed Health Care, (888) 466-2219, 1-877-688-9891 (TTY), <http://www.dmhc.ca.gov>.

- For more information on your rights to continue coverage, contact the plan at 1-866-529-2517.
- 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 <https://www.dol.gov/agencies/ebsa>.
- 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 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 1-866-529-2517.
- California Department of Managed Health Care, (888) 466-2219, 1-877-688-9891 (TTY), <http://www.dmhc.ca.gov>.
- 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 <https://www.dol.gov/agencies/ebsa>.
- 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 California Consumer Assistance Program, Operated by the California Department of Managed Health Care and Department of Insurance, 980 9th Street, Suite #500, Sacramento, CA 95814, (888) 466-2219, <http://www.healthhelp.ca.gov>

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 **\$6,300**
- Specialist copayment **\$105**
- Hospital (facility) coinsurance **100%**
- Other coinsurance **100%**

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	\$12,800
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles*	\$6,300
Copayments	\$100
Coinsurance	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$7,560

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

- The plan's overall deductible **\$6,300**
- Specialist copayment **\$105**
- Hospital (facility) coinsurance **100%**
- Other coinsurance **100%**

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	\$7,400
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles*	\$500
Copayments	\$800
Coinsurance	\$5,500
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$6,820

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

- The plan's overall deductible **\$6,300**
- Specialist copayment **\$105**
- Hospital (facility) coinsurance **100%**
- Other coinsurance **100%**

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	\$1,900
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles*	\$1,300
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,700

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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 1-866-529-2517.

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

Aetna provides 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 1-866-529-2517.

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 24030, Fresno, CA 93779

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705)

Fax: 860-262-7705

Email: 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.

TTY: 711

Language Assistance:

For language assistance in your language call 1-866-529-2517 at no cost.

- Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-866-529-2517.
- Amharic - ለቋንቋ እገዛ በ አማርኛ በ 1-866-529-2517 በነጻ ይደውሉ
- Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-866-529-2517
- Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-866-529-2517 առանց գնով:
- Bahasa-Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-866-529-2517 tanpa dikenakan biaya.
- Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-866-529-2517 ku busa
- Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-866-529-2517-তে কল করুন।
- Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-866-529-2517 nga walay bayad.
- Burmese - ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-866-529-2517 ကို ခေါ်ဆိုပါ။
- Catalan - Per rebre assistència en (català), truqui al número gratuït 1-866-529-2517.
- Chamorro - Para ayuda gi fino' (Chamoru), ágang 1-866-529-2517 sin gástu.
- Cherokee - ᠄᠄᠋᠎᠋᠋ ᠰᠤᠬᠤ᠎᠋᠋ ᠠᠬᠤᠰᠦᠷ᠋᠎᠋ ᠄᠋᠎᠋᠋ (GWY) ᠄᠋᠎᠋᠋᠎᠋᠋ 1-866-529-2517 ᠄᠋᠎᠋᠋ ᠎᠋ ᠠᠭ᠋᠎᠋᠋ ᠎᠋᠎᠋᠋᠎᠋᠋ ᠎᠋᠎᠋᠋᠎᠋᠋.
- Chinese - 欲取得繁體中文語言協助，請撥打 1-866-529-2517，無需付費。
- Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-866-529-2517.
- Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-866-529-2517 irratti bilisaan bilbilaa.
- Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-866-529-2517.
- French - Pour une assistance linguistique en français appeler le 1-866-529-2517 sans frais.
- French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-866-529-2517 gratis.
- German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-866-529-2517 an.
- Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-866-529-2517 χωρίς χρέωση.
- Gujarati - ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-866-529-2517 પર કોલ કરો.

- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-866-529-2517. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - हिन्दी में भाषा सहायता के लिए, 1-866-529-2517 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-866-529-2517.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-866-529-2517 na akwụghị ụgwọ ọ bụla
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-529-2517 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-866-529-2517.
- Japanese - 日本語で援助をご希望の方は、1-866-529-2517 まで無料でお電話ください。
- Karen - လာတိုမာစာတိုကတိကိတ်အင်္ဂါ ကို နိ: 1-866-529-2517 လာတိုအိတ်ဒီးတိုလာတိုဘူတ်လာတိုဘူတ်
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-529-2517 번으로 전화해 주십시오.
- Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pídyi dé Bašwó`wuḍuñ wεε, dá 1-866-529-2517
- Kurdish - برای راهنمایی به زبان فارسی با شماره 1-866-529-2517 به خورایی پیوندی بکن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-866-529-2517 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - तीलभाषा(मराठी)सहाय्यासाठी 1-866-529-2517 क्रमांकावरकोणत्याहीखर्चाशवियकॉलकरा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-866-529-2517 ilo ejjelok wōnān.
- Micronesian - Pohnpeyan Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-529-2517 ni sohte isais.
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទទៅកាន់លេខ 1-866-529-2517 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shiká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-529-2517
- Nepali - (नेपाली) मा नःशुल्क भाषा सहायता पाउनका लागि 1-866-529-2517 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tën kuwoony ë thok ë Thuonjäŋ cöl 1-866-529-2517 kecïn ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-866-529-2517 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵਿੱਚੋਂ ਭਾਸ਼ਾਈ ਮਦਦ ਲਈ, 1-866-529-2517 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hilfe in Deutsch, ruf: 1-866-529-2517 aa. Es Aaruf koschtet nix.

- Persian - برای راهنمایی به زبان فارسی با شماره 1-866-529-2517 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
- Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-866-529-2517.
- Portuguese - Para obter assistência linguística em português ligue para o 1-866-529-2517 gratuitamente.
- Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-866-529-2517
- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-529-2517.
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-866-529-2517 e aunoa ma se totogi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-866-529-2517.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-866-529-2517.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-866-529-2517 Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-866-529-2517 bila malipo.
- Syriac - ܠܗܘܢܘܟܘܢ ܩܘܒܘܠܘܢ ܩܘܒܘܠܘܢ ܩܘܒܘܠܘܢ ܩܘܒܘܠܘܢ ܩܘܒܘܠܘܢ ܩܘܒܘܠܘܢ ܩܘܒܘܠܘܢ ܩܘܒܘܠܘܢ ܩܘܒܘܠܘܢ ܩܘܒܘܠܘܢ 1-866-529-2517 ܩܘܒܘܠܘܢ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-529-2517 nang walang bayad.
- Telugu - భషణ్ణి సాయం కిరకు ఎలంటి ఖరీచు లేకుండా 1-866-529-2517 కు కల్ చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-866-529-2517 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-866-529-2517 'o 'ikai hā tōtōngi.
- Trukese - Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-866-529-2517 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedi 1-866-529-2517.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-866-529-2517.
- Urdu - اریکل گفتفم رپ 1-866-529-2517 یحل یکتن و اع مین لیل ریم ودر
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-866-529-2517.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-866-529-2517 פריי פון אפצאל.
- Yoruba - Fún iránlọwọ nípa èdè (Yorùbá) pe 1-866-529-2517 láí san owó kankan rárá.

HMO Basic Bronze

Supplemental Information

Coverage for: Employee + Family | Plan Type: HMO

How is the overall <u>deductible</u> or <u>out-of-pocket limit</u> met?	Individual <u>deductible</u> and <u>out-of-pocket limit</u> payments apply to the family <u>deductible</u> and <u>out-of-pocket limit</u> .	The family <u>deductible</u> and family <u>out-of-pocket limit</u> are cumulative for all family members. The family <u>deductible</u> and <u>out-of-pocket limit</u> can be met by a combination of family members; however no single individual within the family will be subject to more than the individual <u>deductible</u> or <u>out-of-pocket limit</u> amount.
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How your out-of-network care is reimbursed:

Your plan does not cover care you get outside of our network. Generally, we will not pay anything for that care. But your plan will pay for emergency services you receive from health care providers not in our network. Your cost sharing – deductibles, coinsurance, copayments – will be the same as if you got the care in-network. You are not responsible for paying anything else. If you get a bill for anything more, contact us.

Other important information about your plan:

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent.

Additional information regarding your plan is available in the Disclosure Document on www.aetna.com.

Information includes:

- “Knowing what is covered” which describes how we review a request for coverage for a service or supply
- “Prescription drug benefit” which describes procedures we use to manage prescription drug benefits. These procedures include how to obtain a list of covered drugs and the exception policy for receiving coverage of a drug that is not on a closed formulary

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc., Aetna Health of California Inc., Aetna Health Insurance Company of New York, Aetna Health Insurance Company and/or Aetna Life Insurance Company (Aetna). In Florida, by Aetna Health Inc. and/or Aetna Life Insurance Company. In Maryland, by Aetna Health Inc., 151 Farmington Avenue, Hartford, CT 06156. Each insurer has sole financial responsibility for its own products. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. We do not provide care or guarantee access to health services.

Supplemental Information

Coverage for: Employee + Family | **Plan Type:** HMO

The following is a partial list of services and supplies that are generally not covered. However, your **plan** documents may contain exceptions to this list based on state mandates or the **plan** design or rider(s) purchased by you or your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your **plan** documents
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for **medically necessary** routine patient care costs for members participating in a cancer clinical trial with respect to the treatment of cancer or other life-threatening disease or condition
- Home births
- Immunizations for travel or work except where **medically necessary** or indicated
- Implantable drugs and certain injectable drugs including injectable infertility drugs
- Long-term rehabilitation therapy
- Non-**medically necessary** services or supplies
- Orthotics except diabetic orthotics
- Outpatient **prescription drugs** (except for treatment of diabetes), unless covered by a prescription **plan** rider and over-the-counter medications (except as provided in a hospital) and supplies
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling or **prescription drugs**
- Therapy or rehabilitation other than those listed as covered

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

We consider your personal information to be private. We have policies and procedures in place to protect your personal information from unlawful use and disclosure. For a summary of our policy, go to www.aetna.com. You'll find the Privacy Notices link at the bottom of the page.

Plan features and availability may vary by location and group size.

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