



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=081500-110020-021866> or by calling 1-888-802-3862. 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 1-888-802-3862 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	In-network: Individual \$2,000 / Family \$4,000.	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> .
<b>Are there services covered before you meet your deductible?</b>	Yes. Certain office visits, <u>preventive care</u> and <u>urgent care</u> in-network.	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	Yes. For <u>prescription drug</u> expenses - In-network: Individual \$150 / Family \$300. Does not apply to in-network for preferred generic drugs. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	In-network: Individual \$7,900 / Family \$15,800.	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 out-of-pocket limit?</b>	<u>Premiums</u> and 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 network provider?</b>	Yes. See <a href="http://www.aetna.com/docfind">http://www.aetna.com/docfind</a> or call 1-888-802-3862 for a list of in-network <u>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 charge</u> 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 referral to see a specialist?</b>	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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	None
	<u>Specialist</u> visit	\$75 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	None
	<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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	Lab: \$50 <u>copay</u> /visit, <u>deductible</u> does not apply; X-ray: 40% <u>coinsurance</u>	Not covered	None
	Imaging (CT/PET scans, MRIs)	40% <u>coinsurance</u>	Not covered	Applies to services received in office or in outpatient setting.
<b>If you need drugs to treat your illness or condition</b>  More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://client.formularynavigator.com/Search.aspx?siteCode=4391485344">http://client.formularynavigator.com/Search.aspx?siteCode=4391485344</a>	Preferred/non-preferred generic drugs (Tier 1)	\$20 <u>copay</u> / prescription (retail), \$40 <u>copay</u> / prescription (mail order), <u>deductible</u> does not apply	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- <u>network</u> . Precertification and step therapy for certain <u>prescription drugs</u> is required.
	Preferred brand drugs (Tier 2)	\$75 <u>copay</u> / prescription (retail), \$150 <u>copay</u> / prescription (mail order)	Not Covered	
	Non-preferred brand drugs (Tier 3)	\$100 <u>copay</u> / prescription (retail), \$200 <u>copay</u> / prescription (mail order)	Not Covered	
	Preferred/non-preferred <u>specialty drugs</u> (Tier 4)	40% <u>coinsurance</u> up to a \$250 maximum/ prescription for up to a 30 day supply	Not Covered	All specialty <u>prescription drug</u> fills on initial fill must be filled at a <u>network</u> specialty pharmacy except for urgent situations. Your <u>plan</u> may include access to CVS retail pharmacies for certain <u>specialty drugs</u> .
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	40% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	40% <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 immediate medical attention	<u>Emergency room care</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	No coverage for non-emergency care.
	<u>Emergency medical transportation</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification is required for certain services.
	<u>Urgent care</u>	\$50 <u>copay/visit</u> , <u>deductible</u> does not apply	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	40% <u>coinsurance</u>	Not covered	None
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: 40% <u>coinsurance</u>	Not covered	Precertification is required for certain services.
	Inpatient services	40% <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	40% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	40% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	40% <u>coinsurance</u>	Not covered	Coverage is limited to 100 visits per year.
	<u>Rehabilitation services</u>	40% <u>coinsurance</u>	Not covered	None
	<u>Habilitation services</u>	40% <u>coinsurance</u>	Not covered	None
	<u>Skilled nursing care</u>	40% <u>coinsurance</u>	Not covered	Coverage is limited to 100 days per benefit period.
	<u>Durable medical equipment</u>	40% <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>	40% <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 your child needs dental or eye care	Children's eye exam	\$30 <u>copay</u> /visit, <u>deductible</u> does not apply	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	0% <u>coinsurance</u>	Not covered	Coverage is limited to 2 prophylaxis (cleanings) and 2 fluoride applications a year.

### Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Hearing aids</li> <li>• Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)	
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care - Coverage is limited to 20 visits.</li> <li>• Infertility treatment - Benefit limitations may apply.</li> </ul>

### 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 Insurance, Consumer Communications Bureau Health, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-800-482-4833 (TTY), <http://www.insurance.ca.gov>.

- For more information on your rights to continue coverage, contact the plan at 1-888-802-3862.
- 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 <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](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 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 1-888-802-3862.
- California Department of Insurance, Consumer Communications Bureau Health, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-800-482-4833 (TTY), <http://www.insurance.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](http://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 **\$2,000**
- Specialist copayment **\$75**
- Hospital (facility) coinsurance **40%**
- Other coinsurance **40%**

**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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
Deductibles*	\$2,000
Copayments	\$300
Coinsurance	\$3,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,160</b>

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

- The plan's overall deductible **\$2,000**
- Specialist copayment **\$75**
- Hospital (facility) coinsurance **40%**
- Other coinsurance **40%**

**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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
Deductibles*	\$200
Copayments	\$2,500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,720</b>

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

- The plan's overall deductible **\$2,000**
- Specialist copayment **\$75**
- Hospital (facility) coinsurance **40%**
- Other coinsurance **40%**

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
Deductibles*	\$1,600
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,800</b>

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-888-802-3862.

\*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 1-888-802-3862.

### 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.

### 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 1-888-802-3862.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030, Fresno, CA 93779)

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

Email: [CRCoordinator@aetna.com](mailto: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 1-888-802-3862 at no cost.

- Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-888-802-3862.
- Amharic - ለቋንቋ እገዛ በ አማርኛ በ 1-888-802-3862 በነጻ ይደውሉ
- Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-802-3862
- Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-802-3862 ամասնց գնով:
- Bahasa-Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-802-3862 tanpa dikenakan biaya.
- Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-888-802-3862 ku busa
- Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-888-802-3862-তে কল করুন।
- Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-802-3862 nga walay bayad.
- Burmese - ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-802-3862 ကို ခေါ်ဆိုပါ။
- Catalan - Per rebre assistència en (català), truqui al número gratuït 1-888-802-3862.
- Chamorro - Para ayuda gi fino' (Chamoru), ágang 1-888-802-3862 sin gástu.
- Cherokee - ᠄᠋᠂ᠤ᠉ ᠰᠣ᠏ᠠ᠊᠎ᠠ᠃ᠤ ᠯᠠᠭᠠᠰᠤᠰᠤ᠃ᠤ᠉ ᠄᠋᠂ᠤ᠉ (GWY) ᠄᠋᠂ᠣ᠊᠄ᠤᠰᠤ 1-888-802-3862 ᠄᠋᠂ᠤ᠉ ᠤ ᠠ᠊᠋᠋ ᠰᠤ᠅ᠤ᠊᠋᠋ ᠰᠤ᠅ᠤ᠊᠋᠋ ᠰᠤ᠅ᠤ᠊᠋᠋ ᠰᠤ᠅ᠤ᠊᠋᠋ ᠰᠤ᠅ᠤ᠊᠋᠋.
- Chinese - 欲取得繁體中文語言協助，請撥打 1-888-802-3862，無需付費。
- Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-888-802-3862.
- Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-802-3862 irratti bilisaan bilbilaa.
- Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-802-3862.
- French - Pour une assistance linguistique en français appeler le 1-888-802-3862 sans frais.
- French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-802-3862 gratis.
- German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-802-3862 an.
- Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-802-3862 χωρίς χρέωση.
- Gujarati - ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-802-3862 પર કોલ કરો.



- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-888-802-3862. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - हन्दिी में भाषा सहायता के लएि, 1-888-802-3862 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-802-3862.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-888-802-3862 na akwụghị ụgwọ ọ bụla
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-802-3862 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-802-3862.
- Japanese - 日本語で援助をご希望の方は、1-888-802-3862 まで無料でお電話ください。
- Karen - လာတၢ်မၤစၢၤလာတၢ်ကတိၤကျိၣ်အဂီၢ် ကျိၣ် ကိး 1-888-802-3862 လာတၢ်အိၣ်ဒီးတၢ်လာတၢ်ညၢၣ်လာတၢ်စၢၤဘၣ်
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-802-3862 번으로 전화해 주십시오.
- Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pídyi dé Bašwá-wuḍuñ wεε, dá 1-888-802-3862
- Kurdish - برای راهنمایی به زبان فارسی با شماره 1-888-802-3862 به خۆرای پهیوهندی بکهن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-802-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - तीलभाषा(मराठी)सहाय्यासाठी 1-888-802-3862 क्रमांकावरकोणत्याहीखर्चाशवियकॉलकरा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-802-3862 ilo ejjelok wōnān.
- Micronesian - Pohnpeyan Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-802-3862 ni sohte isais.
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទទេៅកាន់លេខ 1-888-802-3862 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shiká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-802-3862
- Nepali - (नेपाली) मा नःशुल्क भाषा सहायता पाउनका लागि 1-888-802-3862 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tën kuwoony ë thok ë Thuonjäŋ cöl 1-888-802-3862 kecïn ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-888-802-3862 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵੱਲੋਂ ਭਾਸ਼ਾਈ ਮਦਦ ਲਈ, 1-888-802-3862 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hilfe in Deutsch, ruf: 1-888-802-3862 aa. Es Aaruf koschtet nix.

- Persian - برای راهنمایی به زبان فارسی با شماره 1-888-802-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
- Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-802-3862.
- Portuguese - Para obter assistência linguística em português ligue para o 1-888-802-3862 gratuitamente.
- Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-888-802-3862
- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-802-3862.
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-802-3862 e aunoa ma se totogi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatno broj 1-888-802-3862.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-888-802-3862.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-888-802-3862 Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-802-3862 bila malipo.
- Syriac - ܠܗܘܢܐ ܕܘܫܬܘܢܐ ܕܠܘܟܘܢ ܕܡܘܨܬܐ ܕܡܘܨܬܐ ܕܡܘܨܬܐ ܕܡܘܨܬܐ ܕܡܘܨܬܐ 1-888-802-3862 ܕܡܘܨܬܐ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-802-3862 nang walang bayad.
- Telugu - భృషణీ సాయం కిరకు ఎలంటి ఖరీచు లోకుండా 1-888-802-3862 కు శ్రీ చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-802-3862 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-802-3862 'o 'ikai hā tōtōngi.
- Trukese - Ren ánnisinis chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-888-802-3862 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedi 1-888-802-3862.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-802-3862.
- Urdu - اریکل کتفم رپ 1-888-802-3862 یول کتتو اع مین لیل ریم ودر
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-802-3862.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-888-802-3862 פרי פון אפצאל.
- Yoruba - Fún iránlọwọ nípa èdè (Yorùbá) pe 1-888-802-3862 láí san owó kankan rárá.

## AWH Providence OA Elect Choice EPO Silver

### Supplemental Information

Coverage for: Employee + Family | Plan Type: EPO

<b>How is the overall <u>deductible</u> or <u>out-of-pocket limit</u> met?</b>	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](http://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

Plans are provided by: Aetna Life Insurance Company. 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.

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.

## AWH Providence OA Elect Choice EPO Silver

### Supplemental Information

- 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

### Coverage for: Employee + Family | Plan Type: EPO

- 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](http://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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