



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-800-490-6145. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-490-6145 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In- <u>Network</u> : Individual \$600 / Family \$1,800. Out-of- <u>Network</u> : Individual \$600 / Family \$1,800.	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.
Are there services covered before you meet your deductible?	Yes. In- <u>network</u> office visits & <u>preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. Pharmacy \$100	You must pay all of the costs for these services up to the <u>deductible</u> amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In- <u>Network</u> : Individual \$1,950 / Family \$5,850. Out-of- <u>Network</u> : Individual \$2,955 / Family \$8,865.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , non-network transplant benefits, <u>balance-billing</u> , prescription charges, health care this plan doesn't cover and penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call 1(800)490-6145 for a list of in- <u>network</u> providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network	Out-of-Network	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /office visit only, <u>deductible</u> doesn't apply; 10% <u>coinsurance</u> for all other services	20% <u>coinsurance</u>	Includes Telemedicine. Coinsurance is after deductible.
	<u>Specialist</u> visit	\$25 <u>copay</u> /office visit only, <u>deductible</u> doesn't apply; 10% <u>coinsurance</u> for all other services	20% <u>coinsurance</u>	Includes Telemedicine. Coinsurance is after deductible.
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Coinurance is after deductible.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Coinurance is after deductible.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.medimpact.com	Generic drugs	30% co-insurance with a minimum \$5 copay/script	Not covered	Pharmacy <u>deductible</u> applies. Certain drugs require step therapy, quantity limits, and/or prior authorization. Some drugs are excluded from coverage.
	Preferred brand drugs			
	Non-preferred brand drugs	30% co-insurance of the brand cost plus the difference between the cost of the brand and generic		
	<u>Specialty drugs</u>	30% co-insurance with a minimum \$5 copay/script		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Coinurance is after deductible.
	Physician/surgeon fees	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Coinurance is after deductible.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network	Out-of-Network	
If you need immediate medical attention If you need immediate medical attention	<u>Emergency Room Care</u>	\$75 co-pay then 10% <u>coinsurance</u>		Copay is waived if patient is admitted or accidental injury. 20% <u>coinsurance</u> for out-of-network non-emergency use. Coinsurance is after deductible.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Coinsurance is after deductible.
	<u>Urgent care</u>	\$25 <u>copay</u> /office visit only, <u>deductible</u> doesn't apply; 10% <u>coinsurance</u> for all other services	10% <u>coinsurance</u>	20% <u>coinsurance</u> for out-of-network non-urgent use. Coinsurance is after deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Coinsurance is after deductible. Penalty of \$1,000 (or 20% of <u>allowed amount</u> if less) for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Coinsurance is after deductible.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: 10% <u>coinsurance</u>	Office & other outpatient services: 20% <u>coinsurance</u> of allowed amount	Coinsurance is after deductible.
	Inpatient services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Coinsurance is after deductible. Penalty of \$1,000 (or 20% of <u>allowed amount</u> if less) for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge; except \$25 <u>copay</u> for initial visit to confirm pregnancy, <u>deductible</u> doesn't apply	20% <u>coinsurance</u>	None.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Coinsurance is after deductible. Cost sharing doesn't apply to certain <u>preventive</u> services. Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound)..

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network	Out-of-Network	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Coinsurance is after deductible. Cost sharing doesn't apply to certain <u>preventive</u> services. Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Coinsurance is after deductible. Prior authorization is required.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	60 visits/calendar year for Physical, Occupational & Speech Therapy combined. Coinsurance is after deductible.
	<u>Habilitation services</u>	\$25 co-pay/visit	20% <u>coinsurance</u>	Coinsurance is after deductible.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Coinsurance is after deductible. Prior authorization is required.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Coinsurance is after deductible. Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. Prior authorization required on some devices.
	<u>Hospice services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	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.)

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

- Chiropractic care
- Hearing Services
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Private-duty nursing

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:

- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information 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:

- Anthem directly by calling the toll free number on your Medical ID Card, .
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 Standard? 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 <u>plan's</u> overall <u>deductible</u>	\$600
■ <u>Specialist</u> <u>copayment</u>	\$25
■ Hospital (facility) <u>copayment</u>	\$0
■ Other <u>coinsurance</u>	10%

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	\$600
Copayments	\$25
Coinsurance	\$1200
<i>What isn't covered</i>	
Limits or exclusions	\$150
The total Peg would pay is	\$1975

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

■ The <u>plan's</u> overall <u>deductible</u>	\$600
■ <u>Specialist</u> <u>copayment</u>	\$25
■ Hospital (facility) <u>copayment</u>	0%
■ Other <u>coinsurance</u>	10%

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	\$600
Copayments/Coinsurance	\$500
Prescription Costs	\$1200
<i>What isn't covered</i>	
Limits or exclusions	\$80
The total Joe would pay is	\$2380

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

■ The <u>plan's</u> overall <u>deductible</u>	\$600
■ <u>Specialist</u> <u>copayment</u>	\$25
■ Hospital (facility) <u>copayment</u>	\$0
■ Other <u>coinsurance</u>	10%

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	\$600
Copayments	\$100
Coinsurance	\$120
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$820

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.

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 the number on your ID card.

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

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: 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.

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).

TTY: 711

Language Assistance:

For language assistance in your language call 1-888-982-3862 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.
Amharic -	ለ ቋንቋ እገዛ በ አሜሪካ በ 1-888-982-3862 በነጻ ይደውሉ
Arabic -	1-888-982-3862 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-888-982-3862 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-888-982-3862-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
Burmese -	ဧကူန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gåstu.
Cherokee -	ᎠᎩᎠᎵ ᎠᎩᎠᎵ ᎠᎩᎠᎵ ᎠᎩᎠᎵ ᎠᎩᎠᎵ (CWY) ᎠᎩᎠᎵ 1-888-982-3862 ᎠᎩᎠᎵ ᎠᎩᎠᎵ ᎠᎩᎠᎵ ᎠᎩᎠᎵ.
Chinese -	欲取得繁體中文語言協助，請撥打1-888-982-3862，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi l paya hinla 1-888-982-3862.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.
French -	Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-982-3862 પર કોલ કરો.

Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ‘ole ‘ia kēia kōkua nei.

Hindi - हन्दिी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.

Ibo - Maka enyemaka asusu na Igbo kpoo 1-888-982-3862 na akwughi ugwo o bula

Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.

Japanese - 日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。

Karen - လာတာမစာတာကတီးကျိပ်အင်္ဂါ ကျိပ် ကိး 1-888-982-3862 လာတအိပ်ဒီးတာလောင်ဘျင်လောင်စုဘျင်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.

Kru-Bassa - ʔe'm'ké gbo-kpá-kpá dyé pídyi dé ʔašóò-wuḍuũn wēē, dá 1-888-982-3862

Kurdish - برای راهنمایی به زبان فارسی یا شماره 1-888-982-3862 به خورایی پیروندی بکن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi - () 1-888-982-3862

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Marshallese - Ñan bōk jipañ ilo Kajin Maiol, kallok 1-888-982-3862 ilo ejjelok wōnān.

Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.

សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទទួលបានលេខ 1-888-982-3862 ដោយឥតគិតថ្លៃ។

Navaio - T'áá shi shizaad k'ehí bee shíká a'doowol nínízingo Diné k'ehí koji' t'áá jíík'e hólne' 1-888-982-3862

Nepali - () 1-888-982-3862

Nilotic-Dinka - Tën kuɔny ë thok ë Thuɔnjän cɔl 1-888-982-3862 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.

Punjabi - ਪੰਜਾਬੀ ਵੱਚਿ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Hilfe in Deutsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.

Persian - برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.

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