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=070600-060020-051751](https://www.aetna.com/sbcsearch/getpolicydocs?u=070600-060020-051751) or by calling 1-800-370-4526. 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/](https://www.healthcare.gov/sbc-glossary/) or call 1-800-370-4526 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>Network: Individual $0 / Family $0.</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>No.</td>
<td>You will have to meet the deductible before the plan pays for any services.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Network: Individual $1,500 / Family $3,000. Prescription drugs: Individual $3,000 / Family $9,000.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, and health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-800-370-4526 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
</tr>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15 copay/visit</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20 copay/visit</td>
</tr>
<tr>
<td></td>
<td>Preventive care / screening / immunization</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge for laboratory; $20 copay/visit for x-ray</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$20 copay/visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Copay/prescription: $10 (retail), $20 (mail order)</td>
</tr>
<tr>
<td>More information about <strong>prescription drug coverage</strong> is available at <a href="http://www.aetnapharmacy.com/premierplus">www.aetnapharmacy.com/premierplus</a></td>
<td>Preferred brand drugs</td>
<td>Copay/prescription: 30% (retail &amp; mail order)</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Copay/prescription: 50% (retail &amp; mail order)</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Applicable cost as noted above for generic or brand drugs</td>
</tr>
<tr>
<td>Premier Plus Formulary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$75 copay/visit</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$75 copay/visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$35 copay/visit</td>
</tr>
</tbody>
</table>

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

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$300 copay/stay</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office &amp; other outpatient services: $15 copay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$300 copay/stay</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$300 copay/stay</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$20 copay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$20 copay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$300 copay/stay</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>$300 copay/stay for inpatient; no charge for outpatient</td>
<td>Not covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
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
- Cosmetic surgery
- Dental care (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs - Except for required preventive services.

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

- Acupuncture
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs - Except for required preventive services.
- Bariatric surgery
- Chiropractic care
- Private-duty nursing
- Routine eye care (Adult) - 1 routine eye exam/12 months.

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Financial Services, (800) 342-3736, http://www.dfs.ny.gov/consumer/chealth.htm
- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- 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:
- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- 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 plan's overall deductible: $0
- Specialist copayment: $20
- Hospital (facility) copayment: $300
- 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** $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions $60

**The total Peg would pay is** $460

### 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: $20
- Hospital (facility) copayment: $300
- Other copayment: $0

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$700</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$800</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions $20

**The total Joe would pay is** $1,520

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

- The plan's overall deductible: $0
- Specialist copayment: $20
- Hospital (facility) copayment: $300
- 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** $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions $0

**The total Mia would pay is** $200

Note: If your plan has a wellness program and you choose to participate, you may be able to reduce your costs.

The plan would be responsible for the other costs of these EXAMPLE covered services.
**Assistive Technology**
Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

**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 on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com.

California HMO/HNO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY 711, Fax 860-262-7705, CRCoordinator@aetna.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (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.
Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.
Amharic - ለጭጥነት እገዛ ያለም እና የ 1-800-370-4526 በነጻ ይደውሉ
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال بالرقم المجاني 1-800-370-4526.
Armenian - հերթական գործունեություն ազատ գումարով (համար) կանգնետ 1-800-370-4526 առաջադեմ փուրձ.
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-800-370-4526 ku busa
Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-370-4526-তে কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese - ေငြကုန္က်ခံစရာမလိုဘဲ (ျမန္မာဘာသာစကား)ျဖင့္ ဘာသာစကားအကူအညီရယူရန္ 1-800-370-4526 ကို ေခၚဆိုပါ။
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.
Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu.
Chinese - 欲取得繁體中文語言協助，請撥打 1-800-370-4526，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi ! paya hinla 1-800-370-4526.
Cushite - Gargaarsa afan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.
French - Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.
French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.
Gujarati - ગુજરાતીમાં ભાષા સહાય માટે કોઈ પણ પ્રાચીન વચાર 1-800-370-4526 પર કોલ કરો.
No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ‘ole ia kēia kōkua nei.

1-800-370-4526 is available in the following languages:

Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ‘ole ia kēia kōkua nei.
Hindi - हनिदी में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ्त कॉल करें।
Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.
Ibo - Maka enyemaka asusu na Igbo kpoọ 1-800-370-4526 na akwughi ọgwọ ọ bụla
Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.
Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.
Japanese - 日本語で援助をご希望の方は、1-800-370-4526まで無料でお電話ください。
Karen - သင်များသည် ဘာသာစာရေးစားသည် မှာ အခြေခံမှု များ ရခြင်း ရှိသည်။ သင်ကြားရည်ရွယ်ချက် 1-800-370-4526
Kurdish - 1-800-370-4526
Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-370-4526 ເປີດໂທຊ່ວຍເນົາ ຜ່ານກະບົດຂໍ້ມູນນີ້.
Malay - Dimana anda memerlukan bantuan bahasa, telepon ke 1-800-370-4526
Marathi - मराठी भाषा सहाय्यासाठी 1-800-370-4526 क्रमांकावर कोणत्याही खर्चाशिवाय कॉल करा.
Marshallese - Ñan bōk jipa ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wönän.
Micronesian - Ohng palien sawas en sou kawewe ni omw loka Ponape koahl 1-800-370-4526 ni sohte isais.
Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ដោយឥតគិតថ្លៃ។
Nilotic-Dinka - Tën kuroony ê thok ê Thuecjan cöl 1-800-370-4526 kecín ayöc.
Norwegian - For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.
Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 ਵਿੱਚ ਫੋਨ ਲਾਗੋ।
Persian - برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.
Para obtener asistencia lingüística em português ligue para o 1-800-370-4526 gratuitamente.

Покупкаلحقوقو زاین از رویکرد ولوله یکی از دسته‌بندی‌هایهای است که با کمک یک کارشناس زبان، پیامدهایی را که به وسیله استفاده از عدد 1-800-370-4526، به کارگردانی شده‌اند.

Русский — Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.

Romanian — Pentru asistență lingvistică în românescă telefonați la numărul gratuit 1-800-370-4526.

Russian — Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.

Samoan — Mo fesoasoani tau gagana le Gagana Samoa vala’au le 1-800-370-4526 e auu ma se totogi.

Serbo-Croatian — Za jezičnu pomoć na hrvatskom jeziku pozovite besplatni broj 1-800-370-4526.

Spanish — Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.

Sudanic-Fulfude — Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-800-370-4526. Njodi woo fawaaki on.

Swahili — Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.

Syriac — ܐܲܠܢܘܦܝܠܬܕ ܐܳܡܩܰܪ ܟܳܠ ܐܳܗ ܐܳܿܝܳܝܪܽܘܣ ܐܳܢܫܶܠܒ ܐܬܽܘܢܪܕܰܥܡ ܬ 1-800-370-4526 ܠܫܛܝܐ ܠܠܐ ܐܲܒܪܬܳܢܝܐ.

Tagalog — Para sa tulong sa wika na Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.

Telugu — భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-800-370-4526 కు కాల్ చేయండి. (తెలుగు)

Thai — สำหรับความช่วยเหลือทางด้านภาษาเป็นภาษาไทยโทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย.

Tongan — Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-370-4526 ʻo ‘ikai hā tōtōngi.

Trukese — Ren ániminisin chiakú ren (Kapasen Chuuk) kopwe kěkkéeri 1-800-370-4526 nge esapw kamé ngonuk.

Turkish — (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526.

Ukrainian — Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.

Urdu — ایکی کس کی آپ کو کمک کردار، 1-800-370-4526 سے دوہری کارکردگی کا لئے.

Vietnamese — Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526.

Yiddish — 1-800-370-4526

Yoruba — Fún irànloṣọ́ nípa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan rará.
Supplemental Information

<table>
<thead>
<tr>
<th>How is the overall deductible or out-of-pocket limit met?</th>
<th>Individual deductible and out-of-pocket limit payments apply to the family deductible and out-of-pocket limit.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The family deductible and family out-of-pocket limit are cumulative for all family members. The family deductible and out-of-pocket limit can be met by a combination of family members; however no single individual within the family will be subject to more than the individual deductible or out-of-pocket limit amount.</td>
<td></td>
</tr>
</tbody>
</table>

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

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.
Supplemental Information

This health insurance issuer believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 1-800-370-4526. If your plan is governed by ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/elsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

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.

- 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
- 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

Questions: Call the toll free number on your ID card (1-888-982-3862 for prospective members), TDD 1-800-628-3323 (hearing impaired only), or visit us at www.HealthReformPlanSBC.com.
Supplemental Information

- 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

Coverage for: Individual + Family | Plan Type: EPO

- 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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