



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](http://www.HealthReformPlanSBC.com) or by calling 1-888-982-3862. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	Aexcel Designated/In-Network: Individual \$500 / Family \$1,000. Out-of-Network: Individual \$1,500 / Family \$3,000.	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.
<b>Are there services covered before you meet your deductible?</b>	Yes. Prescription drugs & preventive care are covered before you meet your deductible.	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 <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 prescription drugs- Individual \$100 / Family \$200. 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.
<b>What is the out-of-pocket limit for this plan?</b>	Aexcel Designated/In-Network: Individual \$3,000 / Family \$6,000. Out-of-Network: Individual \$6,000 / Family \$12,000.	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.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billing charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-888-982-3862 for a list of designated in-network providers.	You pay the least if you use a provider that's Aexcel Designated. You pay more if you use a provider in In-Network or Aexcel Non-Designated. 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.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the specialist you choose without a referral.



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
		Aexcel Designated Provider (You will pay the least)	In-Network Provider (You will pay more)	Aexcel Non-Designated Provider (You will pay more)	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	10% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Specialist visit	10% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Preventive care /screening /immunization	No charge	No charge	No charge	No charge up to \$250; 40% <u>coinsurance</u> thereafter, <u>deductible</u> doesn't apply	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	Diagnostic test (x-ray, blood work)	Not applicable	20% <u>coinsurance</u>	Not applicable	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	Not applicable	20% <u>coinsurance</u>	Not applicable	40% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition	Generic drugs	Not applicable	Copay/prescription, after specific <u>deductible</u> : \$10 (retail), \$20 (mail order)	Not applicable	Not covered	Covers 31-day supply (retail), up to 90-day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's
<u>Prescription drug coverage is administered by Caremark</u>	Preferred brand drugs	Not applicable	Copay/prescription, after specific <u>deductible</u> : \$30 (retail), \$75 (mail order)	Not applicable	Not covered	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Aexcel Designated Provider (You will pay the least)	In-Network Provider (You will pay more)	Aexcel Non-Designated Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
More information about <b>prescription drug coverage</b> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Non-preferred brand drugs	Not applicable	Copay/prescription, after specific deductible: 50% coinsurance with a \$50 minimum (min) and a \$150 maximum (max)/prescription (retail), 50% coinsurance with a \$125 min and a \$375 max/prescription (mail order)	Not applicable	Not covered	contraceptives in-network.
	<u>Specialty drugs</u>	Not applicable	Copay/prescription, after specific deductible: \$20 (generic), 25% coinsurance with \$50 minimum & \$150 maximum/prescription (formulary), 50% coinsurance with \$100 minimum & \$250 maximum/prescription (non-formulary) (retail & mail order)	Not applicable	Not covered	Covers 31 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not applicable	20% coinsurance	Not applicable	40% coinsurance	None
	Physician/surgeon fees	10% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	None
If you need immediate medical	<u>Emergency room care</u>	Not applicable	20% coinsurance	Not applicable	20% coinsurance	No coverage for non-emergency use.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Aexcel Designated Provider (You will pay the least)	In-Network Provider (You will pay more)	Aexcel Non-Designated Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
attention	<u>Emergency medical transportation</u>	Not applicable	20% <u>coinsurance</u>	Not applicable	20% <u>coinsurance</u>	Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	Not applicable	20% <u>coinsurance</u>	Not applicable	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Not applicable	20% <u>coinsurance</u>	Not applicable	40% <u>coinsurance</u>	<u>Pre-authorization</u> required out-of-network care.
	Physician/surgeon fees	10% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not applicable	Office & other outpatient services: 20% <u>coinsurance</u>	Not applicable	Office & other outpatient services: 40% <u>coinsurance</u>	None
	Inpatient services	Not applicable	20% <u>coinsurance</u>	Not applicable	40% <u>coinsurance</u>	<u>Pre-authorization</u> required out-of-network care.
If you are pregnant	Office visits	No charge	No charge	No charge	40% <u>coinsurance</u>	Cost sharing does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) <u>Pre-authorization</u> required out-of-network care may apply.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	Not applicable	20% <u>coinsurance</u> , <u>deductible</u> doesn't apply to newborn initial confinement	Not applicable	40% <u>coinsurance</u> , <u>deductible</u> doesn't apply to newborn initial confinement	
If you need help recovering or have other special health needs	<u>Home health care</u>	Not applicable	20% <u>coinsurance</u>	Not applicable	40% <u>coinsurance</u>	200 visits/calendar year combined with private-duty nursing. <u>Pre-authorization</u> required out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Aexcel Designated Provider (You will pay the least)	In-Network Provider (You will pay more)	Aexcel Non-Designated Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	<u>Rehabilitation services</u>	Not applicable	20% <u>coinsurance</u> 1st 60 visits Physical Therapy & Occupational Therapy; 1st 90 visits Speech Therapy, 30% <u>coinsurance</u> thereafter, <u>deductible</u> doesn't apply	Not applicable	40% <u>coinsurance</u> 1st 60 visits Physical Therapy & Occupational Therapy; 1st 90 visits Speech Therapy, 50% <u>coinsurance</u> thereafter, <u>deductible</u> doesn't apply	60 visits/calendar year for Physical & Occupational Therapy combined, 90 visits Speech Therapy.
	<u>Habilitation services</u>	Not applicable	20% <u>coinsurance</u>	Not applicable	40% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	Not applicable	20% <u>coinsurance</u>	Not applicable	40% <u>coinsurance</u>	120 days/calendar year. <u>Pre-authorization</u> required out-of-network care.
	<u>Durable medical equipment</u>	Not applicable	20% <u>coinsurance</u>	Not applicable	40% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	Not applicable	20% <u>coinsurance</u>	Not applicable	40% <u>coinsurance</u>	<u>Pre-authorization</u> required out-of-network care.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not applicable	No charge	Not applicable	No charge up to \$250; 40% <u>coinsurance</u> , <u>deductible</u> doesn't apply	1 routine eye exam/calendar year
	Children's glasses	Not applicable	Not covered	Not applicable	Not covered	Not covered.
	Children's dental check-up	Not applicable	Not covered	Not applicable	Not covered	Not covered.

## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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
- Bariatric surgery - Limited to Institutes of Quality contracted facility for in-network only.
- Chiropractic care - 20 visits/calendar year.
- Hearing aids - 1 hearing aid per ear/2 years up to age 19, every 3 years thereafter.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. Artificial insemination, ovulation induction & advanced reproductive technology: \$24,000 Medical maximum/lifetime and \$7,500 Rx maximum/lifetime.
- Private-duty nursing - 200 visits/calendar year combined with home health care.
- Routine eye care (Adult) - 1 routine eye exam/calendar year.

## 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:

- For more information on your rights to continue coverage, contact the plan at 1-888-982-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or : <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 1-888-982-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA

(3272) or <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 information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

**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 \$500
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 20%
- Other coinsurance 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
Deductibles*	\$500
Copayments	\$0
Coinsurance	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,760</b>

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

- The plan's overall deductible \$500
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 20%
- Other coinsurance 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
Deductibles*	\$600
Copayments	\$1,000
Coinsurance	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,700</b>

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

- The plan's overall deductible \$500
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 20%
- Other coinsurance 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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
Deductibles*	\$500
Copayments	\$0
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$700</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: 1-888-982-3862.

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

## 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](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).

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