



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/getcbpolicydocs?P=0759952&Y=23>, or by calling 1-844-365-7373. 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 1-844-365-7373 to request a copy.

| Important Questions | Answers | Why This Matters: |
|--|--|---|
| What is the overall deductible? | In- <u>Network</u> : Individual \$1,500 / Family \$3,000. | 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> . |
| Are there services covered before you meet your deductible? | Yes. Certain office visits, <u>preventive care</u> , emergency care and <u>urgent care</u> in- <u>network</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? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the out-of-pocket limit for this plan? | In- <u>Network</u> : Individual \$7,000 / Family \$14,000. | 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. |
| What is not included in the out-of-pocket limit? | <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> . |
| Will you pay less if you use a network provider? | Yes. See https://aet.na/providersearch_aetna or call 1-844-365-7373 for a list of in- <u>network 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</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 Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$20 <u>copay</u> /visit, <u>deductible</u> does not apply | Not covered | None |
| | <u>Specialist</u> visit | \$40 <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. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 20% <u>coinsurance</u> | Not covered | Applies to services received in office or in outpatient setting. |
| | Imaging (CT/PET scans, MRIs) | 20% <u>coinsurance</u> | Not covered | Applies to services received in office or in outpatient setting. Cost share applies to all places of service. |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at http://aet.na/gaivl23 | Preferred generic drugs | \$15 <u>copay</u> / prescription (retail), \$37.50 <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> . |
| | Preferred brand drugs | \$40 <u>copay</u> / prescription (retail), \$100 <u>copay</u> / prescription (mail order) | Not covered | |
| | Non-preferred generic/brand drugs | 40% <u>coinsurance</u> (retail & mail order) | Not covered | |
| | Preferred/non-preferred <u>specialty drugs</u> | 50% <u>coinsurance</u> for up to a 30 day supply | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u> for hospital facility; 10% <u>coinsurance</u> for free standing facility | Not covered | None |
| | Physician/surgeon fees | 20% <u>coinsurance</u> for hospital facility; 10% <u>coinsurance</u> for free standing facility | 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> | \$750 <u>copay/visit</u> , <u>deductible</u> does not apply | \$750 <u>copay/visit</u> , <u>deductible</u> does not apply | <u>Copay</u> waived if admitted. Out-of-network <u>emergency room care</u> cost-share same as in-network. No coverage for non-emergency care. |
| | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | Out-of-network cost-share same as in-network. |
| | <u>Urgent care</u> | \$40 <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) | 20% <u>coinsurance</u> | Not covered | None |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | Not covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Outpatient office visits: \$20 <u>copay/visit</u> , <u>deductible</u> does not apply; All other outpatient services: 20% <u>coinsurance</u> | Not covered | None |
| | Inpatient services | 20% <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> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | Not covered | |
| | Childbirth/delivery facility services | 20% <u>coinsurance</u> | Not covered | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 20% <u>coinsurance</u> | Not covered | Coverage is limited to 120 visits. |
| | <u>Rehabilitation services</u> | 20% <u>coinsurance</u> | Not covered | Coverage is limited to 40 visits for Physical Therapy and Occupational Therapy combined, 40 visits for Speech Therapy. |
| | <u>Habilitation services</u> | 20% <u>coinsurance</u> | Not covered | None |
| | <u>Skilled nursing care</u> | 20% <u>coinsurance</u> | Not covered | Coverage is limited to 60 days. |
| | <u>Durable medical equipment</u> | 45% <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> | 20% <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 | 50% <u>coinsurance</u> | Not covered | Coverage is limited to 1 exam every 12 months, through the end of the month after the person attains age 19. |
| | Children's glasses | 50% <u>coinsurance</u> | Not covered | Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses every 12 months, through the end of the month after the person attains age 19. |
| | 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.)

- | | | |
|-------------------------------|--|----------------------------|
| • Abortion | • Infertility treatment | • Private-duty nursing |
| • Bariatric surgery | • Long-term care | • Routine eye care (Adult) |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Routine foot care |
| • Dental care (Adult & Child) | | • Weight loss programs |

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

- | | |
|---|--|
| • Acupuncture - Coverage is limited to 10 visits. | • Hearing aids - Coverage is limited to \$3,000 maximum per 48 months per ear for hearing aid. Paid as billed. |
| • Chiropractic care - Coverage is limited to 20 visits. | |

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: Georgia Office of the Commissioner of Insurance and Safety Fire, Consumer Services Division, Local: (404) 656-2070, Toll-free: 800-656-2298, <https://oci.georgia.gov/insurance-resources>.

- For more information on your rights to continue coverage, contact the plan at 1-844-365-7373.

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 or state health insurance marketplace or SHOP.

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 on how 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:

- Georgia Office of the Commissioner of Insurance and Safety Fire, Consumer Services Division, Local: (404) 656-2070, Toll-free: 800-656-2298,

<https://oci.georgia.gov/insurance-resources>.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Not Applicable.

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 **\$1,500**
- Specialist copayment **\$40**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

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 | \$12,700 |
| In this example, Peg would pay: | |
| <i>Cost Sharing</i> | |
| <u>Deductibles</u> | \$1,500 |
| <u>Copayments</u> | \$10 |
| <u>Coinsurance</u> | \$2,000 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$3,570 |

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

- The plan's overall deductible **\$1,500**
- Specialist copayment **\$40**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

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 | \$5,600 |
| In this example, Joe would pay: | |
| <i>Cost Sharing</i> | |
| <u>Deductibles</u> | \$1,500 |
| <u>Copayments</u> | \$1,000 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,520 |

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

- The plan's overall deductible **\$1,500**
- Specialist copayment **\$40**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

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 | \$2,800 |
| In this example, Mia would pay: | |
| <i>Cost Sharing</i> | |
| <u>Deductibles</u> | \$1,300 |
| <u>Copayments</u> | \$700 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,000 |

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: 1-844-365-7373.

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 1-844-365-7373.

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 unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide 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: P.O. Box 24030, Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), 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).

Health plans are offered or underwritten or administered by Aetna Health Inc. (Georgia) (Aetna). Aetna is part of the CVS Health family of companies.

- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-844-365-7373. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - हन्दिी में भाषा सहायता के लएि, 1-844-365-7373 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-844-365-7373.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-844-365-7373 na akwughị ugwo ọ bụla
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-844-365-7373 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-844-365-7373.
- Japanese - 日本語で援助をご希望の方は、1-844-365-7373 まで無料でお電話ください。
- Karen - လာတၢ်မၤစၢလၢတၢ်ကတိၤကိၣ်အဂီၢ် ကိၣ် ဂိး 1-844-365-7373 လၢတအိၣ်ဒီးတၢ်လၢတၢ်ညးလၢတၢ်စၢလၢ
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-844-365-7373 번으로 전화해 주십시오.
- Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pídyi dé Bašwó`wuḍuñ wεε, dá 1-844-365-7373
- Kurdish - برای راهنمایی به زبان فارسی با شماره 1-844-365-7373 به خۆرای پهیوهندی بکهن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-844-365-7373 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - कोणत्याही शुल्काशुवाय भाषा सेवा प्राप्त करण्यासाठी, 1-844-365-7373 वर फोन करा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-844-365-7373 ilo ejjelok wōnān.
- Micronesian - Pohnpeyan Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-844-365-7373 ni sohte isais.
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-844-365-7373 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-844-365-7373
- Nepali - (नेपाली) मा नःशुल्क भाषा सहायता पाउनका लागि 1-844-365-7373 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tèn kuwoony ë thok ë Thuonjäng col 1-844-365-7373 kecïn ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-844-365-7373 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵੱਚੋਂ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-844-365-7373 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hilfe in Deutsch, ruf: 1-844-365-7373 aa. Es Aaruf koschtet nix.

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| Persian - | برای راهنمایی به زبان فارسی با شماره 1-844-365-7373 بدون هیچ هزینه ای تماس بگیرید. انگلیسی |
| Polish - | Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-844-365-7373. |
| Portuguese - | Para obter assistência linguística em português ligue para o 1-844-365-7373 gratuitamente. |
| Romanian - | Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-844-365-7373 |
| Russian - | Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-844-365-7373. |
| Samoan - | Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-844-365-7373 e aunoa ma se totogi. |
| Serbo-Croatian - | Za jezičnu pomoć na hrvatskom jeziku pozovite besplatno broj 1-844-365-7373. |
| Spanish - | Para obtener asistencia lingüística en español, llame sin cargo al 1-844-365-7373. |
| Sudanic-Fulfude - | Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-844-365-7373 Njodi woo fawaaki on. |
| Swahili - | Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-844-365-7373 bila malipo. |
| Syriac - | 1-844-365-7373 . |
| Tagalog - | Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-844-365-7373 nang walang bayad. |
| Telugu - | భూషణి సాయం కొరకు ఎలాంటి ఖరీచు లేకుండా 1-844-365-7373 కు కల్ చేయండి. (తెలుగు) |
| Thai - | สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-844-365-7373 ฟรีไม่มีค่าใช้จ่าย |
| Tongan - | Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-844-365-7373 'o 'ikai hā tōtōngi. |
| Trukese - | Ren ánnisinis chiakú ren (Kapasen Chuuk) kopwe kékékéeri 1-844-365-7373 nge esapw kamé ngonuk. |
| Turkish - | (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedin 1-844-365-7373. |
| Ukrainian - | Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-844-365-7373. |
| Urdu - | بلا قیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-844-365-7373 پر بات کریں |
| Vietnamese - | Đề được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-844-365-7373. |
| Yiddish - | פאר שפראך הילף אין אידיש רופט 1-844-365-7373 פון אפצאל. |
| Yoruba - | Fún iranlọwọ nípa èdè (Yorùbá) pe 1-844-365-7373 láí san owó kankan rárá. |