



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=0760437&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 <u>deductible</u>? | In- <u>Network</u> : Individual \$5,000 / Family \$10,000. | 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 <u>deductible</u>? | Yes. Certain office visits, <u>preventive care</u> 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 <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u>? | In- <u>Network</u> : Individual \$8,700 / Family \$17,400. | 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 <u>out-of-pocket limit</u>? | <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 <u>network provider</u>? | 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 <u>referral</u> to see a <u>specialist</u>? | 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 | \$25 <u>copay</u> /visit, <u>deductible</u> does not apply | Not covered | None |
| | <u>Specialist</u> visit | \$50 <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) | Lab: \$25 <u>copay</u> /visit, <u>deductible</u> does not apply; X-ray: \$50 <u>copay</u> /visit, <u>deductible</u> does not apply | Not covered | Applies to services received in outpatient setting, varies in a physician or <u>specialist</u> office. |
| | Imaging (CT/PET scans, MRIs) | 40% <u>coinsurance</u> | Not covered | Applies to services received in outpatient setting, varies in a physician or <u>specialist</u> office. |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at http://aet.na/moiv123 | 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). Your cost will be higher for choosing Brand over Generics; cost difference penalty doesn't apply to overall <u>deductible</u> or <u>out-of-pocket limit</u> . No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> . Maintenance drugs- after two retail fills, you are required to fill a 90-day supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy. |
| | Preferred brand drugs | \$50 <u>copay</u> / prescription (retail), \$125 <u>copay</u> / prescription (mail order) | Not covered | |
| | Non-preferred generic/brand drugs | 45% <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) | 40% <u>coinsurance</u> | Not covered | None |
| | Physician/surgeon fees | 40% <u>coinsurance</u> | Not covered | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need immediate medical attention | <u>Emergency room care</u> | 40% <u>coinsurance</u> | 40% <u>coinsurance</u> | 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> | 40% <u>coinsurance</u> | 40% <u>coinsurance</u> | Out-of-network cost-share same as in-network. |
| | <u>Urgent care</u> | \$50 <u>copay/visit</u> , <u>deductible</u> does not apply | Not covered | No coverage for non-urgent use. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 40% <u>coinsurance</u> | Not covered | None |
| | Physician/surgeon fees | 40% <u>coinsurance</u> | Not covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Outpatient office visits: \$25 <u>copay/visit</u> , <u>deductible</u> does not apply; All other outpatient services: 40% <u>coinsurance</u> | Not covered | None |
| | Inpatient services | 40% <u>coinsurance</u> | Not covered | None |
| If you are pregnant | Office visits | No charge | Not covered | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 40% <u>coinsurance</u> | Not covered | |
| | Childbirth/delivery facility services | 40% <u>coinsurance</u> | Not covered | |

| 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 help recovering or have other special health needs | <u>Home health care</u> | 40% <u>coinsurance</u> | Not covered | Coverage is limited to 100 visits. |
| | <u>Rehabilitation services</u> | \$25 <u>copay/visit</u> , <u>deductible</u> does not apply for Physical Therapy and Occupational Therapy; \$50 <u>copay/visit</u> , <u>deductible</u> does not apply for Speech Therapy | Not covered | Coverage is limited to 20 visits each for Physical Therapy and Occupational Therapy. |
| | <u>Habilitation services</u> | No charge | Not covered | None |
| | <u>Skilled nursing care</u> | 40% <u>coinsurance</u> | Not covered | Coverage is limited to 150 days. |
| | <u>Durable medical equipment</u> | 40% <u>coinsurance</u> | Not covered | Coverage is limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse. |
| | <u>Hospice services</u> | 40% <u>coinsurance</u> | Not covered | None |
| 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 up to 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 up to 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.)

- | | | |
|--|---|---|
| <ul style="list-style-type: none"> • Abortion - except when the life of the mother is endangered, or complications arise. • Bariatric surgery • Cosmetic surgery • Dental care (Adult & Child) | <ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. • Routine eye care (Adult) | <ul style="list-style-type: none"> • 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.)

- | | | |
|--|---|--|
| <ul style="list-style-type: none"> • Acupuncture - Coverage is limited to 10 visits. • Chiropractic care | <ul style="list-style-type: none"> • Hearing aids - 1 per ear every 4 years. | <ul style="list-style-type: none"> • Private-duty nursing - Coverage is limited to 82 eight hour shifts in home setting only. |
|--|---|--|

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:

Missouri Department of Commerce and Insurance, Harry S. Truman State Office Building, 573-751-4126, <https://insurance.mo.gov/consumers/complaints/index.php>.

- 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:

- Missouri Department of Commerce and Insurance, Harry S. Truman State Office Building, 573-751-4126, <https://insurance.mo.gov/consumers/complaints/index.php>.

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 \$5,000
- Specialist copayment \$50
- Hospital (facility) coinsurance 40%
- Other coinsurance 40%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

| | |
|--|-----------------|
| Total Example Cost | \$12,700 |
| In this example, Peg would pay: | |
| <i>Cost Sharing</i> | |
| <u>Deductibles</u> | \$5,000 |
| <u>Copayments</u> | \$200 |
| <u>Coinsurance</u> | \$2,000 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$7,260 |

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

- The plan's overall deductible \$5,000
- Specialist copayment \$50
- Hospital (facility) coinsurance 40%
- Other coinsurance 40%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Diabetic supplies (*glucose meter*)

| | |
|--|----------------|
| Total Example Cost | \$5,600 |
| In this example, Joe would pay: | |
| <i>Cost Sharing</i> | |
| <u>Deductibles</u> | \$3,100 |
| <u>Copayments</u> | \$800 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$3,920 |

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

- The plan's overall deductible \$5,000
- Specialist copayment \$50
- Hospital (facility) coinsurance 40%
- Other coinsurance 40%

This EXAMPLE event includes services like:

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

| | |
|--|----------------|
| Total Example Cost | \$2,800 |
| In this example, Mia would pay: | |
| <i>Cost Sharing</i> | |
| <u>Deductibles</u> | \$1,900 |
| <u>Copayments</u> | \$200 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,100 |

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).

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TTY: 711

Language Assistance:

For language assistance in your language call 1-844-365-7373 at no cost.

- Albanian - Për shërbime përkthimi falas për ju, telefononi 1-844-365-7373.
- Amharic - የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-844-365-7373 ይደውሉ።
- Arabic - مقرر على اصوات الاء اجرال، ءفلكت يى نود ءيوغلل ال اءءءل عل لوصحلل 1-844-365-7373
- Armenian - Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-844-365-7373 հեռախոսահամարով:
- Bahasa-Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-844-365-7373 tanpa dikenakan biaya.
- Bantu-Kirundi - Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-844-365-7373.
- Bengali-Bangala - আপনাকে বিনামূল্যে ভাষা পবকিষাি পপকে হকয এই নম্বকি পবেযক ান ব্লেন: 1-844-365-7373।
- Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-844-365-7373.
- Burmese - သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန် 1-844-365-7373 သို့ ဖုန်းခေါ်ဆိုပါ။
- Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-844-365-7373.
- Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-844-365-7373.
- Cherokee - ႠႩႪႩ ႩႪႩႪႩ ႪႩႪႩႪႩ ႪႩႪႩႪႩ ႪႩႪႩႪႩ ႪႩႪႩႪႩ ႪႩႪႩႪႩ 1-844-365-7373.
- Chinese - 如欲使用免費語言服務，請致電 1-844-365-7373。
- Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-844-365-7373.
- Cushite - Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-844-365-7373.
- Dutch - Voor gratis toegang tot taaldiensten, bell 1-844-365-7373.
- French - Afin d'accéder aux services langagiers sans frais, composez le 1-844-365-7373.
- French Creole - Pou jwenn sèvis lang gratis, rele 1-844-365-7373.
- German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-844-365-7373 an.
- Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-844-365-7373.

- Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-844-365-7373.
- Persian - دیری گب سامت 1-844-365-7373 مراش اب، ناگیار روط هب نابز تامدخ هب یسرتسد یارب
- Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonić 1-844-365-7373.
- Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-844-365-7373.
- Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਨਿੰ ਬਸਿੰ ਮਿਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਰਿਨ ਲਈ, 1-844-365-7373 'ਤੇ ਫੋਨ ਰਿੰ।
- Romanian - Pentru a accesa gratuit serviciile de limbă, apălați 1-844-365-7373.
- Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-844-365-7373.
- Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-844-365-7373.
- Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-844-365-7373.
- Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-844-365-7373.
- Sudanic-Fulfulde - Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-844-365-7373.
- Swahili - Kupata huduma za lugha bila malipo kwako, piga 1-844-365-7373.
- Syriac - 1-844-365-7373 .
- Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-844-365-7373.
- Telugu - మరొక భాష నవలను ఉచితంగా అందుకునందుకు, 1-844-365-7373 కు కల్ చీయండి.
- Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-844-365-7373.
- Tongan - Kapau 'oku ke fiema'u ta'etötōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-844-365-7373.
- Trukese - Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-844-365-7373.
- Turkish - Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-844-365-7373 numarayı arayın.
- Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-844-365-7373.
- Urdu - سیرک تاب رپ 1-844-365-7373 سے نرک لصاح تامدخ مقل عتم سے نابز تم قلاب۔
- Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-844-365-7373.
- Yiddish - 1-844-365-7373 צו צוטריט באדינונגען אין קיין פרייז צו איר, רופן
- Yoruba - Lati wonú awon isẹ èdè l'ofẹ fun o, pe 1-844-365-7373.