



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=0760799&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-network: Individual \$6,000 / Family \$12,000.	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.
Are there services covered before you meet your deductible?	Yes. Preventive care in-network.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: Individual \$7,100 / Family \$14,200.	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.
What is not included in the out-of-pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://aetna.com/providersearch_aetna or call 1-844-365-7373 for a list of in-network providers.	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.
Do you need a referral to see a specialist?	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
		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	50% <u>coinsurance</u>	Not covered	None
	<u>Specialist</u> visit	50% <u>coinsurance</u>	Not covered	None
	<u>Preventive care</u> / <u>screening</u> /immunization	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)	50% <u>coinsurance</u>	Not covered	Applies to services received in office or in outpatient setting.
	Imaging (CT/PET scans, MRIs)	50% <u>coinsurance</u>	Not covered	Applies to services received in office or in outpatient setting.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://aet.na/deiv123	Preferred generic drugs	50% <u>coinsurance</u> for up to a 90 day supply	Not covered	Covers up to a 30 day supply (retail prescription), 31-90 day supply (retail & 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	50% <u>coinsurance</u> for up to a 90 day supply	Not covered	
	Non-preferred generic/brand drugs	50% <u>coinsurance</u> for up to a 90 day supply	Not covered	
	Preferred/non-preferred <u>specialty drugs</u>	50% <u>coinsurance</u> up to a \$150 maximum/ prescription for up to a 30 day supply	Not covered	All specialty <u>prescription drug</u> fills on initial fill must be filled at a <u>network</u> specialty pharmacy except for urgent situations. Your <u>plan</u> may include access to CVS retail pharmacies for certain <u>specialty drugs</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	50% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Out-of-network <u>emergency room care</u> cost-share same as in- <u>network</u> . No coverage for non-emergency care.
	<u>Emergency medical transportation</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Out-of-network cost-share same as in- <u>network</u> .
	<u>Urgent care</u>	50% <u>coinsurance</u>	Not covered	No coverage for non-urgent use.

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 have a hospital stay	Facility fee (e.g., hospital room)	50% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	50% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits and all other outpatient services: 50% <u>coinsurance</u>	Not covered	None
	Inpatient services	50% <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	50% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	50% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	50% <u>coinsurance</u>	Not covered	Coverage is limited to 100 visits.
	<u>Rehabilitation services</u>	25% <u>coinsurance</u> for Physical Therapy and Occupational Therapy; 50% <u>coinsurance</u> for Speech Therapy	Not covered	Coverage is limited to 30 visits for Speech Therapy.
	<u>Habilitation services</u>	50% <u>coinsurance</u>	Not covered	None
	<u>Skilled nursing care</u>	50% <u>coinsurance</u>	Not covered	Coverage is limited to 120 days per confinement.
	<u>Durable medical equipment</u>	50% <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>	50% <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 per calendar year 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.)

- Abortion
- Cosmetic surgery
- Dental care (Adult & Child)
- Long-term care
- Routine eye care (Adult)
- 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.)

- Acupuncture - Coverage is limited to 10 visits.
- Bariatric surgery
- Chiropractic care
- Hearing aids - Coverage is limited to 1 per ear every 36 months.
- Infertility treatment - Benefit limitations may apply.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing - Coverage is limited to inpatient when medically necessary.

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: Insurance Commissioner and Department of Insurance, Consumer Services Division, 302-674-7310 or In-State: 800-282-8611, <http://www.delawareinsurance.gov>.

- 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:

- Insurance Commissioner and Department of Insurance, Consumer Services Division, 302-674-7310 or In-State: 800-282-8611, <http://www.delawareinsurance.gov>.

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 **\$6,000**
- Specialist coinsurance **50%**
- Hospital (facility) coinsurance **50%**
- Other coinsurance **50%**

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>	\$6,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$7,160

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

- The plan's overall deductible **\$6,000**
- Specialist coinsurance **50%**
- Hospital (facility) coinsurance **50%**
- Other coinsurance **50%**

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>	\$5,400
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$5,420

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

- The plan's overall deductible **\$6,000**
- Specialist coinsurance **50%**
- Hospital (facility) coinsurance **50%**
- Other coinsurance **50%**

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>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

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), CRCordinator@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. (Pennsylvania) (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 - हिन्दी में भाषा सहायता के लिए, 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 - လာတိုမာစာတော်ကတိကျအင်္ဂါ ကျိန် ကိ: 1-844-365-7373 လာတအိန်ဒီးတော်လာဒ်ဘူင်လာဒ်စာဘာ
- 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 خورایی پیوندی بکن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-844-365-7373 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - कोणत्याही शुल्काशुधिविषय 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 ਵੱਜੋਂ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-844-365-7373 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hilfe in Deutsch, ruf: 1-844-365-7373 aa. Es Aaruf koschtet nix.

