aetnaCVSHealth : MO Aetna Silver $30 Copay 4000 Carelink SW OAEPO CSR 94

Coverage for: Individual + Family | Plan Type: EPO

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=0756094&Y=22, 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 $100 / Family $200.	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. Certain office visits, preventive care, emergency care and urgent 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 $1,000 / Family $2,000.	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.
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://aet.na/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	No charge	Not covered	None
	Specialist visit	$5 copay/visit, deductible does not apply	Not covered	None
	Preventive care /screening /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab: No charge; X-ray: 25% coinsurance	Not covered	Applies to services received in office or in outpatient setting.
	Imaging (CT/PET scans, MRIs)	25% coinsurance	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/moivl	Preferred generic drugs	No charge (retail & mail order)	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 deductible or out-of-pocket limit. No charge for preferred generic FDA-approved women's contraceptives in-network. 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	$25 copay/ prescription (retail), $62.50 copay/ prescription (mail order), deductible does not apply	Not covered	
	Non-preferred generic/brand drugs	35% coinsurance (retail & mail order)	Not covered	
	Preferred Specialty drugs, Non-preferred Specialty drugs	40% coinsurance for up to a 30 day supply	Not covered	First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	Not covered	None
	Physician/surgeon fees	25% coinsurance	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	Emergency room care	$500 copay/visit, deductible does not apply	$500 copay/visit, deductible does not apply	Copay waived if admitted. Out-of-network emergency room care cost-share same as in-network. No coverage for non-emergency care.
	Emergency medical transportation	25% coinsurance	25% coinsurance	Out-of-network cost-share same as in-network.
	Urgent care	$10 copay/visit, deductible does not apply	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	Not covered	None
	Physician/surgeon fees	25% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient office visits: No charge; All other outpatient services: 25% coinsurance	Not covered	None
	Inpatient services	25% coinsurance	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	25% coinsurance	Not covered	
	Childbirth/delivery facility services	25% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	Not covered	Coverage is limited to 100 visits.
	Rehabilitation services	$0 copay/visit, deductible does not apply for Physical Therapy and Occupational Therapy; $5 copay/visit, deductible does not apply for Speech Therapy	Not covered	Coverage is limited to 20 visits each for Physical Therapy and Occupational Therapy.
	Habilitation services	No charge	Not covered	None
	Skilled nursing care	25% coinsurance	Not covered	Coverage is limited to 150 days.
	Durable medical equipment	25% coinsurance	Not covered	Coverage is limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	25% coinsurance	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% coinsurance	Not covered	Coverage is limited to 1 exam every 12 months up to age 19.
	Children's glasses	50% coinsurance	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.)

- Abortion - except when the life of the mother is endangered, or complications arise.
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.
- Chiropractic care
- Hearing aids - Coverage is limited to 1 per ear.
- 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** **$100**
- **Specialist copayment** **$5**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **25%**

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:	
Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,060**

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

- **The plan's overall deductible** **$100**
- **Specialist copayment** **$5**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **25%**

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:	
Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$320**

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

- **The plan's overall deductible** **$100**
- **Specialist copayment** **$5**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **25%**

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:	
Cost Sharing	
Deductibles	$100
Copayments	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$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), 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).

TTY: 711

Language Assistance:

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

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-844-365-7373.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-844-365-7373 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني1-844-365-7373
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-844-365-7373 առանց զնով:
Bahasa-Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-844-365-7373 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-844-365-7373 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-844-365-7373-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-844-365-7373 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-844-365-7373 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-844-365-7373.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-844-365-7373 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᏚᏬᏂᎯᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᎿᎢ (ᏣᎳᎩ) ᏫᏏᎳᏁᎢᏚ 1-844-365-7373 ᏅᎾᎢ Ꮭ ᎠᎱᏍᏗ ᏧᎬᏩᎵᏗ ᏂᎨᏒᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-844-365-7373，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-844-365-7373.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-844-365-7373 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-844-365-7373.
French -	Pour une assistance linguistique en français appeler le 1-844-365-7373 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-844-365-7373 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-844-365-7373 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-844-365-7373 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-844-365-7373 પર કૉલ કરો.

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 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 akwụghị ụgwọ 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 -	လၢတၫ်မၤစၢၤတၫ်ကတိၤကျိာ်ညီၣ်အဂီၤ် ကျိာ် ကိး 1-844-365-7373 လၢတအိာ်ဒီးတၫ်လၢာ်ဘူာ်လၢာ်စ့ၤဘာ့
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-844-365-7373 번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ´m`ké gbo-kpá-kpá dyé piɗyi ɖé Ɓaɓɔɔ̀-wuɖuǔn wɛ̃ɛ, ɖá 1-844-365-7373
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-844-365-7373 به خۆرایی پەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ **1-844-365-7373** ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	कोणत्याही शुल्काशविाय 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 नःिशुल्क भाषा सहायता पाउनका लागि 1-844-365-7373 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-844-365-7373 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-844-365-7373 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵੱਚਿ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-844-365-7373 ‘ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-844-365-7373 aa. Es Aaruf koschtet nix.

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 asistenţă lingvistică în româneşte telefonaţi 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 besplatan 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 heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 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 - ܐܢ ܐܢܬ ܟܐ ܡܡܠܠܬ ܠܫܢܐ ܐܬܘܪܝܐ ܟܐ ܡܨܝܬ ܕܩܒܠܬ ܥܘܕܪܢܐ ܒܠܫܢܐ ܡܓܢܐܝܬ ܩܪܝ ܠ 1-844-365-7373 ܡܓܢܐ.

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-844-365-7373 nang walang bayad.

Telugu - భాషతో సయం కొరకు ఎలాంటి ఖర్చు లేకుండా **1-844-365-7373** కు కాల్ 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 áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-844-365-7373 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-844-365-7373.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-844-365-7373.

Urdu - بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-844-365-7373 . پر بات کریں

Vietnamese - Để 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 פריי פון אפצאל.

Yoruba - Fún ìrànlọ́wọ́ nípa èdè (Yorùbá) pe 1-844-365-7373 lái san owó kankan rárá.