Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

◆aetnaCVSHealth.: MO Aetna Bronze 8700 100% I-35 Preferred OAEPO NA CSR \$0 : AI/AN Zero Cost Sharing

Coverage for: Individual + Family | Plan Type: EPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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=0756127&Y=22, or by calling 1-844-365-7373. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> 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> ?	\$0.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes.	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 <u>https://www.healthcare.gov/coverage/preventive-care-benefits</u> /.
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</u> <u>limit</u> for this <u>plan</u> ?	Not Applicable.	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</u> <u>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> ?	Not Applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
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 Indian Health Care (IHCP) or Non-IHCP Provider <u>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</u> <u>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 specialist you choose without a referral.

		What You \	Will Pay	
Common Medical Event	Services You May Need	Indian Health Care (IHCP) or Non-IHCP Provider Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	No charge	Not covered	None
If you visit a health care	<u>Specialist</u> visit	No charge	Not covered	None
provider's office or clinic	<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	Diagnostic test (x-ray, blood work)	No charge	Not covered	Applies to services received in office or in outpatient setting.
n you have a lest	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Applies to services received in office or in outpatient setting.
	Preferred generic drugs	No charge	Not covered	Covers up to a 30 day supply (retail
	Preferred brand drugs	No charge	Not covered	prescription), 31-90 day supply (mail order
If you need drugs to treat your illness or condition More information about prescription drug <u>coverage</u> is available at http://aet.na/moivl	Non-preferred generic/brand drugs	No charge	Not covered	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 in- <u>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 <u>Specialty drugs,</u> Non-preferred <u>Specialty drugs</u>	No charge	Not covered	First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy <u>network</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
gor y	Physician/surgeon fees	No charge	Not covered	None

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Common Medical Event	Services You May Need	Indian Health Care (IHCP) or Non-IHCP Provider Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	No charge	No charge	Out-of-network <u>emergency room care</u> cost-share same as IHCP or Non-IHCP. No coverage for non-emergency care.
	Emergency medical transportation	No charge	No charge	None
	<u>Urgent care</u>	No charge	Not covered	No coverage for non-urgent use.
If you have a	Facility fee (e.g., hospital room)	No charge	Not covered	None
hospital stay	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or	Outpatient services	No charge	Not covered	None
substance abuse services	Inpatient services	No charge	Not covered	None
	Office visits	No charge	Not covered	Cost sharing does not apply for preventive
If you are pregnant	Childbirth/delivery professional services	No charge	Not covered	services. Maternity care may include tests and services described elsewhere in the SBC
	Childbirth/delivery facility services	No charge	Not covered	(i.e. ultrasound).
	Home health care	No charge	Not covered	Coverage is limited to 100 visits.
	Rehabilitation services	No charge	Not covered	Coverage is limited to 20 visits each for Physical Therapy and Occupational Therapy.
If you need help	Habilitation services	No charge	Not covered	None
recovering or have other	Skilled nursing care	No charge	Not covered	Coverage is limited to 150 days.
special health needs	Durable medical equipment	No charge	Not covered	Coverage is limited to 1 <u>durable medical</u> <u>equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	No charge	Not covered	None

		What You Will Pay			
Common Medical Event	Services You May Need	Indian Health Care (IHCP) or Non-IHCP Provider Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Children's eye exam	No charge	Not covered	Coverage is limited to 1 exam every 12 months up to age 19.	
 If your child needs dental or eye care	Children's glasses	No charge	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 Infertility treatment Routine foot care					
endangered, or complications arise.	Long-term care	 Weight loss programs 			
Bariatric surgery	 Non-emergency care when traveling or 	utside the			
Cosmetic surgery	U.S.				
Dental care (Adult & Child)	 Routine eye care (Adult) 				

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)			
 Acupuncture - Coverage is limited to 10 visits. Chiropractic care 	Acupuncture - Coverage is limited to 10 visits. Hearing aids - Coverage is limited to 1 per ear. Private-duty nursing - Coverage is limited to 82		

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, <u>https://insurance.mo.gov/consumers/complaints/index.php</u>.

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

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance <u>Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596 or state health insurance <u>marketplace</u> or SHOP.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> 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 <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$0
Specialist copayment	\$0
Hospital (facility) <u>copayment</u>	\$0
Other <u>copayment</u>	\$0
This EXAMPLE event includes services like	e :
Specialist office visits (prenatal care)	
Childbirth/Delivery Professional Services	
Childbirth/Delivery Facility Services	
Diagnostic tests (ultrasounds and blood work)	
<u>Specialist</u> visit <i>(anesthesia)</i>	

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
Deductibles	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$60

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

The plan's overall deductible	\$0
Specialist copayment	\$0
Hospital (facility) <u>copayment</u>	\$0
Other <u>copayment</u>	\$0
This EXAMPLE event includes services lik	e:
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:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$20

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

The <u>plan's</u> overall <u>deductible</u>	\$0
Specialist copayment	\$0
Hospital (facility) <u>copayment</u>	\$0
Other <u>copayment</u>	\$0
This EXAMPLE event includes services	like:
Emergency room care (including medical s	supplies)
<u>Diagnostic test</u> (x-ray)	
Durable medical equipment (crutches)	
Rehabilitation services (physical therapy)	

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

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 Life Insurance Company (Aetna). Aetna is part of the CVS Health family of companies.

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 <i>እገ</i> ዛ በ አማርኛ በ 1-844-365-7373 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 7373-365-1844
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-844-365-7373 առանց գնով։
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 বনিামুল্য(1–844–365–7373–ত(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 -	ӨӘУӨ Տ ೮հ.ՁӘ. ЛһӘՏРӘУ Ө५Т (СѠУ) Չ ЬѠᲝℹ Տ 1-844-365-7373 ОӨТ Ը АГӘЛ ЈЕС.Р.Л һՒRӨ.
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 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.
lbo -	Maka enyemaka asụsụ na Igbo kpọọ 1-844-365-7373 na akwụghị ụgwọ ọ bụla
llocano -	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 -	လ၊တၢ်မာစားတၢ်ကတိၤကျိဉ်အဂီၢ် ကျိဉ် ကိး 1-844-365-7373 လ၊တအိဉ်ဒီးတၢ်လ၊၁်ဘူဉ်လ၊၁်စ္၊ဘာ
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-844-365-7373 번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ´m`ké gbo-kpá-kpá dyé pidyi dé Ɓašɔɔ́-̀wù̀dùùň wɛ̃ɛ, dá 1-844-365-7373
Kurdish -	برای راهنمایی به زبان فارسی با شمار ه 7373-844-1 ا به خۆرایی پهیومندی بکهن.
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 -	សម្ភរាប់ជំនួយភាសាជា ភាសាខ្ ម រែ សូមទូរស័ព្ ទទ ៅកាន់លខេ1-844-365-7373ដ ោយឥតគិតថ្ ល។ៃ
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 नन्शिुल्क भाषा सहायता पाउनका लाग ि1-844-365-7373 मा फोन गर् नुहोस् ।
Nilotic-Dinka -	Tën kuoony ë thok ë Thuonjän col 1-844-365-7373 kecin avöc.
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 ۲373-844-1 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 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 -	к - эск к a bir ale ~ к vaime on ly ioper sol, so - 1-844-365-7373 ap
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-844-365-7373 nang walang bayad.
Telugu -	భషతో సయం కొరకు ఎలింటి ఖర్చు లేకుండా 1-844-365-7373 కు శల్ చేయండి. (తిలుగు)
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 ، 7373-365-844-1 . پر بات کریں
Vietnamese -	Đê được hố trở ngôn ngữ băng (ngôn ngữ), hấy gọi miến phi đên số 1-844-365-7373.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-844-365-7373 פריי פון אפצאל.
Yoruba -	Fún ìrànlowo nípa èdè (Yorùbá) pe 1-844-365-7373 lái san owó kankan rárá.