



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/getpolicydocs?u=081500-050020-011812> or by calling 1-888-982-3862. 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 1-888-982-3862 to request a copy.

| Important Questions  | Answers   | Why This Matters:   |
|--|---|---|
| <b>What is the overall deductible?</b>                             | Participating: Individual \$1,000 / Family \$2,000.   | 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> .   |
| <b>Are there services covered before you meet your deductible?</b> | Yes. Emergency care; plus in- <u>network</u> office visits, <u>prescription drugs</u> & <u>preventive care</u> are covered before you meet your <u>deductible</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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .  |
| <b>Are there other deductibles for specific services?</b>          | No.   | You don't have to meet <u>deductibles</u> for specific services.  |
| <b>What is the out-of-pocket limit for this plan?</b>              | Participating: Individual \$3,000 / Family \$6,000.   | 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.   |
| <b>What is not included in the out-of-pocket limit?</b>            | <u>Premiums</u> , <u>balance-billing</u> charges & 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> .  |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="http://www.aetna.com/docfind">http://www.aetna.com/docfind</a> or call 1-888-982-3862 for a list of participating <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 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. |
| <b>Do you need a referral to see a specialist?</b>                 | Yes.  | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</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  |
|---|--|---|--|---|
|   |  | Participating Provider (You will pay the least)   | Non-Participating Provider (You will pay the most) |   |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply                                     | Not covered  | None  |
|   | <u>Specialist</u> visit                          | \$45 <u>copay</u> /visit, <u>deductible</u> doesn't 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)       | No charge for laboratory; \$45 <u>copay</u> /visit for x-ray, <u>deductible</u> doesn't apply | Not covered  | None  |
|   | Imaging (CT/PET scans, MRIs)                     | \$125 <u>copay</u> /visit, <u>deductible</u> doesn't apply                                    | Not covered  | None  |

| Common Medical Event  | Services You May Need  | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information   |
|---|--|---|--|--|
|   |  | Participating Provider (You will pay the least)   | Non-Participating Provider (You will pay the most)         |  |
| <p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b>prescription drug coverage</b> is available at <a href="http://www.aetnapharmacy.com/value">www.aetnapharmacy.com/value</a></p> <p>Value <u>Formulary</u></p> | Preferred generic drugs (Includes Tier 1A - Value Drugs and Tier 1 Preferred Generic <u>Prescription Drugs</u> ) | <u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$3 for 30 day supply (retail), \$6 for 31-90 day supply (retail & mail order); Preferred Generic \$10 for 30 day supply (retail), \$20 for 31-90 day supply (retail & mail order) | Not covered  | Covers 30 day supply (retail), 31-90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> . Review your <u>formulary</u> for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written. |
|   | Preferred brand drugs  | <u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$30 for 30 day supply (retail), \$60 for 31-90 day supply (retail & mail order)   | Not covered  |  |
|   | Non-preferred generic/brand drugs  | <u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$60 for 30 day supply (retail), \$120 for 31-90 day supply (retail & mail order)  | Not covered  |  |
|   | <u>Specialty drugs</u>   | Applicable cost as noted above for generic or brand drugs   | Not covered  |  |
| <p><b>If you have outpatient surgery</b></p>  | Facility fee (e.g., ambulatory surgery center)   | 20% <u>coinsurance</u>  | Not covered  | None   |
|   | Physician/surgeon fees   | 20% <u>coinsurance</u>  | Not covered  | None   |
| <p><b>If you need immediate medical attention</b></p>   | <u>Emergency room care</u>   | \$150 <u>copay</u> /visit, <u>deductible</u> doesn't apply  | \$150 <u>copay</u> /visit, <u>deductible</u> doesn't apply | No coverage for non-emergency use.   |
|   | <u>Emergency medical transportation</u>  | No charge   | No charge  | No coverage for non-emergency transport.   |
|   | <u>Urgent care</u>   | \$75 <u>copay</u> /visit, <u>deductible</u> doesn't apply   | Not covered  | No coverage for non-urgent use.  |
| <p><b>If you have a hospital stay</b></p>   | Facility fee (e.g., hospital room)   | 20% <u>coinsurance</u>  | Not covered  | None   |
|   | Physician/surgeon fees   | 20% <u>coinsurance</u>  | Not covered  | None   |

| Common Medical Event  | Services You May Need                     | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information  |
|---|---|---|--|---|
|   |   | Participating Provider (You will pay the least)   | Non-Participating Provider (You will pay the most) |   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | Office: \$45 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: no charge | Not covered  | None  |
|   | Inpatient services                        | 20% <u>coinsurance</u>  | Not covered  | None  |
| If you are pregnant   | Office visits                             | No charge; except \$45 <u>copay</u> for initial visit to confirm pregnancy                              | 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 | \$45 <u>copay</u> /pregnancy, <u>deductible</u> doesn't apply   | 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>                   | No charge   | Not covered  | None  |
|   | <u>Rehabilitation services</u>            | \$45 <u>copay</u> /visit, <u>deductible</u> doesn't apply   | Not covered  | 60 visits/calendar year for Physical, Occupational & Speech Therapy combined. Includes treatment of Autism.   |
|   | <u>Habilitation services</u>              | \$45 <u>copay</u> /visit, <u>deductible</u> doesn't apply   | Not covered  |   |
|   | <u>Skilled nursing care</u>               | 20% <u>coinsurance</u>  | Not covered  | None  |
|   | <u>Durable medical equipment</u>          | No charge   | Not covered  | 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> for inpatient; no charge for outpatient  | Not covered  | None  |
| If your child needs dental or eye care                                    | Children's eye exam                       | Not covered   | Not covered  | Not covered.  |
|   | Children's glasses                        | Not covered   | Not covered  | Not covered.  |
|   | 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.)

- |                               |  |   |
|-------------------------------|--|---|
| • Acupuncture                 | • Hearing aids                                       | • Routine eye care (Adult & Child)                                |
| • Bariatric surgery           | • Long-term care                                     | • Routine foot care   |
| • Cosmetic surgery            | • Non-emergency care when traveling outside the U.S. | • Weight loss programs - Except for required preventive services. |
| • Dental care (Adult & Child) |  |   |
| • Glasses (Child)             | • Private-duty nursing                               |   |

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

- |                     |   |
|---------------------|---|
| • Chiropractic care | • Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. |
|---------------------|---|

## 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: South Carolina Department of Insurance, Office of Consumer Services, (800) 768-3467, (803) 737-6180, <http://doi.sc.gov/consumers>.

- For more information on your rights to continue coverage, contact the plan at 1-888-982-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa>.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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](http://www.HealthCare.gov) or call 1-800-318-2596.

## 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 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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-888-982-3862.
- South Carolina Department of Insurance, Office of Consumer Services, (800) 768-3467, (803) 737-6180, <http://doi.sc.gov/consumers>.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa>.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

- Additionally, a consumer assistance program can help you file your appeal. Contact South Carolina Department of Insurance, Office of Consumer Services, P.O. Box 100105, Columbia, SC 29202, (800) 768-3467, (803) 737-6180, <http://www.doi.sc.gov/638/Health-Insurance>, [consumers@doi.sc.gov](mailto:consumers@doi.sc.gov)

**Does this plan provide Minimum Essential Coverage? Yes.**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet Minimum Value Standards? Yes.**

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 **\$1,000**
- Specialist copayment **\$45**
- 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,800</b> |
|---------------------------|-----------------|

**In this example, Peg would pay:**

*Cost Sharing*

|             |         |
|-------------|---------|
| Deductibles | \$1,000 |
| Copayments  | \$200   |
| Coinsurance | \$1,600 |

*What isn't covered*

|                      |      |
|----------------------|------|
| Limits or exclusions | \$60 |
|----------------------|------|

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Peg would pay is</b> | <b>\$2,860</b> |
|-----------------------------------|----------------|

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible **\$1,000**
- Specialist copayment **\$45**
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

**In this example, Joe would pay:**

*Cost Sharing*

|             |       |
|-------------|-------|
| Deductibles | \$0   |
| Copayments  | \$900 |
| Coinsurance | \$0   |

*What isn't covered*

|                      |      |
|----------------------|------|
| Limits or exclusions | \$20 |
|----------------------|------|

|                                   |              |
|-----------------------------------|--------------|
| <b>The total Joe would pay is</b> | <b>\$920</b> |
|-----------------------------------|--------------|

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible **\$1,000**
- Specialist copayment **\$45**
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,900</b> |
|---------------------------|----------------|

**In this example, Mia would pay:**

*Cost Sharing*

|             |       |
|-------------|-------|
| Deductibles | \$0   |
| Copayments  | \$400 |
| Coinsurance | \$0   |

*What isn't covered*

|                      |     |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

|                                   |              |
|-----------------------------------|--------------|
| <b>The total Mia would pay is</b> | <b>\$400</b> |
|-----------------------------------|--------------|

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 1-888-982-3862.

### 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 discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides 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: PO Box 24030, Fresno, CA 93779)

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705)

Email: [CRCoordinator@aetna.com](mailto: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).

**Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.**





- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - हिन्दी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwughị ugwo ọ bụla
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.
- Japanese - 日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。
- Karen - လာတိုမၤစာတၢ်ကတိၤကျိၣ်အဂီၢ် ကျိၣ် ကိး 1-888-982-3862 လာတၢ်အိၣ်ဒီးတၢ်လာၣ်ဘူၣ်လာၣ်စ့ၤဘၣ်
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.
- Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pídyi dé Bašwó`wuḍuñ wεε, dá 1-888-982-3862
- Kurdish - برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 به خۆرای پهیوهندی بکەن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - तीलभाषा(मराठी)सहाय्यासाठी 1-888-982-3862 क्रमांकावरकोणत्याहीखर्चाशवियकॉलकरा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.
- Micronesian - Pohnpeyan Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទទេៅកាន់លេខ 1-888-982-3862 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shiká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862
- Nepali - (नेपाली) मा नःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tën kuwoony ë thok ë Thuonjäng col 1-888-982-3862 kecïn ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵੱਲੋਂ ਭਾਸ਼ਾਈ ਮਦਦ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hilfe in Deutsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.

