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

# Aetna ALDINE ISD : Memorial Hermann ACO Open Access® Aetna SelectSM

**Coverage Period: 01/01/2020-12/31/2020**

**Coverage for:** Individual + Family **|** **Plan Type:** EPO

**The Summary of Benefits and Coverage (SBC) document will help you choose a health** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**. The SBC shows you how you and the** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **would share the cost for covered health care services. NOTE: Information about the cost of this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **(called the** [**premium**](https://www.healthcare.gov/sbc-glossary/#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, [www.HealthReformPlanSBC.com](http://www.HealthReformPlanSBC.com) or by calling 1-800-370-4526. For general definitions of common terms, such as [allowed amount](https://www.healthcare.gov/sbc-glossary/#allowed-amount), [balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing), [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance), [copayment](https://www.healthcare.gov/sbc-glossary/#copayment), [deductible](https://www.healthcare.gov/sbc-glossary/#deductible), [provider](https://www.healthcare.gov/sbc-glossary/#provider), or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-370-4526 to request a copy.

| **Important Questions** | **Answers** | **Why This Matters:** |
| --- | --- | --- |
| **What is the overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | [Network](https://www.healthcare.gov/sbc-glossary/#network): Individual $2,500 / Family $5,000. | Generally, you must pay all of the costs from [providers](https://www.healthcare.gov/sbc-glossary/#provider) up to the [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) amount before this [plan](https://www.healthcare.gov/sbc-glossary/#plan) begins to pay. If you have other family members on the [plan](https://www.healthcare.gov/sbc-glossary/#plan), each family member must meet their own individual [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) until the total amount of [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) expenses paid by all family members meets the overall family [deductible](https://www.healthcare.gov/sbc-glossary/#deductible). |
| **Are there services covered before you meet your** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | Yes. In-[network](https://www.healthcare.gov/sbc-glossary/#network) [preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care) & office visits are covered before you meet your [deductible](https://www.healthcare.gov/sbc-glossary/#deductible). | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) covers some items and services even if you haven't yet met the [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) amount. But a [copayment](https://www.healthcare.gov/sbc-glossary/#copayment) or [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) may apply. For example, this [plan](https://www.healthcare.gov/sbc-glossary/#plan) covers certain [preventive services](https://www.healthcare.gov/sbc-glossary/#preventive-services) without [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) and before you meet your [deductible](https://www.healthcare.gov/sbc-glossary/#deductible).  See a list of covered [preventive services](https://www.healthcare.gov/sbc-glossary/#preventive-care) at  <https://www.healthcare.gov/coverage/preventive-care-benefits/> |
| **Are there other** [**deductibles**](https://www.healthcare.gov/sbc-glossary/#deductible) **for specific services?** | No. | You don’t have to meet [deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) for specific services. |
| **What is the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) **for this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**?** | [Network](https://www.healthcare.gov/sbc-glossary/#network): Individual $6,500 / Family $13,100. | The [out–of–pocket limit](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#plan), they have to meet their own [out–of–pocket limits](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) until the overall family [out–of–pocket limit](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) has been met. |
| **What is not included in the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)**?** | [Premiums](https://www.healthcare.gov/sbc-glossary/#premium), [balance-billing](https://www.healthcare.gov/sbc-glossary/#balance-billing) charges & health care this [plan](https://www.healthcare.gov/sbc-glossary/#plan) doesn't cover. | Even though you pay these expenses, they don’t count toward the [out–of–pocket limit](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit). |
| **Will you pay less if you use a** [**network provider**](https://www.healthcare.gov/sbc-glossary/#network-provider)**?** | Yes. See [www.aetna.com/docfind](http://www.aetna.com/docfind) or call 1-800-370-4526 for a list of [network providers](https://www.healthcare.gov/sbc-glossary/#network-provider). | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) uses a [provider](https://www.healthcare.gov/sbc-glossary/#provider) [network](https://www.healthcare.gov/sbc-glossary/#network). You will pay less if you use a [provider](https://www.healthcare.gov/sbc-glossary/#provider) in the [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) [network](https://www.healthcare.gov/sbc-glossary/#network). You will pay the most if you use an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider), and you might receive a bill from a [provider](https://www.healthcare.gov/sbc-glossary/#provider) for the difference between the [provider's](https://www.healthcare.gov/sbc-glossary/#provider) charge and what your [plan](https://www.healthcare.gov/sbc-glossary/#plan) pays ([balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). Be aware, your [network provider](https://www.healthcare.gov/sbc-glossary/#network-provider) might use an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) for some services (such as lab work). Check with your [provider](https://www.healthcare.gov/sbc-glossary/#provider) before you get services. |
| **Do you need a** [**referral**](https://www.healthcare.gov/sbc-glossary/#referral) **to see a** [**specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)**?** | No. | You can see the [specialist](https://www.healthcare.gov/sbc-glossary/#specialist) you choose without a [referral](https://www.healthcare.gov/sbc-glossary/#referral). |

  
All [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) and [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) costs shown in this chart are after your [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) has been met, if a [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) applies.

| **Common Medical Event** | **Services You May Need** | **What You Will Pay** | | **Limitations, Exceptions, & Other Important Information** |
| --- | --- | --- | --- | --- |
| **Network Provider**  **(You will pay the least)** | **Out-of-Network Provider**  **(You will pay the most)** |
| **If you visit a health care** [**provider**](https://www.healthcare.gov/sbc-glossary/#provider)**’s office or clinic** | Primary care visit to treat an injury or illness | $50 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit, [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn't apply | Not covered | None |
| [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit | $100 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit, [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn't apply | Not covered | None |
| [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care) /[screening](https://www.healthcare.gov/sbc-glossary/#screening) /immunization | No charge | Not covered | You may have to pay for services that aren’t preventive. Ask your [provider](https://www.healthcare.gov/sbc-glossary/#provider) if the services needed are preventive. Then check what your [plan](https://www.healthcare.gov/sbc-glossary/#plan) will pay for. |
| **If you have a test** | [Diagnostic test](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) (x-ray, blood work) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Not covered | None |
| Imaging (CT/PET scans, MRIs) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Not covered | None |
| **If you need drugs to treat your illness or condition**  More information about [**prescription drug coverage**](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage) is available at [www.aetna.com/pharmacy-insurance/individuals-families](http://www.aetna.com/pharmacy-insurance/individuals-families) | Generic drugs | Not covered | Not covered | Not covered. |
| Preferred brand drugs | Not covered | Not covered | Not covered. |
| Non-preferred brand drugs | Not covered | Not covered | Not covered. |
| [Specialty drugs](https://www.healthcare.gov/sbc-glossary/#specialty-drug) | Not covered | Not covered | Not covered. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Not covered | None |
| Physician/surgeon fees | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Not covered | None |
| **If you need immediate medical attention** | [Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after $250 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after $250 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) for non-emergency use. [Copay](https://www.healthcare.gov/sbc-glossary/#copayment) doesn't apply if admitted to the hospital. |
| [Emergency medical transportation](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Non-emergency transport: not covered, except if pre-authorized. |
| [Urgent care](https://www.healthcare.gov/sbc-glossary/#urgent-care) | $75 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit, [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn't apply | Not covered | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Not covered | None |
| Physician/surgeon fees | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Not covered | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office & other outpatient services: $50 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit, [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn't apply | Not covered | None |
| Inpatient services | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Not covered | None |
| **If you are pregnant** | Office visits | $100 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit, [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn't apply | Not covered | [Cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) does not apply for [preventive services](https://www.healthcare.gov/sbc-glossary/#preventive-care). Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| Childbirth/delivery professional services | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Not covered |
| Childbirth/delivery facility services | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Not covered |
| **If you need help recovering or have other special health needs** | [Home health care](https://www.healthcare.gov/sbc-glossary/#home-health-care) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Not covered | 100 visit/calendar year. |
| [Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Not covered | 60 visits/calendar year for Physical, Occupational & Speech Therapy combined, including outpatient hospital services. Includes treatment of Autism. |
| [Habilitation services](https://www.healthcare.gov/sbc-glossary/#habilitation-services) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Not covered |
| [Skilled nursing care](https://www.healthcare.gov/sbc-glossary/#skilled-nursing-care) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Not covered | 60 days/calendar year. |
| [Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Not covered | Limited to 1 [durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) for same/similar purpose. Excludes repairs for misuse/abuse. |
| [Hospice services](https://www.healthcare.gov/sbc-glossary/#hospice-services) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 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**](https://www.healthcare.gov/sbc-glossary/#plan) **Generally Does NOT Cover (Check your policy or** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document for more information and a list of any other** [**excluded services**](https://www.healthcare.gov/sbc-glossary/#excluded-services)**.)** | | |
| * Acupuncture * Cosmetic surgery * Dental care (Adult & Child) * Glasses (Child) | * Hearing aids * Long-term care * Non-emergency care when traveling outside the U.S. * Prescription drugs | * Private-duty nursing * Routine eye care (Adult & Child) * Routine foot care * Weight loss programs - Except for require preventive services. |

|  |  |  |
| --- | --- | --- |
| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document.)** | | |
| * Bariatric surgery - Limited to Institutes of Quality contracted facility only, 20% coinsurance, $12,000 maximum/lifetime. | * Chiropractic care - 20 visits/calendar year. | * 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:

* For more information on your rights to continue coverage, contact the [plan](https://www.healthcare.gov/sbc-glossary/#plan) at 1-800-370-4526.
* 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 [www.dol.gov/ebsa/healthreform.](http://www.dol.gov/ebsa/healthreform)
* For non-federal governmental group health [plans](https://www.healthcare.gov/sbc-glossary/#plan), 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](https://www.healthcare.gov/sbc-glossary/#plan), church [plans](https://www.healthcare.gov/sbc-glossary/#plan) 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](https://www.healthcare.gov/sbc-glossary/#marketplace). For more information about

the [Marketplace](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#plan) for a denial of a [claim](https://www.healthcare.gov/sbc-glossary/#claim). This complaint is called a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) or [appeal](https://www.healthcare.gov/sbc-glossary/#appeal). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](https://www.healthcare.gov/sbc-glossary/#claim). Your [plan](https://www.healthcare.gov/sbc-glossary/#plan) documents also provide complete information to submit a [claim](https://www.healthcare.gov/sbc-glossary/#claim), [appeal](https://www.healthcare.gov/sbc-glossary/#appeal), or a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) for any reason to your [plan](https://www.healthcare.gov/sbc-glossary/#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 1-800-370-4526.
* 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 [www.dol.gov/ebsa/healthreform.](http://www.dol.gov/ebsa/healthreform)
* For non-federal governmental group health [plans](https://www.healthcare.gov/sbc-glossary/#plan), 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](https://www.healthcare.gov/sbc-glossary/#appeal). Contact information is at: [http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.](http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html)

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

If you don't have [**Minimum Essential Coverage**](https://www.healthcare.gov/sbc-glossary/#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 Standard? No.

If your [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) doesn't meet the [**Minimum Value Standards**](https://www.healthcare.gov/sbc-glossary/#minimum-value-standard), you may be eligible for a [**premium tax credit**](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits) to help you pay for a [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) through the [**Marketplace**](https://www.healthcare.gov/sbc-glossary/#marketplace)**.**

*-------------------To see examples of how this* [*plan*](https://www.healthcare.gov/sbc-glossary/#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**](https://www.healthcare.gov/sbc-glossary/#plan)might cover medical care. Your actual costs will bedifferent depending on the actual care you receive, the prices your [**providers**](https://www.healthcare.gov/sbc-glossary/#provider) charge, and many other factors. Focus on the [**cost sharing**](https://www.healthcare.gov/sbc-glossary/#cost-sharing) amounts ([**deductibles**](https://www.healthcare.gov/sbc-glossary/#deductible), [**copayments**](https://www.healthcare.gov/sbc-glossary/#copayment) and [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance)) and [**excluded services**](https://www.healthcare.gov/sbc-glossary/#excluded-services) under the [**plan**](https://www.healthcare.gov/sbc-glossary/#plan). Use this information to compare the portion of costs you might pay under different health [**plans**](https://www.healthcare.gov/sbc-glossary/#plan). Please note these coverage examples are based on self-only coverage.

**Managing Joe’s type 2 Diabetes**(a year of routine in-network care of a well-controlled condition)

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

**Peg is Having a Baby**(9 months of in-network pre-natal care and a hospital delivery)

◼ **The** [**plan's**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$2,500**

◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)[**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) **$100**

◼ **Hospital (facility)** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **20%**

◼ **Other** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#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)*

|  | **Total Example Cost** | **$12,800** |  |
| --- | --- | --- | --- |
|  | **In this example, Peg would pay:** |  |  |
|  | *Cost Sharing* |  |  |
|  | Deductibles | $2,500 |  |
|  | Copayments | $100 |  |
|  | Coinsurance | $2,000 |  |
|  | *What isn't covered* |  |  |
|  | Limits or exclusions | $100 |  |
|  | **The total Peg would pay is** | **$4,700** |  |

Note: These numbers assume the patient does not participate in the [plan's](https://www.healthcare.gov/sbc-glossary/#plan) wellness program. If you participate in the [plan's](https://www.healthcare.gov/sbc-glossary/#plan) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-370-4526.

◼ **The** [**plan's**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$2,500**

◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)[**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) **$100**

◼ **Hospital (facility)** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **20%**

◼ **Other** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#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)*

|  | **Total Example Cost** | | **$7,400** |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **In this example, Joe would pay:** | |  |  |  |
|  | *Cost Sharing* | |  |  |  |
|  | Deductibles |  | $100 |  |  |
|  | Copayments |  | $600 |  |  |
|  | Coinsurance |  | $0 |  |  |
|  | *What isn't covered* | | |  |  |
|  | Limits or exclusions |  | $6,000 |  |  |
|  | **The total Joe would pay is** |  | **$6,700** |  |  |

◼ **The** [**plan's**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$2,500**

◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)[**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) **$100**

◼ **Hospital (facility)** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **20%**

◼ **Other** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#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)*

|  | **Total Example Cost** | **$1,900** |  |
| --- | --- | --- | --- |
|  | **In this example, Mia would pay:** |  |  |
|  | *Cost Sharing* |  |  |
|  | Deductibles | $1,600 |  |
|  | Copayments | $200 |  |
|  | Coinsurance | $0 |  |
|  | *What isn't covered* |  |  |
|  | Limits or exclusions | $0 |  |
|  | **The total Mia would pay is** | **$1,800** |  |

The [**plan**](https://www.healthcare.gov/sbc-glossary/#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 1-800-370-4526.

## 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 (Aetna).**

TTY: 711

## Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.

Amharic -

ለቋንቋ እገዛ በ አማርኛ በ 1-800-370-4526 በነጻ ይደውሉ

Arabic - 1-800-370-4526

Armenian -

Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-370-4526 առանց գնով:

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-800-370-4526-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.

Burmese - 1-800-370-4526

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu.

Cherokee - ᎾᏍᎩᎾ ᎦᏬᏂᎯᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᎿᎢ (ᏣᎳᎩ) ᏫᏏᎳᏛᎥᎦ 1-800-370-4526 ᎤᎾᎢ Ꮭ ᎪᎱᏍᏗ ᏧᎬᏩᎵᏗ ᏂᎨᏒᎾ.

Chinese - 欲取得繁體中文語言協助，請撥打 1-800-370-4526，無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-800-370-4526.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.

French - Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-370-4526 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ʻole ʻia kēia kōkua nei.

Hindi - 1-800-370-4526

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.

Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwụghị ụgwọ ọ bụla

Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.

Japanese - 日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。

Karen - 1-800-370-4526

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.

Kru-Bassa - 1-800-370-4526

Kurdish - 1-800-370-4526

Laotian - 1-800-370-4526

Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-800-370-4526 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.

Micronesian- Pohnpeyan -

Mon-Khmer, Cambodian -

Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.

 1-800-370-4526

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-800-370-4526 kecïn aɣöc.

Norwegian - For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 ‘ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.

Persian - 1-800-370-4526

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.

Portuguese - Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.

Romanian - Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-800-370-4526

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-370-4526 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-370-4526. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.

Syriac - 1-800-370-4526

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-800-370-4526 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-370-4526 ‘o ‘ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.

Urdu - 1-800-370-4526

Vietnamese - 1-800-370-4526.

Yiddish - 1-800-370-4526

Yoruba - Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan rárá.