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

# BAYADA HOME HEALTH CARE, INC. : Aetna Choice® POS II - MT APCN Plus Multi-Tier HDHP Narrow



**Coverage Period: 01/01/2024-12/31/2024**

**Coverage for:** **EE Only; EE+ Family** **|** **Plan Type:** **POS**

**The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](https://www.healthcare.gov/sbc-glossary/" \l "plan). The SBC shows you how you and the [plan](https://www.healthcare.gov/sbc-glossary/" \l "plan) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](https://www.healthcare.gov/sbc-glossary/" \l "plan) (called the [premium](https://www.healthcare.gov/sbc-glossary/" \l "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 1-888-982-3862. For general definitions of common terms, such as [allowed amount](https://www.healthcare.gov/sbc-glossary/" \l "allowed-amount), [balance billing](https://www.healthcare.gov/sbc-glossary/" \l "balance-billing), [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance), [copayment](https://www.healthcare.gov/sbc-glossary/" \l "copayment), [deductible](https://www.healthcare.gov/sbc-glossary/" \l "deductible), [provider](https://www.healthcare.gov/sbc-glossary/" \l "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:** |
| --- | --- | --- |
| **What is the overall [deductible](https://www.healthcare.gov/sbc-glossary/" \l "deductible)?** | Tier 1 In-[Network](https://www.healthcare.gov/sbc-glossary/" \l "network): EE Only $1,750; EE+ Family $3,500. Tier 2 In-[Network](https://www.healthcare.gov/sbc-glossary/" \l "network): EE Only $2,500; EE+ Family $5,000. Out-of-Network: EE Only $5,000; EE+ Family $10,000. | Generally, you must pay all of the costs from [providers](https://www.healthcare.gov/sbc-glossary/" \l "provider) up to the [deductible](https://www.healthcare.gov/sbc-glossary/" \l "deductible) amount before this [plan](https://www.healthcare.gov/sbc-glossary/" \l "plan) begins to pay. If you have other family members on the policy, the overall family [deductible](https://www.healthcare.gov/sbc-glossary/" \l "deductible) must be met before the [plan](https://www.healthcare.gov/sbc-glossary/" \l "plan) begins to pay. |
| **Are there services covered before you meet your [deductible](https://www.healthcare.gov/sbc-glossary/" \l "deductible)?** | Yes. Tier 1 & Tier 2 In-[Network](https://www.healthcare.gov/sbc-glossary/" \l "network) [preventive care](https://www.healthcare.gov/sbc-glossary/" \l "preventive-care) is covered before you meet your [deductible](https://www.healthcare.gov/sbc-glossary/" \l "deductible). | This [plan](https://www.healthcare.gov/sbc-glossary/" \l "plan) covers some items and services even if you haven't yet met the [deductible](https://www.healthcare.gov/sbc-glossary/" \l "deductible) amount. But a [copayment](https://www.healthcare.gov/sbc-glossary/" \l "copayment) or [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) may apply. For example, this [plan](https://www.healthcare.gov/sbc-glossary/" \l "plan) covers certain [preventive services](https://www.healthcare.gov/sbc-glossary/" \l "preventive-care) without [cost sharing](https://www.healthcare.gov/sbc-glossary/" \l "cost-sharing) and before you meet your [deductible](https://www.healthcare.gov/sbc-glossary/" \l "deductible).  See a list of covered [preventive services](https://www.healthcare.gov/sbc-glossary/" \l "preventive-care) at  <https://www.healthcare.gov/coverage/preventive-care-benefits/> |
| **Are there other [deductible](https://www.healthcare.gov/sbc-glossary/" \l "deductible)s for specific services?** | No. | You don’t have to meet [deductibles](https://www.healthcare.gov/sbc-glossary/" \l "deductible) for specific services. |
| **What is the [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/" \l "out-of-pocket-limit) for this [plan](https://www.healthcare.gov/sbc-glossary/" \l "plan)?** | Tier 1 In-[Network](https://www.healthcare.gov/sbc-glossary/" \l "network): EE Only $4,500; EE+ Family: Individual $4,500 / Family $9,000. Tier 2 In-[Network](https://www.healthcare.gov/sbc-glossary/" \l "network): EE Only $7,000; EE+ Family: Individual $7,000 / Family $14,000. Out-of-Network: EE Only $15,000; EE+ Family: Individual $15,000 / Family $30,000. | The [out–of–pocket limit](https://www.healthcare.gov/sbc-glossary/" \l "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/" \l "plan), they have to meet their own [out–of–pocket limits](https://www.healthcare.gov/sbc-glossary/" \l "out-of-pocket-limit) until the overall family [out–of–pocket limit](https://www.healthcare.gov/sbc-glossary/" \l "out-of-pocket-limit) has been met. |
| **What is not included in the [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/" \l "out-of-pocket-limit)?** | [Premium](https://www.healthcare.gov/sbc-glossary/" \l "premium)s, [balance-billing](https://www.healthcare.gov/sbc-glossary/" \l "balance-billing) charges, health care this [plan](https://www.healthcare.gov/sbc-glossary/" \l "plan) doesn't cover & penalties for failure to obtain [pre-authorization](https://www.healthcare.gov/sbc-glossary/" \l "preauthorization) for services. | Even though you pay these expenses, they don’t count toward the [out–of–pocket limit](https://www.healthcare.gov/sbc-glossary/" \l "out-of-pocket-limit). |
| **Will you pay less if you use a [network provider](https://www.healthcare.gov/sbc-glossary/" \l "network-provider)?** | Yes. See <https://www.aetnadocfind.com/2024-apcn-plus-mt-cpii/> or call 1-888-982-3862 for a list of Tier 1 and Tier2 In-[Network providers](https://www.healthcare.gov/sbc-glossary/" \l "network-provider). | You pay the least if you use a [provider](https://www.healthcare.gov/sbc-glossary/" \l "provider) in Tier 1 In-[Network](https://www.healthcare.gov/sbc-glossary/" \l "network). You pay more if you use a [provider](https://www.healthcare.gov/sbc-glossary/" \l "provider) in Tier 2 In-[Network](https://www.healthcare.gov/sbc-glossary/" \l "network). You will pay the most if you use an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/" \l "out-of-network-provider), and you might receive a bill from a [provider](https://www.healthcare.gov/sbc-glossary/" \l "provider) for the difference between the [provider’s](https://www.healthcare.gov/sbc-glossary/" \l "provider) charge and what your [plan](https://www.healthcare.gov/sbc-glossary/" \l "plan) pays ([balance billing](https://www.healthcare.gov/sbc-glossary/" \l "balance-billing)). Be aware, your [network provider](https://www.healthcare.gov/sbc-glossary/" \l "network-provider) might use an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/" \l "out-of-network-provider) for some services (such as lab work). Check with your [provider](https://www.healthcare.gov/sbc-glossary/" \l "provider) before you get services. |
| **Do you need a [referral](https://www.healthcare.gov/sbc-glossary/" \l "referral) to see a [specialist](https://www.healthcare.gov/sbc-glossary/" \l "specialist)?** | No. | You can see the [specialist](https://www.healthcare.gov/sbc-glossary/" \l "specialist) you choose without a [referral](https://www.healthcare.gov/sbc-glossary/" \l "referral). |

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

| **Common Medical Event** | **Services You May Need** | **What You Will Pay** | | | **Limitations, Exceptions, & Other Important Information** |
| --- | --- | --- | --- | --- | --- |
| **Tier 1 In-Network**  **(You will pay the least)** | **Tier 2 In-Network**  **(You will pay more)** | **Out-of-Network Provider**  **(You will pay the most)** |
| **If you visit a health care [provider](https://www.healthcare.gov/sbc-glossary/" \l "provider)’s office or clinic** | Primary care visit to treat an injury or illness | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | None |
| [Specialist](https://www.healthcare.gov/sbc-glossary/" \l "specialist) visit | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | None |
| [Preventive care](https://www.healthcare.gov/sbc-glossary/" \l "preventive-care) /[screening](https://www.healthcare.gov/sbc-glossary/" \l "screening) /immunization | No charge | No charge | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | You may have to pay for services that aren't preventive. Ask your [provider](https://www.healthcare.gov/sbc-glossary/" \l "provider) if the services needed are preventive. Then check what your [plan](https://www.healthcare.gov/sbc-glossary/" \l "plan) will pay for. |
| **If you have a test** | [Diagnostic test](https://www.healthcare.gov/sbc-glossary/" \l "diagnostic-test) (x-ray, blood work) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | None |
| Imaging (CT/PET scans, MRIs) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | None |
| **If you need drugs to treat your illness or condition**  More information about **[prescription drug coverage](https://www.healthcare.gov/sbc-glossary/" \l "prescription-drug-coverage)** is available at [www.aetnapharmacy.com/advancedcontrol](http://www.aetnapharmacy.com/advancedcontrol) | Generic drugs | [Copay](https://www.healthcare.gov/sbc-glossary/" \l "copayment)/prescription: $10 (retail), $25 (mail order) | [Copay](https://www.healthcare.gov/sbc-glossary/" \l "copayment)/prescription: $10 (retail), $25 (mail order) | Not covered | Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-[network](https://www.healthcare.gov/sbc-glossary/" \l "network). Your cost will be higher for choosing Brand over Generics; cost difference penalty doesn't apply to [deductible](https://www.healthcare.gov/sbc-glossary/" \l "deductible) or [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/" \l "out-of-pocket-limit). Maintenance drugs- after three retail fills, members are required to fill a 90-day supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy. |
| Preferred brand drugs | [Copay](https://www.healthcare.gov/sbc-glossary/" \l "copayment)/prescription: $35 (retail), $88 (mail order) | [Copay](https://www.healthcare.gov/sbc-glossary/" \l "copayment)/prescription: $35 (retail), $88 (mail order) | Not covered |
| Non-preferred brand drugs | [Copay](https://www.healthcare.gov/sbc-glossary/" \l "copayment)/prescription: $55 (retail), $138 (mail order) | [Copay](https://www.healthcare.gov/sbc-glossary/" \l "copayment)/prescription: $55 (retail), $138 (mail order) | Not covered |
| [Specialty drugs](https://www.healthcare.gov/sbc-glossary/" \l "specialty-drug) | [Coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance)/prescription: 30% | [Coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance)/prescription: 30% | Not covered | All prescriptions must be filled through the Aetna Specialty Performance Pharmacy [Network](https://www.healthcare.gov/sbc-glossary/" \l "network). Precertification required for coverage. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | None |
| Physician/surgeon fees | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | None |
| **If you need immediate medical attention** | [Emergency room care](https://www.healthcare.gov/sbc-glossary/" \l "emergency-room-care-emergency-services) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | Out-of-[network](https://www.healthcare.gov/sbc-glossary/" \l "network) emergency use paid the same as in-[network](https://www.healthcare.gov/sbc-glossary/" \l "network). No coverage for non-emergency use. |
| [Emergency medical transportation](https://www.healthcare.gov/sbc-glossary/" \l "emergency-medical-transportation) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | Out-of-[network](https://www.healthcare.gov/sbc-glossary/" \l "network) emergency use paid the same as in-[network](https://www.healthcare.gov/sbc-glossary/" \l "network). Non-emergency transport: not covered, except if pre-authorized. |
| [Urgent care](https://www.healthcare.gov/sbc-glossary/" \l "urgent-care) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | No coverage for non-urgent use. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | Penalty of $500 for failure to obtain [pre-authorization](https://www.healthcare.gov/sbc-glossary/" \l "preauthorization) for out-of-network care. |
| Physician/surgeon fees | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office & other outpatient services: 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | Office & other outpatient services: 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | Office & other outpatient services: 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | None |
| Inpatient services | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | Penalty of $500 for failure to obtain [pre-authorization](https://www.healthcare.gov/sbc-glossary/" \l "preauthorization) for out-of-network care. |
| **If you are pregnant** | Office visits | No charge | No charge | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | [Cost sharing](https://www.healthcare.gov/sbc-glossary/" \l "cost-sharing) does not apply to certain [preventive services](https://www.healthcare.gov/sbc-glossary/" \l "preventive-care). Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of $500 for failure to obtain [pre-authorization](https://www.healthcare.gov/sbc-glossary/" \l "preauthorization) for out-of-network care may apply. |
| Childbirth/delivery professional services | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) |
| Childbirth/delivery facility services | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) |
| **If you need help recovering or have other special health needs** | [Home health care](https://www.healthcare.gov/sbc-glossary/" \l "home-health-care) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | Penalty of $500 for failure to obtain [pre-authorization](https://www.healthcare.gov/sbc-glossary/" \l "preauthorization) for out-of-network care. |
| [Rehabilitation services](https://www.healthcare.gov/sbc-glossary/" \l "rehabilitation-services) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | None |
| [Habilitation services](https://www.healthcare.gov/sbc-glossary/" \l "habilitation-services) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | None |
| [Skilled nursing care](https://www.healthcare.gov/sbc-glossary/" \l "skilled-nursing-care) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | Penalty of $500 for failure to obtain [pre-authorization](https://www.healthcare.gov/sbc-glossary/" \l "preauthorization) for out-of-network care. |
| [Durable medical equipment](https://www.healthcare.gov/sbc-glossary/" \l "durable-medical-equipment) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | Limited to 1 [durable medical equipment](https://www.healthcare.gov/sbc-glossary/" \l "durable-medical-equipment) for same/similar purpose. Excludes repairs for misuse/abuse. |
| [Hospice services](https://www.healthcare.gov/sbc-glossary/" \l "hospice-services) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | Penalty of $500 for failure to obtain [pre-authorization](https://www.healthcare.gov/sbc-glossary/" \l "preauthorization) for out-of-network care. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | No charge | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | 1 routine eye exam/calendar year. |
| Children's glasses | Not covered | Not covered | Not covered | Not covered. |
| Children's dental check-up | Not covered | Not covered | Not covered | Not covered. |

## Excluded Services & Other Covered Services:

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| --- | --- | --- |
| **Services Your [Plan](https://www.healthcare.gov/sbc-glossary/" \l "plan) Generally Does NOT Cover (Check your policy or [plan](https://www.healthcare.gov/sbc-glossary/" \l "plan) document for more information and a list of any other [excluded services](https://www.healthcare.gov/sbc-glossary/" \l "excluded-services).)** | | |
| * Acupuncture * Cosmetic surgery * Dental care (Adult & Child) | * Glasses (Child) * Long-term care * Non-emergency care when traveling outside the U.S. | * Routine foot care * Weight loss programs - Except for required [preventive services](https://www.healthcare.gov/sbc-glossary/" \l "preventive-care). |

|  |  |  |
| --- | --- | --- |
| **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/" \l "plan) document.)** | | |
| * Bariatric surgery * Chiropractic care | * Hearing aids - $3,000 maximum per ear/24 months. * Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card. | * Private-duty nursing * Routine eye care (Adult) - 1 routine eye exam/calendar year. |

## 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/" \l "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 [http://www.dol/gov/ebsa/healthreform](https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/)
* For non-federal governmental group health [plans](https://www.healthcare.gov/sbc-glossary/" \l "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/" \l "plan), church [plans](https://www.healthcare.gov/sbc-glossary/" \l "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](https://www.healthcare.gov/sbc-glossary/" \l "health-insurance) [Marketplace](https://www.healthcare.gov/sbc-glossary/" \l "marketplace). For more information about

the [Marketplace](https://www.healthcare.gov/sbc-glossary/" \l "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/" \l "plan) for a denial of a [claim](https://www.healthcare.gov/sbc-glossary/" \l "claim). This complaint is called a [grievance](https://www.healthcare.gov/sbc-glossary/" \l "grievance) or [appeal](https://www.healthcare.gov/sbc-glossary/" \l "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/" \l "claim). Your [plan](https://www.healthcare.gov/sbc-glossary/" \l "plan) documents also provide complete information on how to submit a [claim](https://www.healthcare.gov/sbc-glossary/" \l "claim), [appeal](https://www.healthcare.gov/sbc-glossary/" \l "appeal), or a [grievance](https://www.healthcare.gov/sbc-glossary/" \l "grievance) for any reason to your [plan](https://www.healthcare.gov/sbc-glossary/" \l "plan). For more information about your rights, this notice, or assistance, contact:

* If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-888-982-3862. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [http://www.dol/gov/ebsa/healthreform](https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/)
* For non-federal governmental group health [plans](https://www.healthcare.gov/sbc-glossary/" \l "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/" \l "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.

[Minimum Essential Coverage](https://www.healthcare.gov/sbc-glossary/" \l "minimum-essential-coverage) generally includes [plans](https://www.healthcare.gov/sbc-glossary/" \l "plan), [health insurance](https://www.healthcare.gov/sbc-glossary/" \l "health-insurance) available through the [Marketplace](https://www.healthcare.gov/sbc-glossary/" \l "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](https://www.healthcare.gov/sbc-glossary/" \l "minimum-essential-coverage), you may not be eligible for the [premium tax credit](https://www.healthcare.gov/sbc-glossary/" \l "premium-tax-credits).

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

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

|  |
| --- |
| *To see examples of how this [plan](https://www.healthcare.gov/sbc-glossary/" \l "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/" \l "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/" \l "provider) charge, and many other factors. Focus on the [cost-sharing](https://www.healthcare.gov/sbc-glossary/" \l "cost-sharing) amounts ([deductibles](https://www.healthcare.gov/sbc-glossary/" \l "deductible), [copayments](https://www.healthcare.gov/sbc-glossary/" \l "copayment) and [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance)) and [excluded services](https://www.healthcare.gov/sbc-glossary/" \l "excluded-services) under the [plan](https://www.healthcare.gov/sbc-glossary/" \l "plan). Use this information to compare the portion of costs you might pay under different health [plans](https://www.healthcare.gov/sbc-glossary/" \l "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/" \l "plan) overall [deductible](https://www.healthcare.gov/sbc-glossary/" \l "deductible) $1,750**

◼ **[Specialist](https://www.healthcare.gov/sbc-glossary/" \l "specialist) [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) 20%**

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

◼ **Other [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) 20%**

**This EXAMPLE event includes services like:**

[Specialist](https://www.healthcare.gov/sbc-glossary/" \l "specialist) office visits (*prenatal care)*

Childbirth/Delivery Professional Services

Childbirth/Delivery Facility Services

[Diagnostic tests](https://www.healthcare.gov/sbc-glossary/" \l "diagnostic-test) (*ultrasounds and blood work)*

[Specialist](https://www.healthcare.gov/sbc-glossary/" \l "specialist) visit *(anesthesia)*

|  | **Total Example Cost** | **$12,700** |  |
| --- | --- | --- | --- |
|  | **In this example, Peg would pay:** |  |  |
|  | *[Cost Sharing](https://www.healthcare.gov/sbc-glossary/" \l "cost-sharing)* |  |  |
|  | [Deductibles](https://www.healthcare.gov/sbc-glossary/" \l "deductible) | $1,750 |  |
|  | [Copayments](https://www.healthcare.gov/sbc-glossary/" \l "copayment) | $10 |  |
|  | [Coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | $2,000 |  |
|  | *What isn't covered* |  |  |
|  | Limits or exclusions | $60 |  |
|  | **The total Peg would pay is** | **$3,820** |  |

The [plan](https://www.healthcare.gov/sbc-glossary/" \l "plan) would be responsible for the other costs of these EXAMPLE covered services.

◼ **The [plan's](https://www.healthcare.gov/sbc-glossary/" \l "plan) overall [deductible](https://www.healthcare.gov/sbc-glossary/" \l "deductible) $1,750**

◼ **[Specialist](https://www.healthcare.gov/sbc-glossary/" \l "specialist) [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) 20%**

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

◼ **Other [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) 20%**

**This EXAMPLE event includes services like:**

[Primary care physician](https://www.healthcare.gov/sbc-glossary/" \l "primary-care-physician) office visits *(including disease education)*

[Diagnostic tests](https://www.healthcare.gov/sbc-glossary/" \l "diagnostic-test) *(blood work)*

[Prescription drugs](https://www.healthcare.gov/sbc-glossary/" \l "prescription-drugs)

[Diabetic supplies](https://www.healthcare.gov/sbc-glossary/" \l "durable-medical-equipment) *(glucose meter)*

|  | **Total Example Cost** | | **$5,600** |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **In this example, Joe would pay:** | |  |  |  |
|  | *[Cost Sharing](https://www.healthcare.gov/sbc-glossary/" \l "cost-sharing)* | |  |  |  |
|  | [Deductibles](https://www.healthcare.gov/sbc-glossary/" \l "deductible) |  | $1,750 |  |  |
|  | [Copayments](https://www.healthcare.gov/sbc-glossary/" \l "copayment) |  | $700 |  |  |
|  | [Coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) |  | $100 |  |  |
|  | *What isn't covered* | | |  |  |
|  | Limits or exclusions |  | $20 |  |  |
|  | **The total Joe would pay is** |  | **$2,570** |  |  |

◼ **The [plan's](https://www.healthcare.gov/sbc-glossary/" \l "plan) overall [deductible](https://www.healthcare.gov/sbc-glossary/" \l "deductible) $1,750**

◼ **[Specialist](https://www.healthcare.gov/sbc-glossary/" \l "specialist) [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) 20%**

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

◼ **Other [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) 20%**

**This EXAMPLE event includes services like:**

[Emergency room care](https://www.healthcare.gov/sbc-glossary/" \l "emergency-room-care-emergency-services) *(including medical supplies)*

[Diagnostic test](https://www.healthcare.gov/sbc-glossary/" \l "diagnostic-test) *(x-ray)*

[Durable medical equipment](https://www.healthcare.gov/sbc-glossary/" \l "durable-medical-equipment) *(crutches)*

[Rehabilitation services](https://www.healthcare.gov/sbc-glossary/" \l "rehabilitation-services) *(physical therapy)*

|  | **Total Example Cost** | **$2,800** |  |
| --- | --- | --- | --- |
|  | **In this example, Mia would pay:** |  |  |
|  | *[Cost Sharing](https://www.healthcare.gov/sbc-glossary/" \l "cost-sharing)* |  |  |
|  | [Deductibles](https://www.healthcare.gov/sbc-glossary/" \l "deductible) | $1,750 |  |
|  | [Copayments](https://www.healthcare.gov/sbc-glossary/" \l "copayment) | $0 |  |
|  | [Coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) | $200 |  |
|  | *What isn't covered* |  |  |
|  | Limits or exclusions | $0 |  |
|  | **The total Mia would pay is** | **$1,950** |  |

## 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 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).

**Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).**

TTY: 711

## Language Assistance:

To access language services at no cost to you, call 1-888-982-3862.

Albanian - Për shërbime përkthimi falas për ju, telefononi 1-888-982-3862.

Amharic - የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-888-982-3862 ይደውሉ፡፡

Arabic - 1-888-982-3862 للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم

Armenian - Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-888-982-3862 հեռախոսահամարով:

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.

Bantu-Kirundi - Kugira uronke serivisi z’indimi atakiguzi, hamagara 1-888-982-3862.

Bengali-Bangala - আপনাকে বিনামূকযে ভাষা পবিকষিা পপকে হকয এই নম্বকি পেবযক ান েরুন: 1-888-982-386।

Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-888-982-3862.

Burmese - သင့္အေနျဖင့္ အခေၾကးေငြ မေပးရပဲ ဘာသာစကား၀န္ေဆာင္မႈမ်ား ရရွိႏုိင္ရန္ 1-888-982-3862 သို႕ ဖုန္းေခၚဆုိပါ။

Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-888-982-3862.

Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-888-982-3862.

Cherokee - ᏩᎩᏍᏗ ᏚᏬᏂᎯᏍᏗ ᎤᏳᎾᏓᏛᏁᏗ Ꮭ ᎪᎱᏍᏗ ᏗᏣᎬᏩᎳᏁᏗ ᏱᎩ, ᏫᎨᎯᏏᎳᏛᏏ 1-888-982-3862.

Chinese - 如欲使用免費語言服務，請致電 1-888-982-3862.

Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-888-982-3862.

Cushite - Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-888-982-3862.

Dutch - Voor gratis toegang tot taaldiensten, bell 1-888-982-3862.

French - Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862.

French Creole - Pou jwenn sèvis lang gratis, rele 1-888-982-3862.

German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an.

Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-982-3862.

Gujarati - તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેિાઓની પહોોંર્ માટે, કોલ કરો1-888-982-3862.

Hawaiian - No ka walaʻau ʻana me ka lawelawe ʻōlelo e kahea aku i kēia helu kelepona 1-888-982-3862. Kāki ʻole ʻia kēia kōkua nei.

Hindi - आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए,1-888-982-3862 पर कॉल करें।

Hmong - Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-888-982-3862.

Igbo - Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-888-982-3862

Ilocano - Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-888-982-3862.

Indonesian - Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-888-982-3862.

Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-982-3862.

Japanese - 言語サービスを無料でご利用いただくには、1-888-982-3862 までお電話ください。

Karen - 1-888-982-3862

Korean - 무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오.

Kru-Bassa - M̀ dyi wuɖu-dù kà kò ɖò ɓě dyi mɔú ń nì Pídyi ní, nìí, ɖá nɔ̀ɓà nìà kɛ: 1-888-982-3862

Kurdish - 1-888-982-3862 بۆ دەسپێڕاگەيشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەيوەندی بکە بە ژمارەی

Laotian - ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ1-888-982-3862

Marathi - कोणत्याही शल्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-888-982-3862 वर फोन करा.

Marshallese - Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-888-982-3862.

Micronesian-

Pohnpeyan - Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-888-982-3862.

Mon-Khmer, ដើម្បីទទួលបាន​សេវាកម្ម​ភាសា​ដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់​លេខ 1-888- 982-3862។

Cambodian -

Navajo - 1-888-982-3862.

Nepali - निःशुल्क भाषा सेवा प्राप्त गर्न  1-888-982-3862 मा टेलिफोन गर्नुहोस् ।

Nilotic-Dinka - Të kɔɔr yïn wɛɛ̈r̈ de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-888-982-3862.

Norwegian - For tilgang til kostnadsfri språktjenester, ring 1-888-982-3862.

Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-982-3862.

Persian - . تماس بگیريد 1-888-982-3862 برای دسترسی بە خدمات زبان بە طور رايگان، با شماره

Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-982-3862.

Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862.

Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-888-982-3862 ‘ਤੇ ਫ਼ੋਨ ਕਰੋ।

Romanian - Pentru a accesa gratuit serviciile de limbă, apelați 1-888-982-3862.

Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862.

Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala’au le 1-888-982-3862.

Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-888-982-3862.

Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862.

Sudanic-Fulfude - Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-888-982-3862.

Swahili - Kupata huduma za lugha bila malipo kwako, piga 1-888-982-3862.

Syriac - ܐܸܢ ܣܢܝܼܩܵܐ ܝ̄ܬܘܼܢ ܥܲܠ ܚܸܠܡܲܬܹ̈ܐ ܕܗܲܝܲܪܬܵܐ ܒܠܸܫܵܢܵܐ ܡܲܓܵܢܵܐܝܼܬ، ܩܪܝܼܡܘܿܢ: 1-888-982-3862

Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862.

Telugu - మీరు భాష సేవలను ఉచితంగా అందుకునoదుకు, 1-888-982-3862 కు కాల్ చేయండి.

Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-888-982-3862.

Tongan - Kapau ‘oku ke fiema’u ta’etōtōngi ‘a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-888-982-3862.

Trukese - Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-888-982-3862.

Turkish - Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-888-982-3862 numarayı arayın.

Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-982-3862.

Urdu - .پر بات کریں۔ 1-888-982-3862بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ،

Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862.

Yiddish - 1-888-982-3862 צו צוטריט שּפרַאך בַאדינונגען אין קייןּ פרייַז צו איר, רופן

Yoruba - Lati wọnú awọn isẹ èdè l’ọfẹ fun ọ, pe 1-888-982-3862.