The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://www.aetna.com/sbcsearch/getcbpolicydocs?P=0760148&Y=23, or by calling 1-844-365-7373. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-844-365-7373 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>In-Network: Individual $1,000 / Family $2,000.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Certain office visits, preventive care, emergency care and urgent care in-network.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>In-Network: Individual $2,900 / Family $5,800.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="https://aet.na/providersearch_aetna">https://aet.na/providersearch_aetna</a> or call 1-844-365-7373 for a list of in-network providers. Select 2023 TX Aetna CVS Silver 3: HMO CSR 87 ON.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td><strong>In-Network Provider (You will pay the least)</strong>: $25 copay/visit, deductible does not apply</td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong>: Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td><strong>In-Network Provider (You will pay the least)</strong>: $50 copay/visit, deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td><strong>In-Network Provider (You will pay the least)</strong>: $25 copay/visit, deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td><strong>In-Network Provider (You will pay the least)</strong>: 30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Preferred generic drugs</td>
<td>No charge for up to a 90 day supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td><strong>In-Network Provider (You will pay the least)</strong>: $25 copay/ prescription for up to a 30 day supply, $62.50 copay prescription for up to a 90 day supply, deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred generic/brand drugs</td>
<td><strong>In-Network Provider (You will pay the least)</strong>: 40% coinsurance for up to a 90 day supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preferred/non-preferred specialty drugs</td>
<td><strong>In-Network Provider (You will pay the least)</strong>: 50% coinsurance for up to a 30 day supply</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td><strong>In-Network Provider (You will pay the least)</strong>: 30% coinsurance for hospital facility; 20% coinsurance for free standing facility</td>
<td>Not covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Physician/surgeon fees</td>
<td>30% coinsurance for hospital facility; 20% coinsurance for free standing facility</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Emergency room care</td>
<td>$500 copay/visit, deductible does not apply</td>
<td>$500 copay/visit, deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 copay/visit, deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Outpatient office visits: $25 copay/visit, deductible does not apply; All other outpatient services: 30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>----------------------------------------------------</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$50 copay/visit, deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**Excluded Services & Other Covered Services:**

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.):**

- Abortion - except when the life of the mother is endangered, or complications arise.
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

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

- Acupuncture - Coverage is limited to 10 visits.
- Chiropractic care - Coverage is limited to 35 visits for Physical Therapy, Occupational Therapy, Speech Therapy and Chiropractic care combined.
- Hearing aids
- Private-duty nursing - Coverage is limited to inpatient when medically necessary.

**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: Texas Department of Insurance, 1-800-252-3439 (Consumer HelpLine), (512) 676-6000 (Local), (800) 578-4677 (Toll-Free), [https://www.tdi.texas.gov/consumer/index.html](https://www.tdi.texas.gov/consumer/index.html).

- For more information on your rights to continue coverage, contact the plan at 1-844-365-7373.
Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596 or state health insurance marketplace or SHOP.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Texas Department of Insurance, 1-800-252-3439 (Consumer HelpLine), (512) 676-6000 (Local), (800) 578-4677 (Toll-Free), [https://www.tdi.texas.gov/consumer/index.html](http://www.tdi.texas.gov/consumer/index.html).

- Additionally, a consumer assistance program can help you file your appeal. Contact Texas Department of Insurance, Consumer Protection, Mail Code 111-1A, 333 Guadalupe, P.O. Box 149091, Austin, TX 78714-9091, Phone toll-free: 1-800-252-3439, [http://www.texashealthoptions.com](http://www.texashealthoptions.com), ConsumerProtection@tdi.texas.gov.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Not Applicable.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

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

- **The plan’s overall deductible**: $1,000
- **Specialist copayment**: $50
- **Hospital (facility) coinsurance**: 30%
- **Other coinsurance**: 30%

This EXAMPLE event includes services like:
- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

**Total Example Cost**: $12,700

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,700</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $60
- The total Peg would pay is: $2,960

### 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**: $50
- **Hospital (facility) coinsurance**: 30%
- **Other coinsurance**: 30%

This EXAMPLE event includes services like:
- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

**Total Example Cost**: $5,600

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$700</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $20
- The total Joe would pay is: $720

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

- **The plan’s overall deductible**: $1,000
- **Specialist copayment**: $50
- **Hospital (facility) coinsurance**: 30%
- **Other coinsurance**: 30%

This EXAMPLE event includes services like:
- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

**Total Example Cost**: $2,800

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$900</td>
</tr>
<tr>
<td>Copayments</td>
<td>$800</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $0
- The total Mia would pay is: $1,700

Note: These numbers assume the patient does not participate in the plan’s wellness program. If you participate in the plan’s wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-844-365-7373.

The plan would be responsible for the other costs of these EXAMPLE covered services.
**Assistive Technology**

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-844-365-7373.

**Smartphone or Tablet**

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

**Non-Discrimination**

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at [https://ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf), or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Health plans are offered or underwritten or administered by Aetna Health Inc. (Texas) (Aetna). Aetna is part of the CVS Health family of companies.
TTY: 711

Language Assistance:

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

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-844-365-7373.

Amharic - እኔጋጆች ከጠናቀቁ ከ 1-844-365-7373 ቤት የታደጋል.

Arabic - للمساعدة في (اللغة العربية)، الوجاه الاتصال على الرقم المجاني 1-844-365-7373

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-844-365-7373 առանց գնով:

Bahasa-Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-844-365-7373 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-844-365-7373 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনিময়ে 1-844-365-7373-এ কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-844-365-7373 nga walay bayad.

Burmese - 1-844-365-7373

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-844-365-7373.

Chamorro - Para ayuda gi fino’ (Chamoru), ágang 1-844-365-7373 sin gástu.

Cherokee - ᎠᏂᎦᏬᏂᎢᏗ ᎠᏂᏍᎵᏍᏗ ᎣᏬᏂᎦ / (ᎠᏣᎳᏩ) 1-844-365-7373 ᎣᏞᏬᏗ ᎣᎣᏫᎳᏩ ᎣᏬᏩᏗ.

Chinese - 欲取得繁體中文語言協助，請撥打 1-844-365-7373，無需付費。

Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-844-365-7373.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-844-365-7373 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-844-365-7373.

French - Pour une assistance linguistique en français appeler le 1-844-365-7373 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-844-365-7373 grinat.


Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-844-365-7373 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં લાંબા માટે કોઈ પણ પરસ્પર વચ્ચે 1-844-365-7373 પર કોલ કરો.
Hawaiian - No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-844-365-7373. Kāki ʻole ia kēia kōkua nei.
Hindi - हिन्दी में भाषा सहायता के लिए, 1-844-365-7373 पर मुफ्त कॉल करें।
Hmong - Yôg xav tau kev tshais lus Hmoob hu dawb tau rau 1-844-365-7373.
Ibo - Maka enyemaka asusu na Igbo kpọọ 1-844-365-7373 na akwụgbọ ọgbọ bula
Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-844-365-7373 nga awan ti bayadanyo.
Italian - Per ricevere assistenza linguistica in italiano, puo chiamare gratuitamente 1-844-365-7373.
Japanese - 日本語で援助をご希望の方は、1-844-365-7373 まで無料でお電話ください。
Karen - ហ៊ុនតារអ៊ុលីសចិត្តចិនទឹកមកក្រង់ 1-844-365-7373 កំពួតទារីចិត្តចិនទឹកមកក្រង់។
Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-844-365-7373 번으로 전화해 주십시오.
Kurdish - برای راهنمایی به زبان فارسی با شماره 1-844-365-7373 به خوزایی پایه‌های بکان.
Laotian - ເັດຖາທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ,
             ກະລານໂທຫາ 1-844-365-7373 ່ອໄປເທັງແລະ.
Marathi - कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-844-365-7373 वर फोन करा.
Marshallese - Ñan bök jipañ ilo Kajin Majol, kallok 1-844-365-7373 ilo ejjelok wōnān.
Micronesian - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-844-365-7373 ni sohte isais.
Mon-Khmer, Cambodian - ភាសាខ្មែរនិយមវិទ្យាសាស្ត្រវិជ្ជាជីវិត 1-844-365-7373 សំណាងការ៉េបាន។
Navajo - T'áá shi shizaad k'ehji bee shiká a'doowol ninizando Diné k'ehji koji' t'áá jiik'e hólne' 1-844-365-7373
Nepali - (नेपाली) मा निष्जलक भाषा सहायता पाउनका लागाउँ 1-844-365-7373 मा फोन गर्नुहोस्।
Nilotic-Dinka - Tên kucony è thok è Thuonjên col 1-844-365-7373 kećin ayòc.
Norwegian - For språkassistanse på norsk, ring 1-844-365-7373 kostnadsfritt.
Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਲਈ, 1-844-365-7373 ਉੜੇ ਬੁਧਦਾਨ ਵਾਲੀ ਚੰਗੀ।