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

Coverage Period: 01/01/2023 - 12/31/2023

Coverage for: Individual + Family  |  Plan Type: HMO

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=0760157&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.

### Important Questions | Answers | Why This Matters:
--- | --- | ---
What is the overall deductible? | $0. | See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible? | No. | You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services? | No. | You don’t have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan? | In-Network: Individual $2,000 / Family $4,000. | 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.
What is not included in the out-of-pocket limit? | Premiums and health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit.
Will you pay less if you use a network provider? | Yes. See https://aetna/providersearch_aetna or call 1-844-365-7373 for a list of in-network providers. Select 2023 TX Aetna CVS Silver 4: HMO CSR 94 ON. | 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.
Do you need a referral to see a specialist? | Yes. | 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.
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>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>In-Network Provider (You will pay the least): No charge</td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$10 copay/visit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Lab: No charge; X-ray: $10 copay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>Applies to services received in office or in outpatient setting.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Preferred generic drugs</td>
<td>$5 copay/ prescription for up to a 30 day supply, $12.50 copay/ prescription for up to a 90 day supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$50 copay/ prescription for up to a 30 day supply, $125 copay/ prescription for up to a 90 day supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred generic/brand drugs</td>
<td>10% 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>40% coinsurance for up to a 30 day supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

More information about **prescription drug coverage** is available at [http://aet.na/txiv123](http://aet.na/txiv123)

Texas TX Shoppers: To find TX plan consumer drug cost estimates go to [https://www.aetna.com/individuals-families/aca-texas-plans.html](https://www.aetna.com/individuals-families/aca-texas-plans.html) or call us toll-free at 1-844-393-7139.

All specialty prescription drug fills on initial fill must be filled at a network specialty pharmacy except for urgent situations. Your plan may include access to CVS retail pharmacies for certain specialty drugs.
<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>In-Network Provider (You will pay the least): 10% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most): 10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$10 copay/visit</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or</td>
<td>Outpatient services</td>
<td>Outpatient office visits: No charge; All other outpatient services: 10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>substance abuse services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>None</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</td>
<td>10% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other</td>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>special health needs</td>
<td>Rehabilitation services</td>
<td>$10 copay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>10% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% 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>10% 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:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>• Abortion - except when the life of the mother is endangered, or complications arise.</td>
<td>• Infertility treatment</td>
<td>• Routine foot care</td>
</tr>
<tr>
<td>• Bariatric surgery</td>
<td>• Long-term care</td>
<td>• Weight loss programs</td>
</tr>
<tr>
<td>• Cosmetic surgery</td>
<td>• Non-emergency care when traveling outside the U.S.</td>
<td></td>
</tr>
<tr>
<td>• Dental care (Adult &amp; Child)</td>
<td>• Routine eye care (Adult)</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture - Coverage is limited to 10 visits.</td>
<td>• Hearing aids</td>
<td>• Private-duty nursing - Coverage is limited to inpatient when medically necessary.</td>
</tr>
<tr>
<td>• Chiropractic care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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 at 1-844-365-7373.
- State Consumer Assistance Program, if other than state insurance department 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, ConsumerProtection@tdi.texas.gov

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 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.
- 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, 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.

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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 $0
- Specialist copayment $10
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
<td>$30</td>
<td>$1,000</td>
</tr>
<tr>
<td>Copayments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What isn't covered
Limits or exclusions $60
The total Peg would pay is $1,090

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

- The plan’s overall deductible $0
- Specialist copayment $10
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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

What isn't covered
Limits or exclusions $20
The total Joe would pay is $920

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

- The plan’s overall deductible $0
- Specialist copayment $10
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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

What isn’t covered
Limits or exclusions $0
The total Mia would pay is $260

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), CRCordinator@aetna.com.

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

Health plans are offered or underwritten or administered by Aetna 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 - እንግ×</s>ርን እንategicን ያለ 1-844-365-7373 በተቋንቋ ይቋርስ.</s>
Arabic - للمساعدة في (اللغة العربية)، الوجهاء الاتصال على الرقم المجاني 1-844-365-7373.
Armenian - կենսակները ապաгայիր են (հայերեն) քայքայան 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 বিনামূল্যে 1-844-365-7373-তে 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 - ᎰᏍᏏᏬᏂᏍᏗ ᎤᏘᏭᏪᏭ ᎨᏬᏂᏍᎵᏍᎩ ᎨᏲ᏶Ꭲ (Gwy) ᎨᏲᏲᎵᏱ 1-844-365-7373 ᎨᏩᏲ Ꭱ ᎡางᏲᏳ ᎠᏩᏱ ᅭᏯᏲ.</s>
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 સાહિત્ય માટે કોઈ પણ પરિયું વડે 1-844-365-7373 પર કોલ કરો.
No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-844-365-7373. Kāki ‘ole ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-844-365-7373 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-844-365-7373.

Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-844-365-7373 na akwụgwị ugwọ ọ buła

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, può chiamare gratuitamente 1-844-365-7373.

Japanese - 日本語で援助をご希望の方は、1-844-365-7373まで無料でお電話ください。

Karen - ვითარების დამატებითი დაწესებულების გუნდი ში: 1-844-365-7373 ვითარების დამატებითი დაწესებულების გუნდი.

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-844-365-7373 번으로 전화해 주십시오.

Kurdish - برای راهنمایی به زبان فارسی با شماره 365-364-365-7373 به خوزایی پاموئندی پکام.

Laotian - ເປີຄັບຜູ້ຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-844-365-7373 ເຢັ່ສະໜ່ວຍເຫຼືອ.

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 - ភាសាខ្មែរបាន ស្នាដៃ ប្រការណ៍ ត្រូវបានការពារការជំនួស 1-844-365-7373 នៃប្រការណ៍ថ្មីថ្មី។

Navajo - T'áá shi shizaad k'ehji bee shiká a'doowol ninizingo Diné k'ehji koi' t'áá jiik'e hólne' 1-844-365-7373

Nepali - (नेपाली) मा नसीलक्ष्य भाषा सहायता पाउनका लागाउँ 1-844-365-7373 मा फोन गर्नुहोस्।

Nilotic-Dinka - Tên kuconn y thok ê Thuonjâñ cöl 1-844-365-7373 kecîn ayôc.

Norwegian - For språkassistanse på norsk, ring 1-844-365-7373 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਲਈ, 1-844-365-7373 ਦੇ ਭੂਤ ਵਾਲਾ ਵੇਦੇ।

1-844-365-7373