Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** POS

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **https://www.aetna.com/sbcsearch/getpolicydocs?u=070300-020020-111798** or by calling **1-866-253-8885**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: Individual **$6,550** / Family **$13,100**. Out-of-network: Individual **$13,100** / Family **$26,200**. Does not apply to preventive care in-network.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. In-network: Individual **$6,550** / Family **$13,100**. Out-of-network: Individual **Unlimited** / Family **Unlimited**.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for services, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.aetna.com** or call 1-866-253-8885 for a list of in-network **providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	30% coinsurance	———————none———————
	Specialist visit	0% coinsurance	30% coinsurance	———————none———————
	Other practitioner office visit	0% coinsurance for Chiropractic care	30% coinsurance for Chiropractic care	Coverage is limited to 20 visits for Chiropractic care.
	Preventive care /screening /immunization	No charge	30% coinsurance, except deductible waived for well child, well baby & immunizations; no charge for immunizations to age 6	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	30% coinsurance	———————none———————
	Imaging (CT/PET scans, MRIs)	0% coinsurance	30% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetna.com/pharmacy-insurance/individuals-families	Preferred generic drugs	0% coinsurance for up to a 90 day supply	0% coinsurance for up to a 30 day supply	Covers up to a 30 day supply (retail prescription), 31-90 day supply (retail & mail order prescription). Applicable cost share plus difference (brand minus generic cost) applies for brand when generic available. No charge for preferred generic FDA-approved women's contraceptives in-network. Precertification and step therapy required. No coverage for mail order prescriptions out-of-network.
	Preferred brand drugs	0% coinsurance for up to a 90 day supply	0% coinsurance for up to a 30 day supply	
	Non-preferred generic/brand drugs	0% coinsurance for up to a 90 day supply	0% coinsurance for up to a 30 day supply	
Five Tier Closed Individual Formulary	Preferred/non-preferred specialty drugs	0% coinsurance for up to a 30 day supply	0% coinsurance for up to a 30 day supply	——————none——————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	30% coinsurance	——————none——————
	Physician/surgeon fees	0% coinsurance	30% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	0% coinsurance	0% coinsurance	Out-of-network emergency room services cost-share same as in-network. No coverage for non-emergency care.
	Emergency medical transportation	0% coinsurance	0% coinsurance	Out-of-network cost-share same as in-network.
	Urgent care	0% coinsurance	30% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	30% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.
	Physician/surgeon fee	0% coinsurance	30% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% coinsurance	30% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	0% coinsurance	30% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.
	Substance use disorder outpatient services	0% coinsurance	30% coinsurance	——————none——————
	Substance use disorder inpatient services	0% coinsurance	30% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	Prenatal: No charge; Postnatal: 0% coinsurance	30% coinsurance	———————none———————
	Delivery and all inpatient services	0% coinsurance	30% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	30% coinsurance	Coverage is limited to 120 visits.
	Rehabilitation services	0% coinsurance	30% coinsurance	Coverage is limited to 40 visits for Physical Therapy & Occupational Therapy combined, 40 visits for Speech Therapy.
	Habilitation services	0% coinsurance	30% coinsurance	Coverage is limited to 40 visits for Physical Therapy & Occupational Therapy combined and 40 visits for Speech Therapy, rehabilitation & habilitation separate.
	Skilled nursing care	0% coinsurance	30% coinsurance	Coverage is limited to 60 days. Out-of-network precertification required or $400 penalty applies per occurrence.
	Durable medical equipment	0% coinsurance	30% coinsurance	———————none———————
	Hospice service	0% coinsurance	30% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.
If your child needs dental or eye care	Eye exam	No charge	30% coinsurance	Coverage is limited to 1 exam per calendar year age 0-19.
	Glasses	0% coinsurance	30% coinsurance	Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per calendar year age 0-19.
	Dental check-up	0% coinsurance	0% coinsurance	Coverage is limited to 2 exams per calendar year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Abortion - except in cases of rape, incest, or when the life of the mother is endangered.
- Acupuncture - except as form of anesthesia.
- Bariatric surgery
- Cosmetic surgery - except when medically necessary.
- Dental care (Adult) - except accidental injury.
- Hearing aids
- Infertility treatment - except the diagnosis and surgical treatment of underlying conditions.
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care - Coverage is limited to 20 visits.

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-866-253-8885. You may also contact your state insurance department at Customer Services Division, (800) 656-2298, **http://www.oci.ga.gov/consumerservice/home.aspx**

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact us by calling the toll free number on your Medical ID Card. You may also contact the Georgia Office of Insurance and Safety Fire Commissioner, Customer Services Division, (800) 656-2298, **http://www.oci.ga.gov/consumerservice/home.aspx**

Additionally, a consumer assistance program can help you file your **appeal**. Contact Georgia Office of Insurance and Safety Fire Commissioner, Customer Services Division, 2 Martin Luther King, Jr. Drive West Tower, Suite 716 Atlanta, GA 30334, (800) 656-2298, **http://www.oci.ga.gov/consumerservice/home.aspx**

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides**.

------------------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*------------------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $2,140
- **Patient pays:** $5,400

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$5,200
Copays	$0
Coinsurance	$0
Limits or exclusions	$200
Total	**$5,400**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $20
- **Patient pays:** $5,380

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$5,300
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$5,380**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-253-8885.

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 on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 1-859-425-3379, CRCoordinator@aetna.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.

TTY: 711

Language Assistance:

For language assistance in your language call 1-866-253-8885 at no cost.

Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-866-253-8885 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-866-253-8885
Chinese -	欲取得繁體中文語言協助，請撥打 1-866-253-8885，無需付費。
French -	Pour une assistance linguistique en français appeler le 1-866-253-8885 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-866-253-8885 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-866-253-8885 an.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-866-253-8885 પર કૉલ કરો.
Hindi -	हिन्दी में भाषा सहायता के लिए, 1-866-253-8885 पर मुफ्त कॉल करें।
Japanese -	日本語で援助をご希望の方は、1-866-253-8885 まで無料でお電話ください。
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-253-8885 번으로 전화해 주십시오.
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-253-8885
Persian -	برای راهنمایی به زبان فارسی با شماره 1-866-253-8885 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Portuguese -	Para obter assistência linguística em português ligue para o 1-866-253-8885 gratuitamente.
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-253-8885.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-866-253-8885.
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-253-8885 nang walang bayad.
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-866-253-8885.