



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, go to <http://www.mcclatchylivewell.com/> or by calling 1-888-982-3862. 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 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<u>Network</u> : Individual \$400 / Family \$1,200. <u>Out-of-Network</u> : Individual \$1,000 / Family \$3,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive care</u> , <u>in-network</u> office visits and prescription drugs are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	<u>Network</u> : Individual \$5,500 / Family \$11,000. <u>Out-of-Network</u> : Individual \$10,000 / Family \$20,000.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-888-982-3862 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	Includes internal medicine, general practice, family practice and pediatrics.
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	None
	<u>Preventive care / screening / immunization</u>	No charge	No charge	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are preventive, then check what your <u>plan</u> will pay for. Age and frequency limits may apply.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition  Prescription drug coverage is administered by CVS/Caremark  More information about <b>prescription drug coverage</b> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic drugs	<u>Copay</u> /prescription: \$15 for 30-day supply; \$37.50 for 31- to 90-day supply	Not covered	Covers 30-day supply (retail), 31-90 day supply (mail order). Review your formulary for prescriptions requiring precertification or step therapy.
	Preferred brand drugs	20% <u>coinsurance</u> /prescription with \$25 minimum to \$90 maximum for 30-day supply; \$62.50 minimum to \$225 maximum for 31- to 90-day supply	Not covered	
	Non-preferred brand drugs	40% <u>coinsurance</u> /prescription with \$60 minimum to \$150 maximum for 30-day supply; \$150 minimum to a \$375 maximum for 31-90-day supply	Not covered	
	<u>Specialty drugs</u>	Applicable cost as noted above for generic or brand drugs	Not covered	First prescription must be filled at a participating retail pharmacy or CVS Specialty Pharmacy. Subsequent fills must be through CVS Specialty Pharmacy.

<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	Emergency room care	30% <u>coinsurance</u> after \$125 <u>copay/visit</u>	30% <u>coinsurance</u> after \$125 <u>copay/visit</u>	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$40 <u>copay/visit</u> , <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% <u>coinsurance</u> after \$400 <u>copay/stay</u>	50% <u>coinsurance</u> after \$1,000 <u>copay/stay</u>	Max <u>copay</u> /calendar year: \$1,200 in-network, \$3,000 out-of-network. Penalty of \$250 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office & other outpatient services: \$25 <u>copay/visit</u> , <u>deductible</u> doesn't apply	Office & other outpatient services: 50% <u>coinsurance</u>	None
	Inpatient services	30% <u>coinsurance</u> after \$400 <u>copay/stay</u>	50% <u>coinsurance</u> after \$1,000 <u>copay/stay</u>	Max <u>copay</u> /calendar year: \$1,200 in-network, \$3,000 out-of-network. Penalty of \$250 for failure to obtain <u>pre-authorization</u> for out-of-network care.
<b>If you are pregnant</b>	Office visits	No charge	50% <u>coinsurance</u>	<u>Cost sharing</u> doesn't apply to certain <u>preventive services</u> . Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound). Includes outpatient postnatal care.
	Childbirth/delivery professional services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	30% <u>coinsurance</u> after \$400 <u>copay/stay</u>	50% <u>coinsurance</u> after \$1,000 <u>copay/stay</u>	Max <u>copay</u> /calendar year: \$1,200 in-network, \$3,000 out-of-network. Penalty of \$250 for failure to obtain <u>pre-authorization</u> for out-of-network
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage is limited to 120 visits/calendar year. Penalty of \$250 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Rehabilitation services</u>	\$40 <u>copay/visit</u> , <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	None
	<u>Habilitation services</u>	\$40 <u>copay/visit</u> , <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	Limited to children up to age 6 for neurodevelopmental therapy.
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage is limited to 100 days/calendar year. Penalty of \$250 for failure to obtain <u>pre-authorization</u> for out-of-network care.

	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Hospice services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$250 for failure to obtain <u>pre-authorization</u> for out-of-network care.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

**Excluded Services & Other Covered Services:**

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

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs - Except for required preventive services.

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

- Acupuncture - 12 visits/calendar year.
- Bariatric surgery - \$5,000 maximum/lifetime for in-network only.
- Chiropractic care - 20 visits/calendar year.
- Hearing aids - 1 hearing aid to \$1,000 maximum per ear/24 months for children up to age 19 & 1 hearing aid to \$1,000 maximum per ear/36 months thereafter.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Private-duty nursing - 70- 8 hour shifts/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 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 [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

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

### 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 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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number 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 [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this plan Meet Minimum Value Standard? Yes.

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** \$400
- **Specialist copayment** \$40
- **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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$500
Coinsurance	\$2,800

<i>What isn't covered</i>	
Limits or exclusions	\$60

<b>The total Peg would pay is</b>	<b>\$3,760</b>
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**Managing Joe's type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

- The **plan's overall deductible** \$400
- **Specialist copayment** \$40
- **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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$700
Coinsurance	\$1,200

<i>What isn't covered</i>	
Limits or exclusions	\$60

<b>The total Joe would pay is</b>	<b>\$2,360</b>
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**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- The **plan's overall deductible** \$400
- **Specialist copayment** \$40
- **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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$400
Coinsurance	\$300

<i>What isn't covered</i>	
Limits or exclusions	\$0

<b>The total Mia would pay is</b>	<b>\$1,100</b>
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Note: If your **plan** has a wellness program and you choose to participate, you may be able to reduce your costs.

## 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 discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

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

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

Civil Rights Coordinator

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030, Fresno, CA 93779)

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705)

Email: CRCoordinator@aetna.com

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

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





- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - हन्दिी में भाषा सहायता के लएि, 1-800-370-4526 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.
- Ibo - **Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwughị ugwo ọ bụla**
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.
- Japanese - 日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。
- Karen - လၢတၢ်မၤစၢၤတၢ်ကတိၤကိၣ်အီၣ်နီၣ် ဂိၣ်နီၣ် ဂိး 1-800-370-4526 လၢတၢ်အိၣ်ဒီးတၢ်လၢတိၣ်ကတိၣ်စၢၤတၢ်
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526번으로 전화해 주십시오.
- Kru-Bassa - **Ɓe'm`ké gbo-kpá-kpá dyé pídyi dé Ɓasoó`wuḍuũn wěe, dá 1-800-370-4526**
- Kurdish - برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خۆراییی په یه هندی بکس.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-800-370-4526 क्रमांकावरकोणत्याहीखर्चाशुधायिकॉलकरा.
- Marshallese - Ñan bōk jįpañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.
- Micronesian-Pohnpeyan - **Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.**
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526
- Nepali - (नेपाली) मा नःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tën kuony ë thok ë Thuonjän col 1-800-370-4526 kec'in ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵੱਲੋਂ ਭਾਸ਼ਾਈ ਮਦਦ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hilfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.
- Persian - برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
- Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.

- Portuguese - Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.
- Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-370-4526
- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-370-4526 e aunoa ma se totagi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-800-370-4526. Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.
- Syriac - ܠܗܘܢܘܢ ܘܠܗܘܢܘܢ ܕܘܠܗܘܢܘܢ ܘܠܗܘܢܘܢ ܘܠܗܘܢܘܢ ܘܠܗܘܢܘܢ ܘܠܗܘܢܘܢ ܘܠܗܘܢܘܢ 1-800-370-4526 ܘܠܗܘܢܘܢ .
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.
- Telugu - భృషణి సాయం కోరకు ఎలాంటి ఖరీదు లేకుండా 1-800-370-4526 కు కలి చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-800-370-4526 'o 'ikai hā tōtōngi.
- Trukese - Ren ánnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-800-370-4526 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödmeden 1-800-370-4526.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.
- Urdu - اے ریگال کسٹما رپ 1-800-370-4526 سے مل سکتے ہیں اور یہاں سے مدد حاصل کی جا سکتی ہے۔
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-800-370-4526 פון אפצאל.
- Yoruba - Fún iranlọwọ nípa èdè (Yorùbá) pe 1-800-370-4526 láí san owó kankan rárá.