## Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>For each Plan Year, In-Network: Individual $300. Out-of-Network: Individual $600.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Prescription drugs; plus in-network preventive care are covered before you meet your deductible.</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 $6,850. Out-of-Network: Individual NONE.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, health care this plan doesn’t cover &amp; penalties for failure to obtain pre-authorization for services.</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="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-877-480-4161 for a list of in-network providers.</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>No.</td>
<td>You can see the specialist you choose without a referral.</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>0% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>0% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>0% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>0% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>Copay/prescription, deductible doesn't apply: $20 (retail)</td>
<td>Covers 30 day supply (retail). Includes contraceptive drugs &amp; devices obtainable from a pharmacy, oral &amp; injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Copay/prescription, deductible doesn't apply: $40 (retail)</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Copay/prescription, deductible doesn't apply: $40 (retail)</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Copay/prescription, deductible doesn't apply</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>0% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need</strong></td>
<td>Emergency room care</td>
<td>0% coinsurance</td>
<td>No coverage for non-emergency use.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay In-Network Provider (You will pay the least)</td>
<td>What You Will Pay Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>-----------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>immediate medical attention</td>
<td>Emergency medical transportation</td>
<td>0% coinsurance</td>
<td>0% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>0% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>0% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office &amp; other outpatient services:</td>
<td>Office &amp; other outpatient services:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>0% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>0% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>0% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>20% coinsurance, deductible doesn't apply</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>0% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>0% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>0% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>0% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>0% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>30% coinsurance, deductible doesn't apply</td>
<td>30% coinsurance, deductible doesn't apply</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>No charge</td>
<td>0% coinsurance</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.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- 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
- Bariatric surgery
- Chiropractic care
- Hearing aids - 1 hearing aid per ear/24 months.
- Non-emergency care when traveling outside the U.S.

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: Department of Financial Services, Consumer Assistance Unit, 800-342-3736, http://www.dfs.ny.gov/consumer/fileacomplaint.htm.
- For more information on your rights to continue coverage, contact the plan at 1-877-480-4161.
- State Consumer Assistance Program, if other than state insurance department contact Community Health Advocates, Community Service Society of New York, 633 Third Avenue, 10th Floor, New York, NY 10017, 1-888-614-5400, http://www.communityhealthadvocates.org/.

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 1-877-480-4161.
- Additionally, a consumer assistance program can help you file your appeal, Contact Community Health Advocates, Community Service Society of New York, 633 Third Avenue, 10th Floor, New York, NY 10017, 1-888-614-5400, http://www.communityhealthadvocates.org/.

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 Standards? 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: $300
- Specialist coinsurance: 0%
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

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)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,800</th>
</tr>
</thead>
</table>

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$300</td>
</tr>
<tr>
<td>Copayments</td>
<td>$40</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn't covered

| Limits or exclusions | $60 |

The total Peg would pay is $400

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

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

- The plan’s overall deductible: $300
- Specialist coinsurance: 0%
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

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)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$7,400</th>
</tr>
</thead>
</table>

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$300</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,500</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 $1,820

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

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

- The plan’s overall deductible: $300
- Specialist coinsurance: 0%
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

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

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$1,900</th>
</tr>
</thead>
</table>

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$300</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</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 $300

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 1-877-480-4161.

**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.**
Hawaiian -
No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-877-480-4161. Kāki ‘ole ‘ia kēia kōkua nei.

Hindi -
हिन्दी में भाषा सहायता के लिए 1-877-480-4161 पर मुफ्त कॉल करें।

Hmong -
Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-877-480-4161.

Ibo -
Maka enyemaka asusu na Igbo kpọ 1-877-480-4161 na akwughị úgwọ ọ bụla

Ilocano -
Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-480-4161 nga awan ti bayadanyo.

Italian -
Per ricevere assistenza linguistica in italiano, puoi chiamare gratuitamente 1-877-480-4161.

Japanese -
日本語で援助をご希望の方は、1-877-480-4161 まで無料でお電話ください。

Karen -
 כל תבורי קארה יבה צו נמר צו תבורי קארה עגו 1-877-480-4161 עגיו יביו לארה יבה קארה.

Korean -
한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-480-4161 번으로 전화해 주십시오.

Kru-Bassa -
Be’m ké gbo-kpa-kpá dyé pidyi dë Basco-wuɗuɗn wëe, qa 1-877-480-4161

Kurdish -
برای راهنمایی به زبان فارسی با شماره 1-877-480-4161 به خوراکی باشندی که.

Laotian -
Maka enyemaka asusu na Igbo kpọ 1-877-480-4161 na akwughị úgwọ ọ bụla

Marathi -
तीलभाषा (मराठी) सहाय्यासाठी 1-877-480-4161 क्रमांकावतकोणत्याहीक्षितविशिष्टकॉलकरा.

Marshallese -
Ñan bôk jipaŋ ilo Kajin Majol, kallok 1-877-480-4161 ilo ejjelok wônân.

Micronesian-Pohnpeyan -
Ohng palien sawas en souk kawewe ni omw lokaia Ponape koahl 1-877-480-4161 ni sohte isais.

Mon-Khmer, Cambodian -
តារាយ័យអាហារ៍ប្រចាំថ្ងៃ៖ 1-877-480-4161 យើងនឹងជួយកាន់ក្រុមរបស់អ្នក.

Navajo -
T'áá shi shíaab k'éhjí bee shíká a'doowol nínìzingo Diné k'éhjí kojjí t'áá jíík'e hólne' 1-877-480-4161

Nepali -
(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-877-480-4161 मा फोन गर्नुहोस्।

Nilotic-Dinka -
Tën kuoony ê thok ê Thuonjñaj col 1-877-480-4161 kecîn ayóc.

Norwegian -
For språkassistanse på norsk, ring 1-877-480-4161 kostnadsfritt.

Panjabi -
ਪੰਜਾਬੀ ਸਿੰਘ ਕਰਪਾਚਕ ਮਾਰਦੀਆ ਦੋਸੀ, 1-877-480-4161 ‘ਵੇ ਸਟ੍ਰੀਟ ਵਰਤ ਵਲੇ।

Pennsylvania Dutch -
Fer Helfe in Deitsch, ruf: 1-877-480-4161 aa. Es Aaruf koschtet nix.

Persian -
برای راهنمایی به زبان فارسی با شماره 1-877-480-4161 بدون هیچ هزینه ای تماس بگیرید. انگلیسی

Polish -
Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-480-4161.

Proprietary
Para obter assistência linguística em português ligue para 1-877-480-4161 gratuitamente.

Получите помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-480-4161.

Para obtener asistencia lingüística en español, llame sin cargo al 1-877-480-4161.

Пожалуйста, позвоните по бесплатному номеру 1-877-480-4161 для получения помощи языкового переводчика.

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-480-4161.

Пожалуйста, позвоните по бесплатному номеру 1-877-480-4161 для получения помощи языкового переводчика.

Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-877-480-4161. Njodi woo fawaaki on.

Para asistência linguística em português, ligue para o número gratuito 1-877-480-4161.

Пожалуйста, позвоните по бесплатному номеру 1-877-480-4161 для получения помощи языкового переводчика.

Пожалуйста, позвоните по бесплатному номеру 1-877-480-4161 для получения помощи языкового переводчика.

Fímá yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-877-480-4161. Njodi wóo fawaaki on.

Пожалуйста, позвоните по бесплатному номеру 1-877-480-4161 для получения помощи языкового переводчика.

Пожалуйста, позвоните по бесплатному номеру 1-877-480-4161 для получения помощи языкового переводчика.

Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-877-480-4161. Njodi wììì fawaaki on.