



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, www.trselectivecareetna.com or by calling 1-800-222-9205. 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 1-800-222-9205 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	For each <u>Plan</u> Year, Kelsey Select: Individual \$1,200 / Family \$3,600.	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> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Prescription drugs</u> ; plus in- <u>network</u> office visits, urgent care visits & <u>preventive care</u> 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. \$200 for <u>prescription drugs</u> expenses. Doesn't apply to generic drugs. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Kelsey Select: Individual \$7,350 / Family \$14,700.	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.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges & health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.trselectivecareetna.com or call 1-800-222-9205 for a list of Kelsey Select <u>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.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</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
		Kelsey Care 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	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply; except 20% <u>coinsurance</u> for office surgery	Not covered	Includes Internist, General Physician, Family Practitioner, Pediatrician or Gynecologist.
	<u>Specialist</u> visit	\$70 <u>copay</u> /visit, <u>deductible</u> doesn't apply; except 20% <u>coinsurance</u> for office surgery	Not covered	None
	<u>Preventive care / screening / immunization</u>	No charge, except \$70 copay/visit for hearing or eye exam	Not covered	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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u> , except 100% at a Kelsey laboratory	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after \$100 <u>copay</u> /visit	Not covered	Pre-authorization may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		KelsyCare Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>Prescription drug coverage is administered by CVS/Caremark</p> <p>More information about prescription drug coverage is available at www.cvscaremark.com</p>	Generic drugs	<u>Copay/prescription, deductible doesn't apply:</u> \$20 (Retail first fill), \$35 (Retail refill), \$45 <u>copay</u> (Mail Order or Retail-Plus)	<u>Copay/prescription, deductible doesn't apply:</u> \$20 (Retail first fill), \$35 (Retail refill), \$45 <u>copay</u> (Mail Order or Retail-Plus)	<p>Covers 31 day supply (Retail), 60-90 day supply (Mail Order or Retail-Plus). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u>. Precertification & step therapy are required. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written.</p> <p>Out-of-Network: reimbursement is the <u>allowed amount</u> of what would have been charged by a network pharmacy less the <u>copay</u> after the drug <u>deductible</u> is met.</p>
	Preferred brand drugs	<u>Copay/prescription, after specific deductible:</u> \$40 (Retail first fill), \$60 (Retail refill), \$105 <u>copay</u> (Mail Order or Retail-Plus)	<u>Copay/prescription, after specific deductible:</u> \$40 (Retail first fill), \$60 (Retail refill), \$105 <u>copay</u> (Mail Order or Retail-Plus)	
	Non-preferred brand drugs	50% <u>coinsurance</u> , after specific <u>deductible</u> (Retail & Mail Order or Retail-Plus)	50% <u>coinsurance</u> , after specific <u>deductible</u> (Retail & Mail Order or Retail-Plus)	
	Specialty drugs	20% coinsurance, after specific deductible	Not covered	
<p>If you have outpatient surgery</p> <p>If you need immediate medical attention</p> <p>Emergency room (ER)</p>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u> after \$150 <u>copay/visit</u>	Not covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None
	<u>Emergency room care</u> (hospital-affiliated emergency room)	20% <u>coinsurance</u> after \$250 <u>copay/visit</u>	20% <u>coinsurance</u> after \$250 <u>copay/visit</u>	None
	<u>Emergency room care</u> (freestanding emergency room)	20% <u>coinsurance</u> after \$500 <u>copay/visit</u>	20% <u>coinsurance</u> after \$250 <u>copay/visit</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$50 <u>copay/visit</u> , <u>deductible doesn't apply</u>	Not covered	None
<p>If you have a hospital stay</p>	Facility fee (e.g., hospital room)	20% coinsurance after \$150 <u>copay/day</u> first 5 days	Not covered	Maximum/ <u>plan</u> year per individual: \$2,250.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		KelsyCare Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient: 20% <u>coinsurance</u> Office: \$70 <u>copay</u> /visit	Not covered	<u>Pre-authorization</u> may be required for care.
	Inpatient services	20% <u>coinsurance</u> after \$150 <u>copay</u> /day first 5 days	Not covered	Maximum/ <u>plan</u> year per individual: \$2,250.
If you are pregnant	Office visits	No charge	Not covered	<u>Cost sharing</u> doesn't apply to certain preventive services. Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound). Maximum/ <u>plan</u> year per individual: \$2,250.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	20% <u>coinsurance</u> after \$150 <u>copay</u> /day first 5 days	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not covered	60 visits/ <u>plan</u> year.
	<u>Rehabilitation services</u>	\$70 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	None
	<u>Habilitation services</u>	\$70 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	Limited to treatment of Autism.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not covered	25 days/ <u>plan</u> year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	20% <u>coinsurance</u>	Not covered	None
If your child needs dental or eye care	Children's eye exam	\$70 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	1 routine eye exam/ <u>plan</u> year if performed by an ophthalmologist or optometrist using calibrated instruments.
	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.)

- | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">• Acupuncture• Bariatric surgery• Cosmetic surgery• Dental care (Adult & Child) | <ul style="list-style-type: none">• Glasses (Child)• Long-term care• Non-emergency care when traveling outside the U.S.• Private-duty nursing | <ul style="list-style-type: none">• 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.)

- | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">• Chiropractic care - 35 visits/plan year.• Hearing aids - \$1,000 maximum/36 months. | <ul style="list-style-type: none">• Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. | <ul style="list-style-type: none">• Routine eye care (Adult) - 1 routine eye exam/plan 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 1-800-222-9205.
- 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.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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.

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 1-800-222-9205.
- 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.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- 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** \$1,200
- **Specialist copay** \$70
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

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	\$12,800
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles*	\$1,200
Copayments	\$100
Coinsurance	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,460

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

- The **plan's** overall **deductible** \$1,200
- **Specialist copay** \$70
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

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	\$7,400
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles*	\$200
Copayments	\$1,900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,120

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

- The **plan's** overall **deductible** \$1,200
- **Specialist copay** \$70
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

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	\$1,900
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles*	\$1,200
Copayments	\$300
Coinsurance	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,530

Note: If your **plan** has a wellness program and you choose to participate, you may be able to reduce your costs.

*Note: This **plan** has other **deductibles** for specific services included in this coverage example. See "Are there other **deductibles** for specific services?" row above

[Assistive Technology](#)

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-222-9205.

[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 859-425-3379, CRCoordinator@aetna.com.

California HMO/HNO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY 711, Fax 860-262-7705, 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 <http://www.hhs.gov/ocr/office/file/index.html>.

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.

TTY: 711

Language Assistance:

For language assistance in your language call 1-800-222-9205 at no cost.

- Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-222-9205.
- Amharic - ለቋንቋ እገዛ በ አማርኛ በ 1-800-222-9205 በነጻ ይደውሉ
- Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-222-9205
- Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-222-9205 առանց գնով:
- Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-222-9205 tanpa dikenakan biaya.
- Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-800-222-9205 ku busa
- Bengali-Bangala - ১৮০০২২২৯২০৫ (১৮০০২২২৯২০৫) ১-৮০০-২২২-৯২০৫-০০ কল করুন।
- Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-222-9205 nga walay bayad.
- Burmese - () 1-800-222-9205
- Catalan -Per rebre assistència en (català), truqui al número gratuït 1-800-222-9205.
- Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-800-222-9205 sin gåstu.
- Cherokee - () 1-800-222-9205
- Chinese - 欲取得繁體中文語言協助，請撥打1-800-222-9205，無需付費。
- Choctaw - (Chahta) anumpa ya apela a chi l_paya hinla 1-800-222-9205.
- Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-222-9205 irratti bilisaan bilbilaa.
- Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-222-9205.
- French - Pour une assistance linguistique en français appeler le 1-800-222-9205 sans frais.
- French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-222-9205 gratis.
- German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-222-9205 an.
- Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-222-9205 χωρίς χρέωση.
- Gujarati - 1-800-222-9205

