



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.HealthReformPlanSBC.com or by calling 1-800-370-4526. 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 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In- <u>Network</u> : Individual \$500 / Family \$1,000. Out-of- <u>Network</u> : Individual \$1,500 / 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> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. In-network <u>preventive care</u> is 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?	There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In- <u>Network</u> : Individual \$5,500 / Family \$11,000. Out-of- <u>Network</u> : Individual \$11,000 / Family \$22,000.	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.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , balance-billing charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain pre-authorization for services.	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.aetna.com/docfind or call 1-800-987-9072 for a list of UVA <u>Network providers</u> .	You pay the least if you use a <u>provider</u> in the UVA <u>Provider Network</u> . You pay more if you use a <u>provider</u> in the Aetna <u>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</u> charge 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> ?	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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	15% <u>coinsurance</u>	35% <u>coinsurance</u>	Includes Internist, General Physician, Family Practitioner or Pediatrician. Coverage is limited to 26 visits for Chiropractic care and 20 visits for acupuncture per calendar year. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. Age and frequency schedules apply.
	<u>Specialist</u> visit	15% <u>coinsurance</u>	35% <u>coinsurance</u>	
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge, except hearing exams not covered	Not covered	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.aetnapharmacy.com/standard	Generic drugs	\$6 <u>copay</u> /30 days; \$14 <u>copay</u> /90 days mail order	\$6 <u>copay</u> plus billed amount minus contracted rate/30 days	Covers up to 30-day supply (retail), 90-day supply (mail order, UVA pharmacies, CVS pharmacies). No charge for formulary generic FDA-approved women's contraceptives <u>in-network</u> . Your cost will be higher for choosing Brand over Generics.
	Preferred brand drugs	After <u>deductible</u> , 20% <u>coinsurance</u> with \$34 min/\$150 max/30 days, 15% <u>coinsurance</u> with \$75 min/\$375 max 90 days mail order	After <u>deductible</u> , 20% <u>coinsurance</u> with \$34 min/\$150 max plus billed amount minus contracted rate/30 days	
	Non-preferred brand drugs	After <u>deductible</u> , 20% <u>coinsurance</u> with \$68 min/\$225 max/30 days, 15% <u>coinsurance</u> with \$150 min/\$475 max/ 90 days mail order	After <u>deductible</u> , 20% <u>coinsurance</u> with \$68 min/\$225 max plus billed amount minus contracted rate/30 days	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Specialty drugs: Generic (G), Preferred brand (P), Non-preferred brand (N)</u>	After deductible, G: 20% <u>coinsurance</u> with \$100 max; P: 20% <u>coinsurance</u> with \$150 max; N: 20% <u>coinsurance</u> with \$200 max	Not covered	Covers up to 30-day supply. <u>Specialty drugs</u> must be filled through UVA Specialty Pharmacy. Limited Distribution Specialty Drugs may be filled through CVS Specialty Pharmacy. Mandatory generics required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	Physician/surgeon fees	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	No coverage for non-emergency transport.
	<u>Urgent care</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <u>coinsurance</u>	35% <u>coinsurance</u>	Pre-authorization required for out-of-network care
	Physician/surgeon fees	15% <u>coinsurance</u>	35% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 15% <u>coinsurance</u>	Office & other outpatient services: 35% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
	Inpatient services	15% <u>coinsurance</u>	35% <u>coinsurance</u>	Pre-authorization required for out-of-network care
If you are pregnant	Office visits	No charge for routine services	35% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	15% <u>coinsurance</u>	35% <u>coinsurance</u>	
	Childbirth/delivery facility services	15% <u>coinsurance</u>	35% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	90 visits/calendar year. Pre-authorization required for out-of-network care
	<u>Rehabilitation services</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	Coverage is limited to 40 visits per calendar year for Physical and

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Habilitation services</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	Occupational Therapy combined, 40 visits per calendar year for Speech Therapy.
	<u>Skilled nursing care</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	180 days/calendar year. Pre-authorization required for out-of-network care
	<u>Durable medical equipment</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	15% <u>coinsurance</u>	35% <u>coinsurance</u>	Pre-authorization required for out-of-network care
If your child needs dental or eye care	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 (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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 - 20 visits/calendar year.
- Bariatric surgery
- Chiropractic care - 26 visits/calendar year.
- Infertility treatment - Limited to diagnosis & treatment of underlying medical condition.
- Artificial insemination, ovulation induction & advanced reproductive technology: \$15,000 maximum/lifetime.

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 1-800-370-4526.
- 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 <http://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 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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- 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 <http://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.

[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? 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 \$500
- Specialist coinsurance 15%
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$24
<u>Coinsurance</u>	\$1,260
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,844

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

- The plan's overall deductible \$500
- Specialist coinsurance 15%
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$600
<u>Copayments</u>	\$186
<u>Coinsurance</u>	\$1,009
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$1,850

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

- The plan's overall deductible \$500
- Specialist coinsurance 15%
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$193
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$693

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 866-393-0002.

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, or disability.

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), 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).

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