



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 www.aetnainternational.com.com. 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 www.aetnainternational.com

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in- network providers \$0 person /\$0 family; for out-of-network providers \$0 person/ \$0 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	N/A	You don't have to meet deductibles for any services.
Are there other deductibles for specific services?	There are no other specific deductibles .	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in- network providers \$0 person /\$0 family; for out-of-network providers \$0 person/ \$0 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain precertification/preauthorization, services in excess of Plan maximums or limits, premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider?	Yes. See www.aetnainternational.com for a list of network providers .	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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral .



All "[copayment](#)" 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 provider's office or clinic	Primary care visit to treat an injury or illness	0% Deductible does not apply	20% coinsurance	30% coinsurance (10% coinsurance for mental health providers)	Does not include office surgery. Limited to general practice, family practice, medicine, osteopaths, pediatricians, nurse practitioners, physician assistants and health providers.
	Specialist visit	0% Deductible does not apply	20% coinsurance	30% coinsurance	Does not include office surgery.
	Preventive care/screening/immunization	0% Deductible does not apply	No charge (deductible does not apply).	30% coinsurance	You may have to pay for services that aren't preventive . Ask your provider what services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% Deductible does not apply	20% coinsurance	30% coinsurance	Does not include emergency room or urgent care diagnostic services.
	Imaging (CT/PET scans, MRIs)	0% Deductible does not apply	20% coinsurance	30% coinsurance	Does not include urgent care imaging services.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medonrx.com	Generic drugs	0% Deductible does not apply	25% (up to \$10) copay /prescription (retail) 25% (up to \$20) copay /prescription (mail-order)		Covers up to a 30-day supply (retail prescription); 90-days supply (mail order). Once the out-of-pocket maximum has been met, prescription drugs shall be covered for the remainder of the calendar year. *See Plan Document for non-use of generic drug penalty.
	Preferred brand drugs	0% Deductible does not apply	25% (up to \$40) copay /prescription (retail) 25% (up to \$80) copay /prescription (mail-order)		
	Non-preferred brand drugs	0% Deductible does not apply	25% (up to \$60) copay /prescription (retail) 25% (up to \$120) copay /prescription (mail-order)		
	Specialty drugs	0% Deductible does not apply	Contact Vivio at 800-470-4034 for applicable cost		*Please see Prescription Drug Benefit section within your Plan Document
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% Deductible does not apply	20% coinsurance	30% coinsurance	Preauthorization is required in order to avoid \$300.00 penalty per occurrence.

*For more information about limitations and exceptions, see plan document at www.aetnainternational.com.

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)	
	Physician/surgeon fees	0% Deductible does not apply	20% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	0% Deductible does not apply	20% coinsurance		None
	Emergency medical transportation	0% Deductible does not apply	20% coinsurance	Paid same as in-network	Transportation from the city or town in which the Covered Person becomes ill from the nearest Hospital qualified to provide treatment for the accidental disease. Preauthorization is required in order to avoid \$300.00 penalty per occurrence.
	Urgent care	0% Deductible does not apply	15% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% Deductible does not apply	20% coinsurance	30% coinsurance	Preauthorization is required in order to avoid \$300.00 penalty per occurrence.
	Physician/surgeon fees	0% Deductible does not apply	20% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% Deductible does not apply	20% coinsurance	20% coinsurance office visits and 30% coinsurance other outpatient services	None
	Inpatient services	0% Deductible does not apply	20% coinsurance	30% coinsurance	Preauthorization is required in order to avoid \$300.00 penalty per occurrence.
If you are pregnant	Office visits	0% Deductible does not apply	20% coinsurance	30% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity care and services described elsewhere in the SBC (i.e., ultrasound). Preauthorization is required for vaginal deliveries requiring more than a 4-hour stay and cesarean section deliveries requiring more than a 96-hour stay in order to avoid \$300.00 penalty.
	Childbirth/delivery professional services	0% Deductible does not apply	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	0% Deductible does not apply	20% coinsurance	30% coinsurance	
If you need help recovering or have other	Home health care	0% Deductible does not apply	20% coinsurance	30% coinsurance	Limited to a maximum of 40 visits per Calendar Year. Preauthorization is required in order to avoid \$300.00 penalty per occurrence.
	Rehabilitation services	0% Deductible does not apply	20% coinsurance	30% coinsurance	

*For more information about limitations and exceptions, see plan document at www.aetnainternational.com.

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)	
special health needs	Habilitation services	0% Deductible does not apply	20% coinsurance	30% coinsurance	Physical and occupational per therapy type: limited to a combined maximum office and outpatient facility services per Calendar Year. Speech therapy: maximum per Calendar Year
	Skilled nursing care		20% coinsurance	30% coinsurance	Limited to 60 days per Calendar Year. Preauthorization is required in order to avoid \$300.00 penalty per occurrence.
	Durable medical equipment		20% coinsurance	30% coinsurance	Preauthorization is required in order to avoid \$300.00 penalty per occurrence.
	Hospice services		20% coinsurance	30% coinsurance	Patient's life expectancy is 6 months or less. Preauthorization is required in order to avoid \$300.00 penalty per occurrence.
If your child needs dental or eye care	Children's eye exam		No charge (deductible does not apply).	30% coinsurance	Applies from birth through age 5. Vision care outside of the US is covered limited to \$350 per Calendar Year
	Children's glasses		No charge (deductible does not apply).	No charge (deductible does not apply).	Limited to services outside of the United States up to a maximum payment per Calendar Year.
	Children's dental check-up		No charge (deductible does not apply).	No charge (deductible does not apply).	Limited to services outside of the United States.

Services Your Plan Generally Does NOT Cover (Check your plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> • Cosmetic Surgery 	<ul style="list-style-type: none"> • Long Term Care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Routine Foot Care

*For more information about limitations and exceptions, see plan document at www.aetnainternational.com.

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

- Acupuncture and Massage therapy (limited to a combined maximum of 20 visits per Calendar Year)
- Bariatric Surgery (limited to 1 procedure per Lifetime.)
- Chiropractic Care (limited to 60 visits per Calendar Year)
- Dental Care- (Adult/Child) limited to services outside the United States up to a maximum payment of \$1,250 per Calendar year, dollar limit does not apply to preventive dental care.
- Glasses (Child) limited to services outside of the United States up to a maximum payment of \$350 per Calendar Year.
- Hearing Aids (limited \$750 per ear every 2 Calendar Year(s).)
- Infertility treatment (except promotion of conception)
- Private-duty nursing (limited to 40 visits (one per day) per Calendar Year.)
- Routine eye care (Adult) limited to services outside of the United States up to a maximum payment of \$350 per 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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: the Plan Administrator at (800) 700-2651 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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](#) \$0
- [Specialist coinsurance](#) 20%
- 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	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,060

Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist coinsurance](#) 20%
- 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	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,020

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist coinsurance](#) 20%
- 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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$600