



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.mymta.info or by calling 1-646-376-0123. 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 1-646-376-0123 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In- <u>Network</u> : \$0. Out-of- <u>Network</u> : Individual \$100 / Family \$0.	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 deductible?	No.	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services
Are there other deductibles for specific services?	Yes. \$100 for <u>durable medical equipment</u> & \$50 for out-of- <u>network</u> <u>home health care</u> . 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 out-of-pocket limit for this plan?	Not applicable	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
What is not included in the out-of-pocket limit?	Not applicable	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
Will you pay less if you use a network provider?	Yes. See www.aetnaNYCT.com or call 1-855-824-5943 for a list of in- <u>network</u> providers.	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</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 referral to see a specialist?	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 provider's office or clinic	Primary care visit to treat an injury or illness	\$15 <u>copay</u> /visit, <u>deductible</u> (DED) doesn't apply	Subject to Type D3/EMB Schedule of Allowances.	None
	<u>Specialist</u> visit	\$15 <u>copay</u> /visit	Subject to Type D3/EMB Schedule of Allowances.	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	Subject to Type D3/EMB Schedule of Allowances.	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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$15 <u>copay</u> /visit	Subject to Type D3/EMB Schedule of Allowances.	None
	Imaging (CT/PET scans, MRIs)	\$15 <u>copay</u> /visit	Subject to Type D3/EMB Schedule of Allowances.	None
If you need drugs to treat your illness or condition <u>Prescription drug coverage</u> is	Generic drugs- Your Lowest-Cost Option	Retail/Specialty Medications (med): 1-30 day: \$0 <u>copay</u> ; Mail order (MOD) med: 31-90 day \$0 <u>copay</u> ; MOD Specialty med: 30 day \$0 <u>copay</u>	You will pay the cost of the med & submit a paper <u>claim</u> for possible reimbursement	<u>Provider</u> means <u>network</u> pharmacy for purposes of this section. Retail: Up to a 30 day supply. MOD: Up to a 90 day supply. MOD Specialty: up to 30 day supply.

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)	
administered by CVS Caremark More information about prescription drug coverage is available at www.caremark.com	Preferred brand drugs- Your Mid-Range Cost Option	Retail/Specialty Med: 1-30 day: \$20 <u>copay</u> ; MOD/Specialty Med: 31-90 day \$40 <u>copay</u>	You will pay the cost of the med & submit a paper <u>claim</u> for possible reimbursement	
	Non-preferred brand drugs- Your Highest Cost Option	Retail/Specialty Med: 1-30 day: \$40 <u>copay</u> ; MOD Med: 31-90 day \$80 <u>copay</u> ; MOD Specialty Med: 30 day \$0 <u>copay</u>	You will pay the cost of the med & submit a paper <u>claim</u> for possible reimbursement	
	<u>Specialty drugs</u>	Applicable cost as noted above for generic or brand drugs	You will pay the cost of the med & submit a paper <u>claim</u> for possible reimbursement	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Subject to Type D3/EMB Schedule of Allowances.	None
	Physician/surgeon fees	No charge	Subject to Type D3/EMB Schedule of Allowances.	None
If you need immediate medical attention	<u>Emergency room care</u>	\$100 copay per visit	\$100 copay per visit	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	No charge	No charge	Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$15 <u>copay</u> /visit	\$15 <u>copay</u> /visit, deductible doesn't apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$50 <u>copay</u> /stay	Subject to Type D3/EMB Schedule of Allowances.	Max <u>copay</u> /calendar year: \$240 in- <u>network</u> . Penalty of \$250/day (up to \$500) for failure to obtain <u>pre-authorization</u> for out-of-network care.

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	No charge	Subject to Type D3/EMB Schedule of Allowances.	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: \$15 <u>copay</u> /visit	Office & other outpatient services: Subject to Type D3/EMB Schedule of Allowances.	None
	Inpatient services	\$50 <u>copay</u> /stay	0% <u>coinsurance</u>	Max <u>copay</u> /calendar year: \$240 in- <u>network</u> . Penalty of \$250/day (up to \$500) for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge	Office & other outpatient services: Subject to Type D3/EMB Schedule of Allowances.	Cost sharing does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Max <u>copay</u> /calendar year: \$240 in- <u>network</u> . Penalty of \$250/day (up to \$500) for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery professional services	No charge	Office & other outpatient services: Subject to Type D3/EMB Schedule of Allowances.	
	Childbirth/delivery facility services	\$50 <u>copay</u> /stay	Office & other outpatient services: Subject to Type D3/EMB Schedule of Allowances.	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	25% <u>coinsurance</u> , after specific <u>deductible</u>	200 visits/calendar year in- <u>network</u> & 40 visits/calendar year out-of-network. Max <u>copay</u> /calendar year: \$240 in- <u>network</u> . Penalty of \$250/day (up to \$500) for failure to obtain <u>pre-authorization</u> for out-of-network care.

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>Rehabilitation services</u>	\$15 <u>copay</u> /visit	Subject to Type D3/EMB Schedule of Allowances.	Physical and occupational therapy each limited to 20 visits/calendar year unless additional visits are medically necessary.
	<u>Habilitation services</u>	No charge	Subject to Type D3/EMB Schedule of Allowances.	Limited to treatment of Autism.
	<u>Skilled nursing care</u>	No charge	Subject to Type D3/EMB Schedule of Allowances.	100 days/calendar year. Penalty of \$250/day (up to \$500) for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	0% <u>coinsurance</u> , after specific <u>deductible</u>	50% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	No charge	Subject to Type D3/EMB Schedule of Allowances.	Penalty of \$250/day (up to \$500) for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	Subject to Type D3/EMB Schedule of Allowances.	1 routine eye exam/calendar year
	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 | • Hearing aids | • Routine eye care (Adult & Child) |
| • Dental care (Adult & Child) | • Long-term care | • Routine foot care |
| • Glasses (Child) | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |

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
- Infertility treatment
- Private-duty nursing

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 1-646-376-0123.
- 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 1-646-376-0123.
- 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 \$0
- Specialist copayment \$15
- Hospital (facility) copayment \$50
- Other copayment \$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*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$0
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$260

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 copayment \$15
- Hospital (facility) copayment \$50
- Other copayment \$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*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$0
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$420

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

- The plan's overall deductible \$0
- Specialist copayment \$15
- Hospital (facility) copayment \$50
- Other copayment \$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*)

Total Example Cost	\$2,800
In this example, Mia would pay:	
<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$0
<u>Copayments</u>	\$80
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$80

*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 1-646-376-0123.

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).

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.

- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-646-376-0123.
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-646-376-0123 e aunoa ma se totogi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-646-376-0123.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-646-376-0123.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-646-376-0123. Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-646-376-0123 bila malipo.
- Syriac - ܠܟܘܢ ܥܘܢܘܢܐ ܕܥܘܢܘܢܐ ܕܥܘܢܘܢܐ ܕܥܘܢܘܢܐ ܕܥܘܢܘܢܐ ܕܥܘܢܘܢܐ ܕܥܘܢܘܢܐ ܕܥܘܢܘܢܐ ܕܥܘܢܘܢܐ ܕܥܘܢܘܢܐ ܕܥܘܢܘܢܐ 1-646-376-0123 ܕܥܘܢܘܢܐ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-646-376-0123 nang walang bayad.
- Telugu - భాషతో సాయం కోరకు ఎలాంటి ఖర్చు లేకుండా 1-646-376-0123 కు కాల్ చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-646-376-0123 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-646-376-0123 ‘o ‘ikai hā ʻōtōngi.
- Trukese - Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-646-376-0123 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedен 1-646-376-0123.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-646-376-0123.
- Urdu - بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-646-376-0123 پر بات کریں۔
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-646-376-0123.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-646-376-0123 פון אפצאל.
- Yoruba - Fún ìrànṣọwọ nípa èdè (Yorùbá) pe 1-646-376-0123 láí san owó kankan rárá.