



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](http://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:
<b>What is the overall deductible?</b>	<u>Network</u> : Individual \$0 / Family \$0.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
<b>Are there services covered before you meet your deductible?</b>	No.	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services.
<b>Are there other deductibles for specific services?</b>	Yes. \$100 for <u>durable medical equipment</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.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	Not Applicable	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Not Applicable	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.aetnaNYCT.com">www.aetnaNYCT.com</a> or call 1-855-824-5349 for a list of in- <u>network 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	No charge	Not covered	None
	<u>Specialist</u> visit	No charge	Not covered	None
	<u>Preventive care</u> / <u>screening</u> / immunization	No charge	Not covered	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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	None

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)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p><b>Prescription drug coverage</b> is administered by CVS Caremark</p> <p>More information about <b>prescription drug coverage</b> is available at <a href="http://www.caremark.com">www.caremark.com</a>.</p>	Generic drugs – Your Lowest Cost-Option	Retail/Specialty Medications: 1-30 day: \$0 copay; Mail Order Medications: 31-90 day: \$0 copay; Mail order Specialty Medications: 30 day: \$0 copay	You will pay the cost of the medication and submit a paper <u>claim</u> for possible reimbursement	<p>Provider means network pharmacy for purposes of this section. Retail: Up to a 30 day supply. Mail- Order: Up to a 90 day supply. Mail Order Specialty: up to 30 day supply. See the website listed for information on drugs covered by your plan. Not all drugs are covered.</p>
	Preferred brand drugs – Your Mid-Range Cost Option	Retail/Specialty Medications: 1-30 day: \$10 copay; Mail Order/Specialty Medications: 31-90 day: \$20 copay	You will pay the cost of the medication and submit a paper <u>claim</u> for possible reimbursement	
	Non-preferred brand drugs – Your Highest-Cost Option	Retail/Specialty Medications: 1-30 day: \$15 copay; Mail Order Medications: 31-90 day: \$30 copay; Mail order Specialty Medications: 30 day: \$0 copay	You will pay the cost of the medication and 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 medication and submit a paper <u>claim</u> for possible reimbursement	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
<p><b>If you need immediate medical attention</b></p>	<u>Emergency room care</u>	No charge	No charge	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	No charge	No charge	None
	<u>Urgent care</u>	No charge	No charge	None
<p><b>If you have a hospital stay</b></p>	Facility fee (e.g., hospital room)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None

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 need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not covered	None
	Inpatient services	No charge	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Cost sharing doesn't apply to certain preventive services. Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	200 visits/calendar year.
	<u>Rehabilitation services</u>	No charge	Not covered	90 visits/calendar year for Physical, Occupational & Speech Therapy.
	<u>Habilitation services</u>	No charge	Not covered	Limited to treatment of Autism.
	<u>Skilled nursing care</u>	No charge	Not covered	100 days/calendar year.
	<u>Durable medical equipment</u>	0% coinsurance after specific deductible	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam/calendar year.
	Children's glasses	No charge	Not covered	\$45 maximum/24 months.
	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.)**

- |                               |  |                        |
|-------------------------------|--|------------------------|
| • Acupuncture                 | • Hearing aids                                       | • Private-duty nursing |
| • Cosmetic surgery            | • Long-term care                                     | • Routine foot care    |
| • Dental care (Adult & 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.)

- Bariatric surgery
- Infertility treatment
- Routine eye care (Adult) - 1 routine eye exam/calendar year.
- Chiropractic care

### 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 [www.dol.gov/ebsa/healthreform](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](http://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](http://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 1-646-376-0123.
- 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 [www.dol.gov/ebsa/healthreform](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](http://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** \$0
- **Specialist copayment** \$0
- **Hospital (facility) copayment** \$0
- **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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
---------------------------	-----------------

**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$200
<b>The total Peg would pay is</b>	<b>\$200</b>

**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** \$0
- **Hospital (facility) copayment** \$0
- **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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
---------------------------	----------------

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$100
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$2,900
<b>The total Joe would pay is</b>	<b>\$3,000</b>

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

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

<b>Total Example Cost</b>	<b>\$1,900</b>
---------------------------	----------------

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

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 1-646-376-0123.

### 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 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 1-646-376-0123.

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 (Aetna).**





- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-646-376-0123. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - हन्दिी में भाषा सहायता के लएि, 1-646-376-0123 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-646-376-0123.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-646-376-0123 na akwughị ugwo ọ bụla
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-646-376-0123 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-646-376-0123.
- Japanese - 日本語で援助をご希望の方は、1-646-376-0123 まで無料でお電話ください。
- Karen - လာတၢ်မၤစၢၤတၢ်ကတိၢ်တၢ်အိၣ်အိၣ်အိၣ် ကိၣ် ကိး 1-646-376-0123 လာတၢ်အိၣ်အိၣ်အိၣ်အိၣ်အိၣ်
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-646-376-0123번으로 전화해 주십시오.
- Kru-Bassa - Ɓe'm`ké gbo-kpá-kpá dyé pidyi dé Ɓašwá-wuḍuũn wɛɛ, dá 1-646-376-0123
- Kurdish - برای راهنمایی به زبان فارسی با شماره 1-646-376-0123 به خورایی په یومندی بکمن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-646-376-0123 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-646-376-0123 क्रमांकावरकोणत्याहीखर्चाशवियकॉलकरा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-646-376-0123 ilo ejjelok wōnān.
- Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-646-376-0123 ni sohte isais.
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទទេៅកាន់លេខ 1-646-376-0123 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-646-376-0123
- Nepali - (नेपाली) मा नःशुल्क भाषा सहायता पाउनका लागि 1-646-376-0123 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tën kuwony ë thok ë Thuonjän col 1-646-376-0123 kecin ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-646-376-0123 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵੱਚਿ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-646-376-0123 'ਤੇ ਮੁਫ਼ਤ ਵਾਲ ਵਰੋ।
- Pennsylvania Dutch - Fer Hilfe in Deutsch, ruf: 1-646-376-0123 aa. Es Aaruf koschtet nix.
- Persian - برای راهنمایی به زبان فارسی با شماره 1-646-376-0123 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
- Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-646-376-0123.

- Portuguese - Para obter assistência linguística em português ligue para o 1-646-376-0123 gratuitamente.
- Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-646-376-0123
- 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 besplatno 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 - ܠܚܘܨܘܬܐ ܕܠܘܘܬܐ ܕܠܘܘܬܐ ܕܠܘܘܬܐ ܕܠܘܘܬܐ ܕܠܘܘܬܐ ܕܠܘܘܬܐ ܕܠܘܘܬܐ ܕܠܘܘܬܐ ܕܠܘܘܬܐ ܕܠܘܘܬܐ ܕܠܘܘܬܐ ܕܠܘܘܬܐ 1-646-376-0123 ܕܠܘܘܬܐ .
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-646-376-0123 nang walang bayad.
- Telugu - భృషణి సాయం కోరకు ఎలాంటి ఖర్చు లోకుండు 1-646-376-0123 కు కలి చీయండి. (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 tōtōngi.
- Trukese - Ren ánnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-646-376-0123 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödmeden 1-646-376-0123.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-646-376-0123.
- Urdu - اہل زبان کی مدد کے لیے 1-646-376-0123 پر کال 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 ìrànጔwọ nípá èdè (Yorùbá) pe 1-646-376-0123 láí san owó kankan rárá.