This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.mtabsc.info or by calling 646-376-0123**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	Yes, $50 per person in-network in-patient hospital admission up to a maximum of $240 per person or family per calendar year; $100 per person for all eligible out-of-network expenses; $100 per person for durable medical equipment and prosthetics in-network and out-of-network; and $50 per person for Home Health Care visits out-of-network only.	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.
Is there an out–of–pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	N/A	Not applicable because there's no out-of-pocket limit in your expenses.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.aetnaNYCT.com or call 1-855-824-5349	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 co-pay	Subject to Type D3/EMB Schedule of Allowances.	N/A
	Specialist visit	$15 co-pay		N/A
	Other practitioner office visit	$15 co-pay for Chiropractor		N/A
	Preventive care/screening/immunization	$15 co-pay, waived for child up to age 19		Age and frequency schedules may apply
If you have a test	Diagnostic test (x-ray, blood work)	$15 co-pay		N/A
	Imaging (CT/PET scans, MRIs)	$15 co-pay		N/A

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need medi cations the following copayments will apply when using a network pharmacy. **More information about your prescription drug coverage is available at www.Express-Scripts.com**	Generic Drugs – Your Lowest-Cost Option	Retail/Specialty Medications: 1-30 days: $0 co-pay Mail Order Medications: 31-90 days: $0 co-pay Mail order Specialty Medications: 30 days: $0 co-pay	Out-of-Network Providers – you will pay the cost of the medication and submit a paper claim for possible reimbursement	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.
	Preferred Brand Drugs – Your Mid-Range Cost Option	Retail/Specialty Medications: 1-30 days: $10 co-pay Mail Order/Specialty Medications: 31-90 days: $20 co-pay	N/A	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.
	Non-preferred Brand Drugs – Your Highest-Cost Option	Retail/Specialty Medications: 1-30 days: $15 co-pay Mail Order Medications: 31-90 days: $30 co-pay . Mail order Specialty Medications: 30 days: $0 co-pay	N/A	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
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		——————none——————
If you need immediate medical attention	Emergency room services	No charge	No charge	——————none——————
	Emergency medical transportation	No charge	Subject to Type D3/EMB Schedule of Allowances.	——————none——————
	Urgent care	$15 co-pay		——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$50/deductible per admission/$240 maximum per calendar year per contract	Subject to Allowed Charge after the $100 deductible is met, per admission	
	Physician/Surgeon fee	No charge	Subject to Type D3/EMB Schedule of Allowances.	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 co-pay/visit	Subject to Type D3/EMB Schedule of Allowances.	——————none——————
	Mental/Behavioral health inpatient services	$50/deductible per admission/$240 maximum per calendar year per contract	Subject to Allowed Charge after the $100 deductible is met, per admission	
	Substance abuse disorder outpatient services	$15 co-pay/visit	Subject to Type D3/EMB Schedule of Allowances.	——————none——————
	Substance abuse disorder inpatient services	$50/deductible per admission/$240 maximum per calendar year per contract	Subject to Allowed Charge after the $100 deductible is met, per admission	
If you are pregnant	Prenatal and postnatal care	No charge	Subject to Type D3/EMB Schedule of Allowances.	——————none——————
	Delivery and all inpatient services	$50/deductible admission/$240 maximum per calendar year per contract	Subject to Allowed Charge after the $100 deductible is met, per admission	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Covered at 100%	25% coinsurance of allowed amount plus any amount billed above allowed amount, after the $50 per year deductible has been met; for up to 40 visits per calendar year	200-visit limit per calendar year for In Network Only
	Rehabilitation services	$15 co-pay	Subject to Type D3/EMB Schedule of Allowances.	Physical and occupational therapy each limited to 20 outpatient visits per calendar year unless additional visits are medically necessary.
	Habilitation services	$15 co-pay	Subject to Type D3/EMB Schedule of Allowances.	Habilitation services subject to/combined with rehabilitation limits.
	Skilled nursing care	No charge when in an Inpatient Acute Care setting only	Covered in an Inpatient Acute Care setting only. Subject to Allowed Charge after the $100 deductible is met, per admission	Coverage is limited to 100 days per calendar year
	Durable medical equipment	No charge after $100 deductible is met	50% of the DME allowed charges plus any amount billed after the $100 deductible has been met	——————none——————
	Hospice service	No charge	80% of the allowed amount Aetna would have made to an in-network facility	
If your child needs dental or eye care	Eye Exam	Not covered by Aetna	Not covered by Aetna	Not covered by Aetna
	Glasses	Not covered by Aetna	Not covered by Aetna	Not covered by Aetna
	Dental Check-Up	Not covered by Aetna	Not covered by Aetna	Not covered by Aetna

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic Surgery
- Dental care
- Hearing aids
- Long-term care
- Weight loss programs
- Routine foot care
- Routine eye care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Acupuncture
- Infertility treatment
- Care when traveling outside the US
- Bariatric Surgery
- Private Duty Nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **bscservice@mtabsc.org** or **1-646-376-0123**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at **1-877-267-2323 x61565 or www.cciio.cms.gov.**

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Aetna at: 1-855-824-5349 or you can write us at PO Box 14463 Lexington, KY 40512

Additionally, a consumer assistance program can help you file your appeal. Contact:

Community Service Society of New York
Community Health Advocates
105 East 22nd Street, 8th Floor
New York, NY 10010
888-614-5400
http://www.communityhealthadvocates.org/

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This health plan provides the minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage meets the minimum value standard for the benefits provided.**

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [**1-855-824-5349**].

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [**1-855-824-5349**].

[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** [**1-855-824-5349**].

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne [**1-855-824-5349**].

——————————To see examples of how this plan might cover costs for a sample medical situation, see the next page.——

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,475
- **Patient pays** $65

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$50
Co-pays	$15
Coinsurance	$0
Limits or exclusions	$0
Total	**$65**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,115
- **Patient pays** $285

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Co-pays	$185
Coinsurance	$0
Limits or exclusions	$0
Total	**$285**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.