aetna : **GA Bronze HNOption 6000 80/50 HSA Emb**

Coverage for: Employee + Family | **Plan Type:** POS

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 at **https://www.aetna.com/sbcsearch/getpolicydocs?u=072700-090020-621615** or by calling **1-866-529-2517**. 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 1-866-529-2517 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall **deductible**?	In-network: Employee **$6,000** / Family **$12,000**. Out-of-network: Employee **$10,000** / Family **$20,000**.	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**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your **deductible**?	Preventive care in-network.	This **plan** covers some items and services even if you haven't yet met the annual **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost sharing** and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other **deductibles** for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the **out-of-pocket limit** for this plan?	In-network: Employee **$6,550** / Family **$13,100**. Out-of-network: Employee **$19,000** / Family **$38,000**.	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?**	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for services, and health care this plan does not 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.aetna.com/docfind** or call 1-866-529-2517 for a list of in-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** 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	$25 copay/visit	50% coinsurance	None
	Specialist visit	$50 copay/visit	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	50% coinsurance, except deductible does not apply for well child, well baby & immunizations	You may have to pay for services that are not preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Out-of-network precertification required or benefits will be reduced by 50% per service or supply.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetna.com/pharmacy-insurance/individuals-families SG Value Plus Five Tier Open Formulary	Preferred generic drugs	Tier 1A: $5 copay for up to a 30 day supply, $12.50 copay for up to a 90 day supply; Tier 1: $20 copay for up to a 30 day supply, $50 copay for up to a 90 day supply	Not covered	Covers up to a 30 day supply (retail prescription), 31-90 day supply (retail & mail order prescription). Applicable cost share plus difference (brand minus generic cost) applies for brand when generic available. No charge for preferred generic FDA-approved women's contraceptives in-network. Precertification and step therapy required.
	Preferred brand drugs	$50 copay for up to a 30 day supply, $125 copay for up to a 90 day supply	Not covered	
	Non-preferred generic/brand drugs	$75 copay for up to a 30 day supply, $187.50 copay for up to a 90 day supply	Not covered	

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)	
	Preferred specialty drugs, non-preferred specialty drugs	Preferred: 30% coinsurance up to a $250 maximum for up to a 30 day supply; Non-preferred: 50% coinsurance up to a $500 maximum for up to a 30 day supply	Not covered	Aetna Specialty CareRx℠ – First Prescription must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy®. Subsequent fills must be through Aetna Specialty Pharmacy®. Your plan may include access to CVS retail pharmacies for certain specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Out-of-network emergency room care cost-share same as in-network. No coverage for non-emergency care.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network cost-share same as in-network.
	Urgent care	$75 copay/visit	50% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Out-of-network precertification required or benefits will be reduced by 50% per service or supply.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay/visit	50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	Out-of-network precertification required or benefits will be reduced by 50% per service or supply.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	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)	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Out-of-network precertification required or benefits will be reduced by 50% per service or supply.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Coverage is limited to 120 visits.
	Rehabilitation services	20% coinsurance	50% coinsurance	Coverage is limited to 40 visits for Physical Therapy & Occupational Therapy combined, 40 visits for Speech Therapy.
	Habilitation services	20% coinsurance	50% coinsurance	Coverage is limited to 40 visits for Physical Therapy & Occupational Therapy combined and 40 visits for Speech Therapy, rehabilitation & habilitation separate.
	Skilled nursing care	20% coinsurance	50% coinsurance	Coverage is limited to 60 days. Out-of-network precertification required or benefits will be reduced by 50% per service or supply.
	Durable medical equipment	20% coinsurance	50% coinsurance	Excludes vehicle modifications, home modifications & exercise equipment.
	Hospice services	20% coinsurance	50% coinsurance	Out-of-network precertification required or benefits will be reduced by 50% per service or supply.
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	Coverage is limited to 1 exam every 12 months age 0-19.
	Children's glasses	0% coinsurance	50% coinsurance	Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses every 12 months age 0-19.
	Children's dental check-up	0% coinsurance	0% coinsurance	Coverage is limited to 2 exams per calendar year.

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 - except as form of anesthesia.
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult) - except accidental injury.
- Hearing aids
- Infertility treatment - except the diagnosis and surgical treatment of underlying conditions.
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Chiropractic care - Coverage is limited to 20 visits.

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: Georgia Office of Insurance and Safety Fire Commissioner, Customer Services Division, (800) 656-2298, **http://www.oci.ga.gov/consumerservice/home.aspx**.

- 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**.
- 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 options to continue coverage are 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 us by calling the toll free number on your Medical ID Card.

- Georgia Office of Insurance and Safety Fire Commissioner, Customer Services Division, (800) 656-2298, **http://www.oci.ga.gov/consumerservice/home.aspx**.
- 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**.
- 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**.

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 page.*----------

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	$6,000
Specialist copayment	$50
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$6,000
Copays	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,610**

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	$6,000
Specialist copayment	$50
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$6,000
Copays	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$6,251**

Mia's Simple Fracture

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

The plan's overall deductible	$6,000
Specialist copayment	$50
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,900
Copays	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

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 1-866-529-2517.

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 on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

TTY: 711

Language Assistance:

For language assistance in your language call 1-866-529-2517 at no cost.

Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-866-529-2517 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-866-529-2517
Chinese -	欲取得繁體中文語言協助，請撥打 1-866-529-2517，無需付費。
French -	Pour une assistance linguistique en français appeler le 1-866-529-2517 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-866-529-2517 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-866-529-2517 an.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-866-529-2517 પર કૉલ કરો.
Hindi -	हिन्दी में भाषा सहायता के लिए, 1-866-529-2517 पर मुफ्त कॉल करें।
Japanese -	日本語で援助をご希望の方は、1-866-529-2517 まで無料でお電話ください。
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-529-2517번으로 전화해 주십시오.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-866-529-2517 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Portuguese -	Para obter assistência linguística em português ligue para o 1-866-529-2517 gratuitamente.
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-529-2517.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-866-529-2517.
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy goị miễn phí đến số 1-866-529-2517.