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.HealthReformPlanSBC.com or by calling 1-855-337-7170. 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 1-855-337-7170 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	NA	No Deductible
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: Individual $3,500 / Family $7,000.	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-billing charges, infertility treatment & 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.allinahealthaetna.com/ah or call 1-800-343-9264 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 in network 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: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/visit	Not covered	None
	Specialist visit	$50 copay/visit	Not covered	None
	Preventive care /screening /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	$50 copay/visit for free standing facility; $100 copay/visit if performed in a physician's office	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com/allinahealth	Generic drugs	$5 Copay	Not covered	Administered through Express Scripts. First time fills will be covered within the Express Scripts national network.
	Preferred brand drugs	$25 copay	Not covered	
	Non-preferred brand drugs	$60 copay	Not covered	
	Specialty drugs	$25 copay	Not covered	Specialty drugs must be filled at Allina Health Pharmacies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay/visit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
	Emergency room care	$300 copay/visit	$300 copay/visit	No coverage for non-emergency use.

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 immediate medical attention	Emergency medical transportation	$150 copay/trip	$150 copay/trip	Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	$10 copay/visit	$100 copay/visit	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	$750 copay/stay	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $10 copay/visit; other outpatient services: no charge	Not covered	None
	Inpatient services	$750 copay/stay	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$750 copay/stay, except no charge for newborn hospital	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	120 visits/calendar year.
	Rehabilitation services	$15 copay/visit	Not covered	None
	Habilitation services	$15 copay/visit	Not covered	None
	Skilled nursing care	$750 copay/stay	Not covered	None
	Durable medical equipment	No charge	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	$750 copay/stay for inpatient; no charge for outpatient	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	None
	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
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids - 1 hearing aid per ear/3 years for children up to age 18.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, artificial insemination, ovulation induction & advanced reproductive technology.
- Routine eye care (Adult)

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 1-855-337-7170.
- 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 : https://www.dol.gov/agencies/ebsa
- 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 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 1-855-337-7170.
- 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 https://www.dol.gov/agencies/ebsa
- 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.

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 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	$50
Hospital (facility) copayment	$750
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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$860

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	$50
Hospital (facility) copayment	$750
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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$920

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

The plan's overall deductible	$0
Specialist copayment	$50
Hospital (facility) copayment	$750
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	$1,900

In this example, Mia would pay:

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

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-855-337-7170.

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 1-855-337-7170.

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

Allina Health | 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.

Allina Health | 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 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

1-800-648-7817, TTY: 711

Fax: 859-425-3379

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).

Health plans are offered, underwritten or administered by Allina Health and Aetna Insurance Company (Allina Health | Aetna). Allina Health | Aetna is an affiliate of Aetna Life Insurance Company (Aetna). Aetna provides certain management services to Allina Health | Aetna.

TTY: 711

Language Assistance:

For language assistance in your language call 1-855-337-7170 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-855-337-7170.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-855-337-7170 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-855-337-7170
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-855-337-7170 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-855-337-7170 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-855-337-7170 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-855-337-7170-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-855-337-7170 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-855-337-7170 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-855-337-7170.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-855-337-7170 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᏕᏲᏂᎯᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᎿᎢ (ᏣᎳᎩ) ᏫᏏᎳᏉᎥᏕ 1-855-337-7170 ᎤᎾᎢ Ꮭ ᎠᎱᏍᏗ ᏧᎬᏩᎶᏗ ᏂᎨᏒᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-855-337-7170，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-855-337-7170.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-855-337-7170 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-855-337-7170.
French -	Pour une assistance linguistique en français appeler le 1-855-337-7170 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-855-337-7170 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-855-337-7170 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-855-337-7170 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-855-337-7170 પર કૉલ કરો.

Hawaiian -	No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-855-337-7170. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	हिन्दी में भाषा सहायता के लिए, 1-855-337-7170 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-855-337-7170.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-855-337-7170 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-855-337-7170 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-855-337-7170.
Japanese -	日本語で援助をご希望の方は、1-855-337-7170 まで無料でお電話ください。
Karen -	လၢတၢ်မၤစၢးတၢ်ကတိၤကျိာ်အဂီၢ် ကျိာ် ကိး 1-855-337-7170 လၢတအိာ်ဒီးတၢ်လၢာ်ဘျုာ်လၢာ်စုၤဘဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-855-337-7170 번으로 전화해 주십시오.
Kru-Bassa -	Bɛ́m̀ké gbo-kpá-kpá dyé pídyi dé Bǎsɔ́ɔ̀-wùdùǔn wɛ̃ɛ, dá 1-855-337-7170
Kurdish -	بۆ یارمەتی بە زمانی کوردی تەلەفۆن بکەن بە خۆڕایی بۆ ژمارە 1-855-337-7170
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-855-337-7170 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-855-337-7170 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-855-337-7170 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-855-337-7170 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-855-337-7170 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-855-337-7170
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-855-337-7170 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-855-337-7170 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-855-337-7170 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-855-337-7170 ‘ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-855-337-7170 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-855-337-7170 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-855-337-7170.
Portuguese -	Para obter assistência linguística em português ligue para o 1-855-337-7170 gratuitamente.

Romanian -	Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-855-337-7170
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-855-337-7170.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-855-337-7170 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-855-337-7170.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-855-337-7170.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-855-337-7170. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-855-337-7170 bila malipo.
Syriac -	1-855-337-7170
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-855-337-7170 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-855-337-7170 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-855-337-7170 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-855-337-7170 ‘o ‘ikai hā ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-855-337-7170 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-855-337-7170.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-855-337-7170.
Urdu -	1-855-337-7170
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-855-337-7170.
Yiddish -	1-855-337-7170
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-855-337-7170 lái san owó kankan rárá.