



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, including your plan's [Summary Plan Description](#), or to get a copy of the complete terms of coverage, visit <https://crewnet.vanguard.com> or call 1-844-VG1-CREW (1-844-841-2739). 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 <https://crewnet.vanguard.com> or call 1-844-VG1-CREW (1-844-841-2739) to request a copy.

| Important Questions   | Answers  | Why This Matters:  |
|---|--|--|
| What is the overall <u>deductible</u> ?                             | \$1,250 Individual/\$2,500 Family.<br>An employer contribution to your Health Reimbursement Arrangement (HRA) is used to offset the deductible: \$300 Individual/\$600 Family. | 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> .<br><br>Health Reimbursement Arrangement (HRA) is available that works with your medical <u>plan</u> , as described in your plan's <a href="#">Summary Plan Description</a> . |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. In- <u>network</u> <u>preventive care</u> is covered before you meet your <u>deductible</u> .   | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .   |
| Are there other <u>deductibles</u> for specific services?           | No.  | You don't have to meet <u>deductibles</u> for specific services.   |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | \$2,500 Individual/\$5,000 Family.   | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.  |
| What is not included in the <u>out-of-pocket limit</u> ?            | <u>Premiums</u> , <u>balance billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.          | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .   |

| Important Questions  | Answers   | Why This Matters:   |
|--|---|---|
| <p>Will you pay less if you use a <u>network provider</u>?</p>   | <p>Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-800-938-0512 for a list of <u>network providers</u>.</p> | <p>You pay the least if you use a <u>provider</u> in CrewCare (when elected separately under COBRA). You pay more if you use a <u>provider</u> in <u>network provider</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.</p> |
| <p>Do you need a <u>referral</u> to see a <u>specialist</u>?</p> | <p>No.</p>  | <p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>  |



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   |
|--|---|---|--|--|---|
|  |   | CrewCare<br>(You will pay the least)                      | Network Provider<br>(You will pay more)  | Out-of-Network Provider<br>(You will pay the most) |   |
| If you visit a health care <u>provider's</u> office or clinic  | Primary care visit to treat an injury or illness        | \$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>                             | None  |
|  | <u>Specialist</u> visit                                 | Not covered   | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>                             | None  |
|  | <u>Preventive care</u> / <u>screening</u> /immunization | No charge   | No charge  | 30% <u>coinsurance</u>                             | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |
| If you have a test   | <u>Diagnostic test</u> (x-ray, blood work)              | Not covered   | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>                             | None  |
|  | Imaging (CT/PET scans, MRIs)                            | Not covered   | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>                             | None  |
| If you need drugs to treat your illness or condition<br><br><u>Prescription drug coverage</u> is administered by CVS Caremark<br><br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.caremark.com">www.caremark.com</a> | Generic drugs   | Not covered   | <u>Copay</u> /prescription - \$10 (30 day), \$25 (90 day)  | 50% reimbursement of covered expenses              | Retail covers up to a 30-day supply; 31-90 day supply is available through mail order or at a CVS Pharmacy.   |
|  | Preferred brand drugs                                   | Not covered   | 20% <u>coinsurance</u> - \$25 minimum, \$85 maximum (30 day); \$62.50 minimum, \$212.50 maximum (90 day) | 50% reimbursement of covered expenses              |   |
|  | Non-preferred brand drugs                               | Not covered   | 30% <u>coinsurance</u> - \$40 minimum, \$160 maximum (30 day); \$100 minimum, \$400 maximum (90 day)     | 50% reimbursement of covered expenses              |   |
|  | <u>Specialty drugs</u>                                  | Not covered   | See Preferred brand drugs  | Not covered  |   |
| If you have outpatient surgery   | Facility fee (e.g., ambulatory surgery center)          | Not covered   | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>                             | None  |

| Common Medical Event  | Services You May Need                     | What You Will Pay   |  |  | Limitations, Exceptions & Other Important Information   |
|---|---|---|--|--|---|
|   |   | CrewCare (You will pay the least)                         | Network Provider (You will pay more)                       | Out-of-Network Provider (You will pay the most)            |   |
|   | Physician/surgeon fees                    | Not covered   | 10% <u>coinsurance</u>                                     | 30% <u>coinsurance</u>                                     | None  |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                | Not covered   | 10% <u>coinsurance</u>                                     | 10% <u>coinsurance</u>                                     | No coverage for non-emergency use.  |
|   | <u>Emergency medical transportation</u>   | Not covered   | 10% <u>coinsurance</u>                                     | 10% <u>coinsurance</u>                                     | None  |
|   | <u>Urgent care</u>                        | Not covered   | 10% <u>coinsurance</u>                                     | 30% <u>coinsurance</u>                                     | No coverage for non-urgent use.   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)        | Not covered   | 10% <u>coinsurance</u>                                     | 30% <u>coinsurance</u>                                     | Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.   |
|   | Physician/surgeon fees                    | Not covered   | 10% <u>coinsurance</u>                                     | 30% <u>coinsurance</u>                                     | None  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | Not covered   | Office & other outpatient services: 10% <u>coinsurance</u> | Office & other outpatient services: 30% <u>coinsurance</u> | None  |
|   | Inpatient services                        | Not covered   | 10% <u>coinsurance</u>                                     | 30% <u>coinsurance</u>                                     | Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.   |
| If you are pregnant   | Office visits                             | Not covered   | No charge  | 30% <u>coinsurance</u>                                     | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care may apply. |
|   | Childbirth/delivery professional services | Not covered   | 10% <u>coinsurance</u>                                     | 30% <u>coinsurance</u>                                     |   |
|   | Childbirth/delivery facility services     | Not covered   | 10% <u>coinsurance</u>                                     | 30% <u>coinsurance</u>                                     |   |
| If you need help recovering or have other special health needs            | <u>Home health care</u>                   | Not covered   | 10% <u>coinsurance</u>                                     | 30% <u>coinsurance</u>                                     | 200 visits/calendar year. Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.   |
|   | <u>Rehabilitation services</u>            | \$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply | 10% <u>coinsurance</u>                                     | 30% <u>coinsurance</u>                                     | 60 visits/calendar year for Physical, Occupational & Speech Therapy combined, including outpatient hospital services.   |
|   | <u>Habilitation services</u>              | Not covered   | 10% <u>coinsurance</u>                                     | 30% <u>coinsurance</u>                                     | Coverage for Autism Spectrum Disorder is limited to \$36,000 annual maximum, except Applied Behavior Analysis.  |

| Common Medical Event                   | Services You May Need            | What You Will Pay   |                                      |   | Limitations, Exceptions & Other Important Information  |
|--|----------------------------------|---|--------------------------------------|---|--|
|  |                                  | CrewCare (You will pay the least)                         | Network Provider (You will pay more) | Out-of-Network Provider (You will pay the most) |  |
|  | <u>Skilled nursing care</u>      | Not covered   | 10% <u>coinsurance</u>               | 30% <u>coinsurance</u>                          | 240 days/calendar year. Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.  |
|  | <u>Durable medical equipment</u> | \$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply | 10% <u>coinsurance</u>               | 30% <u>coinsurance</u>                          | Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.   |
|  | <u>Hospice services</u>          | Not covered   | 10% <u>coinsurance</u>               | 30% <u>coinsurance</u>                          | Respite Care included up to a maximum of 7 days in a 6 month period. Penalty of 50% of <u>allowed amount</u> 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              | Not covered   | Not covered                          | Not covered                                     | Not covered  |
|  | Children's glasses               | Not covered   | Not covered                          | Not covered                                     | Not covered  |
|  | Children's dental check-up       | Not covered   | 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)
- Long-term care
- Routine eye care (Adult & Child)
- 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 - Limited to Institutes of Quality contracted facility only.
- Chiropractic care - 30 visits/calendar year.
- Hearing aids - \$500 maximum/36 months.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. Artificial insemination & ovulation induction: 6 cycles/lifetime; \$15,000 maximum/lifetime including advanced reproductive technology.
- Non-emergency care when traveling outside the U.S.
- 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 1-844-VG1-CREW (1-844-841-2739).
- 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 (1-800-938-0512), or by calling our general toll free number at 1-888-982-3862.
- 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** \$1,250
- **Specialist coinsurance** 10%
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

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> |
| <b>In this example, Peg would pay:</b> |                 |
| <i>Cost Sharing</i>                    |                 |
| Deductibles                            | \$1,250         |
| Copayments                             | \$30            |
| Coinsurance                            | \$1,100         |
| <i>What isn't covered</i>              |                 |
| Limits or exclusions                   | \$60            |
| <b>The total Peg would pay is</b>      | <b>\$2,440</b>  |

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The **plan's** overall **deductible** \$1,250
- **Specialist coinsurance** 10%
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

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> |
| <b>In this example, Joe would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| Deductibles                            | \$1,250        |
| Copayments                             | \$900          |
| Coinsurance                            | \$80           |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$20           |
| <b>The total Joe would pay is</b>      | <b>\$2,250</b> |

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

- The **plan's** overall **deductible** \$1,250
- **Specialist coinsurance** 10%
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

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> |
| <b>In this example, Mia would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| Deductibles                            | \$1,250        |
| Copayments                             | \$0            |
| Coinsurance                            | \$70           |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Mia would pay is</b>      | <b>\$1,320</b> |

Note: These numbers assume the patient does not have an HRA balance. If you have funds in your HRA, you may be able to reduce your costs.



### Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-938-0512.

### 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 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: 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](mailto: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 1-888-982-3862. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - **हन्दि में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।**
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.
- Ibo - **Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwụghị ụgwọ ọ bụla**
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.
- Japanese - **日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。**
- Karen - လာဘ်တရားတရားကတိကုန်အင်္ဂါ ကျိန် ကိး 1-888-982-3862 လာဘ်အိန်ဒီးတရားလာဘ်ကျိန်လာဘ်ကျိန်
- Korean - **한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.**
- Kru-Bassa - **Ḃe m'ké gbo-kpá-kpá dyé pídyi dé Ḃaśwó-wuḂuñ wěě, dǎ 1-888-982-3862**
- Kurdish - **برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 به خورایی یه یومندی بکن.**
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - **तीलभाषा (मराठी) सहाय्यासाठी 1-888-982-3862 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.**
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.
- Micronesian-Pohnpeyan - **Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.**
- Mon-Khmer, Cambodian - **សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ដោយឥតគិតថ្លៃ។**
- Navajo - T'áá shi shizaad k'ehjí bee shík'a' doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862
- Nepali - **(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- 888-982-3862 मा फोन गर्नुहोस् ।**
- Nilotic-Dinka - **Tèn kuwoɲy è thok è Thuwoɲjäŋ col 1-888-982-3862 kec'in ayöc.**
- Norwegian - **For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.**
- Panjabi - **ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।**
- Pennsylvania Dutch - **Fer Hefte in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.**
- Persian - **برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی**
- Polish - **Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.**

