AGMA Health Fund
Derek J. Davis, Executive Director
1430 Broadway, Suite 1203 • New York, NY 10018
Telephone (212) 765-3664 • Fax (212) 956-7599
info@agmafunds.org

October 30, 2020

Dear AGMA Health Plan A Eligible Member:

As the end of 2020 approaches, the Fund Office is pleased to send you a few updates that will provide you with important information to make the most of the benefits that you have earned through the AGMA Health Fund.

1. **Open Enrollment Materials** and Other Important Annual Reminders;
2. The Health Plan A **Summary of Benefits and Coverage**, as of January 1, 2021;
3. **Consent to Electronic Delivery** – complete and return this form to us if you want to receive future notices from our secure email server (for those currently receiving this by mail)

Should you have any questions about these updates, please do not hesitate to contact the Fund Office. While we are working mostly remote at this time, you can email the Fund Office at info@agmafunds.org or call the Fund Office at (212) 765-3664 to leave a message for a staff member. In addition, you can call Aetna at the number on your ID card.

Thank you.

Derek J. Davis
Executive Director
For The Board of Trustees
AGMA Health Fund

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October 30, 2020

AGMA HEALTH FUND PLAN A OPEN ENROLLMENT,
2021 CHANGES AND OTHER IMPORTANT ANNUAL REMINDERS

Dear Participant:

As you may be aware, the AGMA Health Fund (the "Fund") allows you to make certain changes to your Health Plan enrollment once a year during the Fund's annual Open Enrollment Period. We are writing you this letter to let you know that the Open Enrollment Period for the Fund is beginning on Monday, November 2, 2020 and will end on Friday, December 4, 2020. We also take this opportunity to inform you of some important changes going into effect on January 1, 2021 and provide you and your family with important annual reminders.

I. Plan Changes effective January 1, 2021

The Trustees are constantly working to ensure that your healthcare coverage is provided as cost effectively as possible. To that end, the Health Plan will be changing from fully insured coverage to self-insured coverage effective January 1, 2021. This means that instead of providing coverage through an insurance policy for which the Fund pays premiums, the Fund will pay the cost of benefits directly. The benefits will continue to be administered by Aetna, however, and we anticipate almost no differences as a result of this change, including:

- No changes in the benefits design or member cost sharing
- No changes to the network – members will continue to access the current Aetna network of facilities and providers
- No changes to the Aetna phone numbers you call to receive information or ask questions

Here is what will be different:

- Members will receive new insurance cards around the second week in December. **Please note that you must use the new insurance cards for services after December 31, 2020.**
- The name of the prescription drug formulary (that is, the list of drugs covered under the Plan) will change from *2021 Standard Opt Out Plan - Aetna* to the *Standard Opt Out Plan*. We understand that the formularies are virtually identical, and that any changes being made to the formulary effective January 1, 2021 will be communicated by Aetna directly to impacted members
- Your physicians may have small changes in the pre-certification requirements for certain benefits. This change should not impact your care.

II. Open Enrollment Begins on November 2, 2020

If you wish to make any of the four changes listed below, they will become effective as of January 1, 2021; however, you must provide formal, written notification that is received by the AGMA Health Fund Office by **December 4, 2020**. In addition to notifying the AGMA Health Fund of these changes in writing, you are responsible for notifying the Human Resources Office or the appropriate staff member at the Company that employs you.

Changes to your Health Plan can be any one of the following:

1. Adding Family Coverage (at an additional cost of $1,481 per month*)

2. Adding Domestic Partner Coverage – an application form must be completed prior to adding a Domestic Partner (at an additional cost of $1,481 per month*); same-sex spouses are treated as spouses and not domestic partners
3. Changing to AGMA Health Fund Plan B from AGMA Health Fund Plan A (Only available if this option is included as an option in the Collective Bargaining Agreement between your Company and AGMA; in addition, participants must contact the Fund Office to complete a form and provide proof of other eligible group coverage) **
4. Changing to AGMA Health Fund Plan A from AGMA Health Fund Plan B (Only available if this option is included as an option in the Collective Bargaining Agreement between your Company and AGMA) **

* The Additional Cost for family coverage effective September 1, 2020 has not been finalized by the Trustees; once it is determined, you will be informed of the new price.
** Switching between Plan A and Plan B: The contributions for work in November and December will be directed to the Plan you elect for January 1, so that coverage under your new option can begin on January 1. For example, if you elect to move from Plan B to Plan A, contributions for your work in November and December will be paid to Plan A so that you will qualify for Plan A on January 1. This would mean that your last Plan B contribution will be for October work, due in Mid-November. Similarly, if you elect to move from Plan A to Plan B (and timely submit the necessary proof of other group health coverage), contributions for work in November and December will be paid to Plan B and should be available to you by January 1; your Plan A coverage will end December 31. See also the Changes to Plan B Eligibility note in Section III of this letter.

Self-Pay **Dental** Coverage: During Open Enrollment, you can also join the **self-pay Dental Coverage**, effective January 1, 2021. This plan, available from Aetna Dental, costs $22.62 per month for individual coverage and $64.80 per month for family coverage which is payable directly to the Fund Office and in advance of the coverage month.

Self-Pay **Vision** Coverage: In addition to the option to self-pay for Dental Coverage, the Trustees are pleased to continue to offer the opportunity to join the **self-pay Vision Coverage**, effective January 1, 2021. This plan, which is provided by Aetna Vision Preferred, costs $3.60 for individual coverage and $8.59 per month for family coverage which is payable directly to the Fund Office and in advance of the coverage month. You may elect vision coverage only at Open Enrollment. Please see our website (www.agmafunds.org/faq_dentalvision.html) for additional information on the available benefits of this option.

If you wish to make one of these enrollment changes, your written notice must be received by the AGMA Health Fund Office at the above address by December 4, 2020. Otherwise, no changes will be allowed until the Fund's next annual Open Enrollment Period a year from now, unless you qualify for one of the circumstances described in the Special Enrollment section in Part IV of this letter.

III. Important Benefit Updates and Reminders

Updated Summary of Benefits & Coverage: Enclosed with this mailing is the updated Summary of Benefits & Coverage (SBC) for your plan effective January 1, 2021. This information is also available online at our website www.agmafunds.org.

Changes to Plan B Eligibility: At the conclusion of this year's Open Enrollment period, the AGMA Health Fund shall limit the ability of participants to elect to have Plan A contributions directed to Plan B (or to the Healthy San Francisco Plan for eligible San Francisco Opera members) to those members whose last status since January 1, 2018 was to redirect contributions to Plan B or to the Healthy San Francisco Plan. If you are currently having your employer contributions put in Plan B, you may continue to do so, but newly eligible members will not be able to do so in the future. For example, if you had directed your contributions in 2019 to Plan B, had a break in contributions and are now coming back to active coverage, you can elect this option again.

Pre-certification: Under the terms of our contract with Aetna, certain in-network services require pre-certification before you can begin to receive treatment. Please remember that it is the responsibility of the in-network provider to process all pre-certification requests. If an in-network provider fails to pre-certify a

service, the member is held harmless. However, it is a member's responsibility to pre-certify all out-of-network services and the member will be subject to additional costs applicable if pre-certification is not obtained. Generally, a member is not aware that a pre-certification request was submitted by the provider.

Coverage for Dependents: In response to a number of questions that have been directed to the Fund Office, we would like to remind you of the dates of coverage for your dependents. If you have coverage that includes your dependent children, they may continue on your medical coverage until the end of the month in which they turn age 26. If you are paying for either the vision or dental coverage, your dependent child can continue on this coverage until the end of the month in which they turn age 19 (or age 23 if they are enrolled in school).

Teladoc: Members continue to have access to Teladoc®, which is a provider of phone and online video physician consulting. These doctors will be able to treat common medical conditions such as cold and flu symptoms, bronchitis, allergies, sinus problems, respiratory infections and ear infections, and can also recommend treatment and prescribe medication, when appropriate. The availability of this service is expected to reduce unnecessary visits to the ER and/or urgent care centers. The member pays the PCP office copayment for this service. This service is available 24/7/365 and you can initiate a call by going online to Teladoc.com/Aetna or by calling 1-855-Teladoc (835-2362). Please call Aetna at 866-658-2455 if you have any questions about this or any benefit.

IV. Important Annual Reminders

Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment in writing within 31 days after your or your dependents' other coverage ends.

In addition, if you have a new dependent as a result of marriage, entering into a domestic partnership, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, registration of the domestic partnership, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Executive Director Derek Davis at the Fund Office at (212) 765-3664 or by email at info@agmafunds.org.

Annual Notice of Women's Health and Cancer Rights Act (WHCRA)

Your group health plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

This coverage is subject to any plan copayments, annual deductibles, and coinsurance provisions that may be applicable, consistent with those established for other benefits under the plan. These provisions are described in the Plan's Summary Plan Description (SPD), which has been previously mailed to you and is available upon request by mail or by email.

If you have any questions about whether your plan covers mastectomies or reconstructive surgery, please contact Aetna at the toll-free Member Services number on your Aetna ID card.

Availability of a HIPAA Privacy Notice for Your Group Health Plan

If you would like to see (or obtain a copy of) the plan's HIPAA Notice of Privacy Practices, please contact the Privacy Officer located at 1430 Broadway, Suite 1203, New York, NY 10018, visit www.agmafunds.org or call the Fund Office. The Notice describes how the plan uses and discloses protected health information for the offices of the AGMA Health Fund (the "Fund") and other business associates of the Fund. It also discusses important federal rights that you have with respect to your protected health information. This Notice does not apply to the insured hospital, medical, prescription drug, vision and dental benefits provided through a contract with Aetna. You should have received a HIPAA Privacy Notice directly from Aetna outlining its privacy practices. You may request a copy of Aetna's HIPAA Privacy Notice that pertains to the insured hospital, medical, prescription drug, vision and dental benefits by contacting Aetna directly at the toll-free Member Services number on your Aetna ID card.

V. Notice of Certain Rights Under the Affordable Care Act

Designation of Primary Care Provider

Aetna does not require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or non-network health care provider (including a Pediatrician for a child); however, your out-of-pocket costs may be higher if you use a non-network provider.

Direct Access to Obstetrical and Gynecological Care

You do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Aetna at the telephone number listed on your Aetna ID card.

VI. Electronic Communications

The Fund Office is aware that many participants prefer to receive communications electronically and are willing to forego printed copies of certain documents to improve the delivery of these items and to help reduce operating costs. If you wish to sign up for electronic copies, please complete and return the enclosed **Consent to Electronic Disclosure** (members who are receiving this material electronically will not receive another copy of this form). If you have already submitted this form, there is ***no need to resubmit*** it unless your information has changed. You also have the ability to rescind this option by informing us in writing.

* * *

If you have any questions, please contact the Fund Office by phone at 212-765-3664 or e-mail the general Fund Office mailbox at info@agmafunds.org.

Sincerely,

Derek J. Davis
Executive Director
For the Board of Trustees
AGMA Health Fund

Encs: Summary of Benefits and Coverage – 1/1/21
Consent to Electronic Disclosure (printed copy only)

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2021-12/31/2021

aetna™ AGMA HEALTH FUND : Aetna Choice® POS II

Coverage for: Individual + 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, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. 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 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0. Out-of-Network: Individual $1,000 / Family $2,000.	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?	Yes. Emergency care & prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the 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?	Yes. For prescription drug expenses - Individual $75 / Family $150. There are no other specific deductibles.	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.
What is the out-of-pocket limit for this plan?	In-Network: Individual $1,500 / Family $3,000. Out-of-Network: Individual $4,000 / Family $8,000.	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, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	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 1-800-370-4526 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	$30 copay/visit, deductible doesn't apply	30% coinsurance	None
	Specialist visit	$45 copay/visit, deductible doesn't apply	30% coinsurance	None
	Preventive care /screening /immunization	No charge	30% coinsurance, except no charge for routine physical exams & immunizations	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	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/standardopt out	Generic drugs	After specific deductible: 20% coinsurance (retail), 15% coinsurance (mail order)	30% coinsurance after copay/ prescription, after specific deductible: 20% (retail)	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage.
	Preferred brand drugs	After specific deductible: 25% coinsurance (retail), 20% coinsurance (mail order)	30% coinsurance after copay/ prescription, after specific deductible: 25% (retail)	
	Non-preferred brand drugs	After specific deductible: 30% coinsurance (retail), 25% coinsurance (mail order)	30% coinsurance after copay/ prescription, after specific deductible: 30% (retail)	

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)	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Not covered	First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	None
	Physician/surgeon fees	No charge	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copay/visit, deductible doesn't apply	$150 copay/visit, deductible doesn't apply	No coverage for non-emergency use.
	Emergency medical transportation	$50 copay/trip, deductible doesn't apply	$50 copay/trip, deductible doesn't apply	Non-emergency transport: not covered, except 30% coinsurance if pre-authorized.
	Urgent care	$75 copay/visit, deductible doesn't apply	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay/stay, deductible doesn't apply	30% coinsurance	Penalty of $400 (or 50% of allowed amount) for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	No charge	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: no charge	Office & other outpatient services: 30% coinsurance	None
	Inpatient services	$100 copay/stay, deductible doesn't apply	30% coinsurance	Penalty of $400 (or 50% of allowed amount) for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge	30% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $400 (or 50% of allowed amount) for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	No charge	30% coinsurance	
	Childbirth/delivery facility services	$100 copay/stay, deductible doesn't apply	30% coinsurance	

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 help recovering or have other special health needs	Home health care	No charge	25% coinsurance, deductible doesn't apply	Penalty of $400 (or 50% of allowed amount) for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	$45 copay/visit, deductible doesn't apply	30% coinsurance	60 visits/calendar year for Physical & Occupational Therapy combined.
	Habilitation services	$45 copay/visit, deductible doesn't apply	30% coinsurance	None
	Skilled nursing care	$100 copay/stay, deductible doesn't apply	30% coinsurance	Penalty of $400 (or 50% of allowed amount) for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	No charge	30% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	$100 copay/stay for inpatient, deductible doesn't apply; no charge for outpatient	30% coinsurance	Penalty of $400 (or 50% of allowed amount) for failure to obtain pre-authorization for out-of-network care.
If your child needs dental or eye care	Children's eye exam	$30 copay/visit, deductible doesn't apply	Not covered	1 routine eye exam/12 months.
	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.)

• Acupuncture • Cosmetic surgery • Dental care (Adult & Child)	• Glasses (Child) • Hearing aids • Long-term care	• Non-emergency care when traveling outside the U.S. • 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.)

• Bariatric surgery • Chiropractic care	• Infertility treatment - Limited to the diagnosis and treatment of underlying medical condition, artificial insemination, ovulation induction, cryopreservation and oral and injectable fertility drugs. ART: 3 lifetime cycles	• Private-duty nursing - 70- 8 hour shifts/calendar year. • Routine eye care (Adult) - 1 routine eye exam/12 months for in-network only.

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 1-800-370-4526.
- 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 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.
- 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 on how 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 1-800-370-4526.
- 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 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.
- 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.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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	**$45**
Hospital (facility) copayment	**$100**
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*	$40
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$300**

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	**$45**
Hospital (facility) copayment	**$100**
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*	$75
Copayments	$300
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,495**

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

The plan's overall deductible	**$0**
Specialist copayment	**$45**
Hospital (facility) copayment	**$100**
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	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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 866-393-0002.

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 unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide 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: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), 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).