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IW TRUST FUNDS
Building Futures Together
1470 Worldwide Place • Vandalia, OH 45377-1156
Phone (937) 454-1744

To: All Non-Medicare Retiree Plan Participants

Enclosed are the following documents for 2025:

- **2025 Self-Payment Rate**
- **Wellness Incentive**
- **New Delta Dental Benefit**
- **New VSP Vision Benefit**
- **2025 Summary of Benefits and Coverage**

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November 4, 2024

Dear Non-Medicare Plan Participant,

The non-Medicare Retiree self-pay rates will increase for the upcoming calendar year. The rates you pay for the non-Medicare Retiree plan represent only a portion of the actual cost of the benefit. The cost per adult for the non-Medicare retiree plans are subsidized by **approximately 15%** through active workers' hourly contributions paid into the Benefit Trust.

<u>**If you or your spouse are covered by Medicare, you are not eligible for these Plans.**</u>

The new monthly self-pay rates for Non-Medicare Retiree Plan A and Plan B effective **January 1, 2025 are as follows:**

Non-Medicare Retiree Plan A: $1,021 per person per month. The projected cost for this plan is **$1,228** per month. You pay less than the cost due to the subsidy.

Non-Medicare Retiree Plan B: $881 per person per month. The projected cost for this plan is **$1,059** per month. Plan B has higher medical and prescription deductibles and coinsurances that are payable by the participant. You pay less than the cost due to the subsidy.

Dependent and/or Adult Children of an eligible retiree will be covered under the same plan as the retiree for **$500 per dependent/adult child** per month**.**

Effective January 1, 2025, Plan A will be changed to match the Active Plan benefits. This will result in slightly higher copays and deductibles, but the network coinsurance will be reduced from 20% to 10%. The intent of this change is to minimize disruption when members transition from active to non-Medicare coverage.

We are pleased to announce that effective January 1, 2025, the non-Medicare plan will be enhanced to include dental and vision benefits. The dental plan will be offered through Delta Dental of Ohio and the vision plan through VSP. Additional information on these benefit offerings is included later in this communication.

Two plan choices continue to be available for you for the monthly self-payment rates shown above. All members of your family will be required to be in the same plan unless a family member is on the Humana Medicare Advantage plan. Enclosed please find the ***Summary of Benefits and Coverage*** for Plan A and Plan B for the upcoming plan year.

If you are currently covered under Plan A, you may reduce your coverage by selecting Plan B effective January 1, 2025. If you are currently enrolled in Plan B, you will <u>NOT</u> be allowed to switch back to Plan A.

<u>***No action is necessary to continue coverage under your current plan for the 2025 calendar year.***</u>

If you cancel your coverage, except to be covered under another *group* policy, you may not purchase coverage from the Benefit Trust in the future.

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MEDICARE ELIGIBILITY: Once you or your dependent(s) are eligible for Medicare, coverage under this Plan must end and you may be eligible for coverage under the Plan's insured program through Humana. Due to government guidelines, you must be covered under the Humana program as of your Medicare effective date; Humana cannot retro-activate your coverage. To ensure that you have continuous coverage, **you must notify the Trust Office at least 60 days before your Medicare coverage begins** to request a Retiree Health Insurance Enrollment Form to complete and return with a copy of your Medicare card. It is **your** responsibility to notify the Trust Office and enroll 60 days prior to the date Medicare coverage begins.

Please contact the Trust Office should you have any questions.

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Non-Medicare Retiree Incentive

November 4, 2024

Re: Non-Medicare Retiree Incentive

The Board of Trustees of the Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust is pleased to once again offer an incentive plan designed to reduce the monthly non-Medicare Retiree self-pay cost of health coverage, while encouraging you to maintain your health.

Under the incentive program, while you and/or your spouse are enrolled in the non-Medicare Retiree Plan A or B you will:

- Save $42 per month in self-payments in **2026**, if you complete an annual physical with your primary care physician from November 1, 2024 through October 31, 2025.
- If your spouse is covered under the non-Medicare Retiree plan, save an additional $42 per month in **2026** if your spouse also completes an annual physical.

You must have an in-person annual physical to receive the incentive.

The incentive will be administered as a monthly reduction in the non-Medicare Retiree Plan A or B cost, worth up to **$500 per year** if you complete an annual physical and **$1,000 per year** if your covered spouse also completes an annual physical.

Deadline: You must get your annual physical by October 31, 2025, to be eligible for the incentive for the 2026 calendar year. If you or your spouse do not have a primary care physician, find one now so you can earn the self-pay reduction next year.

The Fund Office will obtain evidence of your routine physical(s) from the Medical Plan provider to apply the incentive.

Please note that you will NOT be penalized if you don't receive an annual physical from your primary care physician. You simply will not receive the self-pay reduction.

We are proud to continue supporting the health care needs of you and your families. If you have questions regarding the incentive, contact the Fund Office at 937-454-1744.

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Dental Insurance

On January 1, 2025, you will now have access to a dental benefit through Delta Dental of Ohio if you are enrolled in non-Medicare Retiree Plan A or B. The Board of Trustees for the Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust voted to enhance your benefits by adding dental coverage. Delta Dental of Ohio is also the dental network on the active plan.

Important Information

Your New Dental Networks – Delta Dental PPO and Delta Dental Premier

You can find participating dental providers by visiting Delta Dental's website using the following link: deltadental.com/us/en/find-a-dentist**, or by calling Delta Dental's Customer Service department at 800-524-0149** from **Monday through Friday from 8:30 a.m. to 8:00 p.m. Eastern Time. The automated system is available 24/7**. If you call Delta Dental before January 1, 2025, be sure to identify yourself as a member of **Group Number: 2452**

In-Network Benefits

The Delta Dental PPO and Premier networks offer 100% coverage for preventive dental services like cleanings, exams, and X-rays; meaning you would pay nothing out of pocket for these services when visiting a dentist within either network.

What Happens If You Use a Non-Network Delta Dental provider?

DelIf you visit a non-network dentist, the Dental Plan will reimburse covered expenses based on Delta Dental's fee schedule. If the amount charged by the non-network dentist exceeds Delta Dental's fee schedule, you may be responsible for the difference.

If you select a non-network dentist, you may have to pay the dental office and then file your own claim forms for reimbursement.

Submit paper claims by mail to:
Delta Dental of Ohio
Claims Processing
P.O. Box 9085
Farmington Hills, MI 48333-9085

All claims for dental services will be processed by Delta Dental of Ohio.

Questions about your new benefits? Call Delta Dental at 800-524-0149. Be sure to identify yourself as a member of **Group Number: 2452**

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The dental benefit will be as follows effective **1/1/2025**:

Dental Plan Highlights

Delta Dental PPO™ (Point-of-Service) Coverage effective *January 1, 2025*	**Delta Dental PPO Dentist**	**Delta Dental Premier® Dentist**	**Non-Network Dentist**
	Plan Pays	**Plan Pays**	**Plan Pays***
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Palliative Treatment - to temporarily relieve pain	100%	100%	100%
Sealants - to prevent decay of permanent teeth	100%	100%	100%
Radiographs - X-rays	100%	100%	100%

* *When you receive services from a non-network Dentist, the percentages in this column indicate the portion of Delta Dental's non-network Dentist Fee that will be paid for those services. The non-network Dentist Fee may be less than what your dentist charges and you are responsible for that difference.*

Maximum Payment – Unlimited per Member total per Benefit Year on all services.
Deductible – None.

Note – *This document is only intended to provide a brief description of your benefits. Delta Dental will send a welcome package in the coming months. This package will include a Plan Summary and Certificate of Coverage that will provide a complete description of benefits, exclusions, and limitations.*

ID Cards
You'll be receiving your ID Cards in the mail from Delta Dental. Regardless of your dental provider's network status, be sure to let your provider know that you are a Delta Dental of Ohio member. If you need ID cards, or if you have any questions about your coverage, contact Delta Dental of Ohio. Once the plan year begins, you may also get a temporary ID card one of three ways:

- **Online at https://www.deltadentaloh.com/**
- **Download the Delta Dental Mobile app in the Apple App Store or Google Play Store for free**

Looking for Information About Dental Claims, Eligibility or Benefits?
After January 1, 2025, you can review your eligibility status, claims paid information, and covered benefits by visiting **www.deltadentaloh.com** or by using the Delta Dental, and logging into your personalized account. Once logged in, you'll see personalized benefit information, including doctor visits, benefits history, how to use your benefits, and how to find a provider.

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Vision Insurance

On January 1, 2025, you will now have access to a vision benefit through VSP if you are enrolled in non-Medicare Retiree Plan A or B. The Board of Trustees for the Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust voted to enhance your benefits by adding vision coverage. VSP is also the vision network on the active plan.

Important Information

Your New Vision Network – VSP Choice Plan
You can find participating vision providers by visiting VSP's website using the following link: www.vsp.com/choicewithaffiliates or by calling VSP's Customer Service department at 800-877-7195 from **Monday through Friday from 8:00 a.m. to 11:00 p.m., Saturday and Sunday from 10:00 a.m. to 11:00 p.m.** Eastern Time. If you call VSP before January 1, 2025, be sure to identify yourself as a member of **Group Number: 30100827**

In-Network Benefits
The Choice Plan network plus affiliates includes providers such as Pearle Vision, Wal-Mart, Sam's Club, Costco, Eye-Mart, Visionworks, Clarkson Eyecare, Wing Eyecare, Midwest Eye Consultants, plus thousands of independent optometrists and ophthalmologists. By choosing an in-network provider, you pay only your co-pay (if applicable), or the amount that exceeded your benefit allowance at the point of service. There are ***no claims for you to file*** for reimbursement from your VSP plan.

What Happens If You Use a Non-Network Vision provider?
Most out-of-network providers will submit a request for reimbursement to VSP on your behalf. This means you won't need to pay the entire bill up front and you will only be responsible for paying applicable copays and any balance above the out-of-network schedule.

If you pay the provider directly, you can submit a claim to VSP for reimbursement, using the following procedures:

1. Complete VSP's **Member Reimbursement Form** which can be found at vsp.com or at iwtrustfund.com/forms

2. Submit claim form along with itemized receipt online at vsp.com or by mail to:
   VSP
   P.O. Box 385018
   Birmingham, AL 35238-5018

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The vision benefit will be as follows effective **1/1/2025**:

Vision Plan Highlights

Benefits	**VSP Choice Plan**		
	In-Network		**Out-of-Network**
Frequency for Exams Frequency for Lenses, Frames, Contact Lenses	Once every 12 months Once every 24 months Benefits start over every January 1st		
Exam Copay	$0		$45
Lens Copays:			
Single Vision	$0		$30
Bifocal	$0		$50
Trifocal	$0		$65
Frame Allowance	$175 allowance, then 20% off any balance		$70 Allowance
Enhanced Feature Frame*	$225 allowance, then $20% off any balance		$70 Allowance
Contact Lens Fitting & Evaluation Allowance	$50 allowance		No Coverage
Contact Lenses	$175 allowance (instead of frames and lenses)		$105 allowance (instead of frames and lenses)
Lens Enhancement Copays:	**Single Vision**	**Bi-Focal or Tri-Focal**	**Out-of-Network**
Anti Reflective Coating	$41	$41	No Coverage
UV Protection	$10	$10	No Coverage
Polycarbonate Lenses (Child)	$0	$0	No Coverage
Polycarbonate Lenses (Adult)	$31	$35	No Coverage
Photochromic Lenses	$75	$75	No Coverage
Progressive Lenses			
Standard Progressive Lenses	N/A	$0	No Coverage
Premium Progressive Lenses**	N/A	$95 or $105	No Coverage
Custom Progressive Lenses**	N/A	$150 or $175	No Coverage
Scratch Resistant Coating	$17	$17	No Coverage

Enhanced Feature Frame: When using VSP providers in the "Premier Program"
*****Progressive Lens copays vary based upon the lens manufacturer and retail cost.***

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ID Cards
An ID Card isn't required for members to receive services or care in-network. Simply let your VSP network provider know that you are a VSP member. The provider and VSP will handle the rest.

While VSP will not send out ID cards, you do have the option to print them from their website. Just visit **www.vsp.com** and login to your account. Once logged in there is an option to print your ID Card.

Do my benefits start over on January 1st?
Yes. Your vision benefits start over every January 1.

Looking for Information About Vision Claims, Eligibility or Benefits?
After January 1, 2025, you can review your eligibility status, claims paid information, and covered benefits by visiting www.vsp.com or by using the VSP app, and logging into your personalized account. Once logged in, you'll see personalized benefit information, including doctor visits, benefits history, how to use your benefits, and how to find a provider.

All claims for vision services will be processed by VSP.

Questions about your new benefits? Call VSP at 800-877-7195. Be sure to identify yourself as a member of
Group Number: 30100827

Sincerely,

Board of Trustees

IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO AND VICINITY BENEFIT TRUST: ACTIVE AND NON MEDICARE PLAN A MEMBERS PACKAGE

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, call 1-800-735-8947 or visit https://aetna.com. 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 937-454-1744 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: Individual $500 / Family $1,000. 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; plus in-network office visits & preventive care 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. $65 per person for prescription drugs (RX).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 $4,000 / Family $8,000. Out-of-Network: Individual $8,000 / Family $16,000. RX: In-network: $4,150 single/$8,300 family; Out-of-network: No limit	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	$30 copay/visit, deductible doesn't apply	30% coinsurance	None
	Preventive care /screening /immunization	No charge	30% coinsurance	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)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$65 deductible/person (waived if using mail order); $10 copay/prescription (retail); $20 copay/prescription (mail order). Medical deductible does not apply.	$65 deductible/person; 50% coinsurance; Minimum $55 for retail pharmacies. Mail order not covered. Medical deductible does not apply.	Prescription Drug Benefits are administered by CVS Caremark. For detailed exclusions and plan limitations, refer to the Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust Summary Plan Description located at https://iwtrustfund.com. Limited to a 30-day supply (retail) for non-maintenance medications.

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
	Brand formulary drugs	$65 deductible/person (waived if using mail order); $40 copay/prescription (retail); $60 copay/prescription (mail order). Medical deductible does not apply.	$65 deductible/person; 50% coinsurance; Minimum $55 for retail pharmacies. Mail order not covered. Medical deductible does not apply.	Maintenance medications are limited to two 30-day supplies (retail). After that, you will need to move to a 90-day supply (retail and mail order). No charge for FDA-approved generic preventive drugs (such as contraceptives) (or brand name drugs if a generic is medically inappropriate). Specialty drugs are filled through the PrudentRx Copay Program. There is no charge for covered specialty medications that are on the Plan's Exclusive Specialty Drug List and filled at CVS Specialty® Pharmacy. If the specialty drug you take is not included on the Exclusive Specialty Drug List, you will continue to pay the specialty drug copay per prescription. If you do not enroll in PrudentRx, you will pay 30% coinsurance for specialty drugs. Prescription Drug out-of-pocket limit: $4,150/single or $8,300/family in-network; no limit out of network.
	Brand non-formulary/specialty drugs	$65 deductible/person (waived if using mail order); $60 copay/prescription (retail); $90 copay/prescription (mail order). Medical deductible does not apply.	$65 deductible/person; 50% coinsurance. Minimum $55 for retail pharmacies. Mail order not covered. Medical deductible does not apply.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$135 copay/visit, deductible doesn't apply	$135 copay/visit, deductible doesn't apply	Out-of-network emergency use paid the same as in-network.
	Emergency medical transportation	$135 copay/trip, deductible doesn't apply	$135 copay/trip, deductible doesn't apply	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	$65 copay/visit, deductible doesn't apply	$65 copay/visit, deductible doesn't apply	No coverage for non-urgent 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 have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Penalty of $300 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $30 copay/visit, deductible doesn't apply; other outpatient services: 10% coinsurance	Office & other outpatient services: 30% coinsurance	None
	Inpatient services	10% coinsurance	30% coinsurance	Penalty of $300 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge Deductible does not apply	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 $300 for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	120 visits/calendar year. Penalty of $300 for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	$30 copay/visit, deductible doesn't apply	30% coinsurance	Speech therapy only covered for the correction of a speech impairment. 36 visits/calendar year for Physical & Occupational Therapy, 20 visits/calendar year for Speech Therapy, including outpatient hospital services.
	Habilitation services	10% coinsurance	30% coinsurance	None
	Skilled nursing care	10% coinsurance	30% coinsurance	180 days/calendar year. Penalty of $300 for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	10% coinsurance	30% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.

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
	Hospice services	10% coinsurance	30% coinsurance	Penalty of $300 for failure to obtain pre-authorization for out-of-network care.
If you, your spouse or child needs dental or eye care	Eye exam	$30 copay/visit, deductible doesn't apply	30% coinsurance	1 routine eye exam/12 months.
	Glasses	Not covered	Not covered	Not covered by the medical plan. You must pay 100% of this service, even from a network provider. The VSP vision plan is available through the Fund if you meet the eligibility requirements and you are covered under the plan; you are eligible for the VSP vision plan if you do not have to supplement or self-pay for your benefits; the vision plan includes coverage for glasses/contacts and eye exams, subject to any limits
	Dental check-up	Not covered	Not covered	Not covered by the medical plan. You must pay 100% of this service, even from a network provider. A dental plan administered by Delta Dental is available through the Fund if you meet the eligibility requirements and you are covered under the plan; you are eligible for the dental plan if you do not have to supplement or self-pay for your benefits.

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery - $10,000 maximum/lifetime. • Chiropractic care - 12 visits/calendar year.	• Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition • Private-duty nursing	• Routine eye care (Adult) - 1 routine eye exam/12 months.

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:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-370-4526. 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? No.

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** **$500**
- **Specialist copayment** **$30**
- **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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$1,670**

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$30**
- **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
Diabetic supplies *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,700**

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$30**
- **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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$410**

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: 1-800-370-4526.

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 1-800-370-4526.

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, disability, gender identity or sexual orientation.

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).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).

TTY: 711

Language Assistance:

To access language services at no cost to you, call 1-800-370-4526.

Albanian -	Për shërbime përkthimi falas për ju, telefononi 1-800-370-4526.
Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-800-370-4526 ይደውሉ።
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 1-800-370-4526
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-800-370-4526 հեռախոսահամարով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi -	Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-800-370-4526.
Bengali-Bangala -	আপনাকে বিনামূকযে ভাষা পবিকষিা পপকে হকয এই নম্বকি পেবযক ান েরুন: 1-800-370-4526 ।
Bisayan-Visayan -	Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-800-370-4526.
Burmese -	သင့္အေနျဖင့္ အခေၾကးေငြ မေပးရပဲ ဘာသာစကားဝန္ေဆာင္မွဳမ်ား ရရွိႏုိင္ရန္ 1-800-370-4526 သို႔ ဖုန္းေခၚဆုိပါ။
Catalan -	Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-800-370-4526.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-800-370-4526.
Cherokee -	ᏀᎩᏍᏗ ᏚᏬᏂᎯᏍᏗ ᎤᏳᎾᏓᏛᏁᏗ Ꮭ ᎪᎱᏍᏗ ᏗᏣᎬᏩᏁᏗ ᏱᎩ, ᏫᏥᎯᏏᏔᏛᏏ 1-800-370-4526.
Chinese -	如欲使用免費語言服務，請致電 1-800-370-4526.
Choctaw -	Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-800-370-4526.
Cushite -	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-800-370-4526.
Dutch -	Voor gratis toegang tot taaldiensten, bell 1-800-370-4526.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-800-370-4526.
French Creole -	Pou jwenn sèvis lang gratis, rele 1-800-370-4526.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-370-4526 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-800-370-4526.
Gujarati -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેિાઓની પહોંર્ માટે, કોલ કરો1-800-370-4526.

Hawaiian -	No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-800-370-4526. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-800-370-4526 पर कॉल करें।
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-800-370-4526.
Igbo -	Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-800-370-4526
Ilocano -	Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-800-370-4526.
Indonesian -	Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-800-370-4526.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-370-4526.
Japanese -	言語サービスを無料でご利用いただくには、1-800-370-4526 までお電話ください。
Karen -	လၢတၢ်ကမၤန့ၢ်ကျိာ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖဉ်လၢတအိဉ်ဒီးအပ့ၢ်လၢကဘဉ်ဟ့ဉ်အီၤအဂီၢ်ဘဉ်နဉ် ကိး 1-800-370-4526 တက့ၢ်.
Korean -	무료 언어 서비스를 이용하려면 1-800-370-4526 번으로 전화해 주십시오.
Kru-Bassa -	M̀ dyi wuɖu-dù kà kò ɖò ɓě dyi mɔ́ú ń nì Pídyi ní, nìí, ɖá nɔ̀ɓà nìà kɛ: 1-800-370-4526
Kurdish -	بۆ دەسپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی 1-800-370-4526
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-800-370-4526
Marathi -	कोणत्याही शल्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-800-370-4526 वर फोन करा.
Marshallese -	Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-800-370-4526.
Micronesian-Pohnpeyan -	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-800-370-4526.
Mon-Khmer, Cambodian -	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ។
Navajo -	T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ą́h ílínígóó kojį’ hólne’ 1-800-370-4526.
Nepali -	निःशुल्क भाषा सेवा प्राप्त गर्न 1-800-370-4526 मा टेलिफोन गर्नुहोस् ।
Nilotic-Dinka -	Të kɔɔr yïn wɛ̈ɛ̈r de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-800-370-4526.
Norwegian -	For tilgang til kostnadsfri språktjenester, ring 1-800-370-4526.
Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff 1-800-370-4526.
Persian -	برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-800-370-4526 تماس بگیرید.
Polish -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-800-370-4526.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para 1-800-370-4526.

Punjabi -	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-800-370-4526 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Romanian -	Pentru a accesa gratuit serviciile de limbă, apelați 1-800-370-4526.
Russian -	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-800-370-4526.
Samoan -	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-800-370-4526.
Serbo-Croatian -	Za besplatne prevodilačke usluge pozovite 1-800-370-4526.
Spanish -	Para acceder a los servicios de idiomas sin costo, llame al 1-800-370-4526.
Sudanic-Fulfude -	Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-800-370-4526.
Swahili -	Kupata huduma za lugha bila malipo kwako, piga 1-800-370-4526.
Syriac -	ܩܪܘܢ: ܡܓܢܐܝܬ، ܕܠܫܢܐ ܕܬܪܓܡܢܘܬܐ ܝܠܦܢܐ ܥܠ ܠܗܘܢ ܡܒܩܫܐ ܟܝ 1-800-370-4526
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-800-370-4526.
Telugu -	మీరు భాష సేవలను ఉచితంగా అందుకునందుకు, 1-800-370-4526 కు కాల్ చేయండి.
Thai -	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-800-370-4526.
Tongan -	Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-800-370-4526.
Trukese -	Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-800-370-4526.
Turkish -	Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-800-370-4526 numarayı arayın.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-800-370-4526.
Urdu -	بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-800-370-4526 پر بات کریں۔
Vietnamese -	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-800-370-4526.
Yiddish -	צו צוטריט שפּראַך באַדינונגען אין קיין פּרייַז צו איר, רופן 1-800-370-4526
Yoruba -	Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe 1-800-370-4526.

aetna® IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO AND VICINITY BENEFIT TRUST : Non Medicare Retiree Plan B Package

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, call 1-800-735-8947 or visit https://aetna.com. 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 937-454-1744 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: Individual $1,000 / Family $2,000. Out-of-Network: Individual $2,000 / Family $4,000.	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. Network: preventive care, primary care & specialist visits, prenatal office visits, outpatient mental/behavioral health/substance abuse office visits, preventive vision exams & outpatient rehabilitation services.	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. $200 per person for prescription drugs (RX). 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?	Medical In-Network: Individual $5,250 / Family $10,500. Out-of-Network: Individual $10,500 / Family $21,000. RX: Network: $2,900 single/ $5,800 family; Out-of-network: unlimited	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: 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	$30 copay/visit, deductible doesn't apply	50% coinsurance	None
	Specialist visit	$30 copay/visit, deductible doesn't apply	50% coinsurance	None
	Preventive care /screening /immunization	No charge. Deductible does not apply	50% coinsurance	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)	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Generic drugs	$200 deductible/person (waived if using mail order); $10 copay/prescription (retail); $20 copay/prescription (mail order). Medical deductible does not apply.	$200 deductible/person; 50% coinsurance; Minimum $50 for retail pharmacies. Medical deductible does not apply.	Prescription Drug Benefits are administered by CVS Caremark. For detailed exclusions and plan limitations refer to the Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust Summary Plan Description located at https://iwtrustfund.com. Limited to a 30-day supply for non-maintenance medications (retail).

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
www.caremark.com.	Brand formulary drugs	$200 deductible/person (waived if using mail order); $30 copay/prescription (retail); $70 copay/prescription (mail order). Medical deductible does not apply.	$200 deductible/person; 50% coinsurance; Minimum $50 for retail pharmacies; Mail order not covered. Medical deductible does not apply.	Maintenance medications are limited to two 30-day supplies (retail). After that, you will need to move to a 90-day supply (retail or mail order). No charge for FDA-approved generic preventive drugs (such as contraceptives) (or brand name contraceptives if a generic is medically inappropriate). Specialty drugs are filled through the PrudentRx Copay Program. There is no charge for covered specialty medications that are on the Plan's Exclusive Specialty Drug List and filled at CVS Specialty® Pharmacy. If the specialty drug you take is not included on the Exclusive Specialty Drug List, you will continue to pay the specialty drug copay per prescription. If you do not enroll in PrudentRx, you will pay 30% coinsurance for specialty drugs. Prescription drug out-of-pocket limit: Network provider: **$2,900**/single **$5,800**/family; Out-of-network provider: unlimited.
	Brand nonformulary/Specialty drugs	$200 deductible/person (waived if using mail order); 50% coinsurance with $50 minimum/$100 maximum (retail); $125 copay/prescription (mail order). Medical deductible does not apply.	$200 deductible/person; 50% coinsurance; Minimum $50 for retail pharmacies; Mail order not covered. Medical deductible does not apply.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	None
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	Out-of-network emergency use paid the same as in-network.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	30% coinsurance	30% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Penalty of $300 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None

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 need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $30 copay/visit, deductible doesn't apply; other outpatient services: 30% coinsurance	Office & other outpatient services: 50% coinsurance	None
	Inpatient services	30% coinsurance	50% coinsurance	Penalty of $300 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge. Deductible does not apply	50% 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 $300 for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	120 visits/calendar year. Penalty of $300 for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	$30 copay/visit, deductible doesn't apply. Inpatient: 30% coinsurance	50% coinsurance	Speech therapy only covered for the correction of a speech impairment. 36 visits/calendar year for Physical & Occupational Therapy, 20 visits/calendar year for Speech Therapy, including outpatient hospital services.
	Habilitation services	30% coinsurance	50% coinsurance	None
	Skilled nursing care	30% coinsurance	50% coinsurance	180 days/calendar year. Penalty of $300 for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	30% coinsurance	50% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. Covered up to the Maximum Allowable Amount for the standard item that is a Covered Service. Rental costs must not be more than the purchase price.

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
	Hospice services	30% coinsurance	50% coinsurance	Penalty of $300 for failure to obtain pre-authorization for out-of-network care.
If you, your spouse or child needs dental or eye care	Eye exam	$30 copay/visit, deductible doesn't apply	50% coinsurance	1 routine eye exam/12 months.
	Glasses	Not covered	Not covered	You must pay 100% of this service, even from a network provider.
	Dental check-up	Not covered	Not covered	You must pay 100% of this service, even from a network provider.

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 (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Infertility Treatment
- Routine foot care
- Weight loss programs
- Routine eye care, except eye exams

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery - $10,000 maximum/lifetime.
- Chiropractic care - 12 spinal maipulations /calendar year.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition
- Private-duty nursing(only covered in the home)
- Emergency care when traveling outside the U.S. or Canada

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:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-370-4526. 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? No.

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** **$1,000**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$3,200
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$4,270**

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

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Diabetic supplies *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,700**

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

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,510**

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: 1-800-370-4526.

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 1-800-370-4526.

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, disability, gender identity or sexual orientation.

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).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).

TTY: 711

Language Assistance:

To access language services at no cost to you, call 1-800-370-4526.

Albanian - Për shërbime përkthimi falas për ju, telefononi 1-800-370-4526.

Amharic - የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-800-370-4526 ይደውሉ።

Arabic - للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 1-800-370-4526

Armenian - Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-800-370-4526 հեռախոսահամարով:

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.

Bantu-Kirundi - Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-800-370-4526.

Bengali-Bangala - আপনাকে বিনামূকযে ভাষা পবিকষিা পপকে হকয এই নম্বকি পেবযক ◌ান ◌েরুন: 1-800-370-4526 ।

Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-800-370-4526.

Burmese - သင့္အေနျဖင့္ အခေၾကးေငြ မေပးရပဲ ဘာသာစကားဝန္ေဆာင္မွဴမ်ား ရရွိႏုိင္ရန္ 1-800-370-4526 သို႔ ဖုန္းေခၚဆုိပါ။

Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-800-370-4526.

Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-800-370-4526.

Cherokee - ᎶᎩᏍᏗ ᏚᏬᏂᎯᏍᏗ ᎤᏩ̈ᎾᏕᎶᏓ Ꮮ ᎠᏁᏍᏗ ᏗᏣᎬᏩᎶᏗ ᏱᎩ, ᏫᏴᎯᏏᎳᏍᏏ 1-800-370-4526.

Chinese - 如欲使用免費語言服務，請致電 1-800-370-4526.

Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-800-370-4526.

Cushite - Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-800-370-4526.

Dutch - Voor gratis toegang tot taaldiensten, bell 1-800-370-4526.

French - Afin d'accéder aux services langagiers sans frais, composez le 1-800-370-4526.

French Creole - Pou jwenn sèvis lang gratis, rele 1-800-370-4526.

German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-370-4526 an.

Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-800-370-4526.

Gujarati - તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેિ◌ાઓની પહોંર્ માટે, કોલ કરો1-800-370-4526.

Hawaiian -	No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-800-370-4526. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-800-370-4526 पर कॉल करें।
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-800-370-4526.
Igbo -	Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-800-370-4526
Ilocano -	Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-800-370-4526.
Indonesian -	Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-800-370-4526.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-370-4526.
Japanese -	言語サービスを無料でご利用いただくには、1-800-370-4526 までお電話ください。
Karen -	လၢတၢ်ကမၤန့ၢ်ကိုၣ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပှ့ၤလၢကဘၣ်ဟ့ၣ်အီၤအဂီၢ်ဘၣ်န့ၣ် ကိး 1-800-370-4526 တက့ၢ်.
Korean -	무료 언어 서비스를 이용하려면 1-800-370-4526 번으로 전화해 주십시오.
Kru-Bassa -	Ɱ̀ dyi wuɖu-dù kà kò ɖò ɓĕ dyi mɔ́ú ń nì Pídyi ní, nìí, ɖá nɔ̀ɓà nìà kɛ: 1-800-370-4526
Kurdish -	بۆ دەسپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی 1-800-370-4526
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-800-370-4526
Marathi -	कोणत्याही शल्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-800-370-4526 वर फोन करा.
Marshallese -	Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-800-370-4526.
Micronesian-Pohnpeyan -	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-800-370-4526.
Mon-Khmer, Cambodian -	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ។
Navajo -	T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ąh ílínígóó kojį’ hólne’ 1-800-370-4526.
Nepali -	निःशुल्क भाषा सेवा प्राप्त गर्न 1-800-370-4526 मा टेलिफोन गर्नुहोस् ।
Nilotic-Dinka -	Të kɔɔr yïn wɛ̈ɛ̈r de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-800-370-4526.
Norwegian -	For tilgang til kostnadsfri språktjenester, ring 1-800-370-4526.
Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff 1-800-370-4526.
Persian -	برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-800-370-4526 تماس بگیرید.
Polish -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-800-370-4526.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para 1-800-370-4526.

Punjabi -	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-800-370-4526 ‘ਤੇ ਫ਼ੋਨ ਕਰੋ।
Romanian -	Pentru a accesa gratuit serviciile de limbă, apelați 1-800-370-4526.
Russian -	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-800-370-4526.
Samoan -	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala’au le 1-800-370-4526.
Serbo-Croatian -	Za besplatne prevodilačke usluge pozovite 1-800-370-4526.
Spanish -	Para acceder a los servicios de idiomas sin costo, llame al 1-800-370-4526.
Sudanic-Fulfude -	Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-800-370-4526.
Swahili -	Kupata huduma za lugha bila malipo kwako, piga 1-800-370-4526.
Syriac -	ܟܝ ܡܨܝܬܘܢ ܕܗܘܝ ܠܟ ܥܠ ܝܠܦܢܘܬܐ ܕܬܪܓܡܢܘܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ، ܡܢܝܢܐ: 1-800-370-4526
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-800-370-4526.
Telugu -	మీరు భాష సేవలను ఉచితంగా అందుకునందుకు, 1-800-370-4526 కు కాల్ చేయండి.
Thai -	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-800-370-4526.
Tongan -	Kapau ‘oku ke fiema’u ta’etōtōngi ‘a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-800-370-4526.
Trukese -	Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-800-370-4526.
Turkish -	Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-800-370-4526 numarayı arayın.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-800-370-4526.
Urdu -	بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-800-370-4526 پر بات کریں۔
Vietnamese -	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-800-370-4526.
Yiddish -	צו צוטריט שפּראך באַדינונגען אין קיין פּרייז צו איר, רופן 1-800-370-4526
Yoruba -	Lati wọnú awọn isẹ èdè l’ọfẹ fun ọ, pe 1-800-370-4526.