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

Coverage Period: 03/01/2023-02/29/2024

aetna® NORDSTROM, INC. : Aetna Open Access® Aetna SelectSM - Advantage Plan

Coverage for: EE Only; EE+ Family | Plan Type: EPO

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 1-877-764-5727. 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 1-877-764-5727 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each Plan Year, In-Network: EE Only $1,500; EE+ Family: Individual $3,000/ Family $3,000.	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. In-network preventive care is 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: EE Only $4,500; EE+ Family: Individual $6,900/ Family $9,000.	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.	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 1-877-764-5727 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	20% coinsurance	Not covered	None
	Specialist visit	20% coinsurance	Not covered	None
	Preventive care /screening /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/advancedcontrol	Generic drugs	Copay/prescription: $10 (retail), $25 (mail order)	Not covered	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 step therapy for coverage. Your cost will be higher for choosing Brand over Generics; cost difference penalty doesn't apply to deductible or out-of-pocket limit. Maintenance drugs- after two retail fills, members are required to fill a 90-day supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy. Deductible doesn't apply to certain preventive medications.
	Preferred brand drugs	Copay/prescription: $40 (retail), $100 (mail order)	Not covered	
	Non-preferred brand drugs	Copay/prescription: $75 (retail), $187.50 (mail order)	Not covered	
	Specialty drugs	Copay/prescription: $125	Not covered	All prescriptions must be filled through the Aetna Specialty Pharmacy Network. Precertification required for coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	None
	Physician/surgeon fees	20% coinsurance	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	40% coinsurance in-network & no coverage out-of-network for non-emergency use.
	Emergency medical transportation	20% coinsurance	20% coinsurance	40% coinsurance in-network & no coverage out-of-network for non-emergency use.
	Urgent care	20% coinsurance	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	None
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 20% coinsurance	Not covered	None
	Inpatient services	20% coinsurance	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	120 visits/plan year.
	Rehabilitation services	20% coinsurance	Not covered	60 visits/plan year for Physical Therapy, 60 visits/plan year for Occupational & Speech Therapy combined. Includes treatment of neurodevelopmental therapy with no visit limit up to age 21.
	Habilitation services	20% coinsurance	Not covered	
	Skilled nursing care	20% coinsurance	Not covered	120 days/plan year.
	Durable medical equipment	20% coinsurance	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs - Except for required preventive services.

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

- Acupuncture - 60 visits/plan year combined with chiropractic care.
- Bariatric surgery
- Chiropractic care - 60 visits/plan year combined with acupuncture.
- Hearing aids - $2,000 maximum/3 years.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Private-duty nursing - 70- 8 hour shifts/plan year.

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 1-877-764-5727.
- 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 1-877-764-5727. 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	**$1,500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,570**

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

The plan's overall deductible	**$1,500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$800
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,420**

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

The plan's overall deductible	**$1,500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,810**

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, 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).

TTY: 711

Language Assistance:

For language assistance in your language call 1-877-764-5727 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-877-764-5727.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-877-764-5727 በነጻ ይደውሉ
Arabic -	1-877-764-5727 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-877-764-5727 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-764-5727 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-877-764-5727 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-877-764-5727-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-877-764-5727 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-877-764-5727 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-877-764-5727.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-877-764-5727 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᏕᏲᏂᎯᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᏓᎢ (ᏣᎳᎩ) ᏫᏏᏔᏮᎥᏕ 1-877-764-5727 ᎤᎾᎢ Ꮭ ᎠᎱᏍᏗ ᏧᎬᏩᎵᏗ ᏂᎨᏒᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-877-764-5727，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-877-764-5727.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-877-764-5727 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-877-764-5727.
French -	Pour une assistance linguistique en français appeler le 1-877-764-5727 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-877-764-5727 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-877-764-5727 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-877-764-5727 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-877-764-5727 પર કૉલ કરો.
Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-877-764-5727. Kāki ʻole ʻia kēia kōkua nei.

Hindi -	हिन्दी में भाषा सहायता के लिए, 1-877-764-5727 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-877-764-5727.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-877-764-5727 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-764-5727 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-877-764-5727.
Japanese -	日本語で援助をご希望の方は、1-877-764-5727 まで無料でお電話ください。
Karen -	လာတက်မၤစၢးတက်ကတိၤကျိာ်အင်္ဂါ် ကျိာ် 1-877-764-5727 လာတအိာ်ဒီးတက်လၢာ်ဘျာ်လၢာ်စုၤဟဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-764-5727 번으로 전화해 주십시오.
Kru-Bassa -	Bɛ́m̀ké gbo-kpá-kpá dyé pídyi dé Bǎsɔ́ɔ̀-wùdùǔn wɛ̃ɛ, dá 1-877-764-5727
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-877-764-5727 به خۆرایی پەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-877-764-5727 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-877-764-5727 वर फोन करा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-877-764-5727 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-877-764-5727 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-764-5727 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-877-764-5727
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-877-764-5727 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-877-764-5727 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-877-764-5727 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-877-764-5727 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-877-764-5727 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-877-764-5727 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-764-5727.
Portuguese -	Para obter assistência linguística em português ligue para o 1-877-764-5727 gratuitamente.
Romanian -	Pentru asistenţă lingvistică în românește telefonați la numărul gratuit 1-877-764-5727

Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-764-5727.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-877-764-5727 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-877-764-5727.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-877-764-5727.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-877-764-5727. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-877-764-5727 bila malipo.
Syriac -	[illegible] 1-877-764-5727 [illegible].
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-764-5727 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-877-764-5727 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-877-764-5727 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-877-764-5727 ‘o ‘ikai hā ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-877-764-5727 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-877-764-5727.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-877-764-5727.
Urdu -	بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-877-764-5727 . پر بات کریں۔
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-877-764-5727.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-877-764-5727 פריי פון אפצאל.
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-877-764-5727 lái san owó kankan rárá.