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

Coverage Period: 01/01/2023-12/31/2023

aetna® SODEXO, INC. : Aetna Choice® POS II - Open Health Plan

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 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 1-833-383-2650 to request a copy. For details on your coverage and costs, you can get the complete terms in the Summary Plan Description at www.SodexoBenefitsCenter.com or by calling 1-855-668-5040.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: Individual $1,250 / Family $2,500. Out-of-Network: Individual $2,500 / Family $5,000.	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. Preventive care & prescription drugs; plus in-network office visits 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual $8,700 / Family $17,400. Out-of-Network: Individual $17,400 / Family $34,800.	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 1-833-383-2650 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% of negotiated charge	None
If you visit a health care provider's office or clinic	Specialist visit	$40 copay/visit, deductible doesn't apply	50% of negotiated charge	None
	Retail Health Clinic	$30 copay/visit, deductible doesn't apply	50% of negotiated charge	None
If you visit a health care provider's office or clinic	Preventive care /screening /immunization	No charge	No charge	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	50% of negotiated charge	None
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% of negotiated charge	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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/standard	Generic drugs	$10 (retail) $20 (mail) Deductible doesn't apply	Not covered	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network. Certain prescriptions require precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics; cost difference penalty doesn't apply to 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.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/standard	Preferred brand drugs	30% coinsurance (retail) $50 min/$125 max 30% coinsurance (mail) $100 min/$250 max Deductible doesn't apply	Not covered	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics; cost difference penalty doesn't apply to 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.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/standard	Non-preferred brand drugs	30% coinsurance (retail) $75 min/$175 max 30% coinsurance (mail) $150 min/$350 max Deductible doesn't apply	Not covered	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics; cost difference penalty doesn't apply to 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.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/standard	Specialty drugs	30% coinsurance (retail) $75 min/$175 max 30% coinsurance (mail) $150 min/$350 max Deductible doesn't apply	Not covered	Covers 90 day supply. All prescriptions must be filled through the Aetna Specialty Performance Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% of negotiated charge	None
If you have outpatient surgery	Physician/surgeon fees	20% coinsurance	50% of negotiated charge	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)	
Orthopedic Surgery	Orthopedic Surgery (Aetna)	Certain joint replacements and Spinal fusion surgery: No Coverage* Other orthopedic procedures: Deductible, then 20% coinsurance	Certain joint replacements and Spinal fusion surgery: No Coverage* Other orthopedic procedures: Deductible, then 50% of negotiated charge	*Carrum Health providers must be used for these surgeries
	Orthopedic Surgery Benefit (*Carrum Health)	If eligible, covers all medical costs incurred and related to the surgery without deductible or coinsurance	Not Covered	Certain orthopedic and spinal procedures are covered at 100% (deductible and coinsurance waived) when received through the Carrum Health surgery benefit. Contact Carrum Health at 888-855-7806 or visit carrum.me/sodexo for more information
If you need immediate medical attention	Emergency room care	20% coinsurance after $150 copay/visit	20% coinsurance after $150 copay/visit	To be used for unexpected, urgently required services; Copay waived if admitted
If you need immediate medical attention	Emergency medical transportation	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
If you need immediate medical attention	Urgent care	$30 copay/visit, deductible doesn't apply	$30 copay/visit, deductible doesn't apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% coinsurance	Deductible, then 50% of negotiated charge	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
If you have a hospital stay	Physician/surgeon fees	Deductible, then 20% coinsurance	Deductible, then 50% of negotiated charge	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 mental health, behavioral health, or substance abuse services	Outpatient services	Office: $40 copay/visit, deductible doesn't apply; other outpatient services: Deductible, then 20% coinsurance	Office & other outpatient services: Deductible, then 50% of negotiated charge	None
If you need mental health, behavioral health, or substance abuse services	Inpatient services	Deductible, then 20% coinsurance	Deductible, then 50% of negotiated charge	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge	Deductible, then 50% of negotiated charge	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 $500 for failure to obtain pre-authorization for out-of-network care may apply.
If you are pregnant	Childbirth/delivery professional services	Deductible, then 20% coinsurance	Deductible, then 50% of negotiated charge	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 $500 for failure to obtain pre-authorization for out-of-network care may apply.
If you are pregnant	Childbirth/delivery facility services	Deductible, then 20% coinsurance	Deductible, then 50% of negotiated charge	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 $500 for failure to obtain pre-authorization for out-of-network care may apply.
If you need help recovering or have other special health needs	Home health care	Deductible, then 20% coinsurance	Deductible, then 50% of negotiated charge	120 visits/calendar year combined with private-duty nursing. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.

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	Rehabilitation services	$30 copay/visit, deductible doesn't apply	Deductible, then 50% of negotiated charge	None
If you need help recovering or have other special health needs	Habilitation services	$30 copay/visit, deductible doesn't apply	Deductible, then 50% of negotiated charge	Exception: Deductible, then 20% coinsurance for Autism
If you need help recovering or have other special health needs	Skilled nursing care	Deductible, then 20% coinsurance	Deductible, then 50% of negotiated charge	60 days/calendar year. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
If you need help recovering or have other special health needs	Durable medical equipment	Deductible, then 20% coinsurance	Deductible, then 50% of negotiated charge	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
If you need help recovering or have other special health needs	Hospice services	20% coinsurance, deductible doesn't apply	20% coinsurance, deductible doesn't apply	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	1 routine eye exam/calendar year.
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Not covered.
If your child needs dental or eye care	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)	• 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.)

• Acupuncture - 10 visits/calendar year for disease, injury & chronic pain. • Bariatric surgery - (through Carrum Health) • Chiropractic care - 30 visits/calendar year.	• Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. • Routine eye care (Adult) - 1 routine eye exam/calendar year.	• Virtual Physical Therapy - Through Hinge Health

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 1-833-383-2650.
- 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

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 1-833-383-2650. 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
- 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.

Language Assistance:

For language assistance in your language call 1-888-982-3862 at no cost.

Spanish	Para obtener asistencia lingüística en español, llame sin cargo al 1-833-383-2650.
Tagalog	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.
Chinese	欲取得繁體中文語言協助，請撥打 1-888-982-3862，無需付費。
Navajo	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862

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To see examples of how this plan might cover costs for a sample medical situation, see the next section

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,250**
Specialist copayment	**$40**
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	$1,250
Copayments	$10
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,420**

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

The plan's overall deductible	**$1,250**
Specialist copayment	**$40**
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	$100
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,420**

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

The plan's overall deductible	**$1,250**
Specialist copayment	**$40**
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	$1,250
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,550**

The plan would be responsible for the other costs of these EXAMPLE covered services.