




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, 1-833-841-6702 or visit [www.trinitycaptivegroup.com](http://www.trinitycaptivegroup.com). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or call 1-833-841-6702 to request a copy.

| Important Questions   | Answers  | Why This Matters:  |
|---|--|--|
| What is the overall <a href="#">deductible</a> ?                                | <a href="#">Network</a> : \$750/Individual,<br>\$1500/ Family<br><a href="#">Out of Network</a> : \$1,500/Individual,<br>\$3,000/Family    | Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. Preventive services are covered before you meet your <a href="#">deductible</a> .   | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .  |
| Are there other <a href="#">deductibles</a> for specific services?              | No.  | There are no other specific <a href="#">deductibles</a> .  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | <a href="#">Network</a> : \$2,000/Individual,<br>\$6,000/Family<br><a href="#">Out of Network</a> : \$3,000/Individual,<br>\$9,000/Family. | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.  |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.               | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .  |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.aetna.com/asa">www.aetna.com/asa</a> or call 1-833-841-6702 for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the First Health Network. You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.  | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .   |

 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   |
|--|--|---|--|--|
|  |  | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)               |  |
| If you visit a health care <a href="#">provider's</a> office or clinic   | Primary care visit to treat an injury or illness       | \$20 <a href="#">copayment</a>  | \$20 <a href="#">copayment</a>                                   | Only one copay per physician visit, per day applied.   |
|  | <a href="#">Specialist</a> visit                       | \$40 <a href="#">copayment</a>  | \$40 <a href="#">copayment</a>                                   | Only one copay per physician visit, per day applied.   |
|  | <a href="#">Preventive care/screening/immunization</a> | \$0 <a href="#">copayment</a>   | \$0 <a href="#">copayment</a>                                    | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for. |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>                                      | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> | \$0 Benefit Applies if Member contacts the Patient Navigator.  |
|  | Imaging (CT/PET scans, MRIs)                           | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>                                      | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> |  |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.Maxor.com">www.Maxor.com</a> | Generic drugs  | Retail 30-day: \$5 <a href="#">copayment</a><br>Retail/Mail 90-day: \$12.50 <a href="#">copayment</a> | Not Covered  |  |
|  | Preferred brand drugs                                  | Retail 30-day: \$20 <a href="#">copayment</a><br>Retail/Mail 90-day: \$50 <a href="#">copayment</a>   | Not Covered  |  |
|  | Non-preferred brand drugs                              | Retail 30-day: \$50 <a href="#">copayment</a><br>Retail/Mail 90-day: \$125 <a href="#">copayment</a>  | Not Covered  |  |
|  | <a href="#">Specialty drugs</a>                        | Retail 30-day: 20% to \$300 maximum<br>Retail/Mail 90-day: n/a  | Not Covered  |  |
| If you have outpatient surgery   | Facility fee (e.g., ambulatory surgery center)         | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>                                      | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> | \$0 Benefit Applies if Member contacts the Patient Navigator.  |
|  | Physician/surgeon fees                                 | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>                                      | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> | \$0 Benefit Applies if Member contacts the Patient Navigator.  |
|  |  |   |  |  |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.trinitycaptivegroup.com](http://www.trinitycaptivegroup.com)

| Common Medical Event  | Services You May Need                            | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information  |
|---|--|--|--|---|
|   |  | Network Provider<br>(You will pay the least)                     | Out-of-Network Provider<br>(You will pay the most)               |   |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$0 <a href="#">copayment</a>                                    | \$0 <a href="#">copayment</a>                                    | \$750 penalty + coinsurance for non-emergency (after deductible)  |
|   | <a href="#">Emergency medical transportation</a> | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> |   |
|   | <a href="#">Urgent care</a>                      | \$50 <a href="#">copayment</a>                                   | \$50 <a href="#">copayment</a>                                   |   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> |   |
|   | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> |   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> |   |
|   | Inpatient services                               | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> |   |
| If you are pregnant   | Office visits                                    | \$20 <a href="#">copayment</a>                                   | \$20 <a href="#">copayment</a>                                   | <a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, [ <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> ] may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e.ultrasound). |
|   | Childbirth/delivery professional services        | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> |   |
|   | Childbirth/delivery facility services            | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> |   |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> |   |
|   | <a href="#">Rehabilitation services</a>          | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> |   |
|   | <a href="#">Habilitation services</a>            | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> |   |
|   | <a href="#">Skilled nursing care</a>             | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> |   |
|   | <a href="#">Durable medical equipment</a>        | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> |   |
|   | <a href="#">Hospice services</a>                 | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> |   |
| If your child needs dental or eye care                                    | Children's eye exam                              | Not Covered  | Not Covered  | None  |
|   | Children's glasses                               | Not Covered  | Not Covered  | None  |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.trinitycaptivegroup.com](http://www.trinitycaptivegroup.com)

| Common Medical Event | Services You May Need      | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information   |
|----------------------|----------------------------|--|--|--|
|                      |                            | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
|                      | Children's dental check-up | Not Covered                                  | Not Covered  | See Summary of Plan Documents regarding Emergency repair due to injury to sound natural teeth. |

### 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](#).)**

- |  |  |  |
|--|--|--|
| <ul style="list-style-type: none"> <li>• Bariatric Surgery</li> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> <li>• Hearing Aids</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility Treatment (Surgery/Artificial Insemination)</li> <li>• Long Term Care</li> <li>• Routine Eye Care (Adult)</li> <li>• Routine Foot Care</li> </ul> | <ul style="list-style-type: none"> <li>• Weight loss programs</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> |
|--|--|--|

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

- |  |                     |                        |
|--|---------------------|------------------------|
| • Acupuncture (only covered in lieu of anesthesia) | • Chiropractic Care | • Private-duty nursing |
|--|---------------------|------------------------|

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov) Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: 1-833-841-6702 or visit [www.trinitycaptivegroup.com](http://www.trinitycaptivegroup.com) or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**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.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.trinitycaptivegroup.com](http://www.trinitycaptivegroup.com)

**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 Access Services:**

[Spanish (Español): Para obtener asistencia en Español, llame al 1-833-841-6702

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-841-6702

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-841-6702

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-841-6702

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$750 |
| ■ <a href="#">Specialist</a> [copayment]                        | \$40  |
| ■ <a href="#">Hospital (facility)</a> [cost sharing]            | 20%   |
| ■ <a href="#">Other</a> [cost sharing]                          | 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$750          |
| Copayments                        | \$50           |
| Coinsurance                       | \$2,360        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,220</b> |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|   |       |
|---|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$750 |
| ■ <a href="#">Specialist</a> [copayment]                        | \$40  |
| ■ <a href="#">Hospital (facility)</a> [cost sharing]            | 20%   |
| ■ <a href="#">Other</a> [cost sharing]                          | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles*                      | \$750          |
| Copayments                        | \$600          |
| Coinsurance                       | \$30           |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,400</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|   |       |
|---|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$750 |
| ■ <a href="#">Specialist</a> [copayment]                        | \$40  |
| ■ <a href="#">Hospital (facility)</a> [cost sharing]            | 20%   |
| ■ <a href="#">Other</a> [cost sharing]                          | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles*                      | \$750          |
| Copayments                        | \$70           |
| Coinsurance                       | \$200          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,020</b> |