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. 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 deductible?	Network: **$2,000**/Individual, **$6,000**/ Family Out of Network: **$3,500**/Individual, **$10,500**/Family	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 services 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.	There are no other specific deductibles.
What is the out-of-pocket limit for this plan?	Network: **$4,000**/Individual, **$10,000**/Family Out of Network: **$6,900**/Individual, **$13,800**/Family.	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, and 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/asa or call 1-833-841-6702 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the First Health 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
		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	$25 copayment	$35 copayment	Only one copay per physician visit, per day applied.
	Specialist visit	$50 copayment	$70 copayment	Only one copay per physician visit, per day applied.
	Preventive care/screening/ immunization	$0 copayment	$0 copayment	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	$0 Benefit Applies if Member contacts the Patient Navigator.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Maxor.com	Generic drugs	Retail 30-day: $10 copayment Retail/Mail 90-day: $25 copayment	Not Covered	
	Preferred brand drugs	Retail 30-day: $25 copayment Retail/Mail 90-day: $62.50 copayment	Not Covered	
	Non-preferred brand drugs	Retail 30-day: $50 copayment Retail/Mail 90-day: $125 copayment	Not Covered	
	Specialty drugs	Retail 30-day: $250 copay + 20% coinsurance, not to exceed $500 Retail/Mail 90-day: n/a	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory	20% coinsurance after deductible	40% coinsurance after deductible	$0 Benefit Applies if Member contacts the

* For more information about limitations and exceptions, see the plan or policy document at www.trinitycaptivegroup.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	surgery center)			Patient Navigator.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	$0 Benefit Applies if Member contacts the Patient Navigator.
If you need immediate medical attention	Emergency room care	$250 copayment	$250 copayment	$750 penalty + coinsurance for non-emergency
	Emergency medical transportation	20% coinsurance after deductible	40% coinsurance after deductible	Out-of-Network Air Ambulance is subject to the Network deductible and coinsurance.
	Urgent care	$45 copayment	$75 copayment	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	40% coinsurance after deductible	
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	
If you are pregnant	Office visits	$25 copayment	$35 copayment	Cost sharing does not apply to certain preventive services. Depending on the type of services, [copayment, coinsurance , or deductible] may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e.ultrasound).
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	40% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	
	Skilled nursing care	20% coinsurance after	40% coinsurance after	Not covered for custodial care.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		deductible	deductible	
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	
	Hospice services	20% coinsurance after deductible	40% coinsurance after deductible	Life expectancy of 6 months or less.
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
	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.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment (Surgery/Artificial Insemination)
- Long Term Care
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight loss programs
- Non-emergency care when traveling outside the U.S.

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 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

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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 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.

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 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, kwiijigo 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 plan's overall deductible	**$2000**
Specialist [copayment]	**$50**
Hospital (facility) [cost sharing]	**20%**
Other [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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2000
Copayments	$0
Coinsurance	$2000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

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

The plan's overall deductible	**$2000**
Specialist [copayment]	**$50**
Hospital (facility) [cost sharing]	**20%**
Other [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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$900
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

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

The plan's overall deductible	**$2000**
Specialist [copayment]	**$50**
Hospital (facility) [cost sharing]	**20%**
Other [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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1700
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,100**

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