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, [insert contact information]. 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 www.HealthReformPlansSBC.com or by calling 1-888-277-1057 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | $1,750 individual / $3,500 family for In-Network Providers.<br>$3,500 individual / $7,000 family for Out-of-Network Providers. | 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 policy, the overall family deductible must be met before the plan begins to pay. |
| Are there services covered before you meet your deductible? | Yes. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. |
| 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? | $3,000 individual / $6,000 family for In-Network Providers. $6,000 individual / $12,000 family for Out-of-Network Providers. | 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-billed charges, Health care this plan doesn't cover, Penalties for non-compliance, and Services deemed not medically necessary by Medical management. | 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, for a list of In-Network providers, see www.aetna.com or call 1-888-277-1057. | 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 |
|---|---|---|---|---|
| | | 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 | 40% coinsurance | --------none-------- |
| | Specialist visit | 20% coinsurance | 40% coinsurance | --------none-------- |
| | Preventive care/screening/ immunization | No cost share | 40% coinsurance | --------none-------- |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | --------none-------- |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | Precertification is recommended. |
| If you need drugs to treat your illness or condition<br>More information about prescription drug coverage is available at www.express-scripts.com | Generic drugs | 20% coinsurance | 40% coinsurance | Certain drugs may be subject to Prior Authorization, Step Therapy, Quantity limits and/or dose or duration limits.<br><br>Certain specialty drugs will be dispensed in smaller quantities. In those cases, copays will be prorated. |
| | Preferred brand drugs | 20% coinsurance | 40% coinsurance | |
| | Non-preferred brand drugs | 20% coinsurance | 40% coinsurance | |
| | Specialty drugs | 20% coinsurance | 40% coinsurance | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | --------none-------- |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | --------none-------- |
| If you need immediate medical attention | Emergency room care | 20% coinsurance | 20% coinsurance | If admitted, failure to obtain authorization no later than 2 business days after admission may result in non-coverage or reduced benefits. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | --------none-------- |
| | Urgent care | 20% coinsurance | 40% coinsurance | --------none-------- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Failure to obtain pre-certification may result in non-coverage or reduced benefits. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | --------none-------- |

| 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 need mental health, behavioral health, or substance abuse services | Outpatient services | 20% coinsurance | 40% coinsurance | --------none-------- |
| | Inpatient services | 20% coinsurance | 40% coinsurance | Failure to obtain pre-certification may result in non-coverage or reduced benefits. |
| If you are pregnant | Office visits | 20% coinsurance | 40% coinsurance | --------none-------- |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | Precertification is recommended for inpatient stay that exceeds 48 hours for a normal delivery and 96 hours after a cesarean delivery.<br><br>Home births are covered at 100% if billed as part of global maternity charge. |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | Precertification is recommended for inpatient stay that exceeds 48 hours for a normal delivery and 96 hours after a cesarean delivery.<br><br>Home births are covered at 100% if billed as part of global maternity charge. |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 40% coinsurance | Coverage is limited to 100 visits maximum per calendar year combined In-Network and Out-of-Network. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | Coverage is limited to 20 visits per calendar year each for Occupational and Speech Therapy combined In-Network and Out-of-Network. Coverage is limited to 60 visits per calendar year for Physical Therapy combined In-Network and Out-of-Network. |
| | Habilitation services | 20% coinsurance | 40% coinsurance | All Rehabilitation and Habilitation visits count towards your Rehabilitation visit limit. |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | Coverage is limited to 90 days per calendar year combined In Network and Out of Network. Failure to obtain pre-certification may result in non-coverage or reduced benefits. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Hearing aid coverage for children under age 19, one hearing aid per year every two years. |

| 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) | |
| | Hospice services | 20% coinsurance | 40% coinsurance | --------none-------- |
| 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 | --------none-------- |

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)
- Long term care
- Routine eye care (Adult
- 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 (limited to $25,000 Lifetime Maximum per member)
- Chiropractic care
- Hearing aids
- Infertility treatment – diagnosis and treatment of underlying medical condition only
- Private duty nursing

Your Rights to Continue Coverage: For more information on your rights to continue coverage, contact the plan at 1-888-982-3862.You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services 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 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: contact Aetna at http://www.aetna.com/individuals-families-health-insurance/member-guidelines/complaints-grievances-appeals.html. Or the Department of Labor (DOL) at:

Department of Labor
Employee Benefits Security Administration
(866) 444-EBSA (3272)
www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

[* For more information about limitations and exceptions, see the plan or policy document Call 1-888-277-1057 or visit us at www.aetna.com.]

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

## Does this plan meet the 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 1-888-277-1057 [

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-277-1057

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-888-277-1057

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-277-1057

*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 | $1750 |
| Specialist | 20% |
| Hospital (facility) | 20% |
| Other | 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 | $12,731 |

In this example, Peg would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $1750 |
| Copayments | $0 |
| Coinsurance | $1250 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| The total Peg would pay is | $3,060 |

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

| | |
|---|---|
| The plan's overall deductible | $1750 |
| Specialist | 20% |
| Hospital | 20% |
| Other | 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 | $7,399 |

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $1750 |
| Copayments | $0 |
| Coinsurance | $1437 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| The total Joe would pay is | $3,242 |

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

| | |
|---|---|
| The plan's overall deductible | $1750 |
| Specialist | 20% |
| Hospital (facility) | 20% |
| Other | 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 | $1,925 |

In this example, Mia would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $1750 |
| Copayments | $0 |
| Coinsurance | $77 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $1,827 |

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