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 1-888-982-3862. 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 1-888-982-3862 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>In-Network: EE Only $2,000; EE+ Family $4,000. Out-of-Network: EE Only $4,000; EE+ Family $8,000.</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. In-network preventive care is covered before you meet your deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a></td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>In-Network: EE Only $4,000; EE+ Family: Individual $4,000/ Family $8,000. Out-of-Network: EE Only NONE; EE+ Family: Individual NONE/ Family NONE.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges &amp; health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-888-982-3862 for a list of In-network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
</table>
| If you visit a health care provider’s office or clinic | Primary care visit to treat an injury or illness
Specialist visit
Preventive care /screening /immunization | 10% coinsurance
10% coinsurance | 50% coinsurance
50% coinsurance | None
None | 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)
Imaging (CT/PET scans, MRIs) | 10% coinsurance
10% coinsurance | 50% coinsurance
50% coinsurance | None
None |
| If you need drugs to treat your illness or condition | Generic drugs
Preferred brand drugs
Non-preferred brand drugs
Specialty drugs | 10% coinsurance
10% coinsurance
10% coinsurance | 50% coinsurance (retail)
50% coinsurance (retail)
50% coinsurance (retail)
Applicable cost as noted above for generic or brand drugs | Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring step therapy for coverage. Maintenance drugs-no refill restrictions or penalties apply. Members save with lower copays at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy. Deductible doesn't apply to certain preventive medications
Emergency First prescription fill at a retail pharmacy. Subsequent fills must be through CVS Specialty Pharmacy Only. Precertification required for coverage. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center)
Physician/surgeon fees
Emergency room care | 10% coinsurance
10% coinsurance
10% coinsurance | 50% coinsurance
50% coinsurance | None
None | Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use. |

**More information about prescription drug coverage** is available at [www.aetna.com/pharmacy-insurance/individuals-families](http://www.aetna.com/pharmacy-insurance/individuals-families).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency medical transportation 10% coinsurance 10% coinsurance</td>
<td></td>
<td>Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.</td>
</tr>
<tr>
<td></td>
<td>Urgent care 10% coinsurance 50% coinsurance</td>
<td></td>
<td>No coverage for non-urgent use.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room) 10% coinsurance 50% coinsurance</td>
<td></td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees 10% coinsurance 50% coinsurance</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services Office &amp; other outpatient services: 10% coinsurance</td>
<td></td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services 10% coinsurance 50% coinsurance</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits No charge 50% coinsurance</td>
<td></td>
<td>Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Pre-authorization required for out-of-network care may apply.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services 10% coinsurance 50% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services 10% coinsurance 50% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care 10% coinsurance 50% coinsurance</td>
<td>130 visits/calendar year. Pre-authorization required for out-of-network care.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services 10% coinsurance 50% coinsurance</td>
<td>60 visits/calendar year for Physical, Occupational &amp; Speech Therapy combined.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services 10% coinsurance 50% coinsurance</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care 10% coinsurance 50% coinsurance</td>
<td>90 days/calendar year. Pre-authorization required for out-of-network care.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment 10% coinsurance 50% coinsurance</td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. Pre-authorization required for out-of-network care.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice services 10% coinsurance 50% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Children's glasses Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>
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.
- Private-duty nursing
- Routine eye care (Adult & Child)
- 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.)

- Acupuncture - 12 visits/calendar year for disease, injury & chronic pain.
- Bariatric surgery - $10,000 maximum/lifetime.
- Chiropractic care - 10 visits/calendar year.
- Hearing aids - $3,000 maximum per ear/36 months.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.

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 1-888-982-3862.
- 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 1-888-982-3862. 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:

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? No.
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: $2,000
- Specialist coinsurance: 10%
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

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:*

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

*What isn’t covered*

- Limits or exclusions: $70

*The total Peg would pay is*: $3,070

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

- The plan’s overall deductible: $2,000
- Specialist coinsurance: 10%
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

This EXAMPLE event includes services like:

- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Diabetic supplies (glucose meter)

**Total Example Cost**: $5,600

*In this example, Joe would pay:*

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

*What isn’t covered*

- Limits or exclusions: $4,300

*The total Joe would pay is*: $5,400

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

- The plan’s overall deductible: $2,000
- Specialist coinsurance: 10%
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

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:*

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$80</td>
</tr>
</tbody>
</table>

*What isn’t covered*

- Limits or exclusions: $10

*The total Mia would pay is*: $2,090

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 1-888-982-3862.

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).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).
TTY: 711

**Language Assistance:**

To access language services at no cost to you, call 1-888-982-3862.

**Albanian**

Për shërbime përkthimi falas për ju, telefononi 1-888-982-3862.

**Amharic**

የቋንቋ ከአገልግሎችን ያለክፍያ ባለማግኝት፣ በ1-888-982-3862 ያደውሉ፡፡

**Arabic**

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 1-888-982-3862.

**Armenian**

Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-888-982-3862 հեռախոսահամարով:

**Bahasa Indonesia**

Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.

**Bantu-Kirundi**

Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-888-982-3862.

**Bengali**

আপনাকে বিনামূেকে ভাষা পবিেবষা পপকে হেে এই নম্ববে পপিেে হেে 1-888-982-3861.

**Bisayan**

Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-888-982-3862.

**Burmese**

သင္ အေနျဖင့္ ေအေၾကးအ့ငင အေပးရပဲ ဘာသာစကား၀န္အ့ဆာငမႈေ ား ရရ  ွိႏ့ ့ ငရန္ 1-888-982-3862 သ  ႕ ဖ န့့္ေၚဆ ့ ပါ။

**Catalan**

Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-888-982-3862.

**Chamorro**

Para un hago' i setbision lengguáhi ni dibátde para hågu, ågang 1-888-982-3862.

**Cherokee**

ᏩᎩᏍᏗ ᏚᏬᏂ᎝Ꮧ ᎤᏳᎾᏓᏛᏗᏗ ᝢᎪᎱᏍᏗ ᏗᏣᎬᏩᏳᏛᏗᏗ ᱄Ꭹ, ᏫᎨ᎝᎝ᏗᏗ 1-888-982-3862.

**Chinese**

如欲使用免費語言服務，請致電 1-888-982-3862.

**Choctaw**

Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-888-982-3862.

**Cushite**

Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-888-982-3862.

**Dutch**

Voor gratis toegang tot taaldiensten, bell 1-888-982-3862.

**French**

Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862.

**French Creole**

Pou jwenn sèvis lang gratis, rele 1-888-982-3862.

**German**

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an.

**Greek**

Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-982-3862.

**Gujarati**

સમારોહી જાતના ભારતીય ભાષાની સેવાઓની પહોંચ માટે, કોલ કરો 1-888-982-3862.
No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-888-982-3862. Kāki ʻole ia kēia kōkua nei.
Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਬਿਸੇ ਮਿੰਝ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਲਈ, 1-888-982-3862 'ਤੇ ਕੋਲ ਕਰੋ।
Romanian - Pentru a accesa gratuit serviciile de limbă, apelați 1-888-982-3862.
Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862.
Samoan - Mo le mauina o auauanga tau gagana e aunoa ma se toto, vala'au le 1-888-982-3862.
Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-888-982-3862.
Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862.
Sudanic-Fulfude - Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-888-982-3862.
Swahili - Kupata huduma za lugha bila malipo kwako, piga 1-888-982-3862.
Syriac - ܠܫܘܬ ܥܼܲܠ ܚܸܠܡܼܲܬ ̈ ܐܕܗܼܲܝܼܲܪܬ ܐܒܠܸܫ ܢ ܐܡܓ ܢ ܐܝܼܬ ، ܩܪܝܼܡ ܘܲܢ ܐܸܢ ܣܢܝܼܩ ܐ ܝ̄ ܬܘܼܲܢ 1-888-982-3862
Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862.
Telugu - మీరు భాష సేవలను ఉచితంగా అందుకు దుకు, 1-888-982-3862 కు కాల్ చేయండి.
Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-888-982-3862.
Tongan - Kapau ‘oku ke fiema’u ta’etötöngi ‘a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-888-982-3862.
Trukese - Ren omw kopwe angei aninisin eman chon awewe (ese kamo), kopwe kori 1-888-982-3862.
Turkish - Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-888-982-3862 numarayı arayın.
Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, здзвоніть за номером 1-888-982-3862.
Urdu - بالقیمت زیان سے متعلقہ خدمات حاصل کرنے کے لئے ، 382-982-1-888 پر بات کریں.
Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862.
Yiddish - צא צו צויטר טיש פראך באנדיוונג און קיי פריז או יא, זא איר, רופע 1-888-982-3862.
Yoruba - Lati wonú awọn isẹ èdè l’ọfẹ fun ọ, pe 1-888-982-3862.