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, call Aetna at 1-855-695-3416. 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 1-855-695-3416 to request a copy. If there is a conflict between the SBC and the plan document, the plan document determines the benefits.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 single / $1,000 family in-network. $1,500 single / $3,000 family out-of-network.	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 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.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,000 single / $6,000 family in-network. $6,000 single / $12,000 family out-of-network.	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, 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 or call 1-855-695-3416 for a list of participating 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		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 copayment	30% Coinsurance After Deductible	Chiropractic care maximum of 20 visits; Walk in Retail Health Clinics have $10 Copay in-network and 30% Coinsurance After Deductible out-of-network; Tele-Health Services have $10 Copay in-network and N/A out-of-network
	Specialist visit	$40 copayment	30% Coinsurance After Deductible	None
	Preventive care/screening/ immunization	No charge	30% Coinsurance After Deductible	None
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance After Deductible	30% Coinsurance After Deductible	None
	Imaging (CT/PET scans, MRIs)	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Preauthorization is required or a $300 penalty applies
If you need drugs to help manage or treat your illness or condition More information about **prescription drug coverage** is available at **http://www.caremark.com** or 844–232–2329	Generic drugs	Retail: $12 copayment Mail: $30 copayment	Reimbursement is based on network-negotiated price of medication. You pay the full amount in excess of network price.	Retail and Specialty Pharmacy: Up to 30-day supply. Mail Order or CVS Pharmacy Prescription Drugs: Up to 90-day supply. Maintenance drugs: After three retail fills, you will need to fill a 90-day supply through CVS Caremark mail order, or at a CVS retail pharmacy; otherwise you will pay the full negotiated price of the prescription. Prescription drugs are not subject to the deductible
	Preferred brand drugs	Retail: $50 copayment Mail: $125 copayment		
	Non-preferred brand drugs	Retail: $75 copayment Mail: $185 copayment		
	Specialty drugs	Same as Retail copayment for Generic and Brand drugs above		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Preauthorization is required or a $300 penalty applies
	Physician/surgeon fees	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Preauthorization is required or a $300 penalty applies
If you need immediate medical attention	Emergency room care	$100 copayment, then 10% Coinsurance After Deductible	$100 copayment, then 10% Coinsurance After Deductible	$100 copayment waived if admitted as inpatient within 24 hours.
	Emergency medical	10% Coinsurance After	10% Coinsurance After	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)	
	transportation	Deductible	Deductible	
	Urgent care	$50 copayment	30% Coinsurance After Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Preauthorization is required or a $300 penalty applies
	Physician/surgeon fees	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Preauthorization is required or a $300 penalty applies
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copayment	30% Coinsurance After Deductible	None
	Inpatient services	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Preauthorization is required or a $300 penalty applies
If you are pregnant	Office visits	100% coverage for pre-natal care, then 10% Coinsurance After Deductible for post-natal care.	30% Coinsurance After Deductible	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance, copayment or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Preauthorization is required for childbirth/delivery or a $300 penalty applies.
	Childbirth/delivery professional services	10% Coinsurance After Deductible	30% Coinsurance After Deductible	
	Childbirth/delivery facility services	10% Coinsurance After Deductible	30% Coinsurance After Deductible	

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 help recovering or have other special health needs	Home health care	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Up to 120 visits per calendar year. Preauthorization is required or a $300 penalty applies
	Rehabilitation services	$20 copayment per visit	30% Coinsurance After Deductible	Covered as medically necessary; 60 visit annual limit for occupation and physical therapy combined; 25 annual visit limit for speech therapy
	Habilitation services	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Subject to carrier guidelines
	Skilled nursing care	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Up to 100 days per calendar year. Preauthorization is required or a $300 penalty applies
	Durable medical equipment	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Preauthorization is required or a $300 penalty applies
	Hospice services	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Preauthorization is required or a $300 penalty may apply
If your child needs dental or eye care	Children's eye exam	No charge	30% Coinsurance After Deductible	Routine eye exam is a covered benefit if performed by a licensed Ophthalmologist.
	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.)

- Children's eye glasses and dental check-ups
- Cosmetic surgery - unless clinically eligible
- Dental care (Child and Adult) - unless due to treatment related to accidental injury within 12 months of an accident
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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
- Bariatric surgery
- Chiropractic care – up to 20 visits per calendar year
- Habilitation Services, subject to carrier guidelines
- Hearing Aids, up to $1,000 lifetime
- Infertility treatment, up to $5,000 lifetime maximum ($2,500 for medical services and $2,500 for prescriptions)
- Private-duty nursing (if medically necessary)
- Routine eye care (Adult)

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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: Aetna at 1-855-695-3416 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**
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 888-772-6372.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-772-6372.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 888-772-6372.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 888-772-6372.

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	$500
Specialist copayment	$40
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$40
Coinsurance	$1,226
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,826**

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

The plan's overall deductible	$500
Specialist copayment	$40
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
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$1,173
Coinsurance	$136
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,864**

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

The plan's overall deductible	$500
Specialist copayment	$40
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$300
Coinsurance	$82
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$882**

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