## Important Questions

| What is the overall deductible? | For each calendar year, 
Network: Individual $800 / Family $1,600. Out-of-Network: Individual $1,600 / Family $3,200. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. |
| Are there services covered before you meet your deductible? | Yes. Preventive care is 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? | There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| What is the out-of-pocket limit for this plan? | Network: Individual $5,500 / Family $11,000. Out-of-Network: Individual $11,000 / Family $22,000. | 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, health care this plan doesn’t cover & penalties for failure to obtain pre-authorization for services. | 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/docfind or call 1-800-370-4526 for a list of network 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.

<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><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>Designated Network Provider (You will pay the least)</td>
<td>Includes Internist, General Physician, Family Practitioner or Pediatrician.</td>
</tr>
<tr>
<td></td>
<td>$25 copay/visit</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$50 copay/visit</td>
<td>40% coinsurance</td>
<td>Coverage is limited to 26 visits for Chiropractic care and 20 visits for acupuncture per calendar year</td>
</tr>
<tr>
<td></td>
<td>Preventive care / screening / immunization</td>
<td>No charge, except hearing exams not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>$50 copay/visit</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Designated Network Provider (You will pay the least)</td>
<td>Non-Designated Network Provider (You will pay more)</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Tier 1 drugs</td>
<td>Tier 1 drugs (most generics and potentially some cost-effective branded medications)</td>
<td>$6 copay/30 days</td>
<td>$6 copay/30 days; $14 copay/90 days mail order</td>
</tr>
<tr>
<td>Tier 2 drugs</td>
<td>Tier 2 drugs (most brand name drugs and most costly or less desirable generics)</td>
<td>After deductible, 20% coinsurance with $150 max/30 days</td>
<td>After deductible, 20% coinsurance with $34 min/$150 max 30 days, 15% coinsurance with $75 min/$375 max 90 days mail order</td>
</tr>
<tr>
<td>Tier 3 drugs</td>
<td>Tier 3 drugs (non-preferred brand drugs and more costly or less desirable generics)</td>
<td>After deductible, 20% coinsurance with $225 maximum/RX 30 days</td>
<td>After deductible, 20% coinsurance with $68 min/$225 max 30 days, 15% coinsurance with $150 min/$475 max 90 days mail order</td>
</tr>
<tr>
<td>Specialty drugs: Tier 1, Tier 2, Tier 3</td>
<td>Specialty drugs: Tier 1, Tier 2, Tier 3</td>
<td>1: 20% coinsurance to $100 max; 2: 20% coinsurance with $150 max; 3: 20% coinsurance with $200 max</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

*If you need drugs to treat your illness or condition*

Prescription drug coverage is administered by OptumRx.


Covers up to 30-day supply; 90-day supply (mail order prescription) from OptumRx Home Delivery only. No Charge for formulary generic FDA-approved women’s contraceptives in-network. Your cost will be higher for choosing Brand over Generic.
<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 have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery)</td>
<td>Designated Network Provider (You will pay the least) 20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Out-of-Network Provider (You will pay the most) 40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td></td>
<td>No coverage for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td></td>
<td>No coverage for non-emergency transport.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</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)</td>
<td>Designated Network Provider (You will pay the least) 20% coinsurance</td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Out-of-Network Provider (You will pay the most) 40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Designated Network Provider (You will pay the least) Office: $25 copay/visit; Other outpatient services: 20% coinsurance</td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>Out-of-Network Provider (You will pay the most) Office &amp; other outpatient services: 40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>Designated Network Provider (You will pay the least) No charge for routine services</td>
<td>Cost sharing doesn’t apply to certain preventive services. Maternity care may include tests &amp; services described elsewhere in the SBC (i.e. ultrasound). Pre-authorization for out-of-network care may apply.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>Out-of-Network Provider (You will pay the most) 40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>Designated Network Provider (You will pay the least) 20% coinsurance</td>
<td>90 visits/calendar year. Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Out-of-Network Provider (You will pay the most) 40% coinsurance</td>
<td>Limited to 40 visits/calendar year for Physical and Occupational Therapy combined, 40 visits/calendar year for Speech Therapy.</td>
</tr>
</tbody>
</table>

- **Facility fee (e.g., ambulatory surgery)**:
  - 20% coinsurance in Designated Network Provider
  - 40% coinsurance in Out-of-Network Provider
- **Physician/surgeon fees**:
  - 20% coinsurance in Designated Network Provider
  - 40% coinsurance in Out-of-Network Provider
- **Emergency room care**:
  - 25% coinsurance in Designated Network Provider
  - 25% coinsurance in Out-of-Network Provider
  - No coverage for non-emergency use.
- **Emergency medical transportation**:
  - 20% coinsurance in Designated Network Provider
  - 20% coinsurance in Out-of-Network Provider
  - No coverage for non-emergency transport.
- **Urgent care**:
  - 20% coinsurance in Designated Network Provider
  - 20% coinsurance in Out-of-Network Provider
  - No coverage for non-urgent use.
- **Outpatient services**:
  - Office: $25 copay/visit
  - Other outpatient services: 20% coinsurance
  - Office & other outpatient services: 40% coinsurance
- **Inpatient services**:
  - 20% coinsurance in Designated Network Provider
  - 40% coinsurance in Out-of-Network Provider
- **Search visits**:
  - No charge for routine services
  - 40% coinsurance in Out-of-Network Provider
- **Childbirth/delivery professional services**:
  - 20% coinsurance in Designated Network Provider
  - 40% coinsurance in Out-of-Network Provider
- **Childbirth/delivery facility services**:
  - 20% coinsurance in Designated Network Provider
  - 40% coinsurance in Out-of-Network Provider
- **Home health care**:
  - 20% coinsurance in Designated Network Provider
  - 40% coinsurance in Out-of-Network Provider
- **Rehabilitation services**:
  - $40 copay/visit in Designated Network Provider
  - 40% coinsurance in Out-of-Network Provider

**Important Note:**
- Pre-authorization required for certain services.
- Maternity care may include tests & services described elsewhere in the SBC (i.e., ultrasound).
- Cost sharing doesn’t apply to certain preventive services.
### Common Medical Event Services You May Need

| Skilled nursing care          | 20% coinsurance | 40% coinsurance | Coverage limited to 180 days/calendar year. Pre-authorization required for out-of-network care. |
| Durable medical equipment     | 20% coinsurance | 40% coinsurance | Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. |
| Hospice services              | 20% coinsurance | 40% coinsurance | Pre-authorization required for out-of-network care. |

### If your child needs dental or eye care

| Children's eye exam           | Not applicable | Not covered | Not covered |
| Children's glasses            | Not applicable | Not covered | Not covered |
| Children's dental check-up    | Not applicable | Not covered | Not covered |

### 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 (Adult & Child)
- Hearing aids
- 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 – Except for required preventive services.

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

- Acupuncture – 20 visits/calendar year
- Bariatric surgery
- Chiropractic care – 26 visits/calendar year
- Infertility treatment – Limited to the diagnosis & treatment of underlying medical condition.
- Artificial insemination, ovulation induction & advanced reproductive technology: $15,000 maximum/lifetime.
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 1-800-370-4526.
- 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 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 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 directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- 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 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: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

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 Minimum Value Standard? 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.

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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 $800
- Specialist copayment $50
- Hospital (facility) coinsurance 20%
- Other coinsurance 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 $12,800

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>$12,800</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td>$800</td>
</tr>
<tr>
<td>Copayments</td>
<td>$74</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,001</td>
</tr>
</tbody>
</table>

What isn’t covered
Limits or exclusions $60
The total Peg would pay is $2,935

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

- The plan's overall deductible $800
- Specialist copayment $50
- Hospital (facility) coinsurance 20%
- Other coinsurance 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 $7,400

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>$7,400</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td>$900</td>
</tr>
<tr>
<td>Copayments</td>
<td>$426</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,089</td>
</tr>
</tbody>
</table>

What isn’t covered
Limits or exclusions $55
The total Peg would pay is $2,470

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

- The plan's overall deductible $800
- Specialist copayment $50
- Hospital (facility) coinsurance 20%
- Other coinsurance 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 $1,900

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>$1,900</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td>$800</td>
</tr>
<tr>
<td>Copayments</td>
<td>$280</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$311</td>
</tr>
</tbody>
</table>

What isn’t covered
Limits or exclusions $0
The total Peg would pay is $1,391

Note: If your plan has a wellness program and you choose to participate, you may be able to reduce your costs.

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