This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.aetna.com** or by calling **1-855-695-3416.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$2,000 single /$4,000 family **in-network.** $6,000 single /$12,000 family **out-of-network.**	See the chart starting on page 2 for yours costs for services this **plan** covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. $6,250 single / $12,500 family **in-network.** $12,500 single / $25,000 family **out-of-network.**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. The **out-of-pocket limit** includes the **deductible**.
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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.aetna.com or call 1-855-695-3416** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.aetna.com** or call 1-855-695-3416 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% **Co-Insurance** After **Deductible**	40% **Co-Insurance** After **Deductible**	None
	Specialist visit	20% **Co-Insurance** After **Deductible**	40% **Co-Insurance** After **Deductible**	None
	Other practitioner office visit	20% **Co-Insurance** After **Deductible**	40% **Co-Insurance** After **Deductible**	Chiropratic care maximum of 20 visits
	Preventive care/screening/ Immunization	No charge	40% **Co-Insurance** After **Deductible**	None
If you have a test	Diagnostic test (x-ray, blood work)	20% **Co-Insurance** After **Deductible**	40% **Co-Insurance** After **Deductible**	None
	Imaging (CT/PET scans, MRIs)	20% **Co-Insurance** After **Deductible**	40% **Co-Insurance** After **Deductible**	**Preauthorization** is required

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or you may call 855-599-1385.	Generic drugs	Retail: 25% **Co-Insurance** (minimum $4, maximum $20). Mail: 25% **Co-Insurance** (minimum $10, maximum $50)	**Out-of-network** pharmacy claims are reimbursed based on what the plan would have paid if the prescriptions were purchased **in-network**; at the contracted rate less applicable **copayments**.	Retail: Up to 30-day supply; Mail Order: Up to 90-day supply. Certain preventative drugs are not subject to the **deductible.**
	Preferred brand drugs	Retail: 25% **Co-Insurance** (minimum $25, maximum $60). Mail: 25% **Co-Insurance** (minimum $60, maximum $150)	**Out-of-network** pharmacy claims are reimbursed based on what the plan would have paid if the prescriptions were purchased **in-network**; at the contracted rate less applicable **copayments**.	Retail: Up to 30-day supply; Mail Order: Up to 90-day supply. Certain preventative drugs are not subject to the **deductible.** Amounts you pay because you purchased a brand-name drug when a generic drug was available will not count toward this **out-of-pocket maximum**
	Non-preferred brand drugs	Retail: 25% **Co-Insurance** (minimum $40, maximum $90). Mail: 25% **Co-Insurance** (minimum $100, maximum $225)	**Out-of-network** pharmacy claims are reimbursed based on what the plan would have paid if the prescriptions were purchased **in-network**; at the contracted rate less applicable **copayments**.	Retail: Up to 30-day supply; Mail Order: Up to 90-day supply. Certain preventive drugs are not subject to the **deductible.** Amounts you pay because you purchased a brand-name drug when a generic drug was available will not count toward this **out-of-pocket maximum**

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Specialty drugs	Same as Retail **Co-Insurance** for Generic and Brand drugs above	Same as Retail **Co-Insurance** for Generic and Brand drugs above	Up to 30-day supply; through CVS Caremark Specialty Pharmacies only
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% **Co-Insurance** After **Deductible**	40% **Co-Insurance** After **Deductible**	None
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services	20% **Co-Insurance** After **Deductible**	20% **Co-Insurance** After **Deductible**	None
	Emergency medical transportation	20% **Co-Insurance** After **Deductible**	20% **Co-Insurance** After **Deductible**	None
	Urgent care	20% **Co-Insurance** After **Deductible**	40% **Co-Insurance** After **Deductible**	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% **Co-Insurance** After **Deductible**	40% **Co-Insurance** After **Deductible**	**Preauthorization** is required
	Physician/surgeon fee	20% **Co-Insurance** After **Deductible**	40% **Co-Insurance** After **Deductible**	**Preauthorization** is required

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% **Co-Insurance** After **Deductible**	40% **Co-Insurance** After **Deductible**	**Preauthorization** may be required for some outpatient services
	Mental/Behavioral health inpatient services	20% **Co-Insurance** After **Deductible**	40% **Co-Insurance** After **Deductible**	**Preauthorization** is required
	Substance abuse disorder outpatient services	20% **Co-Insurance** After **Deductible**	40% **Co-Insurance** After **Deductible**	**Preauthorization** may be required for some outpatient services
	Substance abuse disorder inpatient services	20% **Co-Insurance** After **Deductible**	40% **Co-Insurance** After **Deductible**	**Preauthorization** is required
If you are pregnant	Prenatal and postnatal care	20% **Co-Insurance** After **Deductible**	40% **Co-Insurance** After **Deductible**	**Preauthorization** is required
	Delivery and all inpatient services	20% **Co-Insurance** After **Deductible**	40% **Co-Insurance** After **Deductible**	**Preauthorization** is required

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% **Co-Insurance** After **Deductible**	40% **Co-Insurance** After **Deductible**	Up to 120 days per calendar year. **Preauthorization** is required
	Rehabilitation services	20% **Co-Insurance** After **Deductible**	40% **Co-Insurance** After **Deductible**	'Covered as medically necessary; Up to 60 days per calendar year
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	20% **Co-Insurance** After **Deductible**	40% **Co-Insurance** After **Deductible**	Up to 100 days per calendar year. **Preauthorization** is required
	Durable medical equipment	20% **Co-Insurance** After **Deductible**	40% **Co-Insurance** After **Deductible**	**Preauthorization** is required
	Hospice service	20% **Co-Insurance** After **Deductible**	40% **Co-Insurance** After **Deductible**	None
If your child needs dental or eye care	Eye Exam	Covered at 100%	40% **Co-Insurance** After **Deductible**	Services must be performed by an Ophthalmologist
	Glasses	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for 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
- Habilitation Services
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture – up to 20 visits per calendar year
- Hearing aids - $1,000 minimum lifetime benefit
- Chiropractic care - up to 20 visits per calendar year
- Bariatric surgery - covered **in-network** only; **preauthorization** is required
- Routine eye care- services performed by an Ophthalmologist

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium,** which may be significantly higher than the **premium** you pay while covered under this **plan.** Other limitations on your rights to continue coverage may apply. For more information on your rights to continue coverage, contact the plan at 1-855-695-3416. 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.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your **plan**, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Aetna Member Services at 1-855-695-3416.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,330
- **Patient pays** $3,210

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Copays	$0
Coinsurance	$1,060
Limits or exclusions	$150
Total	**$3,210**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,570
- **Patient pays** $2,830

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,000
Copays	$0
Coinsurance	$750
Limits or exclusions	$80
Total	**$2,830**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Language Access Services:

- Spanish (Español): Para obtener asistencia en Español, llame al 1-888-471-2271.
- Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-471-2271.
- Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-471-2271.
- Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-471-2271.