### Important Questions | Answers | Why This Matters:

| **What is the overall deductible?** | Individual $500 / Family $1,500. | 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 & prescription drugs 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?** | Individual $2,500 / Family $4,500. | 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?** | Not applicable. | This plan does not use a provider network. You can receive covered services from any provider. |
| **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>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Specialist visit</td>
<td>10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>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.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Copay/prescription, deductible doesn't apply: $10 (retail), $20 (mail order)</td>
<td>Pharmacy benefits are provided by CVS/Caremark, please check separate summaries for benefit details</td>
</tr>
</tbody>
</table>

**Prescription drug coverage is administered by CVS Caremark 1-844-345-2824**

More information about **prescription drug coverage** is available at www.caremark.com
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
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</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Preferred brand drugs</td>
<td>Copay/prescription, deductible doesn’t apply: $25 (retail), $50 (mail order)</td>
<td>Pharmacy benefits are provided by CVS/Caremark, please check separate summaries for benefit details</td>
</tr>
<tr>
<td>Prescription drug coverage is administered by CVS Caremark 1-844-345-2824</td>
<td>Non-preferred brand drugs</td>
<td>Copay/prescription, deductible doesn’t apply: $40 (retail), $80 (mail order)</td>
<td>Pharmacy benefits are provided by CVS/Caremark, please check separate summaries for benefit details</td>
</tr>
</tbody>
</table>

More information about prescription drug coverage is available at www.caremark.com
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<th>What You Will Pay</th>
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</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Specialty drugs</td>
<td>Applicable cost as noted for generic or brand drugs</td>
<td>1 grace retail for a 30-day supply of specialty medicines at any network pharmacy. (Ongoing specialty fills must be dispensed through CVS Specialty Pharmacy and/or may be picked up at a CVS Pharmacy.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Copay/prescription, deductible doesn't not apply:</strong></td>
<td>Some specialty medications may qualify for third-party copayment assistance programs that could lower your out-of-pocket costs for those products. For any such specialty medication where third-party copayment assistance is used, the member shall not receive credit toward their maximum out-of-pocket or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate.</td>
</tr>
<tr>
<td>Prescription drug coverage is administered by CVS Caremark 1-844-345-2824</td>
<td></td>
<td>$10 (Generic), $20 (Preferred), $40 (Non-Preferred)</td>
<td></td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.caremark.com">www.caremark.com</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>10% coinsurance</td>
<td>50% coinsurance for non-emergency use.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>Non-emergency transport: not covered, except if pre-authorized.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Urgent care</td>
<td>10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>Penalty of $400 for failure to obtain pre-authorization.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office &amp; other outpatient services: 10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>Penalty of $400 for failure to obtain pre-authorization.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</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.) Penalty of $400 for failure to obtain pre-authorization may apply.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</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.) Penalty of $400 for failure to obtain pre-authorization may apply.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</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.) Penalty of $400 for failure to obtain pre-authorization may apply.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>120 visits/calendar year. Penalty of $400 for failure to obtain pre-authorization.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Rehabilitation services</td>
<td>10% coinsurance</td>
<td>60 visits/calendar year for Physical, Occupational &amp; Speech Therapy.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Habilitation services</td>
<td>10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>-------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>60 days/calendar year. Penalty of $400 for failure to obtain pre-authorization.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Hospice services</td>
<td>10% coinsurance</td>
<td>Penalty of $400 for failure to obtain pre-authorization.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's dental check-up</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.
- 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.):**
<table>
<thead>
<tr>
<th>Service</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>25 visits/calendar year.</td>
</tr>
<tr>
<td>Bariatric surgery</td>
<td>1 surgery/lifetime.</td>
</tr>
<tr>
<td>Chiropractic care</td>
<td>25 visits/calendar year.</td>
</tr>
<tr>
<td>Hearing aids</td>
<td>$5,000 maximum per ear/calendar year.</td>
</tr>
<tr>
<td>Infertility treatment</td>
<td>Limited to the diagnosis &amp; treatment of underlying medical condition.</td>
</tr>
<tr>
<td>Private-duty nursing</td>
<td>180 visits/calendar year.</td>
</tr>
</tbody>
</table>

**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/ebwa/healthreform](http://www.dol.gov/ebwa/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](http://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](http://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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number 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/ebwa/healthreform](http://www.dol.gov/ebwa/healthreform).
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- 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](http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html).

**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?** 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.

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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s Type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
</tbody>
</table>

- **Peg is Having a Baby**
  - The plan’s overall deductible: $500
  - 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:
  - Deductibles: $500
  - Copayments: $10
  - Coinsurance: $1,100
  - **What isn't covered**
    - Limits or exclusions: $60
  - **The total Peg would pay is**: $1,670

- **Managing Joe’s Type 2 Diabetes**
  - The plan’s overall deductible: $500
  - 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
  - Durable medical equipment (glucose meter)

  Total Example Cost: $5,600

  In this example, Joe would pay:
  - Deductibles: $500
  - Copayments: $700
  - Coinsurance: $60
  - **What isn't covered**
    - Limits or exclusions: $20
  - **The total Joe would pay is**: $1,280

- **Mia’s Simple Fracture**
  - The plan’s overall deductible: $500
  - 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:
  - Deductibles: $500
  - Copayments: $10
  - Coinsurance: $200
  - **What isn't covered**
    - Limits or exclusions: $0
  - **The total Mia would pay is**: $710

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 866-393-0002.

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, or disability.

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 subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.
Language Assistance:
For language assistance in your language call 1-888-982-3862 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.
Amharic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862
Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով:
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-888-982-3862 ku busa
Bengali-Bangala - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
Burmese -                         1-888-982-3862
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.
Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gåstu.
Cherokee - Θωθόνος ԭᎣᏭᏫᏲᏱ ᏇᎲᏩᏬᏬᏲ (ᏭᏲ) ᏭᎦᏫᎵᏰᏬ 1-888-982-3862 ᏭᏫᏬ ᏬᏩᏬᏭ ᏲᏫᏬᏲ ମମର.
Chinese - 欲取得繁體中文語言協助，請撥打 1-888-982-3862，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-888-982-3862.
Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkoʃa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.
French - Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.
French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χοίρος.
Gujarati - 1888-982-3862
Proprietary

Hindi - हिन्दी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।
Hmong - Yog xav tau kev txhais lus Hmoob hu dawb tau rau 1-888-982-3862.
Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwughị ụgwọ ọ bula
Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.
Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.
Japanese - 日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。
Karen - 1-888-982-3862
Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.
Kru-Bassa - Be'm ke gbọ-kpá-kpá díyì díyì de Básọ-o-wuqún wɛɛ, ɗá 1-888-982-3862
Kurdish - 1-888-982-3862
Laotian - 1-888-982-3862
Marathi - 1-888-982-3862
Marshallese - Nan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejełok wōnān.
Micronesian - Pohnpeyan - Ohng palien sawas en soum kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.
Mon-Khmer, Cambodian - 1-888-982-3862
Navajo - T'áá shi shizaad k'ehjí bee shiká a'dowol ninízingo Diné k'ehjí kōji' t'áá jiį'eh' höle' 1-888-982-3862
Nepali - (दक्षिणी नेपाल) 1-888-982-3862
Norwegian - For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
Panjabi - 1-888-982-3862
Persian - برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تاسیس بگیرید. انگلیسی
Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.
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