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: Individual $200 / Family $400.</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 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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Emergency care, office visits, prescription drugs &amp; preventive care are 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: Individual $2,200 / Family $4,400.</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 a network specialist for covered services 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>What You Will Pay In-Network Provider (You will pay the least)</th>
<th>What You Will Pay Out-of-Network Provider (You will pay the most)</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>$15 <strong>copay</strong>/visit, <strong>deductible</strong> doesn't apply</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$15 <strong>copay</strong>/visit, <strong>deductible</strong> doesn't apply</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>Not covered</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>No charge for laboratory; $15 <strong>copay</strong>/visit for x-ray, <strong>deductible</strong> doesn't apply</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$15 <strong>copay</strong>/visit, <strong>deductible</strong> doesn't apply</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td><strong>Copay</strong>/prescription, <strong>deductible</strong> doesn't apply: $10 (retail), $20 (mail order)</td>
<td>Not covered</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</td>
<td>Preferred brand drugs</td>
<td><strong>Copay</strong>/prescription, <strong>deductible</strong> doesn't apply: $25 (retail), $50 (mail order)</td>
<td>Not covered</td>
<td></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>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>-------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>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>Not covered</td>
<td>1 grace retail for a 30-day supply of specialty medicines (ongoing specialty fills must be dispensed through CVS Specialty Pharmacy and/or may be picked up at a CVS Pharmacy) 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></td>
<td>Specialty drugs</td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.aetna.com/pharmacy-insurance/individuals-families">www.aetna.com/pharmacy-insurance/individuals-families</a></td>
<td></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>0% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$75 copay/visit, deductible doesn't apply</td>
<td>$75 copay/visit, deductible doesn't apply</td>
<td>No coverage for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>0% coinsurance</td>
<td>0% coinsurance</td>
<td>Non-emergency transport: not covered, except if pre-authorized.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 copay/visit, deductible doesn't apply</td>
<td>Not covered</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>0% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<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: $15 copay/visit, deductible doesn't apply; &amp; other outpatient services: no charge</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</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.)</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$15 copay/visit, deductible doesn't apply</td>
<td>Not covered</td>
<td>60 visits/calendar year for Physical, Occupational &amp; Speech Therapy.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$15 copay/visit, deductible doesn't apply</td>
<td>Not covered</td>
<td>Unlimited visits for Physical, Occupational &amp; Speech Therapy for Autism and Developmental Delay.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>60 days/calendar year.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>None</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>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>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.
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 - 25 visits/calendar year.
Bariatric surgery - 1 surgery/lifetime.
Chiropractic care - 25 visits/calendar year.
Hearing aids - $5,000 maximum/calendar year.
Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
Private-duty nursing - 180 visits/calendar year. Limitations may exist - please refer to your plan documents.

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 https://www.dol.gov/agencies/ebsa
- 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 1-888-982-3862.
- 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 https://www.dol.gov/agencies/ebsa
- 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 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.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan’s overall deductible: $200
- Specialist copayment: $15
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$200</td>
<td>$80</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered:
- Limits or exclusions: $60

The total Peg would pay is: $340

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

- The plan’s overall deductible: $200
- Specialist copayment: $15
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

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:

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

What isn’t covered:
- Limits or exclusions: $20

The total Joe would pay is: $1,120

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

- The plan’s overall deductible: $200
- Specialist copayment: $15
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$200</td>
<td>$200</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered:
- Limits or exclusions: $0

The total Mia would pay is: $400

Note: These numbers assume the patient does not participate in the plan’s wellness program. If you participate in the plan’s wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-888-982-3862.

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 discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides 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: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705),
Email: CRCordinator@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 (Aetna).
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 - እንግወ ትግስትምህን ወግህግጥምህ (ሁምትህ) ያወጣ ከ 1-888-982-3862 የህግ ትምህ፤
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862.
Armenian - Անզանցում է գործադիր լեզու (հայերեն) որը 1-888-982-3862 անցեք հեռախոսից:
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kiri iyi numero 1-888-982-3862 ku busa
Bengali-Bangali - বাংলা এর সাহায্য নিতে যদি চান, তখন নম্বর 1-888-982-3862 কে কেল্পে নিন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
Burmese - သာသနာအတွေ့အမှန် ဖြစ်စေရန် 1-888-982-3862-က အသုံးပြုပါ။
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 gaštu.
Cherokee - ᎠᏂᏍᎩᏯ ᎯᏬᏂᎯᏍᏗ ᏗᏬᏂᏍᏗᎵᏍᏗ ᎡᎻᎢ (ᏣᎳᎩ) ᒪᏣᎳᎩᏗіᏳ 1-888-982-3862 ᎯᏬᎵ Ꭲ ᏣᏣᎳᏗ ᏕᏪᏗ.
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 lakkokkofoa 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 χρέωση.
Gujarati - હેરોડોલલરને અલગી હોય ત્યામાં તમી કોઈ રીતેના બદલ ને પણ 1-888-982-3862 નિર્દિશ કરી શકીએ.
Za jezičnu pomoć na hrvatskom jeziku pozovite besplatni broj 1-888-982-3862.

Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862.

Fii yo on hebal e ko yowitii e haala Pular noddee e oo numero doo 1-888-982-3862. Njodi woo fawaaki on.

Ukhibitaji usaidizi katika lugha ya Kiswahili pigia simu kwa 1-888-982-3862 bila malipo.

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.

Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-888-982-3862 ‘o ‘ikai hā ʻōtongi.

Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkiéri 1-888-982-3862 nge esapw kamé ngonuk.

(Dil) çağrısı dil yardım için. Hiçbir ücret ödeden 1-888-982-3862.

Щоб отримати допомогу перекладача української мови, затегелефонуйте за безкоштовним номером 1-888-982-3862.

Do được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí denn số 1-888-982-3862.

Fún iránlwọ nipa èdé (Yorùbá) pe 1-888-982-3862 lái san owó kankan rará.