### Important Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>In-Network: EE Only $2,000; EE+ Family $6,000. Out-of-Network: EE Only $2,000; EE+ Family $6,000.</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 policy, the overall family deductible must be met before the plan begins to pay.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. In-network preventive care is 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><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>In-Network: EE Only $4,500; EE+ Family $6,750. Out-of-Network: EE Only $6,750; EE+ Family $10,125.</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, the overall family out–of–pocket limit must be met.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billing charges, health care this plan doesn’t cover &amp; penalties for failure to obtain pre-authorization for services.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></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><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the specialist you choose 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>In-Network Provider (You will pay the least)</th>
<th>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>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>40% coinsurance, except routine physicals &amp; immunizations not covered</td>
<td>None</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>After deductible, copay/prescription: $10 (retail), $20 (mail order)</td>
<td>After deductible, copay/prescription: $10 (retail)</td>
<td>Covers up to 90 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs &amp; devices obtainable from a pharmacy, oral &amp; injectable fertility drugs 30% copayment limited to $2,000 maximum benefit per individual per lifetime. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written. Deductible waived for preventive medications.</td>
</tr>
<tr>
<td>Prescription drug coverage is administered by OptumRx</td>
<td>Preferred brand drugs</td>
<td>After deductible, copay/prescription: $35 (retail), $70 (mail order)</td>
<td>After deductible, copay/prescription: $35 (retail)</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>After deductible, copay/prescription: $60 (retail), $120 (mail order)</td>
<td>After deductible, copay/prescription: $60 (retail)</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>After deductible, copay/prescription: $60 (retail)</td>
<td>After deductible, copay/prescription: $60 (retail)</td>
<td>None</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance for out-of-network non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>No coverage for non-emergency transport.</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></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Penalty of $200 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Outpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Penalty of $200 for failure to obtain pre-authorization for out-of-network care may apply.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Office visits</td>
<td>No charge</td>
<td>40% 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 $200 for failure to obtain pre-authorization for out-of-network care may apply.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></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>
<tr>
<td></td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>100 visits/calendar year. Penalty of $200 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Coverage is limited to 39 visits per calendar year for Occupational &amp; Speech Therapy combined, 39 visits per calendar year for Physical Therapy.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>90 days/calendar year. Penalty of $200 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>40% coinsurance</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>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Penalty of $200 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Habilitation services
- Long-term care
- Private-duty nursing
- Routine eye care (Adult & Child)
- 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.
- Chiropractic care – 20 visits/calendar year.
- Hearing aids – Coverage is limited to 1 hearing aid to maximum of $1,000 per lifetime.
- Infertility treatment – Coverage is limited to the diagnosis & treatment of underlying medical condition, artificial insemination & ovulation induction.
- Non-emergency care when traveling outside of the U.S.

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 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 1-888-982-3862.
- 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 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.

-------------------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: $2,000
- Specialist coinsurance: 20%
- 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

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,100</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions: $100

**The total Peg would pay is**: $4,200

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

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

- The plan's overall deductible: $2,000
- Specialist coinsurance: 20%
- 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

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,200</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions: $6,000

**The total Joe would pay is**: $7,200

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

- The plan's overall deductible: $2,000
- Specialist coinsurance: 20%
- 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

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,900</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions: $0

**The total Mia would pay is**: $1,900

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: 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 (Aetna).
No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ‘ole ‘ia kēia kōkua nei.

Hindi -

हिन्दी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।

Hmong -

Maka enyemaka asusû na Igbo kpọọ 1-888-982-3862 na akwughì ìgwọ o bula

Ibo -

Para iti tulong ti pagsaaso iti pagsaaso 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 -

 häkkukochhêbâ koa hjéli tpâghâ 1-888-982-3862 ngâk châxâhêbâ koa hâkkêbâ koa hjéli tpâghâ

Korean -

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.

Kru-Bassa -

'Be m’ké gbo-kpá-kpá dyé pidyi dé Basso-o-wuđū iñ weè, qá 1-888-982-3862

Kurdish -

1-888-982-3862

Laotian -

1-888-982-3862

Marathi -

तीलभाषा (मराठी) सहायता पाऊनका लागि 1-888-982-3862 क्रमांकावरकोण×याहीखचार्िशवायकॉलकरा.

Marshallese -

Ñan bôk jîpañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wônân.

Micronesian-Pohnpeyan -

Ohng palien sawas en souw kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.

Mon-Khmer, Cambodian -

1-888-982-3862

Navajo -

T'áá shí shíāad k'ehjí see shiká a'doowol nínízingo Diné k'ehjí koji' t’áá ji'k' e hólne' 1-888-982-3862

Nepali -

(लेपाली) मा नि: शुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस्।

Nilotic-Dinka -

Tën kuunny ë thok ë Thuornjàŋ col 1-888-982-3862 kecín ayóc.

Norwegian -

For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.

Panjabi -

ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਲਈ 1-888-982-3862 ਦੇ ਫਾਂ ਅਫ਼ਲ ਵਰਤੋਂ ਵਲੇ।

Pennsylvania Dutch -

Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.

Persian -

برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه آی تماس بگیرید. انگلیسی

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.