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, [insert contact information]. 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 here.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: Individual $2,600 / Family $5,200. Out–of–Network: Individual $5,000 / Family $10,000. Does not apply to preventive care in-network.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. This plan's deductible year starts July 1. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services 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, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	In-Network: Individual $6,350 / Family $12,700. Out–of–Network: Individual $12,700 / Family 25,400.	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-billed charges, penalties for failure to obtain pre-authorization for services and health care this plan does not cover.	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. For a list of in-network providers, see www.aetna.com or call 1-800-589-4811.	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 permission from this plan.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance.	50% coinsurance.	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	30% coinsurance.	50% coinsurance.	None.
	Preventive care/screening/ immunization	30% coinsurance.	50% coinsurance.	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance.	50% coinsurance.	None.
	Imaging (CT/PET scans, MRIs)	30% coinsurance.	50% coinsurance.	None.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://info.cvscaremark.com	Generic drugs	Retail: after deductible: $10 copay/ prescription. Mail Order: $20 copay/ prescription.	Retail: after deductible: $10 copay/ prescription. Mail Order: Not covered.	Covers up to a 30 day supply (retail prescription), 90 day supply (mail order prescription). Includes contraceptive drugs and devices obtainable from a pharmacy, injectable fertility drugs. No charge for formulary generic FDA-approved women's contraceptives in-network. Precertification required. Step therapy required. Your cost will be higher for choosing Brand over Generics. You must use CVS Caremark Home Delivery Pharmacy for mail order drugs or a CVS Caremark Pharmacy for the 90-day mail order fill at retail.
	Preferred brand drugs	Retail: after deductible: 30% coinsurance up to a $200 max/prescription. Mail Order: 30% coinsurance up to a $200 max/ prescription.	Retail: after deductible: 30% coinsurance up to a $200 max/ prescription. Mail Order: Not Covered.	
	Non-preferred brand drugs	Retail: after deductible: 50% coinsurance up to a $400 max/ prescription. Mail Order: 50% coinsurance up to a $400 max/ prescription.	Retail: after deductible: 50% coinsurance up to a $400 max/ prescription. Mail Order: Not Covered.	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs.	Not Covered.	Requires exclusive use of CVS Caremark Specialty Pharmacy for filling specialty drugs up to a 1-month supply.

* For more information about limitations and exceptions, contact Aetna at 1-800-589-4811.

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance.	50% coinsurance	None.
	Physician/surgeon fees	30% coinsurance.	50% coinsurance	None.
If you need immediate medical attention	Emergency room care	30% coinsurance.	30% coinsurance.	50% coinsurance for non-emergency use.
	Emergency medical transportation	30% coinsurance.	30% coinsurance	50% coinsurance for non-emergency transport out-of-network.
	Urgent care	30% coinsurance.	50% coinsurance.	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance.	50% coinsurance.	Pre-authorization required for out-of-network care.
	Physician/surgeon fees	30% coinsurance.	50% coinsurance.	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance.	50% coinsurance.	None.
	Inpatient services	30% coinsurance.	50% coinsurance.	Pre-authorization required for out-of-network care.
If you are pregnant	Office visits	30% coinsurance.	50% coinsurance.	No charge for in-network preventive prenatal care.
	Childbirth/delivery professional services	30% coinsurance.	50% coinsurance.	Includes outpatient postnatal care.
	Childbirth/delivery facility services	30% coinsurance.	50% coinsurance.	Pre-authorization may be required for out-of-network care.
If you need help recovering or have other special health needs	Home health care	30% coinsurance.	50% coinsurance.	Coverage is limited to 60 visits in-network and 30 visits out-of-network per plan year. Pre-authorization required for out-of-network care.
	Rehabilitation services	30% coinsurance.	50% coinsurance.	Coverage is limited to 30 visits per plan year for Physical, Occupational, and Speech Therapy.
	Habilitation services	30% coinsurance.	50% coinsurance.	Coverage is limited to 30 visits per plan year for Autism Physical, Occupational & Speech Therapy, combined with rehabilitation services.
	Skilled nursing care	30% coinsurance.	50% coinsurance.	Pre-authorization required for out-of-network care.
	Durable medical equipment	30% coinsurance.	50% coinsurance.	None
	Hospice services	30% coinsurance.	50% coinsurance.	Pre-authorization required for out-of-network care.

* For more information about limitations and exceptions, contact Aetna at 1-800-589-4811.

If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	Not covered.
	Children's glasses	Not covered.	Not covered.	Not covered.
	Children's dental check-up	Not covered.	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.)

- Acupuncture
- Cosmetic Surgery
- Dental care (Adult & Child)
- Long-term care
- Non-emergency care when traveling outside U.S.
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs
- Glasses

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

- Bariatric surgery
- Chiropractic Care
- Hearing Aids
- Infertility treatment – coverage is limited to the diagnoses and treatment of underlying medical condition, artificial insemination & ovulation induction and advanced reproductive therapy limited to $15,000 medical lifetime max and $5,000 prescription lifetime max.
- Private-duty nursing – coverage is unlimited shifts per plan year

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: Your state insurance department at 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. 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 1-800-589-4811.

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 the 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-598-4811

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, contact Aetna at 1-800-589-4811.

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	$2,600
Specialist	30%
Hospital (facility)	30%
Other	30%

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:

Cost Sharing	
Deductibles	$2,600
Copayments	$0
Coinsurance	$3,060
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$5,660

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

The plan's overall deductible	$2,600
Specialist	30%
Hospital (facility)	30%
Other	30%

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:

Cost Sharing	
Deductibles	$2,600
Copayments	$0
Coinsurance	$1,440
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$4,040

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

The plan's overall deductible	$2,600
Specialist	30%
Hospital (facility)	30%
Other	30%

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	$3,000

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,600
Copayments	$0
Coinsurance	$120
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,720

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