

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, call 1-800-974-2873 or see www.aetna.com. 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 www.dol.gov/ebsa/healthreform or call 1-800-974-2873 to request a copy.

Why This Matters:	Answers	Important Questions
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.	In-Network providers: \$500/individual or \$1,250/family Out-of-Network providers: \$1,500/individual or \$3,750/family	What is the overall 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/	Yes. Preventive care, In-Network office visits, diagnostic tests, imaging, urgent care, home health care, outpatient hospice, outpatient skilled nursing care and rehabilitation services, and obesity treatment are covered before you meet your deductible.	Are there services covered before you meet your deductible?
You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.	Yes. \$100/individual for prescription drugs. There are no other specific deductibles.	Are there other deductibles for specific services?
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.	In-Network providers: \$5,350/individual or \$10,700/family Prescription drugs (In-Network): \$1,000/individual or \$2,000/family	What is the out-of-pocket limit for this plan?
Even though you pay these expenses, they don't count toward the out-of-pocket limit.	Premiums, balance-billing charges, penalties for failure to obtain pre-authorization for service and health care this Plan does not cover.	What is not included in the out-of-pocket limit?
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.	Yes. See www.aetna.com or call 1-800-370-4526 for a list of In-Network providers.	Will you pay less if you use a network provider?
This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.	No.	Do you need a referral to see a specialist?



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)	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	\$50 copay/visit. Deductible does not apply.	\$50 copay/visit, then 50% coinsurance	None.	None.
	Specialist visit	\$50 copay/visit. Deductible does not apply.	\$65 copay/visit, then 50% coinsurance	None.	None.
	Other practitioner office visit	Acupuncture and chiropractic care: \$50 copay/visit. Deductible does not apply.	Acupuncture and chiropractic care: \$50 copay/visit, then 50% coinsurance	Acupuncture limited to 20 visits per calendar year.	Age and frequency limits apply. 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.
	Preventive care/screening/immunization	No charge. Deductible does not apply.	50% coinsurance		
	Diagnostic test (x-ray, blood work)	No charge. Deductible does not apply.	50% coinsurance	None.	None.
If you have a test	Imaging (CT/PET scans, MRIs)	\$50 copay. Deductible does not apply.	50% coinsurance	None.	None.
	Generic drugs	Retail (30 days): \$5 copay/script Mail Order (90 days): \$10 copay/script	Not covered	Not covered	ACA preventive medications, including certain over the counter drugs with a prescription, are available at no charge. No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate). Coverage for certain prescription drugs and related supplies requires your physician to obtain authorization prior to prescribing. Prior authorization may include, for example, a step therapy determination. * See the Prescription drug section of the SPD.
	Preferred brand drugs	Not covered	Not covered	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Specialty drugs	Not covered	Not covered	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at www.aetna.com or call 1-800-974-2873.

Common Medical Event	Services You May Need		What You Will Pay		Limitations, Exceptions, & Other Important Information
	Facility fee (e.g., ambulatory surgery center)	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)		
If you have outpatient surgery	Physician/surgeon fees	30% coinsurance	50% coinsurance	50% coinsurance	Failure to pre-certify Out-of-Network services will result in a 50% reduction of benefits.
	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	50% coinsurance	
If you need immediate medical attention	Physician/surgeon fees	30% coinsurance	30% coinsurance	30% coinsurance	Copay waived if admitted to the hospital. Professional/physician charges may be billed separately. Non-emergency use of Out-of-Network emergency room subject to deductible.
	Emergency room care	\$200 copay/visit, then 30% coinsurance	\$200 copay/visit, then 30% coinsurance	\$50 copay/visit	
	Emergency medical transportation	30% coinsurance	30% coinsurance	30% coinsurance	
	Urgent care	\$50 copay/visit. Deductible does not apply.	\$50 copay/visit	None.	
If you have a hospital stay	Physician/surgeon fees	30% coinsurance	30% coinsurance	50% coinsurance	Failure to pre-certify Out-of-Network services will result in a 50% reduction of benefits.
	Facility fee (e.g., hospital room)	\$500 copay/per admission, then 30% coinsurance	\$500 copay/per admission, then 50% coinsurance	50% coinsurance	

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)	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, or substance abuse services	Outpatient services	Office visit: \$50 copay/visit, Deductible does not apply; Other outpatient services: 30% coinsurance	Office visit: \$50 copay/visit, then 50% coinsurance Other outpatient services: 50% coinsurance	Failure to pre-certify Out-of-Network intensive outpatient and partial hospitalization services will result in a 50% reduction of benefits.	Failure to pre-certify Out-of-Network services will result in a 50% reduction of benefits.
	Inpatient services	\$500 copay/per admission, then 30% coinsurance	\$500 copay/per admission, then 50% coinsurance		
If you are pregnant	Office visits	No charge. Deductible does not apply.	50% coinsurance	None. Cost sharing does not apply for In-Network preventive services. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). Depending on the type of services, a copayment, coinsurance, or deductible may apply.	
	Childbirth/delivery professional services	30% coinsurance	\$500 copay/visit, then 50% coinsurance	Pre-certification required for Out-of-Network stays that last longer than 48 hours for vaginal delivery or 96 hours for delivery by Cesarean section. Failure to pre-certify extended Out-of-Network stays will result in a 50% reduction of benefits.	
	Childbirth/delivery facility services	\$500 copay/per admission, then 30% coinsurance	\$500 copay/per admission, then 50% coinsurance		

* For more information about limitations and exceptions, see the plan or policy document at www.aetna.com or call 1-800-974-2873.

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 need help recovering or have other special health needs	Home health care	\$50 copay/visit, then 25% coinsurance. Deductible does not apply.	\$50 copay/visit, then 25% coinsurance	Limited to 120 visits per calendar year. Failure to pre-certify Out-of-Network services will result in a 50% reduction of benefits.	
	Rehabilitation services	Outpatient: \$50 copay/visit. Deductible does not apply.	Outpatient: \$50 copay/visit, then 50% coinsurance	Occupational, physical and speech therapies combined limited to 60 visits per calendar year.	
	Habilitation services	Not covered	Not covered	You must pay 100% of these expenses, even In-Network.	
	Skilled nursing care	Inpatient: 30% coinsurance per admission; Outpatient: \$50 copay/visit, then 25% coinsurance. Deductible does not apply.	Inpatient: 50% coinsurance per admission; Outpatient: \$50 copay/visit, then 25% coinsurance	Limited to 60 days per calendar year. Failure to pre-certify Out-of-Network services will result in a 50% reduction of benefits.	
		Durable medical equipment	30% coinsurance	Not covered	None.
	Hospice services	Inpatient: 30% coinsurance Outpatient: \$50 copay/visit, then 25% coinsurance. Deductible does not apply.	Inpatient: 50% coinsurance Outpatient: \$50 copay/visit, then 25% coinsurance after deductible	Failure to pre-certify Out-of-Network services will result in a 50% reduction of benefits.	
		Children's eye exam	Not covered	Not covered	You must pay 100% of these expenses, even In-Network
		Children's glasses	Not covered	Not covered	You must pay 100% of these expenses, even In-Network
If your child needs dental or eye care	Children's dental check-up	Not covered	Not covered	You must pay 100% of these expenses, even In-Network	

Excluded Services & Other Covered Services:

<p>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</p>	
<ul style="list-style-type: none"> • Cosmetic surgery • Hearing aids • Routine eye care (Adult) • Routine foot care • Routine loss programs (except as required by the Affordable Care Act) 	<ul style="list-style-type: none"> • Habilitation services) • Eye exam and Glasses (Adult & Child) • Dental Care (Adult & Child) • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing
<p>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)</p>	
<ul style="list-style-type: none"> • Acupuncture (limited to 20 visits/calendar year) • Bariatric surgery • Infertility treatment 	<ul style="list-style-type: none"> • Chiropractic care

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: the Department of Labor's Employee Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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, this notice or assistance, contact: Aetna at 1-800-974-2873. You may also look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide 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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 1-800-974-2873.

-----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, see the plan or policy document at www.aetna.com or call 1-800-974-2873.



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)

<ul style="list-style-type: none"> ■ The plan's overall deductible ■ Specialist Co-payment ■ Hospital (facility) coinsurance ■ Other coinsurance 	<p>This EXAMPLE event includes services like:</p> <ul style="list-style-type: none"> Specialist office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood work) Specialist visit (anesthesia) 	<p>Total Example Cost</p> <p>\$12,800</p>
	<p>In this example, Peg would pay:</p> <p><i>Cost Sharing</i></p> <p>Deductibles \$540</p> <p>Copayments \$550</p> <p>Coinsurance \$2,880</p> <p>Limits or exclusions \$60</p> <p>The total Peg would pay is \$4,030</p>	

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

<ul style="list-style-type: none"> ■ The plan's overall deductible ■ Specialist Co-payment ■ Hospital (facility) coinsurance ■ Other coinsurance 	<p>This EXAMPLE event includes services like:</p> <ul style="list-style-type: none"> Primary care physician office visits (including disease education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose meter) 	<p>Total Example Cost</p> <p>\$7,400</p>
	<p>In this example, Joe would pay:</p> <p><i>Cost Sharing</i></p> <p>Deductibles \$170</p> <p>Copayments \$1,360</p> <p>Coinsurance \$0</p> <p>Limits or exclusions \$30</p> <p>The total Joe would pay is \$1,500</p>	

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

<ul style="list-style-type: none"> ■ The plan's overall deductible ■ Specialist Co-payment ■ Hospital (facility) coinsurance ■ Other coinsurance 	<p>This EXAMPLE event includes services like:</p> <ul style="list-style-type: none"> Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy) 	<p>Total Example Cost</p> <p>\$1,900</p>
	<p>In this example, Mia would pay:</p> <p><i>Cost Sharing</i></p> <p>Deductibles \$0</p> <p>Copayments \$560</p> <p>Coinsurance \$340</p> <p>Limits or exclusions \$0</p> <p>The total Mia would pay is \$900</p>	

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