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 1-800-238-3488. 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/sbcglossary or call 1-800-238-3488 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $1,800 individual / $3,600 family; for out-of-network providers $3,600 individual / $7,200 family	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.
Are there services covered before you meet your deductible?	Yes. Preventive care is 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?	For network providers $4,000 individual / $8,000 family; for out-of-network providers $8,000 individual / $16,000 family	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and penalties for failure to obtain pre-authorization for services and health care this plan doesn't 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. See www.aetna.com or call 1-800-238-3488 for a list of network providers.	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.
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.

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	20% coinsurance	40% coinsurance	——————None——————
	Specialist visit	20% coinsurance	40% coinsurance	——————None——————
	Preventive care/screening/ immunization	No charge, deductible waived	40% coinsurance	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for outpatient diagnostic lab deductible waived	40% coinsurance	In-network: 20% coinsurance for X-ray and inpatient diagnostic testing.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	——————None——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	20% coinsurance (retail) with $10 minimum, $20 copay (mail order)	100% of the retail cost (retail), not covered (mail order)	Coverage is limited to a 30-day supply (retail) and 90-day supply (mail order). Out-of-Network retail claims may be submitted for reimbursement. Your plan uses a preferred drug list which identifies the status of covered drugs. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered. You pay the difference in cost if you request a brand name drug instead of its generic equivalent. After a prescription is filled 2 times at retail, you are responsible for the entire cost, with no out–of–pocket limit.
	Preferred brand drugs	20% coinsurance (retail) with $30 minimum, $60 copay (mail order)	100% of the retail cost (retail), not covered (mail order)	
	Non-preferred brand drugs	20% coinsurance (retail) with $60 minimum, $120 copay (mail order)	100% of the retail cost (retail), not covered (mail order)	
	Specialty drugs	Your cost varies based on generic, preferred brand, or non-preferred brand.	100% of the retail cost (retail), not covered (mail order)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	——————None——————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	——————None——————
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Non-emergency use not covered.
	Emergency medical transportation	20% coinsurance	40% coinsurance	——————None——————

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)	
	Urgent care	20% coinsurance	20% coinsurance	Non-urgent use not covered.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required for out-of-network care. Benefits will be reduced by $300 if preauthorization is not obtained.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	——————None——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	——————None——————
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization required for out-of-network care. Benefits will be reduced by $300 if preauthorization is not obtained.
If you are pregnant	Office visits	Prenatal: No charge Postnatal: 20% coinsurance	40% coinsurance	20% coinsurance will apply to initial OBGYN pregnancy test visit. Additional prenatal visits will be covered at 100%.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	——————None——————
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	——————None——————
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Coverage is limited to 60 visits. Preauthorization required for out-of-network care. Benefits will be reduced by $300 if preauthorization is not obtained.
	Rehabilitation services	20% coinsurance	40% coinsurance	Coverage is limited to 60 visits. Preauthorization required for out-of-network care. Benefits will be reduced by $300 if preauthorization is not obtained.
	Habilitation services	Not covered	Not covered	—————— None ————————
	Skilled nursing care	20% coinsurance	40% coinsurance	Coverage is limited to 120 days per calendar year. Preauthorization required for out-of-network care. Benefits will be reduced by $300 if preauthorization is not obtained.
	Durable medical equipment	20% coinsurance	40% coinsurance	Exclude vehicle modifications, home modifications, exercise, and bathroom

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)	
				equipment
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization required for out-of-network care. Benefits will be reduced by $300 if preauthorization is not obtained.
If your child needs dental or eye care	Children's eye exam	No charge	40% coinsurance	Coverage is limited to 1 routine vision exam every 24 consecutive months.
	Children's glasses	Not covered	Not covered	——————None——————
	Children's dental check-up	Not covered	Not covered	——————None——————

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 (Adult)
- Hearing aids
- Long-term Care
- Non-emergency care when traveling outside the US
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Private-duty nursing
- Routine eye care (Adult)
- Mammograms

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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance 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 at 1-800-233-6697, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file an appeal. Contact information is at http://www.aetna.com/individuals-families-health-insurance/member-guidelines/complaints-grievances-appeals.html or at the Connecticut Office of the Healthcare Advocate P.O. Box 1543 Hartford, CT 06144 (866)

466-4446 www.ct.gov/oha healthcare.advocate@ct.gov. *For grievances and appeals regarding your drug coverage, call the number on the back of your prescription benefit card or visit www.express-scripts.com.

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 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 **1-800-238-3488**.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-238-3488**.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码**1-800-238-3488**.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-800-238-3488**.]

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	$1,800
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$0
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,760**

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

The plan's overall deductible	$1,800
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$0
Coinsurance	$700
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,520**

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

The plan's overall deductible	$1,800
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

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