




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 <a href="#">deductible</a> ?                                | For <a href="#">network providers</a> \$1,800 individual / \$3,600 family;<br>for <a href="#">out-of-network providers</a> \$3,600 individual / \$7,200 family  | Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> is covered before you meet your <a href="#">deductible</a> .   | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .   |
| Are there other <a href="#">deductibles</a> for specific services?              | No.   | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For <a href="#">network providers</a> \$4,000 individual / \$8,000 family;<br>for <a href="#">out-of-network providers</a> \$8,000 individual / \$16,000 family | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met.   |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | 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 <a href="#">out-of-pocket limit</a> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.aetna.com">www.aetna.com</a> or call 1-800-238-3488 for a list of <a href="#">network providers</a> .                              | This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.   | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .  |

 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<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) |   |
| If you visit a health care <a href="#">provider's</a> office or clinic   | Primary care visit to treat an injury or illness       | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>                    | —————None—————  |
|  | <a href="#">Specialist</a> visit                       | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>                    | —————None—————  |
|  | <a href="#">Preventive care/screening/immunization</a> | No charge, <a href="#">deductible</a> waived   | 40% <a href="#">coinsurance</a>                    | Age and frequency schedules may apply.  |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | No charge for outpatient diagnostic lab<br><a href="#">deductible</a> waived         | 40% <a href="#">coinsurance</a>                    | In-network: 20% coinsurance for X-ray and inpatient diagnostic testing.   |
|  | Imaging (CT/PET scans, MRIs)                           | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>                    | —————None—————  |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.health.aetna.com">www.health.aetna.com</a> | Generic drugs  | 20% <a href="#">coinsurance</a> (retail) with \$10 minimum, \$20 copay (mail order)  | Not covered (retail),<br>Not covered (mail order)  | Coverage is limited to a 30-day supply (retail) and 90-day supply (mail order). Filling your prescription using an Out-of-Network provider is not covered by the plan and you will be responsible for the full cost of the medication. Your <a href="#">plan</a> uses a preferred drug list which identifies the status of covered drugs. Some drugs may require <a href="#">preauthorization</a> . If the necessary <a href="#">preauthorization</a> 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 <a href="#">out-of-pocket limit</a> . |
|  | Preferred brand drugs                                  | 20% <a href="#">coinsurance</a> (retail) with \$30 minimum, \$60 copay (mail order)  | Not covered (retail),<br>Not covered (mail order)  |   |
|  | Non-preferred brand drugs                              | 20% <a href="#">coinsurance</a> (retail) with \$60 minimum, \$120 copay (mail order) | Not covered (retail),<br>Not covered (mail order)  |   |
|  | <a href="#">Specialty drugs</a>                        | Your cost varies based on generic, preferred brand, or non-preferred brand.          | Not covered (retail),<br>Not covered (mail order)  |   |
| If you have outpatient surgery   | Facility fee (e.g., ambulatory surgery center)         | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>                    | —————None—————  |
|  | Physician/surgeon fees                                 | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>                    | —————None—————  |
| If you need immediate medical attention  | <a href="#">Emergency room care</a>                    | 20% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>                    | Non-emergency use not covered.  |
|  | <a href="#">Emergency medical transportation</a>       | 20% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>                    | —————None—————  |
|  | <a href="#">Urgent care</a>                            | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>                    | Non-urgent use not covered.   |

| Common Medical Event  | Services You May Need                     | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information   |
|---|---|---|--|--|
|   |   | Network Provider<br>(You will pay the least)                      | Out-of-Network Provider<br>(You will pay the most) |  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)        | 20% <a href="#">coinsurance</a>                                   | 40% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> required for out-of-network care. Benefits will be reduced by \$300 if <a href="#">preauthorization</a> is not obtained.  |
|   | Physician/surgeon fees                    | 20% <a href="#">coinsurance</a>                                   | 40% <a href="#">coinsurance</a>                    | —————None—————   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | 20% <a href="#">coinsurance</a>                                   | 40% <a href="#">coinsurance</a>                    | —————None—————   |
|   | Inpatient services                        | 20% <a href="#">coinsurance</a>                                   | 40% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> required for out-of-network care. Benefits will be reduced by \$300 if <a href="#">preauthorization</a> is not obtained.  |
| If you are pregnant   | Office visits                             | Prenatal: No charge<br>Postnatal: 20% <a href="#">coinsurance</a> | 40% <a href="#">coinsurance</a>                    | 20% <a href="#">coinsurance</a> will apply to initial OBGYN pregnancy test visit. Additional prenatal visits will be covered at 100%.  |
|   | Childbirth/delivery professional services | 20% <a href="#">coinsurance</a>                                   | 40% <a href="#">coinsurance</a>                    | —————None—————   |
|   | Childbirth/delivery facility services     | 20% <a href="#">coinsurance</a>                                   | 40% <a href="#">coinsurance</a>                    | —————None—————   |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | 20% <a href="#">coinsurance</a>                                   | 40% <a href="#">coinsurance</a>                    | Coverage is limited to 60 visits. <a href="#">Preauthorization</a> required for out-of-network care. Benefits will be reduced by \$300 if <a href="#">preauthorization</a> is not obtained.                                    |
|   | <a href="#">Rehabilitation services</a>   | 20% <a href="#">coinsurance</a>                                   | 40% <a href="#">coinsurance</a>                    | 90 visits/calendar year for Physical, Occupational & Speech Therapy. <a href="#">Preauthorization</a> required for out-of-network care. Benefits will be reduced by \$300 if <a href="#">preauthorization</a> is not obtained. |
|   | <a href="#">Habilitation services</a>     | Not covered   | Not covered  | —————None—————   |
|   | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a>                                   | 40% <a href="#">coinsurance</a>                    | Coverage is limited to 120 days per calendar year. <a href="#">Preauthorization</a> required for out-of-network care. Benefits will be reduced by \$300 if <a href="#">preauthorization</a> is not obtained.                   |
|   | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a>                                   | 40% <a href="#">coinsurance</a>                    | Exclude vehicle modifications, home modifications, exercise, and bathroom equipment  |

| Common Medical Event                   | Services You May Need            | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information  |
|--|----------------------------------|--|--|---|
|  |                                  | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |   |
|  | <a href="#">Hospice services</a> | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> required for out-of-network care. Benefits will be reduced by \$300 if <a href="#">preauthorization</a> is not obtained. |
| If your child needs dental or eye care | Children's eye exam              | No charge                                    | 40% <a href="#">coinsurance</a>                    | 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](#).)**

- Cosmetic surgery
- Dental (Adult)
- 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
- Acupuncture
- Infertility treatment (covered through WINFertility)
- Private-duty nursing
- Hearing aids
- 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](http://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](http://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](http://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](mailto: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](http://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): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' **1-800-238-3488**.]

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

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,800 |
| ■ <a href="#">Specialist coinsurance</a>                        | 20%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,800        |
| Copayments                        | \$0            |
| Coinsurance                       | \$1,900        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,760</b> |

### Managing Joe's type 2 Diabetes

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

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,800 |
| ■ <a href="#">Specialist coinsurance</a>                        | 20%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,800        |
| Copayments                        | \$0            |
| Coinsurance                       | \$700          |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$2,520</b> |

### Mia's Simple Fracture

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

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,800 |
| ■ <a href="#">Specialist coinsurance</a>                        | 20%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,800        |
| Copayments                        | \$0            |
| Coinsurance                       | \$200          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,000</b> |