**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, contact the plan administrator. 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.HealthReformPlanSBC.com or call 1-888-982-3862 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **Individual / Family** by Network:<br>Home Host In-network: $**0** / $**0**<br>Regional In-network: **$0** / **$0**<br>Out-of-network: **$750** / **$1,500** | You must pay all costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). 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?** | Services subject to copays are covered prior to the deductible. | |
| **Are there other deductibles for specific services?** | **No.** | 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. |
| **What is the out-of-pocket limit for this plan?** | **Individual / Family** by Network:<br>Home Host In-network: **None**<br>Regional In-network:**$1,500** / **$3,000**<br>Out-of-network: **$5,000** / **$10,000** | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. **A combined out-of-pocket limit of $6,850 individual/$13,700 family applies for your 2019 cost sharing across in-network medical and Rx coverage.** |
| **What is not included in the out-of-pocket limit?** | Premiums, deductibles, copayments, balance-billed charges, penalties for failure to obtain pre-authorization, and care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. However, for the combined out-of-pocket limit, in-network deductibles, in-network copays and any Rx copays or coinsurance are counted, in accordance with the Affordable Care Act. |
| **Will you pay less if you use a network provider?** | Yes. For a list of in-network and designated **providers**, see www.Aetna.com or call 1-888-982-3862. | If you use an in-network doctor, designated specialist or other health care **provider**, this plan will pay some or all costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. |
| **Do you need a referral to see a specialist?** | No. | You can see the **specialist** you choose without permission from this plan. |

All 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 |
|---|---|---|---|---|---|
| | | Primary/Home Host Designated Provider (You will pay the least) | Regional In-Network Provider | 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 | $10 copay per visit | $15 copay per visit | 30% coinsurance | Teladoc® is also available 24/7 at a $15 copay per visit. |
| | Specialist visit | $10 copay per visit | $30 copay per visit | 30% coinsurance | Specialist visits include speech therapy, physical therapy, occupational therapy, and spinal therapy, but at the home host network, no charges apply. |
| | Preventive care/screening/ Immunization | No charge | No charge | 30% coinsurance for those services covered (subject to Limitations & Exceptions) | Out-Of-Network limited to $100 per calendar year for routine Adult physical exam. No coverage for Out-Of-Network screenings other than mammogram. Certain other Women's Health Services only covered In-network. Age and frequency schedules apply. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge | $15 copay per procedure | 30% coinsurance | If procedure provided at physician's office as part of visit, no additional copays. |
| | Imaging (CT/PET scans, MRIs) | No charge | 10% coinsurance | 30% coinsurance | If procedure provided at physician's office as part of visit, no additional copays. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.aetna.com/pharmacy-insurance/individuals-families | Generic drugs | Retail: $5 copay per script<br>Mail Order: $0 copay per script | | Not Covered | Retail scripts filled up to 30 day supply; by Mail order up to 90 days. **Your plan has an annual out-of-pocket maximum of $1,500 per person / $3,000 per family**.<br>If you request brand-name when a generic is available, you pay the copay plus the price difference between generic and brand. After 3 fills of maintenance drugs at retail, you are required to fill a 90-day supply at Aetna Rx Home Delivery or a CVS pharmacy, or pay 50% coinsurance. This applies to women's contraceptives too. |
| | Brand drugs | Retail: 20% coinsurance ($7 min per script)<br>Mail Order: 15% ($7 min per script) | | Not Covered | |
| | Specialty drugs | Retail: 20% coinsurance ($7 min)<br>Mail Order: 15% coinsurance ($7 min) | | Not Covered | |
| | Women's Contraceptives (following U.S. Preventive Services Task Force) | Generic: No charge<br>Brand Retail: 20% coinsurance ($7 min)<br>Brand Mail Order: 15% ($7 min) | | Not Covered | |

[* For more information about limitations and exceptions, contact the plan administrator for a copy of the Summary Plan Description.]

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Primary/Home Host Designated Provider (You will pay the least) | Regional In-Network Provider | Out-of-Network Provider (You will pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge | 10% coinsurance | 30% coinsurance | The members cost sharing applies to all covered benefits incurred during the outpatient visit. |
| | Physician/surgeon fees | No charge | 10% coinsurance | 30% coinsurance | The members cost sharing applies to all covered benefits incurred during the outpatient visit. |
| **If you need immediate medical attention** | Emergency room care | $25 copay per visit | $100 copay per visit | $100 copay per visit | Non-emergency use applies 30% coinsurance. |
| | Emergency medical transportation | No charge | No charge | No charge | ———— None ———— |
| | Urgent care | $10 copay per visit | $40 copay per visit | 30% coinsurance | ———— None ———— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge | 10% coinsurance | 30% coinsurance | Pre-authorization is required for out-of-network care. Benefits will be reduced by $200 if pre-authorization is not obtained. |
| | Physician/surgeon fees | No charge | 10% coinsurance | 30% coinsurance | ———— None ———— |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient Services | No charge | $30 copay per visit | 30% coinsurance | ———— None ———— |
| | Inpatient Services | No charge | 10% coinsurance | 30% coinsurance | Pre-authorization is required for out-of-network care. Benefits will be reduced by $200 if pre-authorization is not obtained. |
| **If you are pregnant** | Office visits | $10 copay; No charge preventive care | $30 copay; No charge preventive care | 30% coinsurance | Cost sharing does not apply to certain preventive services if home host or in-network. If other outpatient services are needed, coinsurance or copay may apply. |
| | Childbirth/delivery professional services | $10 copay; No charge for preventive care | $30 copay; No charge for preventive care. | 30% coinsurance | |
| | Childbirth/delivery facility services | No charge | 10% coinsurance | 30% coinsurance | Coinsurance for hospital is separate and additional. |

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| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Primary/Home Host Designated Provider (You will pay the least) | Regional In-Network Provider | Out-of-Network Provider (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | No charge | 10% coinsurance | 30% coinsurance | Pre-authorization is required for out-of-network care. Limited to 100 visits per calendar year. |
| | Rehabilitation services | No charge | $30 copay per visit | 30% coinsurance | Coverage is limited to 60 visits per calendar year for physical, occupational, speech, and chiropractic services related to medical impairment being treated. |
| | Habilitation services | Not covered | Not covered | Not covered | ———————— None ———————— |
| | Skilled nursing care | No charge | 10% coinsurance | 30% coinsurance | Pre-authorization is required for out-of-network care. Benefits will be reduced by $200 if pre-authorization is not obtained. If Medicare is primary, coverage is not available even if Medicare benefits are exhausted. |
| | Durable medical equipment | No charge | 10% coinsurance | 30% coinsurance | ———————— None ———————— |
| | Hospice services | No charge | 10% coinsurance | 30% coinsurance | Pre-authorization is required for out-of-network care. Benefits will be reduced by $200 if pre-authorization is not obtained. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | Not covered | Not covered |
| | Children's glasses | Not covered | Not covered | Not covered | Not covered |
| | Children's dental check-up | Not covered | Not covered | Not covered | Not covered |

[* For more information about limitations and exceptions, contact the plan administrator for a copy of the Summary Plan Description.]

## 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 | • Long-term care | • Routine foot care, shoes, orthotics |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |
| • Dental care (Adult & Child) | • Routine eye care (Adult) & glasses (Child) | • Out-of-network services with Cancer Centers of America |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Bariatric Services subject to Aetna Clinical Management Guidelines | • Hearing aid reimbursement limited to $150 every 36 months | • Private-duty nursing |
| • Chiropractic care combined with short term rehabilitation | • Infertility Treatment - Diagnosis & Treatment of underlying medical condition. Also includes Artificial Insemination, Ovulation Induction, and Advanced Reproductive Technology | |

**Your Rights to Continue Coverage:** If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-800-872-3862. You may also contact your state insurance department, 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.

**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: 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 1-888-982-3862.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-982-3862.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-982-3862.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-982-3862.]

*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 the plan administrator for a copy of the Summary Plan Description.]

## 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 at Regional In-Network)

| | |
|---|---|
| ■ The plan's overall deductible | $0 |
| ■ Specialist *copay* | $30 |
| ■ Hospital (facility) *coinsurance* | 10% |
| ■ Other *copay* | None |

**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 | $0 |
| Copayments | $50 |
| Coinsurance | $900 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,010** |

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

| | |
|---|---|
| ■ The plan's overall deductible | $0 |
| ■ Specialist *copay* | $10 |
| ■ Hospital (facility) *coinsurance* | 0% |
| ■ Other *copay* | $15 |

**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 | $0 |
| Copayments | $255 |
| Coinsurance | $700 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$1,010** |

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

| | |
|---|---|
| ■ The plan's overall deductible | $0 |
| ■ Specialist *copay* | $10 |
| ■ Hospital (ER facility) *copay* | $25 |
| ■ Other *copay* | None |

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $55 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$55** |

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