### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage for:** Individual + Family  |  **Plan Type:** PPO

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>Maximum Savings: Individual $1,000 / Family $2,000. Standard Savings: Individual $2,500 / Family $5,000. Out-of-Network: Individual $2,500 / Family $5,000. Does not apply to office visits, prescription drugs, emergency care, and preventive care in-network.</td>
<td>You must pay all the costs up to the <strong>deductible</strong> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <strong>deductible</strong> 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 <strong>deductible</strong>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don't have to meet <strong>deductibles</strong> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td><strong>Is there an out-of-pocket limit on my expenses?</strong></td>
<td>Yes. Maximum Savings: Individual $3,600 / Family $7,200. Standard Savings: Individual $7,000 / Family $14,000. Out-of-Network: Individual $7,000 / Family $14,000.</td>
<td>The <strong>out-of-pocket limit</strong> 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.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for service, and health care this plan does not cover.</td>
<td>Even though you pay these expenses, they don't count toward the <strong>out-of-pocket limit.</strong></td>
</tr>
<tr>
<td><strong>Is there an overall annual limit on what the plan pays?</strong></td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td><strong>Does this plan use a network of providers?</strong></td>
<td>Yes. See <a href="http://www.aetna.com">www.aetna.com</a> or call 1-888-982-3862 for a list of Maximum Savings providers.</td>
<td>If you use an in-network doctor or other health care <strong>provider</strong>, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <strong>provider</strong> for some services. Plans use the term in-network, <strong>preferred</strong>, or participating for <strong>providers</strong> in their <strong>network</strong>. See the chart starting on page 2 for how this plan pays different kinds of <strong>providers.</strong></td>
</tr>
<tr>
<td><strong>Do I need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the <strong>specialist</strong> you choose without permission from this plan.</td>
</tr>
<tr>
<td><strong>Are there services this plan doesn’t cover?</strong></td>
<td>Yes.</td>
<td>Some of the services this plan doesn’t cover are listed on page 5. See your policy or plan document for additional information about <strong>excluded services.</strong></td>
</tr>
</tbody>
</table>

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.

- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.

- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)

- This plan may encourage you to use Maximum Savings **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

<table>
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<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Maximum Savings Provider</th>
<th>Your Cost If You Use a Standard Savings Provider</th>
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<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 copay/visit</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
<td>Includes Internist, General Physician, Family Practitioner or Pediatrician.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$40 copay/visit</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$40 copay/visit</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/ immunization</td>
<td>No charge</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>30% coinsurance, except deductible waived for well child up to age 22, child immunizations &amp; gynecological exams Age and frequency schedules may apply.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
</tbody>
</table>

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### Limitations & Exceptions

#### Your Cost If You Use an Out-of-Network Provider

- **Preferred generic drugs**
  - **Copay/prescription:** $10 for 30 day supply (retail), $20 for 31-90 day supply (retail & mail order)
  - **Not applicable**
- **Preferred brand drugs**
  - **Copay/prescription:** $40 for 30 day supply (retail), $80 for 31-90 day supply (retail & mail order)
  - **Not applicable**
- **Non-preferred generic/brand drugs**
  - **Copay/prescription:** $70 for 30 day supply (retail), $140 for 31-90 day supply (retail & mail order)
  - **Not applicable**

#### Value Plus Three Tier Open Formulary

- **Specialty drugs**
  - **Applicable cost as noted above for generic or brand drugs.**
  - **Not applicable**
  - **Not covered**

#### If you need drugs to treat your illness or condition

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<thead>
<tr>
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<th>Your Cost If You Use a Maximum Savings Provider</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Preferred generic drugs</td>
<td>Copay/prescription: $10 for 30 day supply (retail), $20 for 31-90 day supply (retail &amp; mail order)</td>
<td>Not applicable</td>
<td>30% coinsurance after copay/prescription: $10 (retail)</td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>Copay/prescription: $40 for 30 day supply (retail), $80 for 31-90 day supply (retail &amp; mail order)</td>
<td>Not applicable</td>
<td>30% coinsurance after copay/prescription: $40 (retail)</td>
</tr>
<tr>
<td>Non-preferred generic/brand drugs</td>
<td>Copay/prescription: $70 for 30 day supply (retail), $140 for 31-90 day supply (retail &amp; mail order)</td>
<td>Not applicable</td>
<td>30% coinsurance after copay/prescription: $70 (retail)</td>
</tr>
</tbody>
</table>

#### If you have outpatient surgery

- **Facility fee (e.g., ambulatory surgery center)**
  - **10% coinsurance**
  - **30% coinsurance**
  - **30% coinsurance**
- **Physician/surgeon fees**
  - **10% coinsurance**
  - **30% coinsurance**
  - **30% coinsurance**

#### If you need immediate medical attention

- **Emergency room services**
  - **$50 copay/visit**
  - **$50 copay/visit**
  - **$50 copay/visit**
- **Emergency medical transportation**
  - **10% coinsurance**
  - **10% coinsurance**
  - **10% coinsurance**
- **Urgent care**
  - **$40 copay/visit**
  - **30% coinsurance**
  - **30% coinsurance**
  - **50% coinsurance for non-urgent use.**

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</thead>
<tbody>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
<td>——none——</td>
</tr>
<tr>
<td><strong>If you have mental health, behavioral health, or substance abuse needs</strong></td>
<td>Mental/Behavioral health outpatient services</td>
<td>$40 copay/visit</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
<td>——none——</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$40 copay/visit</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
<td>——none——</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Prenatal and postnatal care</td>
<td>No charge</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>——none——</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
<td>Includes outpatient postnatal care. Pre-authorization may be required for out-of-network care.</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
<td>Coverage is limited to 90 visits per calendar year. Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$40 copay/visit</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
<td>Coverage is limited to 12 visits per calendar year for Occupational &amp; Speech Therapy combined.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$40 copay/visit</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
<td>Coverage is limited to treatment of Autism.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
<td>Coverage is limited to 100 days per calendar year. Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
<td>——none——</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
</tbody>
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</thead>
<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>No charge</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>Coverage is limited to 1 routine eye exam per 24 months.</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs
- Infertility treatment - Coverage is limited to the diagnosis and treatment of underlying medical condition.
- Private-duty nursing - Coverage is limited to 30 - 8 hour shifts per calendar year.
- Routine eye care (Adult) - Coverage is limited to 1 routine eye exam per 24 months.

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.):

- Bariatric surgery
- Chiropractic care
- Hearing aids - Coverage is limited to a maximum of $1,000 per 36 months.

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 1-888-982-3862. 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.

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Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact us by calling the toll free number on your Medical ID Card. If your group health plan is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Pennsylvania Insurance Department, Bureau of Consumer Services, (877) 881-6388, http://www.pahealthoptions.com.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan or policy does provide minimum essential coverage.

Does this Coverage Meet Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:
Para obtener asistencia en Español, llame al 1-888-982-3862.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-982-3862.
Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 1-888-982-3862.

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To see examples of how this plan might cover costs for a sample medical situation, see the next page.
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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

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### Having a baby (normal delivery)
- **Amount owed to providers:** $7,540
- **Plan pays:** $5,920
- **Patient pays:** $1,620

#### Sample care costs:
- Hospital charges (mother) $2,700
- Routine obstetric care $2,100
- Hospital charges (baby) $900
- Anesthesia $900
- Laboratory tests $500
- Prescriptions $200
- Radiology $200
- Vaccines, other preventive $40

**Total** $7,540

#### Patient pays:
- Deductibles $1,000
- Copays $20
- Coinsurance $400
- Limits or exclusions $200

**Total** $1,620

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)
- **Amount owed to providers:** $5,400
- **Plan pays:** $3,720
- **Patient pays:** $1,680

#### Sample care costs:
- Prescriptions $2,900
- Medical Equipment and Supplies $1,300
- Office Visits and Procedures $700
- Education $300
- Laboratory tests $100
- Vaccines, other preventive $100

**Total** $5,400

#### Patient pays:
- Deductibles $1,000
- Copays $500
- Coinsurance $100
- Limits or exclusions $80

**Total** $1,680

---

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

**Yes.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

**Yes.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

**Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

**Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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