This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document on Inside Guardian or Guardian Online, or by calling MyHR at 1-877-870-6947. You can also access plan details in the Summary Plan Description (SPD). For a copy of the SPD visit Inside Guardian or Guardian Online.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $1,500 Individual* / $3,000 Family Non-Network: $3,000 Individual* / $6,000 Family Per calendar year. Does not apply to services listed below as "No Charge". *Doesn't apply if you are covering dependents.	You must pay all the 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 other deductibles for specific services?	No, there are no other **deductibles**.	You don't have to meet **deductibles** for specific service, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Network: $4,000 Individual* / $8,000 Family Non-Network: $8,000 Individual* / $16,000 Family Per calendar year. *Does apply if you are covering dependents.	The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	**Premiums**, balanced-billed charges, health care this plan doesn't cover, penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes, this plan uses **network providers**. If you use a **non-network provider** your cost may be more. For a list of **network providers**, see www.aetna.com or call 1-866-244-1573.	If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network **provider** for some services. Plans use the term network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on Page 8. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-866-244-1573** or visit **Inside Guardian or Guardian Online**. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call the number above to request a copy.

- **Copayments** are fixed dollar amounts you pay for covered health care, usually when you receive the service. For example, you pay a $10 copay for a generic preventive prescription drug purchased at a retail pharmacy.
- **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 10% would be $100. 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 network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Teladoc - In network 10% coinsurance after deductible by a Designated Teladoc Network Provider. No virtual visit coverage for out of network. If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply.
	Specialist visit	10% Coinsurance After Deductible	30% Coinsurance After Deductible	None
	Other practitioner office visit	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Cost Share applies for only Manipulative (Chiropractic) Care. Maximum of 20 visits per calendar year.
	Preventive care/screening/immunization	No Charge	30% Coinsurance After Deductible	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance After Deductible	30% Coinsurance After Deductible	For sleep studies only. Out of Network Prior Authorization required or benefits will be reduced by a $500 penalty.
	Imaging (CT/PET scans, MRIs)	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Prior Authorization required.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition	Generic	**Non-Preventive** **Retail up to a 30 day supply:** You pay 100% of the cost until you meet the deductible, then $10 copayment. **Mail Order up to a 90 day supply:** You pay 100% of the cost until you meet the deductible, then $25 copayment. **Preventive** **Retail up to a 30 day supply:** You pay $10 copayment, deductible does not apply. **Mail Order up to a 90 day supply:** You pay $25 copayment, deductible does not apply.	Not Covered	None

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
	Preferred Brand Name	**Non-Preventive** **Retail up to a 30 day supply:** You pay 100% of the cost until you meet the deductible, then 25% of the cost with a $35 minimum and a $75 maximum copayment. **Mail Order up to a 90 day supply:** You pay 100% of the cost until you meet the deductible, then 25% of the cost with a $87.50 minimum and $187.50 maximum copayment. **Preventive** **Retail up to a 30 day supply:** You pay 25% of the cost with a $35 minimum and a $75 maximum copayment, deductible does not apply. **Mail Order up to a 90 day supply:** You pay 25% of the cost with an $87.50 minimum and a $187.50 maximum copayment, deductible does not apply.	Not Covered	None

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
More information about **prescription drug coverage** is available at **www.express-scripts.com**.	Non-Preferred Brand Name	**Non-Preventive** **Retail up to a 30 day supply:** You pay 100% of the cost until you meet the deductible, then 35% of cost with a $60 minimum and a $150 maximum copayment. **Mail Order up to a 90 day supply:** You pay 100% of the cost until you meet the deductible, then 35% of the cost with a $150 minimum and a $375 maximum copayment. **Preventive** **Retail up to a 30 day supply:** You pay 35% of cost with a $60 minimum and a $150 maximum copayment, deductible does not apply. **Mail Order up to a 90 day supply:** You pay 35% of the cost with a $150 minimum and a $375 maximum copayment, deductible does not apply.	Not Covered	None
	Specialty	See generic, preferred brand name and non-preferred brand name descriptions above	Not Covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance After Deductible	30% Coinsurance After Deductible	None
	Physician/surgeon fees	10% Coinsurance After Deductible	30% Coinsurance After Deductible	None

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	10% Coinsurance After Deductible	10% Coinsurance After Network Deductible	None
	Emergency medical transportation	10% Coinsurance After Deductible	10% Coinsurance After Network Deductible	None
	Urgent care	10% Coinsurance After Deductible	30% Coinsurance After Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Out of Network Prior Authorization required or benefits will be reduced by a $500 penalty.
	Physician/surgeon fee	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Out of Network Prior Authorization required or benefits will be reduced by a $500 penalty.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% Coinsurance After Deductible	30% Coinsurance After Deductible	None
	Mental/Behavioral health inpatient services	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Out of Network Prior Authorization required or benefits will be reduced by a $500 penalty.
	Substance use disorder outpatient services	10% Coinsurance After Deductible	30% Coinsurance After Deductible	None
	Substance use disorder inpatient services	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Out of Network Prior Authorization required or benefits will be reduced by a $500 penalty.
If you are pregnant	Prenatal and postnatal care	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Routine Pre-Natal is covered at no charge
	Delivery and all inpatient services	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Your cost for inpatient services only. For physician delivery charges, see pre-postnatal care. Stays exceeding delivery timeframes prior authorization is required. Out of Network Prior Authorization required or benefits will be reduced by a $500 penalty.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Out of Network Prior Authorization required or benefits will be reduced by a $500 penalty. Maximum of 100 visits per calendar year combined In and Out-of-Network.
	Rehabilitation services	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Out of Network Prior Authorization required or benefits will be reduced by a $500 penalty. Maximum of 30 visits combined per calendar year for Physical and Occupational Therapy; maximum of 30 visits per calendar year combined for Speech and Post-Cochlear Therapy.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Out of Network Prior Authorization required or benefits will be reduced by a $500 penalty. Maximum of 90 days per calendar year.
	Durable medical equipment	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Out of Network Prior Authorization required or benefits will be reduced by a $500 penalty.
	Hospice service	10% Coinsurance After Deductible	30% Coinsurance After Deductible	Out of Network Prior Authorization required or benefits will be reduced by a $500 penalty.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	None
	Glasses	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Adult routine vision exam (i.e. refraction)
- Child dental check-up
- Child vision glasses
- Child routine vision exam (i.e. refraction)
- Cosmetic Surgery
- Dental Care (Adult)
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S
- Weight loss programs

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.)

- Acupuncture may be covered with limitations: In-Network: 10% coinsurance after deductible, and is limited to 20 visits per calendar year.
- Bariatric Surgery may be covered with limitations: In-Network: 10% coinsurance after deductible; must receive the surgery from an Aetna Institute of Quality (IOQ) to be covered.
- Chiropractic care may be covered with limitations: up to 20 visits per year.
- Hearing aids may be covered with limitations: $2,500 per hearing aid per year, every 3 years.
- Infertility Services (dependent children are not eligible for services): In-Network ONLY: 10% coinsurance after deductible. Benefits for infertility services are limited to $25,000 per covered member during the entire period you are covered under the Plan. There is a separate infertility prescription drug benefit limited to $10,000 per covered member during the entire period you are covered under the Plan. **Please contact Aetna prior to receiving infertility services, as there are certain requirements you must follow in order for infertility services and supplies to be considered covered health services under the Plan.**
- Private-duty nursing limitations may apply
- Routine foot care limitations may apply

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 1-866-451-3399. 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:

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 at 1-866-244-1573 or visit www.aetna.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 the 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:

- Spanish (Español): Para obtener asistencia en Español, llame al 1-866-244-1573.
- Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-244-1573.
- Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-866-244-1573.
- Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-244-1573.

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

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.

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.

If other than individual coverage, the Patient Pays amount may be more.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,290
- **Patient pays** $2,250

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	$1,500
Copays	$0
Coinsurance	$580
Limits or exclusions	$170
Total	**$2,250**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $50
- **Patient pays** $5,350

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	$1,150
Copays	$0
Coinsurance	$0
Limits or exclusions	$4,200
Total	**$5,350**

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?

✘ **No.** 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?

✘ **No.** 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.

Questions: Call **1-866-244-1573** or visit **Inside Guardian or Guardian Online**. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call the number above to request a copy.