### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>For each Calendar Year, Preferred: Individual $0 / Family $0.</td>
<td>See the chart starting on page 2 for your costs for the services this plan covers.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</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>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. Preferred: Individual $2,000 / Family $4,000.</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>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges, 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>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for <strong>specific</strong> covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. For a list of preferred <strong>providers</strong>, see <a href="http://www.aetna.com">www.aetna.com</a> or call 1-888-982-3862.</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>Do I need a referral to see a specialist?</td>
<td>Yes, for in-network <strong>specialists</strong>.</td>
<td>This plan will pay some or all of the costs to see a <strong>specialist</strong> for covered services but only if you have the plan's permission before you see the <strong>specialist</strong>.</td>
</tr>
<tr>
<td>Are there services this plan doesn't cover?</td>
<td>Yes.</td>
<td>Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <strong>excluded services</strong>.</td>
</tr>
</tbody>
</table>

**Questions:** Call 1-888-982-3862 or visit us at [www.HealthReformPlanSBC.com](http://www.HealthReformPlanSBC.com). If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at [www.HealthReformPlanSBC.com](http://www.HealthReformPlanSBC.com) or call 1-888-982-3862 to request a copy.
**Coverage Period:** 07/01/2015 - 06/30/2016

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

- **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 preferred **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use a Preferred Provider</th>
<th>Your Cost If You Use a Non–Preferred Provider</th>
<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></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$25 copay per visit</td>
<td>Not covered</td>
<td>Includes Internist, General Physician, Family Practitioner or Pediatrician.</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$35 copay per visit</td>
<td>Not covered</td>
<td>———— None ————</td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>$35 copay per visit</td>
<td>Not covered</td>
<td>Coverage is limited to 20 visits per calendar year for Chiropractic care.</td>
</tr>
<tr>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>Not covered</td>
<td>Age and frequency schedules may apply.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge for laboratory; $35 copay per visit for x-ray</td>
<td>Not covered</td>
<td>———— None ————</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$35 copay per visit</td>
<td>Not covered</td>
<td>———— None ————</td>
</tr>
</tbody>
</table>

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

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<tr>
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<th>Your Cost If You Use a Non–Preferred Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
</table>
| **If you need drugs to treat your illness or condition** | Generic drugs | $10 copay, retail (30-day supply) | Not covered | Visit [www.envisionRx.com](http://www.envisionRx.com) for coverage details.
| | | $20 copay, mail order (90-day supply) | | |
| | Preferred brand drugs | $35 copay, retail (30-day supply) | Not covered | |
| | | $70 copay, mail order (90-day supply) | | |
| | Non-preferred brand drugs | $55 copay, retail (30-day supply) | Not covered | |
| | | $110 copay, mail order (90-day supply) | | |
| | Specialty drugs | 25% coinsurance up to $125 limit per 30-day supply | Not covered | Visit [www.envisionRx.com](http://www.envisionRx.com) for coverage details.
| | | No mail order option | | |

Your prescription drug benefit is administered by EnvisionRxOptions. More information about prescription drug coverage is available at [www.envisionRx.com](http://www.envisionRx.com).

If you have any questions regarding your prescription drug benefit, please call the EnvisionRxOptions Customer Service Help Desk at 1-800-361-4542.

Questions: Call 1-888-982-3862 or visit us at www.HealthReformPlanSBC.com. If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.HealthReformPlanSBC.com or call 1-888-982-3862 to request a copy.
## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

### Coverage for: Individual + Family  |  Plan Type: EPO

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<thead>
<tr>
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<th>Your Cost If You Use a Non–Preferred Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$175 copay per visit</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room services</td>
<td>$175 copay per visit</td>
<td>$175 copay per visit</td>
<td>No coverage for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 copay per visit</td>
<td>Not covered</td>
<td>No coverage for non-urgent use.</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$300 copay per stay</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No charge</td>
<td>Not covered</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>$35 copay per visit</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>$300 copay per stay</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$35 copay per visit</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>$300 copay per stay</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Prenatal and postnatal care</td>
<td>No charge</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>$35 copay for physician maternity services; $300 copay per stay for facility services</td>
<td>Not covered</td>
<td>Includes outpatient postnatal care.</td>
</tr>
</tbody>
</table>

### Questions:
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### Summary of Benefits and Coverage:

#### What this Plan Covers & What it Costs

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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>No charge</td>
<td>Not covered</td>
<td></td>
<td>——— None ———</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$35 copay per visit</td>
<td>Not covered</td>
<td></td>
<td>——— None ———</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
<td>Not covered.</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>$300 copay per stay</td>
<td>Not covered</td>
<td></td>
<td>——— None ———</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>Not covered</td>
<td></td>
<td>——— None ———</td>
</tr>
<tr>
<td>Hospice service</td>
<td>$300 copay per stay for inpatient; no charge for outpatient</td>
<td>Not covered</td>
<td></td>
<td>——— None ———</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye exam</td>
<td>$35 copay per visit</td>
<td>Not covered</td>
<td>Coverage is limited to 1 routine eye exam per 12 months.</td>
<td></td>
</tr>
<tr>
<td>Glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
<td>Not covered.</td>
</tr>
<tr>
<td>Dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

### Excluded Services & Other Covered Services:

#### Services Your Plan Does NOT Cover

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)

#### Services Your Plan Does NOT Cover

- Habilitation services
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.

- Private-duty nursing
- Routine foot care
- Weight loss programs

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

Other Covered Services

<table>
<thead>
<tr>
<th>This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Chiropractic care - Coverage is limited to 20 visits per calendar year.</td>
</tr>
<tr>
<td>• Infertility treatment - Coverage is limited to the diagnosis and treatment of underlying medical condition.</td>
</tr>
<tr>
<td>• Routine eye care (Adult) - Coverage is limited to 1 routine eye exam per 12 months.</td>
</tr>
</tbody>
</table>

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/ebssa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.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 by calling the toll free number on your Medical ID Card. 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.
• Additionally, a consumer assistance program can help you file an appeal. Contact information is at http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html

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 Provide 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 a'ohlwol ninisingo, kwiijijo holnie' 1-888-982-3862.

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.

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### Having a baby  
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,030
- **Patient pays:** $510

**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: $0
- Copays: $340
- Coinsurance: $0
- Limits or exclusions: $170

**Total:** $510

---

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,220
- **Patient pays:** $3,180

**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: $0
- Copays: $250
- Coinsurance: $0
- Limits or exclusions: $2,930

**Total:** $3,180

---

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.
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.
How your out-of-network care is reimbursed:
We cover the cost of services based on whether doctors are “in-network” or “out-of-network.” We want to help you understand how much Aetna pays for your out-of-network care and help you understand how much you will need to pay.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a provider who is out-of-network, your Aetna health plan may pay some of that provider's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network provider.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount. This amount is based on the out-of-network plan you or your employer has chosen.

To learn more about how we pay out-of-network benefits, carefully review your plan documents or visit Aetna.com and type "how Aetna pays" in the search box.

Your provider sets their own rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna plan "recognizes." Your provider may bill you for the dollar amount that the plan doesn't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. Your payments for the charges above the "recognized charge" do not count toward your deductible or out-of-pocket limit.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator® member site.

This applies when you choose to get care out-of-network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in-network. You pay cost sharing and deductibles for your in-network level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

Other important information about your plan:
This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent.

Additional information regarding your plan is available in the Disclosure Document on aetna.com

Questions: Call the toll free number on your ID card (1-855-228-0510 for prospective members), TDD 1-800-628-3323 (hearing impaired only), or visit us at www.HealthReformPlanSBC.com.
Supplemental Information

Information includes:

- “Knowing what is covered” which describes how we review a request for coverage for a service or supply
- “Prescription drug benefit” which describes procedures we use to manage prescription drug benefits. These procedures include how to obtain a list of covered drugs and the exception policy for receiving coverage of a drug that is not on a closed formulary

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider’s full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. We do not provide care or guarantee access to health services.

The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial
- Home births
- Immunizations for travel or work except where medically necessary or indicated
- Implantable drugs and certain injectable drugs including injectable infertility drugs
- Long-term rehabilitation therapy
- Non-medically necessary services or supplies
- Orthotics except diabetic orthotics
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling or prescription drugs
- Therapy or rehabilitation other than those listed as covered
- Treatment of behavioral disorders

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna’s Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts they may receive from wholesalers, manufacturers, suppliers and distributors.

Questions: Call the toll free number on your ID card (1-855-228-0510 for prospective members), TDD 1-800-628-3323 (hearing impaired only), or visit us at www.HealthReformPlanSBC.com.
Supplemental Information

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

We consider your personal information to be private. We have policies and procedures in place to protect your personal information from unlawful use and disclosure. For a summary of our policy, go to www.aetna.com. You'll find the Privacy Notices link at the bottom of the page.

Plan features and availability may vary by location and group size.

Coverage for: Individual + Family | Plan Type: EPO

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Colorado Supplement to the Summary of Benefits and Coverage Form

**Aetna Life Insurance Company**
Name of Carrier

**Aetna Whole Health - Memorial Hermann - Aetna SelectSM**
Name of Plan

**Large Employer Group Policy**
Policy Type

### TYPE OF COVERAGE

<table>
<thead>
<tr>
<th>TYPE OF PLAN</th>
<th>EPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. OUT-OF-NETWORK CARE COVERED?</td>
<td>No</td>
</tr>
<tr>
<td>3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE</td>
<td>Plan is available throughout Colorado</td>
</tr>
</tbody>
</table>

### SUPPLEMENTAL INFORMATION REGARDING BENEFITS

**Important Note:** The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits and Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.
<table>
<thead>
<tr>
<th>Description</th>
<th>What this means.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4. Deductible Period</strong></td>
<td>Calendar Year</td>
</tr>
<tr>
<td></td>
<td>Calendar year deductibles restart each January</td>
</tr>
<tr>
<td><strong>5. Annual Deductible Type</strong></td>
<td>Individual/Family</td>
</tr>
<tr>
<td></td>
<td>Individual means the deductible amount you and each individual covered by the plan will have to pay for allowable covered expenses before the carrier will cover those expenses. Family is the maximum deductible amount that is required to be met for all family members covered by the plan. It may be an aggregated amount (e.g., $3,000 per family) or specified as the number of individual deductibles that must be met (e.g., 3 deductibles per family).</td>
</tr>
</tbody>
</table>
| **6. What cancer screenings are covered?** | Prostate Cancer Screening  
|                               | Cervical Cancer Screening  
|                               | Breast Cancer Screening  
|                               | Colorectal Cancer Screening  | • Age and Frequency schedule may apply  
|                               |                                       | • Age and Frequency schedule may apply  
|                               |                                       | • Age and Frequency schedule may apply  
|                               |                                       | • Age and Frequency schedule may apply  |
## LIMITATIONS AND EXCLUSIONS

<table>
<thead>
<tr>
<th>7. Period during which pre-existing conditions are not covered for covered person age 19 and older</th>
<th>For members age 19 and older, 180 days for all pre-existing conditions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. How does the policy define a “pre-existing condition”?</td>
<td>Not applicable, Plan does not exclude coverage of pre-existing conditions.</td>
</tr>
<tr>
<td>9. Exclusionary Riders. Can an individual's specific, pre-existing condition be entirely excluded from the policy?</td>
<td>NO</td>
</tr>
</tbody>
</table>

## USING THE PLAN

<table>
<thead>
<tr>
<th>10. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>Yes, refer to your certificate of coverage for details.</td>
<td></td>
</tr>
<tr>
<td>11. Does the plan have a binding arbitration clause?</td>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>
Questions: Call 1-888-982-3862, TDD 1-800-628-3323 (hearing impaired only) or visit www.Aetna.com.

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance
Consumer Affairs Section
1560 Broadway, Suite 850, Denver, CO 80202
Call 303-894-7490 (in state, toll free: 800-930-3745)
Email: insurance@dora.state.co.us

**Endnotes:**

1 “Network” refers to a specified group of physicians, hospitals, medical clinics and other health care providers this plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

2 Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

**Colorado Access Disclosure:**

Aetna maintains and makes available to interested parties upon request a managed care network access plan on its business premises. The managed care network access plan demonstrates the managed care network contains an adequate number of accessible acute care hospitals, primary care providers, and specialists available to provide covered health care services. Among other things, the access plan describes Aetna's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of plan enrollees.

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