**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, [insert contact information]. 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.dol.gov/ebsa/healthreform.com or call (740) 283-8511 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | PPO: $1,000/person and $2,000/family. Non-PPO: $2,000/person and $4,000/family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care and physician's office visits are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | For network providers $3,000 individual/$6,000 family; for out-of-network providers $6,000 individual/$12,000 family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Prescription drug coinsurance, premiums, balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out–of–pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.aetna.com or call (888) 632-3862 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No | You can see the specialist you choose without a referral. |

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 (You will pay the least) | 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 | $20 copay/office visit | 50% coinsurance | None |
| | Specialist visit | $40 copay/visit | 50% coinsurance | None |
| | Teledoc visit | $10 copay | | None |
| | Other practitioner office visit | 20% coinsurance | 50% coinsurance | $40 copay for chiropractors |
| | Preventive care/screening/ immunization | No coinsurance | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 50% coinsurance | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.Caremark.com | Generic drugs (Tier 1) | 25% coinsurance retail<br>20% coinsurance mail order | | All drugs have a max out-of-pocket of $3,000/person / $6,000/family per Plan Year. If Brand is purchased when Generic is available, you pay additional amounts. |
| | Preferred brand drugs (Tier 2) | 25% coinsurance retail<br>20% coinsurance mail order | | |
| | Non-preferred brand drugs (Tier 3) | 25% coinsurance retail<br>20% coinsurance mail order | | |
| | Specialty drugs (Tier 4) | 25% coinsurance retail<br>20% coinsurance mail order | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 50% coinsurance | None |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | 20% coinsurance | $300 copay applies |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | None |
| | Urgent care | 20% coinsurance | 50% coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 50% coinsurance | $200 copay for non-PPO |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $20 copay/office visit | 50% coinsurance | None |
| | Inpatient services | 20% coinsurance | 50% coinsurance | |
| **If you are pregnant** | Office visits | 20% coinsurance | 50% coinsurance | None |
| | Childbirth/delivery professional services | 20% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | Not covered | 100 visits per Plan year |
| | Rehabilitation services | 20% coinsurance | 50% coinsurance | Max 100 days conv facility/Plan yr. $100 copay PPO and $200 copay non-PPO |
| | Habilitation services | 20% coinsurance | 50% coinsurance | |
| | Skilled nursing care | 20% coinsurance | 50% coinsurance | None |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. |
| | Hospice services | 20% coinsurance | Not covered | None |
| **If your child needs dental or eye care** | Children's eye exam | No coinsurance | No coinsurance | $50 maximum |
| | Children's glasses | No coinsurance | No coinsurance | $300 maximum |
| | Children's dental check-up | No coinsurance | No coinsurance | Max of 2 per year |

**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
- Cosmetic surgery
- Infertility Treatment (some)
- Long Term Care
- 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
- Hearing Aids (PPO only)
- Infertility treatment (some)
- Non-emergency care when traveling outside the US

| | | |
|---|---|---|
| • Dental Care | • Private duty nursing | • Routine eye care (some) |

**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: www.sfpi.com. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit 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: www.sfpi.com, or 800-722-7374.

**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 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.

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

## 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 plan's overall deductible | $1000 |
| ■ Specialist copayment | $40 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 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)*

| | |
|---|---|
| **Total Example Cost** | **$12,900** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $0 |
| Coinsurance | $2,000 |
| *What isn't covered* | |
| Limits or exclusions | $00 |
| **The total Peg would pay is** | **$3,000** |

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

| | |
|---|---|
| ■ The plan's overall deductible | $1000 |
| ■ Specialist copayment | $40 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 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)*

| | |
|---|---|
| **Total Example Cost** | **$7,500** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles* | $1,000 |
| Copayments | $360 |
| Coinsurance | $1300 |
| *What isn't covered* | |
| Limits or exclusions | $00 |
| **The total Joe would pay is** | **$2,660** |

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

| | |
|---|---|
| ■ The plan's overall deductible | $1000 |
| ■ Specialist copayment | $40 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 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)*

| | |
|---|---|
| **Total Example Cost** | **$2,000** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles* | $1,000 |
| Copayments | $340 |
| Coinsurance | $117 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **1,457** |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.sfpi.com.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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