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, call 203-934-7991 or 800-922-3240. 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 https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf or call 203-934-7991 or 800-922-3240 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | In-network: $0<br>Out-of-network: $200/individual/calendar year; $400/family/calendar year | In-network: See the Common Medical Events chart below for your costs for services this plan covers.<br>Out-of-network: Generally, you must pay all costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. |
| Are there services covered before you meet your deductible? | Yes. Emergency room care, emergency medical transportation, and dental and vision services are covered before you meet your out-of-network 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. |
| 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? | In-network: $2,000/person/ calendar year; $4,000/family/ calendar year<br>Out-of-network: $4,000/person/ calendar year; $8,000/family/ calendar year | 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? | Premiums, balance billing charges, health care this plan doesn't cover, penalties for failure to obtain preauthorization for services, and cost sharing on dental and vision services. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| Will you pay less if you use a network provider? | Yes. Visit www.aetna.com or call 888-267-2637 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/visit. | 20% coinsurance. | None. |
| | Specialist visit | $20 copay/visit. | 20% coinsurance. | None. |
| | Preventive care/screening/ immunization | No charge. | 20% coinsurance. | Age and frequency limits may apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | $20 copay/test. | 20% coinsurance. | None. |
| | Imaging (CT/PET scans, MRIs) | $20 copay/test. | 20% 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 need drugs to treat your illness or condition<br>More information about prescription drug coverage is available at www.caremark.com | Generic drugs | Retail: $10 copay/prescription.<br>Mail Order: $20 copay/ prescription. | Not covered. | Retail limit: 30-day supply (90-day supply of maintenance drugs available at CVS pharmacies).<br><br>Mail order limit: 90-day supply.<br><br>No charge for FDA-approved generic contraceptives (or brand name contraceptives when generics are not medically appropriate).<br><br>Some drugs require preauthorization or no benefits are provided. |
| | Preferred brand drugs | Retail: $20 copay/prescription.<br>Mail Order: $40 copay/ prescription. | Not covered. | |
| | Non-preferred brand drugs | Retail: $35 copay/prescription.<br>Mail Order: $70 copay/ prescription. | Not covered. | |
| | Specialty drugs | Applicable cost as noted above for generic and brand drugs. | Not covered. | Preauthorization required or no benefits are provided. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge. | 20% coinsurance. | Preauthorization required to avoid penalty in the amount of the lesser of 20% or $500. |
| | Physician/surgeon fees | No charge. | 20% coinsurance. | |
| If you need immediate medical attention | Emergency room care | $235 copay/visit. | $235 copay/visit.<br>Deductible does not apply. | $235 copay waived if admitted to hospital. |
| | Emergency medical transportation | No charge. | No charge.<br>Deductible does not apply. | Air ambulance to nearest appropriate hospital only. |
| | Urgent care | $35 copay/visit. | $35 copay/visit. | None. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | $250 copay/admission. | 20% coinsurance. | Preauthorization required to avoid penalty in the amount of the lesser of 20% or $500.<br>Coverage limited to rate for semi-private room unless a private room is medically necessary. |
| | Physician/surgeon fees | No charge. | 20% coinsurance. | Preauthorization required to avoid penalty in the amount of the lesser of 20% or $500. |

| 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 need mental health, behavioral health, or substance abuse services | Outpatient services | Office visit: $20 copay/visit. Other outpatient services: no charge. | 20% coinsurance. | None. |
| | Inpatient services | $250 copay/admission. | 20% coinsurance. | Preauthorization required to avoid penalty in the amount of the lesser of 20% or $500. |
| If you are pregnant | Office visits | $20 copay/first visit; no charge thereafter. | 20% coinsurance. | Cost sharing does not apply for preventive services. Depending on the type of services, a copay or coinsurance may apply. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | No charge. | 20% coinsurance. | None. |
| | Childbirth/delivery facility services | $250 copay/admission. | 20% 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 need help recovering or have other special health needs | Home health care | No charge. | 20% coinsurance. | Limit: 120 visits/calendar year.<br>Pre-authorization required for out-of-network services to avoid penalty in the amount of the lesser of 20% or $500. |
| | Rehabilitation services | $20 copay/visit. | 20% coinsurance. | Combined physical, speech and occupational therapy limit: 60 sessions/calendar year.<br>Chiropractic care limit: 30 sessions/calendar year.<br>In-network: cardiac rehabilitation program: no charge. |
| | Habilitation services | Not covered. | Not covered. | You must pay 100% of this service, even in-network. |
| | Skilled nursing care | $250 copay/admission. | 20% coinsurance. | Limit: 120 days/calendar year.<br>Preauthorization required for out-of-network services to avoid penalty in the amount of the lesser of 20% or $500. |
| | Durable medical equipment | No charge. | 20% coinsurance. | Preauthorization required to avoid penalty in the amount of the lesser of 20% or $500.<br>In-network orthotics: 20% coinsurance applies; limit to one insert/shoe per 36 months. |
| | Hospice services | $250 copay/admission. | 20% coinsurance. | Must be terminally ill with 6 months or less to live.<br>Preauthorization required for out-of-network services to avoid penalty in the amount of the lesser of 20% or $500. |
| If your child needs dental or eye care | Children's eye exam | No charge. | Charges in excess of $75/exam. | Deductible does not apply.<br>Limit: 1 visit/12 months up to age 19; 1 visit/24 months over age 19.<br>Separately administered through Davis Vision. |
| | Children's glasses | No charge. | Charges in excess of $75/lenses and $75/frames or $200/contact lenses. | Deductible does not apply.<br>Limit: 1 pair/12 months.<br>Copays apply for premium frames, anti-reflective coatings, high-index lenses, etc.<br>Separately administered through Davis Vision. |
| | Children's dental check-up | No charge for preventive services. | No charge for preventive services. | Deductible does not apply.<br>Pre-determination of benefits recommended if charges are expected to exceed $300.<br>Individuals may decline dental coverage. |

## 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.)**

- Cosmetic surgery (except following mastectomy or when necessary because of trauma, disease, or functional congenital anomaly)
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs (except for treatment of morbid obesity and as required by the health reform law)

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture (pre-authorization required to avoid penalty in the amount of the lesser of 20% or $500)
- Bariatric surgery (pre-authorization required to avoid penalty in the amount of the lesser of 20% or $500)
- Chiropractic care (limit: 30 sessions/calendar year)
- Dental care (Adult) (subject to coinsurance and $2,000 maximum/calendar year for dependent children over 19)
- Hearing aids (through University of Connecticut Speech & Hearing only; 20% coinsurance over $2,000/appliance); certain limitations apply
- Infertility treatment (limit: two attempts/person/lifetime; pre-authorization required to avoid penalty in the amount of the lesser of 20% or $500)
- Private duty nursing (pre-authorization required to avoid penalty in the amount of the lesser of 20% or $500).
- Routine eye care (Adult) (limit: one exam per 12 months; limit for spouse, retiree, and dependent 19 and over: one exam per 24 months)

**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: the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 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, call 203-934-7991 or 800-922-3240. You may also contact the Department of Labor's Employee Benefits Security Administration at 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 203-934-7991 or 800-922-3240.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 203-934-7991 or 800-922-3240.

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 203-934-7991 or 800-922-3240.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 203-934-7991 or 800-922-3240.

*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 | $0 |
| Specialist copay | $20 |
| Hospital (facility) copay | $250 |
| Other copay | $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 | $12,800 |

In this example, Peg would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $10 |
| The total Peg would pay is | $510 |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copay | $20 |
| Hospital (facility) copay | $250 |
| Other copay | $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 | $7,400 |

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $1,050 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $220 |
| The total Joe would pay is | $1,270 |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copay | $20 |
| Hospital (facility) copay | $235 |
| Other copay | $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 | $1,900 |

In this example, Mia would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $400 |

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