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 at www.soundhealthwellness.com or by calling 1-800-225-7620. The Uniform Glossary can be accessed at: www.cciio.cms.gov

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Preferred providers: **$300** person/**$600** family Non preferred providers: **$600** person/**$1,800** family The **deductible** does not apply to preventive care by a preferred provider, home health care, hospice, and prescriptions.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Your **deductible** starts over January 1st. See the chart on page 2 for how much you pay for covered services after you meet the **deductible**. **Note:** If you (and your enrolled spouse) take steps to earn HRA funding during the available time period, your **deductible** may decrease by as much as $500 person/$1,000 family.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, 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?	Yes. In-network Medical: **$2,750** person/**$5,500** family Out-of-network Medical: **$5,500** person/**$16,500** family Overall in-network out-of-pocket limit on Essential Health Benefits: **$7,150** person / **$14,300** family	The **out of pocket** limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered Medical services. This limit helps you plan for health care expenses. See **Note** above: Medical **out-of-pocket limit** may increase for the same reasons as the **deductible** above, by as much as $500 person/$1,000 family due to HRA funding.
What is not included in the out–of–pocket limit?	Rx copay, co-premiums, balance-billed charges (except for chiropractic) and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the Medical **out-of-pocket limit**. However, expenses you incur for in-network essential health benefits will count toward the Overall in-network out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services such as of office visits.
Does this plan use a network of providers?	Yes. For a list of Aetna POS II **preferred providers**, call	If you use an in-network doctor, or other health care **provider**, 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 **provider** for some services. Plans use the term in-network,

Important Questions	Answers	Why this Matters:
	1-800-225-7620.	**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 6. See your policy or plan document for additional information about **excluded services**.

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

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance	40% co-insurance	none
	Specialist visit	20% co-insurance	40% co-insurance	none
	Other practitioner office visit	20% co-insurance for chiropractor, naturopath, podiatry and acupuncture	40% co-insurance for chiropractor, naturopaths, podiatry and acupuncture	Chiropractic limited to $30 per visit, max of 20 visits per calendar year, naturopath limited to 5 visits per calendar year, podiatry limited to $20 per visit, max of 12 visits per calendar year acupuncture limited to 8 visits per calendar year.
	Preventive care/screening/immunization	No charge	40% co-insurance	See plan document for specific well care schedule

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	Chiropractic x-rays limited to one set from one chiropractic visit, per calendar year
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	Preauthorization required on PET scan
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.soundhealthwellness.com or call 1-800-225-7620.	Most Generic drugs Tier 1	$6/prescription retail (30-day supply) $18/prescription mail order (90-day supply)	$16/prescription (30-day supply)	Tier 0 in-network have a $0 co-payment
	Some Generic and most Preferred brand drugs Tier 2	$22/prescription retail (30-day supply) $66/prescription mail order (90-day supply)	$42/prescription (30-day supply)	none
	Mostly Non-preferred brand drugs Tier 3	$35/prescription retail (30-day supply) $70/prescription mail order (90-day supply)	$55/prescription (30- day supply)	Maintenance mail at retail at the "Trust Network" pharmacies $66 for 90-day supply
	Specialty drugs	$35/prescription (30-day supply)	Not covered	Must use specialty pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	none
	Physician/surgeon fees	20% co-insurance	40% co-insurance	See plan document for list of surgeries requiring pre-authorizations
If you need immediate medical attention	Emergency room services	$100/visit 20% co-insurance	$100/visit 20% co-insurance	$100 co-payment is waived if admitted
	Emergency medical transportation	20% co-insurance	20% co-insurance	To nearest hospital

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
	Urgent care	20% co-insurance	40% co-insurance	none
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	Benefits will be reduced by $250 for failure to pre authorize hospitalization
	Physician/surgeon fee	20% co-insurance	40% co-insurance	none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance	40% co-insurance	none
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance	Benefits will be reduced by $250 for failure to pre-authorize hospitalization
	Substance abuse disorder outpatient services	20% co-insurance	40% co-insurance	none
	Substance abuse disorder inpatient services	20% co-insurance	40% co-insurance	Benefits reduced by $250 for failure to pre-authorize hospitalization.
If you are pregnant	Prenatal and postnatal care	20% co-insurance	40% co-insurance	Routine prenatal visits with an in-network provider are covered at 100% Benefits for employee or spouse only.
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	Benefits for employee or spouse only.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Preauthorization required.
	Rehabilitation services	20% co-insurance	40% co-insurance	Outpatient maximum of 45 visits per condition per calendar year, In patient is subject to maximum of 30 days per condition for physical, occupational, restorative speech, hand and cardiac therapy combined, including services for neurodevelopmentally disabled children age 6 and under.
	Habilitation services	Not covered	Not covered	No coverage for Habilitation services. See rehabilitation for children age 6 and under
	Skilled nursing care	20% co-insurance	40% co-insurance	Must be medically necessary for treatment of an illness or injury.
	Durable medical equipment	20% co-insurance	40% co-insurance	If purchase price exceeds $2000 or the rental price exceeds $500 a prior authorization is required.
	Hospice service	No charge	No charge	60 visits lifetime maximum payable, preauthorization required
If your child needs dental or eye care	Eye exam	No charge	$10/visit plus charges over $35	Covered once every 12 months from the last date of service.
	Glasses	No charge for lenses For frames, charges over $95	For lenses, any charges over $30 – $90 For frames, any charges over $30	Out of network: single vision is covered up to $30, Bifocal up to $40, Trifocal up to $45, Lenticular up to $90 Frames up to $30. Lenses covered once each 12 months, frames covered once each 24 months.
	Dental check-up	See dental plan	See dental plan	Dental benefits can vary depending on plan choice.

Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs

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

- Acupuncture
- Bariatric Surgery
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Routine foot care

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 1-800-225-7620. 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: Zenith American Solutions at 1-800-225-7620 or the Department of Labor' Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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 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 1-800-225-7620.

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 will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,390
- **Patient pays** $2,150

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	$600
Co-pays	$10
Co-insurance	$1,390
Limits or exclusions	$150
Total	**$2,150**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,340
- **Patient pays** $1060

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	$300
Co-pays	$240
Co-insurance	$440
Limits or exclusions	$80
Total	**$1,060**

Note: These numbers assume the patient has completed HRA funding requirements listed on page 1 and earned credit of $500.

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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