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, www.mycoresource.com. 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.cciio.cms.gov or call 1-877-267-2323 extension 61565 to request a copy. Questions: Call 1-877-367-5690 or visit us at www.mycoresource.com for more information, including a copy of your plan's plan document and summary plan description.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For preferred providers: $1,500/individual or $3,000/family For non-preferred providers: $3,000/individual or $6,000/family Coinsurance does not apply to the deductible.	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preferred provider preventive care.	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 preferred providers: $4,250/ individual or $8,500/family No individual will have more than a $6,850 preferred provider out of pocket expense. For nonpreferred providers: $8,500/ individual or $17,000/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?	Penalties for failure to obtain pre-authorization for services, 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 1-800-US-AETNA; or www.medcost.com or call 800-824-7406 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.

Important Questions	Answers	Why This Matters:
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
		Preferred Provider (You will pay the least)	Nonpreferred 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% coinsurance	40% coinsurance	Non-preferred providers limited to customary and reasonable amount.
	Specialist visit	20% coinsurance	40% coinsurance	Non-preferred providers limited to customary and reasonable amount.
	Preventive care/screening/ immunization	No charge	40% coinsurance	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. Non-preferred providers limited to customary and reasonable amount.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Non-preferred providers limited to customary and reasonable amount.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Non-preferred providers limited to customary and reasonable amount.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com or call 1-866-644-7527	Generic drugs	Preventive Therapy Drugs: No charge (Drugs that are subject to step therapy, brand penalty and prior authorization may not be covered at 100% by the plan) All others drugs 20% coinsurance	Not covered	Each prescription limited to a 30-day supply retail or a 90-day supply mail order. Specialty Drugs must be obtained through Caremark's Specialty Pharmacy. Specialty Drugs are limited to a 30 day supply.
	Preferred brand drugs		Not covered	
	Non-preferred brand drugs		Not covered	
	Specialty drugs		Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Non-preferred providers limited to customary and reasonable amount.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Non-preferred providers limited to customary and reasonable amount.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	Emergency visit 20% coinsurance Non-emergency visit 50% coinsurance	Emergency visit 20% coinsurance (Preferred provider deductible and out of pocket limit apply) Non-emergency visit 50% coinsurance	Non-preferred providers limited to customary and reasonable amount.
	Emergency medical transportation	20% coinsurance	20% coinsurance (Preferred provider deductible and out of pocket limit apply)	Non-preferred providers limited to customary and reasonable amount.
	Urgent care	20% coinsurance	20% coinsurance (Preferred provider deductible and out of pocket limit apply)	Non-preferred providers limited to customary and reasonable amount.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	$300 penalty applies to each inpatient admission that is not pre-certified. Non-preferred providers limited to customary and reasonable amount.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Non-preferred providers limited to customary and reasonable amount.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Non-preferred providers limited to customary and reasonable amount.
	Inpatient services	20% coinsurance	40% coinsurance	$300 penalty applies to each inpatient admission that is not pre-certified. Non-preferred providers limited to customary and reasonable amount.
If you are pregnant	Office visits	No charge	40% coinsurance	Non-preferred providers limited to customary and reasonable amount.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Non-preferred providers limited to customary and reasonable amount.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Non-preferred providers limited to customary and reasonable amount.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to one visit per day. $300 penalty applies if not pre-certified. Non-preferred providers limited to customary and reasonable amount.
	Rehabilitation services	20% coinsurance	40% coinsurance	$300 penalty applies to each inpatient admission that is not pre-certified. Inpatient rehabilitation limited to 81 days while covered by this plan combined with private duty nursing. Non-preferred providers limited to customary and reasonable amount.
	Habilitation services	20% coinsurance	40% coinsurance	Physical, speech, occupational and behavioral therapy limited to a 35 visits per year (each). Non-preferred providers limited to customary and reasonable amount.
	Skilled nursing care	20% coinsurance	40% coinsurance	Home nursing requires pre-certification. Private duty nursing limited to 81 days while covered by this plan combined with inpatient rehabilitation services. Non-preferred providers limited to customary and reasonable amount.
	Durable medical equipment	20% coinsurance	20% coinsurance (Preferred provider deductible and out of pocket limit apply)	Non-preferred providers limited to customary and reasonable amount.
	Hospice services	20% coinsurance	40% coinsurance	$300 penalty applies to each inpatient admission that is not pre-certified. Non-preferred providers limited to customary and reasonable amount.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage for eye exams.
	Children's glasses	Not covered	Not covered	No coverage for glasses.
	Children's dental check-up	Not Covered	Not covered	No coverage for dental exams.

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;
- Dental care;
- Long-term care;
- Non-emergency care when traveling outside the U.S.;
- Routine eye care; and
- Routine foot care.

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

- Acupuncture;
- Bariatric surgery;
- Chiropractic care;
- Hearing aids;
- Infertility treatment;
- Private-duty nursing; and
- Weight-loss programs.

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-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 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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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 1-877-367-5690.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-367-5690.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-877-367-5690.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-367-5690.

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	$1,500
Specialist	20%
Hospital (facility)	20%
Other	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	$1,500
Copayments	$0
Coinsurance	$2,527
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,087**

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

The plan's overall deductible	$1,500
Specialist	20%
Hospital (facility)	20%
Other	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	$1,500
Copayments	$0
Coinsurance	$1,437
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,992**

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

The plan's overall deductible	$1,500
Specialist	20%
Hospital (facility)	20%
Other	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	$1,500
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,885**

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

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, www.mycoresource.com. 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.cciio.cms.gov or call 1-877-267-2323 extension 61565 to request a copy. Questions: Call 1-877-367-5690 or visit us at www.mycoresource.com for more information, including a copy of your plan's plan document and summary plan description.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For preferred providers: $2,500/individual or $5,000/family For non-preferred providers: $5,000/individual or $10,000/family Coinsurance does not apply to the deductible.	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preferred provider preventive care.	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 preferred providers: $5,500/ individual or $11,000/family No individual will have more than a $6,850 preferred provider out-of-pocket expense. For nonpreferred providers: $11,000/ individual or $22,000/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?	Penalties for failure to obtain pre-authorization for services, 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 1-800-US-AETNA; or www.medcost.com or call 1-800-824-7406 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.

Important Questions	Answers	Why This Matters:
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
		Preferred Provider (You will pay the least)	Nonpreferred 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% coinsurance	40% coinsurance	Non-preferred providers limited to customary and reasonable amount.
	Specialist visit	20% coinsurance	40% coinsurance	Non-preferred providers limited to customary and reasonable amount.
	Preventive care/screening/ immunization	No charge	40% coinsurance	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. Non-preferred providers limited to customary and reasonable amount.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Non-preferred providers limited to customary and reasonable amount.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Non-preferred providers limited to customary and reasonable amount.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com or call 1-866-644-7527	Generic drugs	Preventive Therapy Drugs: No charge (Drugs that are subject to step therapy, brand penalty and prior authorization may not be covered at 100% by the plan) All others drugs 20% coinsurance	Not covered	Each prescription limited to a 30-day supply retail or a 90-day supply mail order. Specialty Drugs must be obtained through Caremark's Specialty Pharmacy. Specialty Drugs are limited to a 30 day supply.
	Preferred brand drugs		Not covered	
	Non-preferred brand drugs		Not covered	
	Specialty drugs		Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Non-preferred providers limited to customary and reasonable amount.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Non-preferred providers limited to customary and reasonable amount.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	Emergency visit 20% coinsurance Non-emergency visit 50% coinsurance	Emergency visit 20% coinsurance (Preferred provider deductible and out of pocket limit apply) Non-emergency visit 50% coinsurance	Non-preferred providers limited to customary and reasonable amount.
	Emergency medical transportation	20% coinsurance	20% coinsurance (Preferred provider deductible and out of pocket limit apply)	Non-preferred providers limited to customary and reasonable amount.
	Urgent care	20% coinsurance	20% coinsurance (Preferred provider deductible and out of pocket limit apply)	Non-preferred providers limited to customary and reasonable amount.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	$300 penalty applies to each inpatient admission that is not pre-certified. Non-preferred providers limited to customary and reasonable amount.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Non-preferred providers limited to customary and reasonable amount.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Non-preferred providers limited to customary and reasonable amount.
	Inpatient services	20% coinsurance	40% coinsurance	$300 penalty applies to each inpatient admission that is not pre-certified. Non-preferred providers limited to customary and reasonable amount.
If you are pregnant	Office visits	No charge	40% coinsurance	Non-preferred providers limited to customary and reasonable amount.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Non-preferred providers limited to customary and reasonable amount.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Non-preferred providers limited to customary and reasonable amount.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to one visit per day. $300 penalty applies if not pre-certified. Non-preferred providers limited to customary and reasonable amount.
	Rehabilitation services	20% coinsurance	40% coinsurance	$300 penalty applies to each inpatient admission that is not pre-certified. Inpatient rehabilitation limited to 81 days while covered by this plan combined with private duty nursing. Non-preferred providers limited to customary and reasonable amount.
	Habilitation services	20% coinsurance	40% coinsurance	Physical, speech, occupational and behavioral therapy limited to a 35 visits per year (each). Non-preferred providers limited to customary and reasonable amount.
	Skilled nursing care	20% coinsurance	40% coinsurance	Home nursing requires pre-certification. Private duty nursing limited to 81 days while covered by this plan combined with inpatient rehabilitation services. Non-preferred providers limited to customary and reasonable amount.
	Durable medical equipment	20% coinsurance	20% coinsurance (Preferred provider deductible and out of pocket limit apply)	Non-preferred providers limited to customary and reasonable amount.
	Hospice services	20% coinsurance	40% coinsurance	$300 penalty applies to each inpatient admission that is not pre-certified. Non-preferred providers limited to customary and reasonable amount.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage for eye exams.
	Children's glasses	Not covered	Not covered	No coverage for glasses.
	Children's dental check-up	Not Covered	Not covered	No coverage for dental exams.

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;
- Dental care;
- Long-term care;
- Non-emergency care when traveling outside the U.S.;
- Routine eye care; and
- Routine foot care.

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

- Acupuncture;
- Bariatric surgery;
- Chiropractic care;
- Hearing aids;
- Infertility treatment;
- Private-duty nursing; and
- Weight-loss programs.

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-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 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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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 1-877-367-5690.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-367-5690.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-877-367-5690.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-367-5690.

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	$2,500
Specialist	20%
Hospital (facility)	20%
Other	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	$2,500
Copayments	$0
Coinsurance	$2,527
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,087**

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

The plan's overall deductible	$2,500
Specialist	20%
Hospital (facility)	20%
Other	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	$2,500
Copayments	$0
Coinsurance	$1,437
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,992**

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

The plan's overall deductible	$2,500
Specialist	20%
Hospital (facility)	20%
Other	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	$1,540
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

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

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, www.mycoresource.com. 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.cciio.cms.gov or call 1-877-267-2323 extension 61565 to request a copy. Questions: Call 1-877-367-5690 or visit us at www.mycoresource.com for more information, including a copy of your plan's plan document and summary plan description.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For preferred providers: $4,500/individual or $9,000/family For non-preferred providers: $6,350/individual or $12,700/family Coinsurance does not apply to the deductible.	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preferred provider preventive care.	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 preferred providers: $6,350/ individual or $12,700/family No individual will have more than a $6,850 preferred provider out-of-pocket expense. No out of pocket limit for nonpreferred providers.	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?	Penalties for failure to obtain pre-authorization for services, 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 1-800-US-AETNA; or www.medcost.com or call 1-800-824-7406 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.

Important Questions	Answers	Why This Matters:
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
		Preferred Provider (You will pay the least)	Nonpreferred 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	30% coinsurance	50% coinsurance	Non-preferred providers limited to customary and reasonable amount.
	Specialist visit	30% coinsurance	50% coinsurance	Non-preferred providers limited to customary and reasonable amount.
	Preventive care/screening/ immunization	No charge	Not covered	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)	30% coinsurance	50% coinsurance	Non-preferred providers limited to customary and reasonable amount.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	Non-preferred providers limited to customary and reasonable amount.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com or call 1-866-644-7527.	Generic drugs	Preventive Therapy Drugs: No charge (Drugs that are subject to step therapy, brand penalty and prior authorization may not be covered at 100% by the plan) All others drugs 30% coinsurance	Not covered	Each prescription limited to a 30-day supply retail or a 90-day supply mail order. Specialty Drugs must be obtained through Caremark's Specialty Pharmacy. Specialty Drugs are limited to a 30 day supply.
	Preferred brand drugs		Not covered	
	Non-preferred brand drugs		Not covered	
	Specialty drugs		Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Non-preferred providers limited to customary and reasonable amount.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Non-preferred providers limited to customary and reasonable amount.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	Emergency visit 30% coinsurance Non-emergency visit 50% coinsurance	Emergency visit 30% coinsurance (Preferred provider deductible and out of pocket limit apply) Non-emergency visit 50% coinsurance	Non-preferred providers limited to customary and reasonable amount.
	Emergency medical transportation	30% coinsurance	30% coinsurance (Preferred provider deductible and out of pocket limit apply)	Non-preferred providers limited to customary and reasonable amount.
	Urgent care	30% coinsurance	30% coinsurance (Preferred provider deductible and out of pocket limit apply)	Non-preferred providers limited to customary and reasonable amount.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	$300 penalty applies to each inpatient admission that is not pre-certified. Non-preferred providers limited to customary and reasonable amount.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Non-preferred providers limited to customary and reasonable amount.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	50% coinsurance	Non-preferred providers limited to customary and reasonable amount.
	Inpatient services	30% coinsurance	50% coinsurance	$300 penalty applies to each inpatient admission that is not pre-certified. Non-preferred providers limited to customary and reasonable amount.
If you are pregnant	Office visits	No charge	50% coinsurance	Non-preferred providers limited to customary and reasonable amount.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	Non-preferred providers limited to customary and reasonable amount.
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	Non-preferred providers limited to customary and reasonable amount.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Limited to one visit per day. $300 penalty applies if not pre-certified. Non-preferred providers limited to customary and reasonable amount.
	Rehabilitation services	30% coinsurance	50% coinsurance	$300 penalty applies to each inpatient admission that is not pre-certified. Inpatient rehabilitation limited to 81 days while covered by this plan combined with private duty nursing. Non-preferred providers limited to customary and reasonable amount.
	Habilitation services	30% coinsurance	50% coinsurance	Physical, speech, occupational and behavioral therapy limited to a 35 visits per year (each). Non-preferred providers limited to customary and reasonable amount.
	Skilled nursing care	30% coinsurance	50% coinsurance	Home nursing requires pre-certification. Private duty nursing limited to 81 days while covered by this plan combined with inpatient rehabilitation services. Non-preferred providers limited to customary and reasonable amount.
	Durable medical equipment	30% coinsurance	30% coinsurance (Preferred provider deductible and out of pocket limit apply)	Non-preferred providers limited to customary and reasonable amount.
	Hospice services	30% coinsurance	50% coinsurance	$300 penalty applies to each inpatient admission that is not pre-certified. Non-preferred providers limited to customary and reasonable amount.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage for eye exams.
	Children's glasses	Not covered	Not covered	No coverage for glasses.
	Children's dental check-up	Not Covered	Not covered	No coverage for dental exams.

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;
- Dental care;
- Long-term care;
- Non-emergency care when traveling outside the U.S.;
- Routine eye care; and
- Routine foot care.

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

- Acupuncture;
- Bariatric surgery;
- Chiropractic care;
- Hearing aids;
- Infertility treatment;
- Private-duty nursing; and
- Weight-loss programs.

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-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 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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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 1-877-367-5690.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-367-5690.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-877-367-5690.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-367-5690.

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	$4,500
Specialist	30%
Hospital (facility)	30%
Other	30%

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	$2,630
Copayments	$0
Coinsurance	$3,720
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,410**

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

The plan's overall deductible	$4,500
Specialist	30%
Hospital (facility)	30%
Other	30%

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	$4,443
Copayments	$0
Coinsurance	$1,907
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$6,405**

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

The plan's overall deductible	$4,500
Specialist	30%
Hospital (facility)	30%
Other	30%

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	$1,348
Copayments	$0
Coinsurance	$578
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

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