

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

Coverage for: Individual + Family | Plan Type: EPO

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.trselectivecare.com or by calling 1-800-222-9205.

| Important Questions | Answers | Why this Matters: |
|--|--|---|
| What is the overall deductible? | For each Plan Year, Network: Individual \$1,200 / Family \$3,600 . Does not apply to office visits, prescription drugs, urgent care and preventive care in-network. | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible . |
| Are there other deductibles for specific services? | Yes. \$200 for prescription drug expenses. Does not apply to generic drugs. There are no other specific deductibles . | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| Is there an out-of-pocket limit on my expenses? | Yes. Network: Individual \$6,600 / Family \$13,200 . | 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 services. This limit helps you plan for health care expenses. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billed charges and penalties for failure to obtain pre-authorization for services and health care this plan does not cover. | Even though you pay these expenses, they don't count toward the 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 <i>specific</i> covered services, such as office visits. |
| Does this plan use a network of providers? | Yes. See www.trselectivecare.com or call the TRS-ActiveCare Customer Service number 1-800-222-9205 for a list of network providers . | 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, 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 5. See your policy or plan document for additional information about excluded services . |

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

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|--|---|---|---|
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$30 copay/visit, except 20% coinsurance for office surgery | Not covered | Includes Internist, General Physician, Family Practitioner, Pediatrician or Gynecologist. |
| | Specialist visit | \$60 copay/visit, except 20% coinsurance for office surgery | Not covered | —————none————— |
| | Other practitioner office visit | \$60 copay/visit | Not covered | Coverage is limited to 35 visits per plan year for Chiropractic care. |
| | Preventive care /screening /immunization | No charge, except \$60 copay /visit for hearing exams | Not covered | Age and frequency schedules may apply. |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% coinsurance, except no charge for Quest facility | Not covered | —————none————— |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance after \$100 copay/visit | Not covered | Pre-authorization may be required for care. |

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| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|--|---|---|---|
| <p>If you need drugs to treat your illness or condition Prescription drug coverage is administered by CVS Caremark</p> <p>More information about prescription drug coverage is available at www.cvsremark.com</p> | Generic drugs | Copay/prescription: \$20 (Retail first fill), \$25 (Retail refill), \$45 copay (Mail Order or Retail-Plus) | Copay/prescription: \$20 (Retail first fill), \$25 (Retail refill), \$45 copay (Mail Order or Retail-Plus) | <p>Covers up to a 31 day supply (Retail), up to a 90 day supply (Mail Order or Retail-Plus). Includes performance enhancing medication limited to 8 tablets per month, contraceptive drugs and devices obtainable from a pharmacy. No charge for formulary generic FDA-approved women's contraceptives in-network. Precertification required. Step therapy required. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written. Out-of-Network: reimbursement is the allowed amount for what would have been charged by a network pharmacy less the copay after the drug deductible is met.</p> |
| | Preferred brand drugs | Copay/prescription: \$40 (Retail first fill), \$50 (Retail refill), \$105 copay (Mail Order or Retail-Plus) | Copay/prescription: \$40 (Retail first fill), \$50 (Retail refill), \$105 copay (Mail Order or Retail-Plus) | |
| | Non-preferred brand drugs | 50% coinsurance/prescription (Retail and Mail Order or Retail-Plus) | 50% coinsurance/prescription (Retail and Mail Order or Retail-Plus) | |
| | Specialty drugs | 20% coinsurance/prescription | Not Covered | |
| <p>If you have outpatient surgery</p> | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance after \$150 copay/visit | Not covered | —————none————— |
| | Physician/surgeon fees | 20% coinsurance | Not covered | —————none————— |
| <p>If you need immediate medical attention</p> | Emergency room services | 20% coinsurance after \$150 copay/visit | 20% coinsurance after \$150 copay/visit | —————none————— |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | —————none————— |
| | Urgent care | \$50 copay/visit | Not covered | —————none————— |
| <p>If you have a hospital stay</p> | Facility fee (e.g., hospital room) | 20% coinsurance after \$150 copay per day | Not covered | \$750 maximum copay per individual per stay. |
| | Physician/surgeon fee | 20% coinsurance | Not covered | —————none————— |

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| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|--|--|---|---|
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | \$60 copay/visit | Not covered | Pre-authorization may be required for care. |
| | Mental/Behavioral health inpatient services | 20% coinsurance after \$150 copay per day | Not covered | \$750 maximum copay per individual per stay. |
| | Substance use disorder outpatient services | \$60 copay/visit | Not covered | Pre-authorization may be required for care. |
| | Substance use disorder inpatient services | 20% coinsurance after \$150 copay per day | Not covered | \$750 maximum copay per individual per stay. |
| If you are pregnant | Prenatal and postnatal care | No charge | Not covered | —————none————— |
| | Delivery and all inpatient services | 20% coinsurance after \$150 copay per day | Not covered | \$750 maximum copay per individual per stay. Includes outpatient postnatal care. |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | Not covered | Coverage is limited to 60 visits per plan year. |
| | Rehabilitation services | 20% coinsurance, except \$60 copay/visit if performed by physician | Not covered | —————none————— |
| | Habilitation services | \$60 copay/visit | Not covered | Coverage is limited to treatment of Autism. |
| | Skilled nursing care | 20% coinsurance | Not covered | Coverage is limited to 25 days per plan year. |
| | Durable medical equipment | 20% coinsurance | Not covered | —————none————— |
| | Hospice service | 20% coinsurance | Not covered | —————none————— |
| If your child needs dental or eye care | Eye exam | \$60 copay/visit | Not covered | Coverage is limited to 1 routine eye exam per calendar year. Performed by an ophthalmologist or optometrist using calibrated instruments. |
| | Glasses | Not covered | Not covered | Not covered. |
| | Dental check-up | Not covered | Not covered | Not covered. |

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Excluded Services & Other Covered Services:

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

- | | | |
|-------------------------------|--|------------------------|
| • Acupuncture | • Glasses (Child) | • Private-duty nursing |
| • Bariatric surgery | • Long-term care | • Routine foot care |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |
| • Dental care (Adult & Child) | | |

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

- | | |
|--|---|
| • Chiropractic care - Coverage is limited to 35 visits per plan year. | • Infertility treatment - Coverage is limited to the diagnosis and treatment of underlying medical condition. |
| • Hearing aids - Coverage is limited to \$1,000 maximum per 36 months. | • Routine eye care (Adult) - Coverage is limited to 1 routine eye exam per calendar year. |

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 1-800-222-9205. 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 us by calling the toll free number on your Medical ID Card. If your group health plan is subject to ERISA, 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>

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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 Meet 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 1-800-222-9205.

如果需要中文的帮助, 请拨打这个号码 1-800-222-9205.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-222-9205.

Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-222-9205.

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

Coverage Examples

Coverage for: Individual + Family | Plan Type: EPO

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 also will 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: \$3,960
- Patient pays: \$3,580

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 | \$2,100 |
| Copays | \$340 |
| Coinsurance | \$940 |
| Limits or exclusions | \$200 |
| Total | \$3,580 |

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

- Amount owed to providers: \$5,400
- Plan pays: \$2,820
- Patient pays: \$2,580

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 | \$1,400 |
| Copays | \$900 |
| Coinsurance | \$200 |
| Limits or exclusions | \$80 |
| Total | \$2,580 |

Coverage Examples

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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.