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, visit www.myCampbellBenefits.com or call 1-877-725-2255. For definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms visit www.healthcare.gov/glossary.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $500 per individual / $1,000 family; For out-of-network providers $1,000 individual / $2,000 family.	Generally, you pay all of the costs from providers up to the deductible amount before the plan begins to pay. If you have family members on the plan, each member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible if received in-network.	This plan covers some items and services even if you haven't yet met the deductible amount. 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 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, but see the chart on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For network providers $2,000 individual / $4,000 family; For out-of-network providers $4,000 individual / $8,000 family	The out-of-pocket limit is the most you could pay in a year for covered services under the medical plan. 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. There is a separate $1,500 individual / $3,000 family out-of-pocket limit for prescription drug drugs.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain pre-certification for services 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. For a list of in-network medical providers, visit www.aetna.com or call 1-800-847-8982. For in-network pharmacies, visit www.caremark.com or call 1-833-956-1791.	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 don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

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% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	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 you need are preventive, then check what your plan will pay for. Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Generic drugs (Tier 1)	15% coinsurance; $10 minimum retail, $20 minimum mail order	You will pay at the point of purchase and then file a claim form for reimbursement. The Plan will reimburse you the same amount it would have paid to a participating pharmacy. You are responsible for the difference between what the non-network pharmacy charges and what the plan reimburses.	Covers up to a 30-day supply (retail); 31-90 day supply (mail order prescription). Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered. Drugs for certain chronic conditions such as lipid lowering agents, diabetes and asthma are subject to a maximum cost of $10.
	Preferred brand drugs (Tier 2)	30% coinsurance; $25 minimum retail, $50 minimum mail order		
	Non-preferred brand drugs (Tier 3)	40% coinsurance; $50 minimum retail, $100 minimum mail order		
	Specialty drugs (Tier 4)	The applicable generic, preferred, or non-preferred coinsurance applies to Specialty drugs dispensed through the drug benefit.		Specialty drugs are required to be filled through the CVS Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% 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 immediate medical attention	Emergency room care	$150 copay, then 20% coinsurance	$150 copay, then 20% coinsurance	Out-of-network ERs must contact Aetna for precertification. Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	40% coinsurance	None
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification required. If not obtained, reduced benefits and a penalty may apply.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Precertification required. If not obtained, reduced benefits and a penalty may apply.
If you are pregnant	Office visits – Prenatal	No charge	40% coinsurance	None
	Office visits – Postnatal	20% coinsurance	40% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limit of 120 visits/calendar year. Precertification required. If not obtained, benefits may be reduced or not paid at all.
	Rehabilitation services	20% coinsurance	40% coinsurance	Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	20% coinsurance	40% coinsurance	Limit of 60 visits/calendar year. Precertification required. If not obtained, reduced benefits and a penalty may apply.
	Durable medical equipment	20% coinsurance	40% coinsurance	Limits apply to replacements due to misuse.
	Hospice services	20% coinsurance	40% coinsurance	Precertification required. If not obtained, reduced benefits and a penalty may apply.
If your child needs dental or eye care	Eye exam	No charge	40% coinsurance	Limited to one routine exam/calendar year.
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

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
- Glasses or contacts
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Habilitation services
- Routine Foot Care
- Weight loss programs

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

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric Surgery (when deemed medically necessary)
- Chiropractic Care (Limited to 30 visits per calendar year)
- Hearing Aids (Limited to $2,000 per ear/ 3 years)
- Infertility treatment (Lifetime max of $35,000)
- Private-duty nursing (Limited to 70 shifts per calendar year

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, call 1-800-847-8982 or visit www.aetna.com. 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.You may also contact the NJ Department of Banking and Insurance Consumer Protection Services at 1-888-393-1062 extension 50998.

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services: Spanish (Español): Para obtener asistencia en Español, llame al 844-383-2325. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-383-2325. Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 844-383-2325. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 844-383-2325.

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	$500
Specialist copayment	$0
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$2,460
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,020**

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

The plan's overall deductible	$500
Specialist copayment	$0
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$500
Copayments	$0
Coinsurance	$1,380
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,940**

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

The plan's overall deductible	$500
Specialist copayment	$0
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$500
Copayments	$150
Coinsurance	$280
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$930**

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