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 by calling contact HR Solutions at 800-690-7655 ext. 3012 option 5 or hrsolutions@dcsg.com.

Important Questions	Answers: PPO1	PPO2	PPO3	Why this Matters:
What is the overall deductible?	**$3,000** individual/**$6,000** family in-network **$6,000** individual/**$12,000** family out-of-network Doesn't apply to preventative care, office visits, and prescription drug benefits.	**$1,150** individual/**$2,300** family in-network **$2,300** individual/**$4,600** family out-of-network Doesn't apply to preventative care, office visits, and prescription drug benefits.	**$650** individual/**$1,300** family in-network **$1,300** individual/**$2,600** family out-of-network Doesn't apply to preventative care, office visits, and prescription drug benefits.	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 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	No.	No.	You don't have to meet **deductibles** for specific services.
Is there an out–of–pocket limit on my expenses?	Yes, **$3,250** individual/ **$6,500** family in-network **$12,000** individual/ **$24,000** family out-of-network.	Yes. **$2,600** individual/ **$5,700** family in-network **$4,500** individual/**$9,600** family out-of-network	Yes. **$2,100** individual/ **$4,600** family in-network **$3,500** individual/**7,800** family out-of-network	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 services this plan doesn't cover.	Premiums, balance-billed charges and services this plan doesn't cover.	Premiums, balance-billed charges and services this plan doesn't 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.	No.	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov or call 800-690-7655 ext. 3012 option 5 to request a copy.

Important Questions	Answers: PPO1	PPO2	PPO3	Why this Matters:
Does this plan use a network of providers?	Yes. For a list of participating providers: -See www.aetna.com or call **1-800-635-3364** (use the Choice POS II plan) -See www.highmarkbcbs.com or call **1-800-572-1460** (use the BCBS PPO plan)	Yes. For a list of participating providers: -See www.aetna.com or call **1-800-635-3364** (use the Choice POS II plan) -See www.highmarkbcbs.com or call **1-800-572-1460** (use the BCBS PPO plan)	Yes. For a list of participating providers: -See www.aetna.com or call **1-800-635-3364** (use the Choice POS II plan) -See www.highmarkbcbs.com or call **1-800-572-1460** (use the BCBS PPO plan)	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 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist	No. You don't 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.
Are there services this plan doesn't cover?	Yes.	Yes.	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**.

- **Copayments** are fixed dollar amounts (for example, $20) 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 **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use an In-network Provider		Your Cost if You Use an Out-of-network Provider		Limitations & Exceptions
		PPO1	PPO2 & PPO3	PPO1	PPO2 & PPO3	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	$20 copay/visit	20% coinsurance*	40% coinsurance*	None
	Specialist visit	$40 copay/visit	$40 copay/visit	20% coinsurance*	40% coinsurance*	None
	Other practitioner office visit	0% coinsurance for chiropractor*	20% coinsurance for chiropractor*	20% coinsurance for chiropractor*	40% coinsurance for chiropractor*	Combined network and out-of-network: 25 visits per benefit period.
	- Preventive care - Screening - Immunization	No charge for preventive care services	No charge for preventive care services	No coverage for preventive care visits 20% coinsurance for screening services* 20% coinsurance for immunizations*	No coverage for preventive care visits 40% coinsurance for screening services* 40% coinsurance for immunizations*	None
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance*	20% coinsurance*	20% coinsurance*	40% coinsurance*	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance*	20% coinsurance*	20% coinsurance*	40% coinsurance*	None

Common Medical Event	Services You May Need	Your Cost if You Use an In-network Provider		Your Cost if You Use an Out-of-network Provider		Limitations & Exceptions
		PPO1	PPO2 & PPO3	PPO1	PPO2 & PPO3	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com/DCSG	Generic drugs	$10 copay (retail) $20 copay (mail order)		Not covered	Not covered	Up to 30-day supply retail prescription; 31 - 90-day supply (mail order prescription)
	Formulary Brand drugs	$25 copay (retail) $50 copay (mail order)		Not covered	Not covered	Up to 30-day supply retail prescription; 31 - 90-day supply (mail order prescription)
	Non-Formulary Brand drugs	$55 copay (retail) $110 copay (mail order)		Not covered	Not covered	Up to 30-day supply retail prescription; 31 - 90-day supply (mail order prescription)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance*	20% coinsurance*	20% coinsurance*	40% coinsurance*	None
	Physician/surgeon fees	0% coinsurance*	20% coinsurance*	20% coinsurance*	40% coinsurance*	None
If you need immediate medical attention	Emergency room services	Deductible plus $100 copay/visit	20% coinsurance after $100 copay/visit*	Deductible plus $100 copay/visit	20% coinsurance after $100 copay/visit*	Copay waived if admitted as an inpatient.
	Emergency medical transportation	0% coinsurance*	20% coinsurance*	0% coinsurance*	20% coinsurance*	None
	Urgent care	$40 copay/visit	$40 copay/visit	20% coinsurance*	40% coinsurance*	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance*	20% coinsurance*	20% coinsurance*	40% coinsurance*	None

Common Medical Event	Services You May Need	Your Cost if You Use an In-network Provider		Your Cost if You Use an Out-of-network Provider		Limitations & Exceptions
		PPO1	PPO2 & PPO3	PPO1	PPO2 & PPO3	
	Physician/surgeon fee	0% coinsurance*	20% coinsurance*	20% coinsurance*	40% coinsurance*	None
If you have mental health, behavioral health or substance abuse needs	• Mental/Behavioral health outpatient services	0% coinsurance*	20% coinsurance*	20% coinsurance*	40% coinsurance*	None
	• Mental/Behavioral health inpatient services	$40 copay/visit	$40 copay/visit and 20% coinsurance for other outpatient services	20% coinsurance*	40% coinsurance*	
	• Substance use disorder outpatient services	0% coinsurance*	20% coinsurance*	20% coinsurance*	40% coinsurance*	
	• Substance use disorder inpatient services					
If you are pregnant	Prenatal and postnatal care	0% coinsurance*	20% coinsurance*	20% coinsurance*	40% coinsurance*	None
	Delivery and all inpatient services	0% coinsurance*	20% coinsurance*	20% coinsurance*	40% coinsurance*	None

* after the annual deductible has been satisfied

Common Medical Event	Services You May Need	Your Cost if You Use an In-network Provider		Your Cost if You Use an Out-of-network Provider		Limitations & Exceptions
		PPO1	PPO2 & PPO3	PPO1	PPO2 & PPO3	
If you need help recovering or have other special health needs	Home health care	0% coinsurance*	20% coinsurance*	20% coinsurance*	40% coinsurance*	Combined network and out-of-network: 100 visits per benefit period.
	Rehabilitation services	0% coinsurance*	20% coinsurance*	20% coinsurance*	40% coinsurance*	None
	Habilitation services	0% coinsurance*	20% coinsurance*	20% coinsurance*	40% coinsurance*	
	Skilled nursing care	0% coinsurance*	20% coinsurance*	20% coinsurance*	40% coinsurance*	Combined network and out-of-network: 100 days per benefit period.
	Durable medical equipment	0% coinsurance*	20% coinsurance*	20% coinsurance*	40% coinsurance*	None
	Hospice service	0% coinsurance*	20% coinsurance*	20% coinsurance*	40% coinsurance*	None
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered	Not covered	None
	Glasses	Not covered	Not covered	Not covered	Not covered	None
	Dental check-up	Not covered	Not covered	Not covered	Not covered	None

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.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss program

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

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services.)		
• Acupuncture • Bariatric surgery	• Chiropractic Care • Infertility (Counseling, testing and treatment covered all plans; PPO3 has a 6 attempts limit for assisted fertilization)	Non-emergency care when traveling outside the U.S.

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 800-690-7655 ext. 3012 option 5. 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 HR Solutions at 1-800-690-7655 ext. 3012, option 5.

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 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.**

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 last page for important information about these examples.

Having a baby
(normal delivery)

PPO1

- **Amount owed to providers:** $7,540
- **Plan pays** $4,970
- **Patient pays** $2,570

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 (minus HRA)	$2,500
Copays	$70
Coinsurance	$0
Limits or exclusions	$0
Total	**$2,570**

Having a baby
(normal delivery)

PPO2

- **Amount owed to providers**: $7,540
- **Plan pays** $5,320
- **Patient pays** $2,220

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	$1,150
Copays	$70
Coinsurance	$1,000
Limits or exclusions	$0
Total	**$2,220**

Having a baby
(normal delivery)

PPO3

- **Amount owed to providers**: $7,540
- **Plan pays** $5,820
- **Patient pays** $1,720

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	$650
Copays	$70
Coinsurance	$1,000
Limits or exclusions	$0
Total	**$1,720**

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Managing type 2 diabetes
(routine maintenance of a well-controlled condition) – PPO1

- **Amount owed to providers:** $5,400
- **Plan pays** $3,650
- **Patient pays** $1,750

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 (Minus HRA)	$1,150
Copays	$600
Coinsurance	$0
Limits or exclusions	$0
Total	**$1,750**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition) – PPO2

- **Amount owed to providers:** $5,400
- **Plan pays** $3,550
- **Patient pays** $1,850

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	$1,150
Copays	$600
Coinsurance	$100
Limits or exclusions	$0
Total	**$1,850**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition) – PPO3

- **Amount owed to providers:** $5,400
- **Plan pays** $3,950
- **Patient pays** $1,450

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	$650
Copays	$600
Coinsurance	$200
Limits or exclusions	$0
Total	**$1,450**

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 **deductibles** and **coinsurance**. You should also consider contributions to accounts such as flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.