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, [call 1-800-374-1835 or visit us at https://www.nipponlifebenefits.com/media/1458/2019-revised-med-john-doe-evolution-bklt-lg-ca-w-buy-up-with-teladoc-2-1-19.pdf.] 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 [https://www.healthcare.gov/sbc-glossary] or call 1-800-[374-1835] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	[$1,000 member/$2,000 family]	[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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.]
Are there services covered before you meet your deductible?	[Yes. Preferred Provider services for preventive care, physician office visits, urgent care, LabCard, emergency room visits and Preferred Provider or Non-Preferred Provider services for non-specialty prescription drugs and child immunizations are covered before you meet your deductible.]	[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?	[Yes. $50 deductible for home health care. There are no other specific deductibles.]	[You must pay all the cost for these services up to the specific deductible amount before this plan begins to pay for these services.]
What is the out-of-pocket limit for this plan?	[Preferred Provider $2,000 member/$4,000 family Non-Preferred Provider $4,000 member/$8,000 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?	[Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain Prior Authorization for services and the difference between the Generic Drug price	[Even though you pay these expenses, they don't count toward the out–of–pocket limit.]

	and the Preferred or Non-Preferred Brand Name Drug price when a generic equivalent drug is available.]	
Will you pay less if you use a network provider?	[Yes. See [https://www.aetna.com/dsepublic/#/contentPage?page=providerSearchLanding&site_id=asa&language=en]or call 1-800-374-1835] for a list of preferred 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.]
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)	Non-Preferred 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	[$25 copay/office visit; deductible does not apply]	[40% coinsurance]	[None]
	Specialist visit	[$25 copay/office visit; deductible does not apply]	[40% coinsurance]	[None]
	Preventive care/screening/ immunization	No charge	[child immunizations – no charge up to the allowed amount; excess not covered; other child care – 40% coinsurance; adult not covered]	[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.]
If you have a test	Diagnostic test (x-ray, blood work)	[Non-office visits:20% coinsurance _No charge for LabCard services]	[40% coinsurance; Emergency services – 20% coinsurance]	[None]
	Imaging (CT/PET scans, MRIs)	[20% coinsurance]	[40% coinsurance; Emergency services –20% coinsurance]	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at [https://www.nipponlifebenefits.com/member-service/] [Prior Authorization Guideline NC02021-30 https://www.nipponlifebenefits.com/DATAFOLDER/cs/NC02021-30.pdf Formulary NC02019-32 https://www.nipponlifebenefits.com/DATAFOLDER/cs/NC02019-32.pdf	Generic drugs (Tier 1)	[$15 copay/prescription (retail) $30 copay/prescription (mail order)]	[$15 copay/prescription (retail) $30 copay/prescription (mail order)]	[Copay does not apply to: generic and single source contraceptives for women. Benefits for outpatient prescription drugs will be paid at 100% of Covered Charges in excess of $250 of cost sharing for each 30-day supply of each drug. Covers up to a 30-day supply (retail prescription); up to a 90-day supply (mail order prescription). A 90 day supply of maintenance drugs requires three 30 day copays. Copay applies to all injectables received at the retail pharmacy. An injectable would not be subject to the copay if it is administered in an office or hospital setting. The difference between the Generic Drug price and the Preferred or Non-Preferred Brand Name Drug price when a generic equivalent drug is available will not apply toward the $250 cost sharinglimit for outpatient prescription drugs. Prior Authorization may be required for Specialty Drugs.]
	Preferred brand drugs (Tier 2)	[$30 copay/prescription (retail) $60 copay/prescription (mail order)]	[$30 copay/prescription (retail) $60 copay/prescription (mail order)]	
	Non-preferred brand drugs (Tier 3)	[$50 copay/prescription (retail) $100 copay/prescription (mail order)]	[$50 copay/prescription (retail) $100 copay/prescription (mail order)]	
	Specialty drugs	[20% coinsurance]	[40% coinsurance]	
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]
If you need immediate medical attention	Emergency room care	[$150 copay/visit; deductible does not apply]	[$150 copay/visit up to the allowed amount, excess not covered, deductible does not apply]	[Non-emergency services are subject to applicable deductible and coinsurance. MRIs, CATs, PETs, SPECTs and other similar imaging tests performed in the Emergency room are reimbursed at Preferred Provider plan deductible/coinsurance benefits.]
	Emergency medical transportation	[20% coinsurance]	20% coinsurance]	
	Urgent care	[$25 copay/visit; deductible does not apply]	40% coinsurance]	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	[20% coinsurance]	[40% coinsurance]	Precertification is required. Non-compliance penalty of 30% up to $10,000.]
	Physician/surgeon fees	[20% coinsurance]	[40% coinsurance]	[None]
If you need mental health, behavioral health, or substance abuse services	Outpatient services	[$25 copay/office visit and 20% coinsurance for other outpatient services]	[40% coinsurance]	[Precertification is required for inpatient services. Non-compliance penalty of 30% up to $10,000.]
	Inpatient services	[20% coinsurance]	40% coinsurance]	
If you are pregnant	Office visits	[$25 copay/office visit]	[40% coinsurance]	[Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).]
	Childbirth/delivery professional services	[20% coinsurance]	[40% coinsurance]	
	Childbirth/delivery facility services	[20% coinsurance]	[40% coinsurance]	
If you need help recovering or have other special health needs	Home health care	[20% coinsurance]	[40% coinsurance]	[100 visits/year; subject to a separate $50 deductible.]
	Rehabilitation services	[$25 copay/office visit; 20% coinsurance for other outpatient services]	[40% coinsurance]	[30 visits/year. Includes physical, occupational and speech therapy which are also covered when associated with Developmental Delay.]
	Habilitation services	[$25 copay/office visit; 20% coinsurance for other outpatient services]	[40% coinsurance]	
	Skilled nursing care	[20% coinsurance]	[40% coinsurance]	[120 days for same or related illness. Prior Authorization is required. Non-compliance penalty of 30% up to $10,000.]
	Durable medical equipment	[20% coinsurance]	[40% coinsurance]	[Excludes motorized carts, scooters and strollers (except for wheelchairs), non-hospital type beds and lift chairs.]
	Hospice services	[20% coinsurance]	[40% coinsurance]	[None]
If your child needs dental or eye care	Children's eye exam	[Not covered]	[Not covered]	[None]
	Children's glasses	[Not covered]	[Not covered]	[None]
	Children's dental check-up	[Not covered]	[Not covered]	[None]

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.)

- [Bariatric Surgery]
- [Cosmetic Surgery]
- [Dental Care]
- [Hearing Aids]
- [Long Term Care]
- [Private Duty Nursing]
- [Routine eye care]
- [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 up to $500/year]
- [Chiropractic Care]
- [Infertility Treatment]
- [Non-emergency care when traveling outside the U.S. for up to 6 months except for medical travel]

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:
[• For group health coverage subject to ERISA, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.]
[• For non-federal governmental group health plans, the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or https://www.cms.gov/cciio/index.html.]
[• Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.]
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: [the plan: English and Non-English 1-800-374-1835; Japanese 1-800-971-0638; Korean 1-800-827-8713 or California Department of Insurance at 1-800-927-4337 or 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 your appeal. Contact [1-800-927-4357 or e-mail http://insurance.ca.gov/consumers.]

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 1-800-374-1835.][Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-374-1835.]

[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 [1-800-374-1835.] [Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-374-1835.]

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** **[$1,000]**
- **Specialist copayment** **[$25]**
- **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	[$1,000]
Copayments	[$30]
Coinsurance	[$1,000]
What isn't covered	
Limits or exclusions	[$60]
The total Peg would pay is	**[$2,090]**

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

- **The plan's overall deductible** **[$1,000]**
- **Specialist copayment** **[$25]**
- **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*	[$1,000]
Copayments	[$900]
Coinsurance	[$100]
What isn't covered	
Limits or exclusions	[$20]
The total Joe would pay is	**[$2,020]**

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

- **The plan's overall deductible** **[$1,000]**
- **Specialist copayment** **[$25]**
- **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*	[$900]
Copayments	[$400]
Coinsurance	[$0]
What isn't covered	
Limits or exclusions	[$0]
The total Mia would pay is	**[$1,300]**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [insert]. *Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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