### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>UCHP Home Host UCHP Network: Individual $0 /Family$0.</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>No.</td>
<td>You will have to meet the deductible before the plan pays for any services.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Home Host Network (UCHP): $850 Individual / $1,700 Family.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges &amp; health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.aetna.com/dse/custom/uchp">http://www.aetna.com/dse/custom/uchp</a> for Primary Care Providers (PCP) or call 1-855-824-3632 for UCHP Network providers. Your PCP will handle all referrals to a network specialist</td>
<td>This plan uses a provider network limited to the University of Chicago Medical Center providers covered under the UCHP health plan. There is no coverage outside of the UCHP network.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15 copay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$25 copay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care / screening / immunization</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Generic drugs</td>
<td>Filled at DCAM/Ingalls: $5 copay/30 day prescription $10 copay/90 day prescription</td>
<td>For all maintenance medications, members can use a CVS Caremark network retail pharmacy for the initial prescription and 1st refill – and pay the retail co-pay. All subsequent refills for maintenance Medications should be filled using the CVS Caremark Mail Order service, Duchossois Center for Advanced Medicine (DCAM) Outpatient Pharmacy or Ingalls Outpatient Pharmacy locations. For subsequent refills, the member will be charged 50% of the cost if any other retail pharmacy is utilized, Refer to above limitations for Generic drugs noted above also applicable to preferred brand drugs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Filled at Retail Pharmacy: $15 copay/30 day prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Filled by CVS Caremark Mail Order: $35 copay/90 day prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Filled at DCAM/Ingalls: $15 copay/30 day prescription $30 copay/90 day prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Filled at Retail Pharmacy: $35 copay/30 day prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Filled by CVS Caremark Mail Order: $90 copay/90 day prescription</td>
<td></td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Home Host Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay)</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Filled at DCAM/Ingalls: $30 copay/30 day prescription $60 copay/90 day prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Specialty medications must be filled through DCAM/Ingalls; same copayments as outlined above</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

- **If you have outpatient surgery**
  - Facility fee (e.g., ambulatory surgery center): No charge
  - Physician/surgeon fees: No charge

- **If you need immediate medical attention**
  - Emergency room care: $175 copay/visit
  - Emergency medical transportation: No charge
  - Urgent care: $25 copay/visit

- **If you have a hospital stay**
  - Facility fee (e.g., hospital room): No charge
  - Physician/surgeon fees: No charge

In network providers include University of Chicago Hospitals, Ingalls Quick Care (Crestwood) or CVS Minute Clinics.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Home Host Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>$25/visit for one visit/lifetime; otherwise Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**Excluded Services & Other Covered Services:**

- Acupuncture
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs
  - Except for required preventive services.
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Infertility treatment

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 more information on your rights to continue coverage, contact the plan at 1-888-982-3862.
- If your group health coverage 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.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, 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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-888-982-3862.
- If your group health coverage 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.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

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 Standard? 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.

-------------------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: $0
- Specialist copayment: $25
- Hospital (facility) copayment: $0
- Other copayment: $0

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$25</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn't covered:
- Limits or exclusions: $0

The total Peg would pay is: $25

---

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

- The plan's overall deductible: $0
- PCP copayment: $15
- Hospital (facility) copayment: $0
- Other copayment RX: $10

This EXAMPLE event includes services like:
- Primary care physician office visits of 3 per year (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs (4 – 90 day generic fills)
- Durable medical equipment (glucose meter)

### Total Example Cost
$7,400

### In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$75</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn't covered:
- Limits or exclusions: $0

The total Joe would pay is: $75

---

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

- The plan's overall deductible: $0
- Specialist copayment: $25
- Hospital (facility) copayment ER: $175
- Other copayment: $0

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)
- Specialist visits (2 visits)

### Total Example Cost
$1,900

### In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$325</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn't covered:
- Limits or exclusions: $0

The total Mia would pay is: $325

---

Note: For more information about limitations and exceptions, see the plan or policy document at www.uchbenefits.com

The plan would be responsible for the other costs of these EXAMPLE covered services.
Assistive Technology
Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

Smartphone or Tablet
To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination
Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030, Fresno, CA 93779)
1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705)
Email: CRCoordinator@aetna.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (T DD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).
TTY: 711

Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.
Amharic - ከተማ እንዳን ከተማ ከ 1-800-370-4526 ያለ ያለወራል
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526.
Armenian - Լրատվի գործադիր տպագրություն համար 1-800-370-4526 համար գրիք.
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera urugufasha mu Kirundi, twakure kuri ryi numero 1-800-370-4526 ku busa
Bengali-Bangala - বাংলাদেশ ভাষা সহযোগিতার জন্য নিনাদূর্লভ 1-800-370-4526-তে কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese - ကိုယ်ပေါင်းသိမ်းစိတ်ချန် (အသက်ဆိုင်) နေအထိ 1-800-370-4526 သို့ မိတ်ဆွေး
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.
Chamorro - Para ayuda gi fino’ (Chamoru), ágang 1-800-370-4526 sin gástu.
Cherokee - ႯᏯᏲᏤ ᏭᏣᏕᏲᏤ ᏪᏣᏣᏚᏯ ᎣᏣᏣ (Cherokee) 1-800-370-4526 0ᏣᏣ Ꮲ ᏧᏣᏚᏯ ᏢᏣᏚᏯ Ꮲ ᏧᏣᏚᏯ ᏧᏣᏚᏯ.
Chinese - 欲取得繁體中文語言協助，請撥打 1-800-370-4526，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-800-370-4526.
Cushite - Gargaarsa afan Oromiffa hikku argachuruf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.
Dutch - Bel voor tolk- en vertaalkensten in het Nederlands gratis naar 1-800-370-4526.
French - Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.
French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.
Gujarati - ગુજરાતીમાં લાભમાં લાભ મળે ત્રણ પશુ પરસ્ય પાડો 1-800-370-4526 પર કોચ કરો.
Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.

Portuguese

Pentru asistență lingvistică în română, detașați la numărul gratuit 1-800-370-4526

Romanian

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.

Russian

Mo fesoasoani tau gagana l le Gagana Samoa vala’au le 1-800-370-4526 e auna ma se totoj.

Samoan

Para jezičnu pomoć na hrvatskom jeziku pozovite besplatnom brojem 1-800-370-4526.

Serbo-Croatian

Para obtener asistencia lingüistica en español, llame sin cargo al 1-800-370-4526.

Spanish

Fii yo on hebu balal e ko yowittii e haala Pular noddee e oo numero doo 1-800-370-4526. Njodi woo fawaaki on.

Sudanic-Fulfude

Ukhitaji usu凌地zi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.

Swahili

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.

Tagalog

1-800-370-4526 800-370-4526 800-370-4526

Telugu

สั่งการเรียกทุกที่ในประเทศไทย โทร 1-800-370-4526 เพื่อไม่ต้องใช้จ่าย.

Thai

Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-370-4526 ‘o ‘ikai hā tōtōgi.

Tongan

Ren áinninsin chiakú ren (Kapasen Chuuk) kopwe kékkeéri 1-800-370-4526 nge esapw kamé ngonuk.

Trukese

(İl) çağırıs dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526.

Turkish

Щоб отримати допомогу перекладача українською мовою, затеговуйте за безкоштовним номером 1-800-370-4526.

Ukrainian

1-800-370-4526

Urdu

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526.

Vietnamese

Faur shparacka hili la 1 800 370 4526. 1 800 370 4526 1 800 370 4526

Yiddish

Fún iránlwọ nípa ëdè (Yoruba) pe 1-800-370-4526 lái san owó kankan rárá.

Yoruba