An HSA is an account that may be set up by you or your employer to help you plan for current and future health care costs. You may make contributions to the HSA up to a maximum amount set by the IRS. Any earnings on your contributions grow tax free and any withdrawals you make for eligible medical expenses are also tax free. Contact your employer or call the Customer Service number on your ID Card for more information.

Is a Health Savings Account (HSA) available under this plan option?

Yes

How is the overall deductible or out-of-pocket limit met?

This plan has a separate deductible and out-of-pocket limit for individuals and families.

Once the family deductible or out-of-pocket limit is met, all family members will be considered as having met their deductible or out-of-pocket limit, respectively. There is no individual deductible or out-of-pocket limit to satisfy within the family deductible or out-of-pocket limit.

How your out-of-network care is reimbursed:

We cover the cost of services based on whether doctors are “in-network” or “out-of-network.” We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out-of-network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount.

Professional Services: 105% of Medicare

Facility Services: 140% of Medicare

Questions: Call the toll free number on your ID card (1-855-228-0510 for prospective members), TDD 1-800-628-3323 (hearing impaired only), or visit us at www.HealthReformPlanSBC.com.
Supplemental Information

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna plan "recognizes." Your doctor may bill you for the dollar amount that your plan doesn't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket limit. To learn more about how we pay out-of-network benefits, visit www.aetna.com. Type “how Aetna pays” in the search box.

You can avoid these extra costs by getting your care from Aetna’s network of health care providers. Go to www.aetna.com and click on “Find a Doctor” on the left side of the page. If you are already a member, sign on to your Aetna Navigator® member site.

This applies when you choose to get care out-of-network. When you have no choice (for example: emergency room visit after a car accident or for other emergency services), we will pay the bill as if you got care in-network. You pay cost sharing and deductibles for your in-network level of benefits. Contact Aetna if your health care provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

Other important information about your plan:

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent.

Additional information regarding your plan is available in the Disclosure Document on www.aetna.com.

Information includes:

● “Knowing what is covered” which describes how we review a request for coverage for a service or supply

● “Prescription drug benefit” which describes procedures we use to manage prescription drug benefits. These procedures include how to obtain a list of covered drugs and the exception policy for receiving coverage of a drug that is not on a closed formulary

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

When offered, investment services are independently offered by the HSA Administrator.

HSAs are currently not available to HMO members in California and Illinois.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.
Supplemental Information

Coverage for: Individual + Family | Plan Type: PPO

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. We do not provide care or guarantee access to health services.

The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by you or your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial with respect to the treatment of cancer or other life-threatening disease or condition.
- Home births
- Immunizations for travel or work except where medically necessary or indicated
- Implantable drugs and certain injectable drugs including injectable infertility drugs
- Long-term rehabilitation therapy
- Non-medically necessary services or supplies
- Orthotics except diabetic orthotics
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling or prescription drugs
- Therapy or rehabilitation other than those listed as covered

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.
Supplemental Information

Coverage for: Individual + Family | Plan Type: PPO

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

We consider your personal information to be private. We have policies and procedures in place to protect your personal information from unlawful use and disclosure. For a summary of our policy, go to www.aetna.com. You'll find the Privacy Notices link at the bottom of the page.

Plan features and availability may vary by location and group size.

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Colorado Supplement to the Summary of Benefits and Coverage Form

Aetna Life Insurance Company
Name of Carrier

Aetna HealthFund® Open Choice® - Consumer Choice HSA
Name of Plan

Large Employer Group Policy
Policy Type

TYPE OF COVERAGE

<table>
<thead>
<tr>
<th>1. TYPE OF PLAN</th>
<th>PPO</th>
</tr>
</thead>
</table>

| 2. OUT-OF-NETWORK CARE COVERED?\(^1\) | Yes; but patient pays more for out-of-network care |

| 3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE | Plan is available throughout Colorado |

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits and Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.
<table>
<thead>
<tr>
<th>4. Deductible Period</th>
<th>Description</th>
<th>What this means.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year</td>
<td></td>
<td>Calendar year deductibles restart each January</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Annual Deductible Type</th>
<th>Description</th>
<th>What this means.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single/Non-Single Coverage</td>
<td></td>
<td>Single means the deductible amount you will have to pay for allowable covered expenses under this HSA-qualified health plan when you are the only individual covered by the plan. Non-single is the deductible amount that must be met by one or more family members covered by this HSA-qualified plan before any covered expenses are paid.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. What cancer screenings are covered?</th>
<th>Description</th>
<th>What this means.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostate Cancer Screening</td>
<td></td>
<td>• Age and Frequency schedule may apply</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td></td>
<td>• Age and Frequency schedule may apply</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td></td>
<td>• Age and Frequency schedule may apply</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td></td>
<td>• Age and Frequency schedule may apply</td>
</tr>
</tbody>
</table>
### LIMITATIONS AND EXCLUSIONS

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Period during which pre-existing conditions are not covered for covered person age 19 and older[^2]</td>
<td>Not applicable, plan does not impose limitation periods for pre-existing conditions.</td>
</tr>
<tr>
<td>8. How does the policy define a “pre-existing condition”?</td>
<td>Not applicable, Plan does not exclude coverage of pre-existing conditions.</td>
</tr>
<tr>
<td>9. Exclusionary Riders. Can an individual's specific, pre-existing condition be entirely excluded from the policy?</td>
<td>No</td>
</tr>
</tbody>
</table>

### USING THE PLAN

<table>
<thead>
<tr>
<th>Question</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</td>
<td>No</td>
<td>Yes, refer to your certificate of coverage for details.</td>
</tr>
<tr>
<td>11. Does the plan have a binding arbitration clause?</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
Questions: Call 1-888-982-3862, TDD 1-800-628-3323 (hearing impaired only) or visit www.Aetna.com.

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance
Consumer Affairs Section
1560 Broadway, Suite 850, Denver, CO 80202
Call 303-894-7490 (in state, toll free: 800-930-3745)
Email: insurance@dora.state.co.us

Endnotes:
1 “Network” refers to a specified group of physicians, hospitals, medical clinics and other health care providers this plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).
2 Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

Colorado Access Disclosure:

Aetna maintains and makes available to interested parties upon request a managed care network access plan on its business premises. The managed care network access plan demonstrates the managed care network contains an adequate number of accessible acute care hospitals, primary care providers, and specialists available to provide covered health care services. Among other things, the access plan describes Aetna's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of plan enrollees.

This document is available in other languages. Do you need this in another language? Call us.

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-877-287-0117.

Si necesita asistencia lingüística en español, llámenos al número que figura en su tarjeta de identificación (ID) médica.
Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-877-287-0117.