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, goudse.nl. 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 +31 182-544 544 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**€ 500** per family	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	**No.**	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	**No.**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Not Applicable**	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	**Not Applicable**	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	**Yes.** See www.aetna.com/dse/search or call 1-866-415 1709 for a list of network 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).
Do you need a referral to see a specialist?	**Yes.**	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.

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
		GMMI-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	No charge	No charge	None
	Specialist visit	No charge	20% coinsurance	None
	Preventive care/screening/ immunization	No charge	20% coinsurance	None
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	No charge	No charge	None
	Preferred brand drugs	No charge	No charge	None
	Non-preferred brand drugs	No charge	No charge	None
	Specialty drugs	No charge	No charge	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	None
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need immediate medical attention	Emergency room care	No charge	No charge	None
	Emergency medical transportation	No charge	No charge	None
	Urgent care	No charge	No charge	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	None
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge	None
	Inpatient services	No charge	No charge	None
If you are pregnant	Office visits	No charge	No charge	None
	Childbirth/delivery professional	No charge	50% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.goudse.nl.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		GMMI-network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	services			
	Childbirth/delivery facility services	No charge	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	No charge	No charge	None
	Rehabilitation services	No charge	No charge	Inpatient 45 days; Outpatient is limited on 20 treatments per insurance year, except physiotherapy for which 40 treatments per insurance year are allowed.
	Habilitation services	No charge	No charge	Inpatient 45 days; Outpatient is limited on 20 treatments per insurance year, except physiotherapy for which 40 treatments per insurance year are allowed.
	Skilled nursing care	No charge	No charge	None
	Durable medical equipment	No charge	No charge	None
	Hospice services	No charge	No charge	None
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Eye exam is limited to once per calender year
	Children's glasses	No charge	No charge	Glasses are limited to once per calender year
	Children's dental check-up	No charge	No charge	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 (unless medically necessary)
- Cosmetic surgery (it is covered in case of deformity)
- Dental care (Adult)
- Long-term care
- Weight loss programs

* For more information about limitations and exceptions, see the plan or policy document at www.goudse.nl.

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

- Acupuncture
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S. (no network applicable outside the U.S.)
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

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: Healthcare.gov http://www.HealthCare.gov or call 1-800-318-2596 OR state health insurance marketplace or SHOP. 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 on your rights to continue coverage, contact the insurer at +31 182 544 544. You may also contact Klachteninstituut Financiële Dienstverlening (Kifid) at +31 900 355 22 48.

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 the 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:
Para obtener asistencia en Español, llame al 1-866-415-1709.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.goudse.nl.

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**

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	€ 0
What isn't covered	
Limits or exclusions	€ 0
The total Peg would pay is	**€ 500**

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

■ **The plan's overall deductible** **€ 500**

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	€ 0
What isn't covered	
Limits or exclusions	€ 0
The total Joe would pay is	€ 500

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

■ **The plan's overall deductible** **€ 500**

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	€ 0
Coinsurance	€ 0
What isn't covered	
Limits or exclusions	€ 0
The total Mia would pay is	€ 500

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