 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 1-800-411-3650. 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 [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-800-411-3650 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$1,250</b> individual / <b>\$2,500</b> family for Network <b>\$2,500</b> individual / <b>\$5,000</b> family for Out-of-Network	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of deductible expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Preventive care and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>\$3,500</b> individual / <b>\$7,000</b> family for Network <b>\$10,500</b> individual / <b>\$21,000</b> family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, penalties and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.aetna.com/ASA">www.aetna.com/ASA</a> or call 800-277-8579 for a list of participating providers.	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No. You don't need a referral to see a <a href="#">specialist</a> .	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

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All **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
		Network Provider	Out-of-Network Provider	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <b>copay</b> /visit	50% <b>coinsurance</b>	Teladoc services available
	<b>Specialist</b> visit	\$50 <b>copay</b> /visit	50% <b>coinsurance</b>	None
	Retail/Walk-in Clinic	\$20 <b>copay</b> /visit	\$20 <b>copay</b> /visit	None
	<b>Preventive care/screening</b> /immunization	No charge	50% <b>coinsurance</b>	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
<b>If you have a test</b>	<b>Diagnostic test</b> (x-ray, blood work)	No charge	50% <b>coinsurance</b>	None
	Imaging (CT/PET scans, MRIs)	20% <b>coinsurance</b>	50% <b>coinsurance</b>	<b>Preauthorization</b> is required. If you don't receive <b>preauthorization</b> , benefits may be reduced 50%.
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.Navitus.com">www.Navitus.com</a> or call 844-268-9789.	Generic Drugs	Retail: \$20/prescription Mail Order: \$40/prescription	Retail: 50% <b>coinsurance</b>	Deductible does not apply.
	Formulary Brand Drugs	Retail: \$50/prescription Mail Order: \$100/prescription	Retail: 50% <b>coinsurance</b>	Covers up to a 30-day supply for retail prescriptions and a 90-day supply for mail order prescriptions.
	Non-Formulary Brand Drugs	Retail: \$75/prescription Mail Order: \$150/prescription	Retail: 50% <b>coinsurance</b>	Mail Order not available Out-of-Network.
	<b>Specialty drugs</b>	Retail and Mail Order: 20% coinsurance up to \$100 maximum	Not covered	Available up to 30-day supply

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-of-Network Provider	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't receive <a href="#">preauthorization</a> , benefits may be reduced 50%.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$250 <a href="#">copay</a> /visit	\$250 <a href="#">copay</a> /visit	None
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	Ground:20% <a href="#">coinsurance</a> Air: 50% <a href="#">coinsurance</a>	<a href="#">Network deductible</a> applies to <a href="#">Out-of-Network</a> benefits.
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't receive <a href="#">preauthorization</a> , benefits may be reduced 50%.
	Physician/surgeon fee	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$30 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	None
	Inpatient services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't receive <a href="#">preauthorization</a> , benefits may be reduced 50%.
<b>If you are pregnant</b>	Office visits	No charge	50% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">copays</a> , <a href="#">deductible</a> , <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <a href="#">Preauthorization</a> is required. If you don't receive <a href="#">preauthorization</a> , benefits will be reduced. Note: Maternity is not covered for dependent daughters.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-of-Network Provider	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't receive <a href="#">preauthorization</a> , benefits may be reduced 50%. Limited to 60 visits per Calendar Year.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Physical, Speech, and Occupational Therapy limited to 30 visits per year, per therapy. <a href="#">Preauthorization</a> is required after six visits. If you don't receive <a href="#">preauthorization</a> , benefits may be reduced 50%.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Cardiac and Pulmonary Therapy limited to 36 visits per year, per therapy.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't receive <a href="#">preauthorization</a> , benefits may be reduced 50%. Limited to 60 visits per year.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Hospice services</a>	No charge	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't receive <a href="#">preauthorization</a> , benefits may be reduced 50%.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not Covered	Routine screenings covered as defined under the Patient Protection and Affordable Care Act of 2010.
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Routine screenings covered as defined under the Patient Protection and Affordable Care Act of 2010.

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**Excluded Services & Other Covered Services:**

<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a>.)</b>		
<ul style="list-style-type: none"><li>• Abortion (except in cases of rape, incest, or when the life of the mother is endangered)</li><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Cosmetic Surgery</li></ul>	<ul style="list-style-type: none"><li>• Dental Care</li><li>• Hearing Aids</li><li>• Infertility Treatment</li><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Private-duty Nursing</li><li>• Routine Eye Care</li><li>• Routine Foot Care</li><li>• Weight Loss Programs</li></ul>
<b>Other Covered Services (This isn't a complete list. Check your policy or <a href="#">plan</a> document for other covered services and your costs for these services.)</b>		
<ul style="list-style-type: none"><li>• Chiropractic Care (limited to 30 visits)</li></ul>	<ul style="list-style-type: none"><li>• Hearing Exams (limited to one every two years)</li></ul>	<ul style="list-style-type: none"><li>• Wigs (cancer diagnosis only, up to \$500 maximum per Year.</li></ul>

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**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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](http://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 at 1-877-236-0844. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at: [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and <http://www.cms.gov/CCIO/Resources/Consumer-Assistance-Grants>.

**Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**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 1-877-236-0844

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-236-0844

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-236-0844

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-236-0844

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

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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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,250	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,250	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,250
■ <a href="#">Specialist coinsurance</a>	\$50	■ <a href="#">Specialist coinsurance</a>	\$50	■ <a href="#">Specialist coinsurance</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	20%	■ Hospital (facility) <a href="#">coinsurance</a>	20%	■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%	■ Other <a href="#">coinsurance</a>	20%	■ Other <a href="#">coinsurance</a>	20%
<b>This EXAMPLE event includes services like:</b> Specialist office visits ( <i>prenatal care</i> ) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests ( <i>ultrasounds and blood work</i> ) Specialist visit ( <i>anesthesia</i> )		<b>This EXAMPLE event includes services like:</b> Primary care physician office visits ( <i>including disease education</i> ) Diagnostic tests ( <i>blood work</i> ) Prescription drugs Durable medical equipment ( <i>glucose meter</i> )		<b>This EXAMPLE event includes services like:</b> Emergency room care ( <i>including medical supplies</i> ) Diagnostic test ( <i>x-ray</i> ) Durable medical equipment ( <i>crutches</i> ) Rehabilitation services ( <i>physical therapy</i> )	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,148	<a href="#">Deductibles</a>	\$1,250	<a href="#">Deductibles</a>	\$1,250
<a href="#">Copayments</a>	\$560	<a href="#">Copayments</a>	\$1,710	<a href="#">Copayments</a>	\$180
<a href="#">Coinsurance</a>	\$1,792	<a href="#">Coinsurance</a>	\$346	<a href="#">Coinsurance</a>	\$320
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$55	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$3,560</b>	<b>The total Joe would pay is</b>	<b>\$3,361</b>	<b>The total Mia would pay is</b>	<b>\$1,750</b>

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