
 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 Customer Service at 1-855-458-8551. 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.healthcare.gov or call 1-855-458-8551 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible ? | \$3,000/Individual or \$6,000/Family for In-Network \$5,000/Individual or \$10,000/Family for Out-of-Network | 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. Preventive care and primary care services 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? | No. | You must pay all of the costs 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 ? | \$6,750/Individual or \$13,500/Family for In-Network \$10,000/Individual or \$20,000/Family for Out-of-Network | 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 ? | Copayments for certain services, premiums , balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider ? | Yes, go to www.aetna.com/asa to access 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). 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. | Some plans 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 |
|--|--|---|--|--|
| | | 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 | 0% coinsurance after deductible | 50% coinsurance after deductible | None |
| | Specialist visit | 0% coinsurance after deductible | 50% coinsurance after deductible | None |
| | Preventive care/screening/immunization | No charge | 50% coinsurance, deductible does not apply | 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) | 0% coinsurance after deductible | 50% coinsurance after deductible | None |
| | Imaging (CT/PET scans, MRIs) | 0% coinsurance after deductible | 50% coinsurance after deductible | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at FutureScripts 1-888-678-7012 | Generic drugs (Tier 1) | \$15 copay /prescription 30-day supply retail \$30 copay /prescription 90-day supply mail order | N/A | Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). |
| | Preferred brand drugs (Tier 2) | \$35 copay /prescription 30-day supply retail \$70 copay /prescription 90-day supply mail order | N/A | |
| | Non-preferred brand drugs (Tier 3) | \$75 copay /prescription 30-day supply retail \$150 copay /prescription 90-day supply mail order | N/A | |
| | Specialty drugs (Tier 4) | \$150 copay | N/A | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance after deductible | 50% coinsurance after deductible | Preauthorization is required. |
| | Physician/surgeon fees | 0% coinsurance after deductible | 50% coinsurance after deductible | |
| If you need immediate medical attention | Emergency room care | 0% coinsurance after deductible | 0% coinsurance after In-Network deductible | |

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|--|--|--|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Emergency medical transportation | 0% coinsurance after deductible | 0% coinsurance after in-network deductible | |
| | Urgent care | 0% coinsurance after deductible | 50% coinsurance after deductible | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% coinsurance after deductible | 50% coinsurance after deductible | Preauthorization is required. |
| | Physician/surgeon fees | 0% coinsurance after deductible | 50% coinsurance after deductible | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 0% coinsurance after deductible | 50% coinsurance after deductible | Preauthorization is required for inpatient services. |
| | Inpatient services | 10% coinsurance after deductible | 50% coinsurance after deductible | |
| If you are pregnant | Office visits | 0% coinsurance after deductible | 50% coinsurance after deductible | Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 0% coinsurance after deductible | 50% coinsurance after deductible | |
| | Childbirth/delivery facility services | 10% coinsurance after deductible | 50% coinsurance after deductible | |
| If you need help recovering or have other special health needs | Home health care | 0% coinsurance after deductible | 50% coinsurance after deductible | 60 visits/plan year In-Network and Out-Of-Network (combined) |
| | Rehabilitation services | 0% coinsurance after deductible | 50% coinsurance after deductible | 60 visits/plan year. Includes physical therapy and occupational therapy, in-network and out-of-network (combined). Speech therapy: 20 visits/plan year, in-network and out-of-network combined. |
| | Habilitation services | 0% coinsurance after deductible | 50% coinsurance after deductible | |
| | Skilled nursing care | 0% coinsurance after deductible | 50% coinsurance after deductible | 120 In-Network/Out-of-Network Inpatient days |
| | Durable medical equipment | 0% coinsurance after deductible | 50% coinsurance after deductible | Excludes vehicle modifications, home modifications, and exercise equipment. |
| | Hospice services | 0% coinsurance after deductible | 50% coinsurance after deductible | Preauthorization is required. |
| If you or your child needs dental or eye care | Routine eye exam | \$10 copay | 50% coinsurance after deductible | Coverage limited to one exam/plan year. |
| | Glasses or contact lenses | Up to \$100 reimbursement | Up to \$100 reimbursement to member | Coverage limited to up to \$100 per plan year. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|----------------------|----------------------------|--|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Children's dental check-up | Not covered | Not covered | Separate coverage is offered by employer. |

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](#).)

- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Foot Care

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

- Chiropractic Care

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 855-458-8551. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 612565 or 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 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: INDECS, Appeals Department at 888-446-3327 or the Department of Labor Employee Benefits Security Administration at 1-866-444-EBSA or www.dol.gov/ebsa/healthreform.

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 855-458-8551.

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](#) \$3,000
- [Specialist copayment](#) after deductible 0%
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 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:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$3,000 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$3,000 |

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

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist copayment](#) after deductible 0%
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 0%

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 | \$280 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$1,280 |

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

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist copayment](#) after deductible 0%
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$1,900 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$1,900 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,900 |

*The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.