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, contact your employer. 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 844-657-0900 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$5,000 Individual / $10,000 Family for In-Network The Plan does not cover Out-of-Network care except for emergency care. Deductible is embedded.	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. In-Network preventive care and services covered at "No charge".	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 don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6,650 Individual / $13,300 Family for In-Network The Plan does not cover Out-of-Network care except for emergency care. Out-Of-Pocket Limit is embedded.	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?	Premiums, balance-billing charges, Pre-Certification penalties, 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. See www.aetna.com/ASA 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). 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.	You can see the specialist you choose without a referral.

Benefits and cost sharing accumulate on a Plan Year basis from 12/1 through 11/30 each year. NOTE: This plan is integrated with a Health Savings Account (HSA). Deductibles, Copayments, and other qualified out-of-pocket expenses may be reimbursable under the HSA.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies, unless otherwise stated.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	20% coinsurance after deductible	Not Covered	None
	Specialist visit	20% coinsurance after deductible	Not Covered	None
	Preventive care/screening/ immunization	No charge	Not Covered	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)	20% coinsurance after deductible	Not Covered	$500 penalty if genetic testing and sleep studies not Pre-Certified.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	Not Covered	$500 penalty if not Pre-Certified.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://pharmacy.envolvehealth.com.	Generic drugs	Retail: $10 copay/prescription after deductible Mail Order: $25 copay/prescription after deductible	Not Covered	The Overall deductible must be satisfied before the Plan will reimburse prescription drug benefits. Retail drugs are covered up to a 31-day supply; Mail order drugs are covered up to a 90-day supply. Prior authorization may be required on some prescriptions.
	Preferred brand drugs	Retail: $35 copay/prescription after deductible Mail Order: $87.50 copay/prescription after deductible	Not Covered	
	Non-preferred brand drugs	Retail: $60 copay/prescription after deductible Mail Order: $150 copay/prescription after deductible	Not Covered	
	Specialty drugs	See benefits above	Not Covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Not Covered	$500 penalty if certain surgical procedures not Pre-Certified.
	Physician/surgeon fees	20% coinsurance after deductible	Not Covered	None
If you need immediate medical attention	Emergency room care	$100 copay/visit after	Same as in-network	Copay waived if admitted
	Emergency medical transportation	20% coinsurance after deductible	Not Covered	None
	Urgent care	20% coinsurance after deductible	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/admission, after deductible	Not Covered	$500 penalty if not Pre-Certified.
	Physician/surgeon fees	20% coinsurance after deductible	Not Covered	None

* For more information about limitations and exceptions, see the plan document.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	Not Covered	None
	Inpatient services	$250 copay/admission, after deductible	Not Covered	$500 penalty if not Pre-Certified.
If you are pregnant	Office visits	20% coinsurance after deductible	Not Covered	None
	Childbirth/delivery professional services	20% coinsurance after deductible	Not Covered	None
	Childbirth/delivery facility services	$250 copay/admission, after deductible	Not Covered	$500 penalty if admissions exceeding 48/96 hours not Pre-Certified.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	Not Covered	$500 penalty if not Pre-Certified. 60 visits/calendar year
	Rehabilitation services	20% coinsurance after deductible	Not Covered	30 visits/plan year combined for physical, speech, and occupational, therapies (Limit does not apply to early intervention services). 36 visits/plan year for cardiac rehabilitation therapy 30 visits/plan year for post-cochlear implant aural therapy
	Habilitation services	20% coinsurance after deductible	Not Covered	30 visits/plan year combined for physical, speech, and occupational, therapies (Limit does not apply to early intervention services). 36 visits/plan year for cardiac rehabilitation therapy 30 visits/plan year for post-cochlear implant aural therapy
	Skilled nursing care	$250 copay/admission, deductible	Not Covered	$500 penalty if not Pre-Certified. 60 days/calendar year

* For more information about limitations and exceptions, see the plan document.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	20% coinsurance after deductible	Not Covered	$500 penalty if electric/motorized scooters, wheelchairs or pneumatic compression devices not Pre-Certified. Benefits limited to single purchase of a type of DME (including repair/replacement) every three years or as needed to accommodate growth in young children.
	Hospice services	20% coinsurance after deductible	Not Covered	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	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
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Acupuncture (12 visits/plan year)
- Chiropractic care (20 visits/plan year)
- Hearing aids ($5,000/plan year; single purchase per ear every 3 years)
- Infertility treatment (1 visit/plan year, $2500 max/plan year)
- Private duty nursing

* For more information about limitations and exceptions, see the plan document.

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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 your employer or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) 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 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:

Spanish (Español): Para obtener asistencia en Español, llame al 844-657-0900.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-657-0900.

Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 844-657-0900.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 844-657-0900.

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 document.

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	$5,000
Specialist coinsurance	20%
Hospital (facility) copayment	$250
Other coinsurance	20%

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	$5,000
Copayments	$30
Coinsurance	$1,534
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,624**

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

The plan's overall deductible	$5,000
Specialist coinsurance	20%
Hospital (facility) copayment	$250
Other coinsurance	20%

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	$5,000
Copayments	$455
Coinsurance	$339
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$5,849**

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

The plan's overall deductible	$5,000
Specialist coinsurance	20%
Hospital (facility) copayment	$250
Other coinsurance	20%

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.