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,1-844-380-4548. 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.webtpa.com or call 1-844-380-4548 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In Network $3,300 / Individual or $6,600 Family. Non-Network $5,100 / Individual or $10,200 / Family	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 for In-Network providers	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.	There are no other specific deductibles.
What is the out-of-pocket limit for this plan?	In Network $7,150 / Individual or $14,300 / Family. Non-Network Unlimited	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, prior authorization penalties, amounts in excess of the Reference Base Price for Non-Network providers 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 or call 844-380-4548	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.

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	20% Coinsurance	50% Coinsurance	None
	Specialist visit	20% Coinsurance	50% Coinsurance	None
	Preventive care/screening/ immunization	No Charge	50% Coinsurance	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. The following maximum reimbursement limits apply to all services per episode: Endoscopy: $3,700 Colonoscopy: $3,800
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	50% Coinsurance	The following maximum reimbursement limits apply to all services per episode: Endoscopy: $3,700 Colonoscopy: $3,800
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	50% Coinsurance	Non-Network charges are held to a percentage of Medicare. (Reference Based Price) Prior Authorization Required. $500 penalty applies for no prior authorization The following maximum reimbursement limits apply to all services per episode: MRI with contrast: $3,400 MRI without contrast: $1,800 CT Scan with contrast: $2,800 CT Scan without contrast: $1,500 PET Scan: $7,800

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cvscaremark.com	Generic drugs	Retail 20% Coinsurance Mail Order 20% Coinsurance	Not Covered	Minimum $15 Maximum $45 for Retail. Minimum $30 Maximum $90 or Mail Order
	Preferred brand drugs	Retail 20% Coinsurance Mail Order 20% Coinsurance	Not Covered	Minimum $40 Maximum $120 for Retail. Minimum $65 Maximum $195 or Mail Order
	Non-preferred brand drugs	Retail 20% Coinsurance Mail Order 20% Coinsurance	Not Covered	Minimum $55 Maximum $165 for Retail. Minimum $95 Maximum $285 or Mail Order
	Specialty drugs	Retail 20% Coinsurance Mail Order 20% Coinsurance	Not Covered	Above limits apply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	50% Coinsurance	Bariatric, Joint Replacement and Spinal procedures must be performed by a Surgery Plus Network Provider. Some procedures require prior authorization. $500 penalty applies for no prior authorization The following maximum reimbursement limits apply to all services per episode: MRI with contrast: $3,400 MRI without contrast: $1,800 CT Scan with contrast: $2,800 CT Scan without contrast: $1,500 PET Scan: $7,800
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	

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 need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	Non-Emergency visit benefit applies, $200 copay / visit plus 50% coinsurance after annual deductible has been met.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None
	Urgent care	20% Coinsurance	50% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	50% Coinsurance	Bariatric, Joint Replacement and Spinal procedures must be performed by a Surgery Plus Network Provider. Prior Authorization Required. $500 penalty applies for no prior authorization
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance	50% Coinsurance	Some procedures require prior authorization. $500 penalty applies for no prior authorization
	Inpatient services	20% Coinsurance	50% Coinsurance	Prior Authorization Required. $500 penalty applies for no prior authorization
If you are pregnant	Office visits	20% Coinsurance	50% Coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% Coinsurance	50% Coinsurance	Prior Authorization Required after 48/96-hour federal mandate. $500 penalty applies for no prior authorization
	Childbirth/delivery facility services	20% Coinsurance	50% Coinsurance	

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 need help recovering or have other special health needs	Home health care	20% Coinsurance	50% Coinsurance	100 visits per calendar year. 1 visit is equal to 6 hours. Prior Authorization Required. $500 penalty applies for no prior authorization
	Rehabilitation services	20% Coinsurance	50% Coinsurance	20 visits per calendar year. Prior Authorization Required. $500 penalty applies for no prior authorization
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	20% Coinsurance	50% Coinsurance	100 days per calendar year. 1 visit is equal to 4 hours. Prior Authorization Required. $500 penalty applies for no prior authorization
	Durable medical equipment	20% Coinsurance	50% Coinsurance	Prior Authorization Required for DME over $1,000. $500 penalty applies for no prior authorization
	Hospice services	20% Coinsurance	50% Coinsurance	Prior Authorization Required. $500 penalty applies for no prior authorization
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.)

- Cosmetic Surgery
- Dental Care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (adult)
- Weight Loss Programs

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

- Acupuncture 20 visit limit
- Bariatric Surgery
- Chiropractic 20 visit limit
- Routine foot care with diabetes diagnosis

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. 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 on how 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: 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

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 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 1-844-380-4548.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-380-4548.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-844-380-4548.]

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-380-4548.

*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	**$3,300**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,300
Copayments	$0
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,260**

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

The plan's overall deductible	**$3,300**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$3,300
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,720**

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

The plan's overall deductible	**$3,300**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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