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 1-844-811-6789. 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 or call 1-844-811-6789 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300** per Individual/**$900** per family.	Generally, you must pay all of the costs from provider 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.** Emergency care, in-network Urgent care, prescription drugs; plus in-network office visits and preventive care from network providers 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 don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: **$1,500** per Individual / $**4,500** per family. Prescription Drugs: **$1,500** per Individual / **$4,500** per family.	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-billed charges, health care this plan does not cover and penalties for failure to obtain preauthorization for services.	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/docfind and select Aetna Choice® POS II (Open Access) networkhttp://www.premera.com/ 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.

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	No copay/visit deductible does not apply;	No copay/visit plus amounts over UCR deductible does not apply;	Chiropractic limited to 20 visits per calendar year. Massage therapy limited to 12 visits per calendar year. Massage therapy is not subject to deductible and covered up to $80 per visit.
	Specialist visit			
	Preventive care/screening/ immunization	No Charge Deductible does not apply.	Plan pays the usual customary and reasonable charges ("UCR"). You pay the balance that exceeds the UCR.	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	30% coinsurance for hospital facility; 20% coinsurance for free standing facility plus amounts over UCR	Diagnostic services provided by an out-of-network provider at an in-network facility will be covered as though in-network.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at caremark.com	Generic drugs	$5 copay/prescription, deductible does not apply: (retail and mail order)	$5 copay and 30% coinsurance/prescription deductible does not apply:(retail)	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics.
	Preferred brand drugs	Greater of $5 or 20% of the negotiated charge, not to exceed $80/ prescription, deductible does not apply (retail and mail order)	Copay of the greater $5 or 20% of the negotiated charge, not to exceed $80 and 30% coinsurance of negotiated charges/prescription (retail)	
	Non-preferred brand drugs	Greater of $5 or 35% of the negotiated charge, not to exceed $140 /prescription, deductible does not apply (retail and mail order)	Copay of the greater $5 or 35% of the negotiated charge, not to exceed $140 and 30% coinsurance of the negotiated charge/prescription,(retail)	

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)	
	Specialty drugs	30% coinsurance	Not Covered	30-day supply maximum.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance and amounts over UCR	None
	Physician/surgeon fees	20% coinsurance	30% coinsurance and amounts over UCR	None.
If you need immediate medical attention	Emergency room care	$100 copay/visit deductible does not apply	$100 copay/visit deductible does not apply	No coverage for non-emergency use. Emergency services provided in response to an emergent condition will be covered the same at in-network or out-of-network facilities.
	Emergency medical transportation	20% coinsurance	20% coinsurance and amounts over UCR	No coverage for non-emergency transport.
	Urgent care	$50 copay/visit and 20% coinsurance	$50 copay/visit and 30% coinsurance and amounts over UCR	No coverage for non-urgent use. Emergency services provided at an out-of-network Urgent Care facility will be covered as though in-network.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/visit and 20% coinsurance	$200 copay/visit and 30% coinsurance and amounts over UCR	Penalty of $400 for failure to obtain preauthorization for out-of-network care.
	Physician/surgeon fees	20% coinsurance	30% coinsurance and amounts over UCR	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: No copay/visit deductible does not apply	Office & other outpatient services: No copay/visit deductible does not apply and amounts over UCR	None.
	Inpatient services	20% coinsurance after $200 copay/stay	30% coinsurance after $200 copay/stay and amounts over UCR	Penalty of $400 for failure to obtain preauthorization for out-of-network care.
If you are pregnant	Office visits	No charge for preventive services. No copay/visit for non-preventive services. deductible does not apply	For preventive services, Plan pays the usual customary and reasonable charges ("UCR"). You pay the balance that exceeds the UCR. No copay/visit for non-preventive deductible does not apply.	Cost-sharing does not apply for preventive services. Depending on the type of services, a copayment or coinsurance may apply.

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)	
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance and amounts over UCR	Penalty of $400 for failure to obtain preauthorization may apply to out-of-network care when in excess of maximum stay requirements for maternity services.
	Childbirth/delivery facility services	20% coinsurance after $200 copay/stay	30% coinsurance after $200 copay/stay and amounts over UCR	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance and amounts over UCR	Penalty of $400 for failure to obtain preauthorization for out-of-network care.
	Rehabilitation services	No copay/visit deductible does not apply	No copay/visit and amounts over UCR deductible does not apply	30 visits/calendar year for Physical, Occupational & Speech Therapy combined. Visit limit does not apply to medically necessary treatment of a mental health condition.
	Habilitation services	No copay/visit deductible does not apply	No copay/visit and amounts over UCR deductible does not apply	
	Skilled nursing care	20% coinsurance after $200 copay/stay	30% coinsurance and amounts over UCR after $200 copay/stay	60 days/calendar year. Penalty of $400 for failure to obtain preauthorization for out-of-network care.
	Durable medical equipment	20% coinsurance	30% coinsurance and amounts over UCR	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance after $200 copay/stay for inpatient; 20% coinsurance for outpatient	30% coinsurance and amounts over UCR after $200 copay/stay	Penalty of $400 for failure to obtain preauthorization for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	Costs in excess of $102	1 routine eye exam/12 months. Vision coverage provided through Vision Service Plan (www.vsp.com).
	Children's glasses	No charge	Costs in excess of $108 for frames, $39 for single vision, $62 bifocal lenses, $80 trifocal lenses	$200 maximum/12 months. Vision coverage provided through Vision Service Plan (www.vsp.com).
	Children's dental check-up	Not covered	Not covered	None - Covered under Active Dental Plan only

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 & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Over the counter Foot Orthotics and orthotics for dependents and retired employees
- Private-duty nursing
- Routine foot care
- Weight loss programs – Except for required preventive services.
- Work related injuries or illnesses

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

- Acupuncture
- Chiropractic Care (20 visits/calendar year)
- Foot orthotics for Active Employees only, limited to $200 per calendar year
- Infertility treatment – Limited to the diagnosis & treatment of underlying medical condition.
- Massage
- Routine eye care (Adult) – see www.vsp.com

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 and Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 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 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. You may also contact the Trust Administration Office at 1-844-811-6789.

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 1-844-811-6789.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-811-6789.

*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	**$300**
Specialist *copayment*	**$0**
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	$300
Copayments	$200
Coinsurance	$1000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,560**

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

The plan's overall deductible	**$300**
Specialist *copayment*	**$0**
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	$300
Copayments	$100
Coinsurance	$700
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

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

The plan's overall deductible	**$300**
Specialist *copayment*	**$0**
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	$300
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**

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