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 1-800-974-2873 or see www.aetna.com. 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 1-800-974-2873 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network providers: $300/individual or $750/family Out-of-Network providers: $10,000/individual or $20,000/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, In-Network office visits, diagnostic tests, imaging, urgent care, home health care, outpatient hospice, outpatient skilled nursing care and rehabilitation services, and obesity treatment 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?	Yes. $50/individual or $100/family for brand name prescription drugs. There are no other specific deductibles.	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?	In-Network providers: $2,750/individual or $5,500/family Prescription drugs (In-Network): $1,000/individual or $2,000/family Out-of-Network providers: No out-of-pocket limit	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, penalties for failure to obtain pre-authorization for service and health care this Plan does not 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 or call 1-800-370-4526 for a list of In-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	$35 copay/visit. Deductible does not apply.	$50 copay/visit, then 50% coinsurance	Acupuncture limited to 20 visits per calendar year.
	Specialist visit	$50 copay/visit. Deductible does not apply.	$65 copay/visit, then 50% coinsurance	None.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	50% coinsurance	Age and frequency limits apply. 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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge. Deductible does not apply.	50% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	$50 copay. Deductible does not apply.	50% coinsurance	None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	Medical deductible does not apply Retail (30 days): $5 copay/script Mail Order (90 days): $10 copay/script	Not covered	No charge for generic ACA preventive medications, including certain over-the-counter drugs with a prescription and FDA-approved generic contraceptives (or brand name if a generic is medically inappropriate). Coverage for certain prescription drugs and related supplies requires your physician to obtain authorization prior to prescribing. Preauthorization may include, for example, a step therapy determination. Coverage for certain specialty drugs is available at no charge through copay assistance in the SaveonSP program; contact Fund Office to enroll.
	Formulary brand drugs	Medical deductible does not apply Retail (30 days): $45 copay/script after prescription drug deductible Mail Order (90 days): $90 copay/script after prescription drug deductible	Not covered	
	Non-formulary brand drugs	Not covered	Not covered	

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	Applicable copay above	Not covered	*See the Prescription drug section of the SPD.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Failure to pre-certify Out-of-Network services will result in a 50% reduction of benefits.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$200 copay/visit, then 20% coinsurance	$200 copay/visit, then 20% coinsurance	Copay waived if admitted to the hospital. Professional/physician charges may be billed separately.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Non-emergency use of emergency medical transportation not covered.
	Urgent care	$35 copay/visit. Deductible does not apply.	$50 copay/visit	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/per admission, then 20% coinsurance	$500 copay/per admission, then 50% coinsurance	Failure to pre-certify Out-of-Network services will result in a 50% reduction of benefits.
	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 mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: $35 copay/visit, Deductible does not apply; Other outpatient services: 20% coinsurance	Office visit: $50 copay/visit, then 50% coinsurance; Other outpatient services: 50% coinsurance	Failure to pre-certify Out-of-Network intensive outpatient and partial hospitalization services will result in a 50% reduction of benefits.
	Inpatient services	$250 copay/per admission, then 20% coinsurance	$500 copay/per admission, then 50% coinsurance	Failure to pre-certify Out-of-Network services will result in a 50% reduction of benefits.
If you are pregnant	Office visits	No charge. Deductible does not apply.	50% coinsurance	None. Cost sharing does not apply for In-Network preventive services. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	20% coinsurance	$500 copay/visit, then 50% coinsurance	Pre-certification required for Out-of-Network stays that last longer than 48 hours for vaginal delivery or 96 hours for delivery by Cesarean section. Failure to pre-certify extended Out-of-Network stays will result in a 50% reduction of benefits.
	Childbirth/delivery facility services	$250 copay/per admission, then 20% coinsurance	$500 copay/per admission, then 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	$50 copay/visit, then 20% coinsurance. Deductible does not apply.	$50 copay/visit, then 25% coinsurance	Limited to 120 visits per calendar year. Failure to pre-certify Out-of-Network services will result in a 50% reduction of benefits.
	Rehabilitation services	Outpatient: $35 copay/visit. Deductible does not apply.	Outpatient: $50 copay/visit, then 50% coinsurance	Occupational, physical and speech therapies combined limited to 60 visits per calendar year.
	Habilitation services	100% no deductible, no copay	50% after deductible, $50 copay per visit	None.
	Skilled nursing care	Inpatient:20% coinsurance per admission; Outpatient: $50 copay/visit, then 20% coinsurance, Deductible does not apply	Inpatient: 50% coinsurance per admission Outpatient: $50 copay/visit, then 25% coinsurance	Limited to 60 days per calendar year. Failure to pre-certify Out-of-Network services will result in a 50% reduction of benefits.
	Durable medical equipment	20% coinsurance	Not covered	None.
	Hospice services	Inpatient: 20% coinsurance Outpatient: $50 copay/visit, then 20% coinsurance. Deductible does not apply.	Inpatient: 50% coinsurance Outpatient: $50 copay/visit, then 25% coinsurance	Failure to pre-certify Out-of-Network services will result in a 50% reduction of benefits.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of these expenses, even In-Network
	Children's glasses	Not covered	Not covered	You must pay 100% of these expenses, even In-Network
	Children's dental check-up	Not covered	Not covered	You must pay 100% of these expenses, even In-Network

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 & Child)
- Eye exam and Glasses (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs (except as required by the Affordable Care Act)

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

- Acupuncture (Limited to 20 visits/calendar year)
- Bariatric surgery
- Chiropractic care
- Infertility treatment

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 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 Aetna at 1-800-974-2873. You may also contact 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**

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 1-800-974-2873.

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 Co-payment	**$50**
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*	$310
Copayments	$350
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,620**

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 Co-payment	**$50**
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	$80
Copayments	$1,330
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,410**

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

The plan's overall deductible	**$300**
Specialist Co-payment	**$50**
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*	$310
Copayments	$530
Coinsurance	$290
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,130**

*NOTE: This plan has other deductibles for specific services included in this coverage example.
See "Are there other deductibles for specific services?" row above.
The **plan** would be responsible for the other costs of these EXAMPLE covered services.