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 1-800-544-5085 . 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 1-800-544-5085 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$0** individual / **$0** family. Out-of-Network: **$100** individual / **$100** 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. PPO office visits, preventive care in-network, and PPO Urgent 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 don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network Provider: **$1,500** individual / **$3,000** family; Out-of-Network Provider **$3,000** individual / **$6,000** 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, copays, balance-billing charges, prescription drugs, penalties for failure to obtain preauthorization for services 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/docfind and select "Aetna Choice® POS II (Open Access) Network for a list of network providers. For Teladoc see Teladoc.com/Aetna or call 1-800-835-2362.	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.

Important Questions	Answers	Why This Matters:
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	$10 copay/visit deductible does not apply	40% coinsurance	Includes Internist, General Physician, Family Practitioner or Pediatrician. Other practitioner office visit is $10 copay. Spinal treatment limited to $2,000 per calendar year, includes Chiropractic services. Coinsurance and deductible apply to Teladoc visits.
	Specialist visit			
	Preventive care/screening/ immunization	No charge Deductible does not apply.	40% coinsurance	Age and frequency schedules may 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)	No charge	40% coinsurance	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)	No charge	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	$5 copay/prescription for retail; $10 copay/prescription for mail order.	Not covered	Non-formulary drugs may not be covered without approval through the prior-authorization process. Covers up to a 30-day supply for a retail prescription and a 31- to 90-day supply for a mail order prescription.
	Preferred brand drugs	$15 copay/prescription for retail; $30 copay/prescription for mail order.	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)	
	Non-preferred brand drugs	$30 copay/prescription for retail; $60 copay/prescription for mail order.	Not covered	
	Specialty drugs	Generic - $15 copay/prescription for retail; Preferred - $15 copay/prescription; Non-Preferred - $30 copay/prescription for mail order.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	If you receive services from a non-network provider at an in-network facility, the Plan will provide benefits as though the provider was in-network.
If you need immediate medical attention	Emergency room care	20% coinsurance after $100 copay/visit	20% coinsurance after $100 copay/visit	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	None
	Urgent care	$50 copay/visit deductible does not apply	40% coinsurance Deductible does not apply.	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)	20% coinsurance	40% coinsurance	Preauthorization is required for out-of-network care. $400 penalty for failure to comply.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	If you receive services from a non-network provider at an in-network facility, the Plan will provide benefits as though the provider was

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)	
				in-network.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/visit deductible does not apply	40% coinsurance	If you receive services from a non-network provider at an in-network facility, the Plan will provide benefits as though the provider was in-network.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required for out-of-network care. $400 penalty for failure to comply. If you receive services from a non-network provider at an in-network facility, the Plan will provide benefits as though the provider was in-network.
If you are pregnant	Office visits	$10 copay/visit deductible does not apply	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, a copay or coinsurance may apply. No coverage for dependent child or child of dependent child.
	Childbirth/delivery professional services	$10 copay 1st prenatal visit / no charge subsequent prenatal visits / 20% coinsurance other services	40% coinsurance	If you receive services from a non-network provider at an in-network facility, the Plan will provide benefits as though the provider was in-network. No coverage for dependent child or child of dependent child.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Includes outpatient postnatal care. Preauthorization may be required. If you receive services from a non-network provider at an in-network facility, the Plan will provide benefits as if the provider was in-network. No coverage for dependent child or child of dependent child.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization is required for out-of-network care
	Rehabilitation services	$10 copay/visit deductible does not apply	40% coinsurance	Coverage is limited to 30 visits per calendar year for Physical, Occupational, and Speech Therapy combined.

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)	
	Habilitation services	$10 copay/visit	40% coinsurance	Benefit limitations may apply.
	Skilled nursing care	20% coinsurance	40% coinsurance	Coverage is limited to 60 days per calendar year. Preauthorization is required. $400 penalty for failure to comply.
	Durable medical equipment	20% coinsurance	40% coinsurance	Limited to $10,000 per calendar year.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required for out-of-network care. $400 penalty for failure to comply.
If your child needs dental or eye care	Children's eye exam	$20 copay/exam	Fees in excess of $40	Vision coverage is provided through Vision Service Plan (VSP). Limited to 1 routine eye exam every 12 months. Your child is only covered if you have elected dependent coverage and paid the appropriate premiums (if required).
	Children's glasses	Fees in excess of $175	Fees in excess of $45 for frames and $40 for single vision lenses	VSP allows 1 pair of frames once every 24 months and 1 set of lenses once every 12 months.
	Children's dental check-up	No charge	No charge	Dental coverage is provided through MetLife. Your child is only covered if you have elected dependent coverage and paid the appropriate premiums (if required).

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.)

- Acupuncture
- Bariatric surgery
- Cosmetic Surgery (unless medically necessary)
- Hearing aids
- Long-term care
- Massage therapy
- Pregnancy for a dependent child
- Private-duty nursing
- Routine foot care
- Weight loss programs
- Work related injury or illness

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

- Chiropractic Care
- Dental Care (Adult)
- Infertility treatment (diagnosis and treatment of underlying medical condition)
- Non-emergency care when traveling outside the U.S. when medically necessary and is considered standard of care
- Routine eye care (Adult) – Vision Service Plan

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 1-800-544-5085.

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 1-800-544-5085.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-544-5085.

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	$100
Specialist copayment	$10
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	$100
Copayments	$10
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,500**

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

The plan's overall deductible	$100
Specialist copayment	$10
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	$100
Copayments	$500
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$980**

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

The plan's overall deductible	$100
Specialist copayment	$10
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	$100
Copayments	$80
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$460**

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