



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 888-276-4732. 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](http://www.webtpa.com) or call 1-888-276-4732 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$300/Individual or \$600/family <a href="#">Copayments</a> do not count towards <a href="#">deductible</a> .	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> is covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. \$100/individual and \$300/family for in-network dental; \$150/individual and \$450/family out-of-network dental.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	Individual: \$4,000 (\$2,750 for medical benefits and \$1,250 for pharmacy benefits). Family: \$8,000 (\$5,500 for medical benefits, \$2,500 for pharmacy benefits).	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.aetna.com/asa">www.aetna.com/asa</a> or call 1-888-276-4732 for a list of <a href="#">network providers</a> .	You pay the least if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your plan pays ( <a href="#">balance-billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <a href="#">copayment</a> /visit	Not Covered	<a href="#">Deductible</a> does not apply.
	<a href="#">Specialist</a> visit	\$25 <a href="#">copayment</a> /visit	Not Covered	<a href="#">Deductible</a> does not apply.
	Other practitioner office Visit	Alternative therapy benefits: Acupuncture: 50% <a href="#">coinsurance</a> Chiropractic: 20% <a href="#">coinsurance</a> Massage therapy: 50% <a href="#">coinsurance</a> Diabetes Self-Management Training: 0% <a href="#">coinsurance</a>	Same as network utilization not required for these services.	<a href="#">Deductible</a> does not apply. Acupuncture, chiropractic, and massage limited to combined 45 alternative visits/year and 30 visits/year in a single category. Massage therapy maximum allowable is \$90/visit and participants under age 18 are not eligible for massage therapy benefits. For acupuncture and chiropractic benefits, participants under age 10 are not eligible. Benefits for chiropractic treatment are limited to expenses for spinal manipulation plus one office visit and x-ray per plan year. Diabetes Self-Management Training is up to 10 hours (1 hour private and 9 hours group) in the first plan year and then 2 hours in subsequent years.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not covered	<a href="#">Deductible</a> does not apply. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.

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 have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	Not covered	None.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	Not covered	None.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs (Tier 1)	\$10 <a href="#">copayment</a> /prescription for 30-day retail supply; \$20 <a href="#">copayment</a> /prescription for 90-day mail-order supply or Walgreen's Smart90 retail program.	Not covered	Pre-certification required for some drugs. <a href="#">Deductible</a> does not apply. Benefits for certain drugs subject to step therapy (must try lower cost drug prior to receiving benefits for higher cost drug). Some maintenance drugs require use of mail order or are subject to penalty.
	Preferred brand drugs (Tier 2)	\$20 <a href="#">copayment</a> /prescription for 30-day retail supply; \$40 <a href="#">copayment</a> /prescription for 90-day mail-order supply or Walgreen's Smart90 retail program.	Not covered	
	Non-preferred brand drugs (Tier 3)	\$40 <a href="#">copayment</a> /prescription for 30-day retail supply; \$80 <a href="#">copayment</a> /prescription for 90-day mail-order supply or Walgreen's Smart90 retail program.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	Not covered	Pre-certification required.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not covered	Pre-certification required.
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% after \$100 <a href="#">copayment</a> /visit <a href="#">Deductible</a> waived	20% after \$100 <a href="#">copayment</a> /visit <a href="#">Deductible</a> waived	<a href="#">Copayment</a> waived if admitted to hospital. Emergency hospital admission covered out-of-network at 20% <a href="#">coinsurance</a> until patient stable for transfer.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None.
	<a href="#">Urgent care</a>	20% after \$25 or \$100 <a href="#">copayment</a> /visit	20% after \$25 or \$100 <a href="#">copayment</a> /visit	May be paid as an office visit or as an emergency room visit according to <a href="#">provider</a> contract. Facility fees for office visits not paid

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)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	Not covered	Pre-certification required. Emergency hospital admission covered out-of-network at 20% <a href="#">coinsurance</a> until patient stable for transfer.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not covered	Surgical pre-certification required.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 <a href="#">copayment</a> /visit for office visits; 20% <a href="#">coinsurance</a> for other services.	Not covered	Pre-certification required for inpatient services, intensive outpatient, partial hospitalization, and residential care.
	Inpatient services	20% <a href="#">coinsurance</a>	Not covered	
<b>If you are pregnant</b>	Office visits	\$25 <a href="#">copayment</a> /visit	Not covered	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	Not covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	Not covered	Pre-certification required. Coverage limited to 120 visits/year
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	Not covered	Therapeutic services include physical therapy, occupational therapy, and speech therapy. Collectively, there is a 90-visit/year limit for all therapeutic services. There is a maximum of 60 visits/year for any single therapeutic service. Vision therapy has a maximum of 30 visits/year. Vision therapy and any inpatient services require pre-certification.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	Not covered	
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	Not covered	Pre-certification required. Coverage limited to 120 days/year.

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)	
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	Not covered	\$8,000 maximum payable per plan year. Precertification required for all charges above \$1,500.
	<a href="#">Hospice services</a>	No charge	No charge	Pre-certification required.
If your child needs dental or eye care	Children's eye exam	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	\$450 maximum payable per plan year for vision care benefits.
	Children's glasses	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	Children's dental check-up	No charge for preventive services; 20% <a href="#">coinsurance</a> for restorative care in-network;	No charge for preventive services; 25% for restorative care out-of-network.	Maximum payable per <u>plan</u> year for dental care is \$2,500/individual and \$7,500/family

#### 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
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight-loss programs (Except for CHIP, Full-Plate, and Weight-Watchers)

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

- Acupuncture – covered with some limitations
- Bariatric surgery – covered with some limitations
- Chiropractic care – covered with some limitations
- Dental care (Adult and Children) – covered with some limitations
- Glasses – covered with some limitations
- Hearing aids – covered with some limitations
- Infertility treatment – covered with some limitations
- Private-duty nursing – covered with some limitations
- Routine eye care
- Routine foot care

**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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 X61565 or [www.cciio.cms.gov](http://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](http://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: WEB-TPA at 1-888-276-4732 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](http://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 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 1-888-276-4732.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-276-4732.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-276-4732.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-276-4732.

————— *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](#) \$25
- 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*)

<b>Total Example Cost</b>	<b>\$12,738</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$90
Coinsurance	\$2,480
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,930</b>

**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](#) \$25
- 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$300
Copayments	\$820
Coinsurance	\$372
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1,548</b>

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

- The [plan's](#) overall [deductible](#) \$300
- [Specialist copayment](#) \$25
- 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*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$300
Copayments	\$75
Coinsurance	\$326
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$701</b>