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 or call 1-888-276-4732 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$375/Individual or $750/family Copayments do not count towards deductible.	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, office/outpatient visits, hospice, prescription drugs, and some of the items listed in the "Other Covered Services" box on p. 6 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. $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 deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Individual: $4,200 ($2,950 for medical plus $1,250 for pharmacy). Family: $8,400 ($5,900 for medical plus $2,500 for pharmacy).	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, some of the items listed in the "Other Covered Services" box on p. 6, amounts paid or credited for the specialty drugs listed at www.saveonsp.com/adventistrisk, 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 1-888-276-4732 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.

Your employer may further subsidize your benefits under this plan (e.g., reduce/waive deductibles/copayments). Please contact your human resources department or call 888-276-4732 for details about any such subsidy.

* Please note that, because the plan is self-funded and not insured, the term "premiums" actually means your employee-share contribution.

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	$25 copayment/visit	Not Covered	Deductible does not apply.
	Specialist visit	$25 copayment/visit	Not Covered	Deductible does not apply.
	Telehealth visit	No Charge	Not Covered (except for mental health and substance abuse counseling)	Deductible does not apply. Network providers for telehealth include the plan's usual network plus Amwell.
	Other practitioner office Visit	Alternative therapy benefits: Acupuncture: 50% coinsurance Chiropractic: 20% coinsurance Massage therapy: 50% coinsurance Diabetes Self-Management Training: 0% coinsurance	Same as network since network utilization not required for these services.	Deductible does not apply. Acupuncture, chiropractic, and massage limited to 15 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 benefits, participants under age 18 are not eligible. For 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.
	Preventive care/screening/ immunization	No Charge	Not covered	Deductible does not 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)	20% coinsurance	Not covered	None.

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)	
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	Pre-certification required for some imaging services.
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 (Tier 1)	Chronic preventive generics: $2 copayment/prescription for 30-day retail supply; $4 copayment/prescription for 90-day mail-order supply or Walgreen's Smart90 retail program. All other generics: $10 copayment/prescription for 30-day retail supply; $20 copayment/ prescription for 90-day mail-order supply or Walgreen's Smart90 retail program.	Not covered	Pre-certification required for some drugs. Deductible 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. Specialty drugs require use of Accredo mail order.
	Preferred brand drugs (Tier 2)	$25 copayment/prescription for 30-day retail supply; $50 copayment/ prescription for 90-day mail-order supply or Walgreen's Smart90 retail program.	Not covered	
	Non-preferred brand drugs (Tier 3)	$45 copayment/prescription for 30-day retail supply; $90 copayment/ prescription for 90-day mail-order supply or Walgreen's Smart90 retail program.	Not covered	
	Specialty drugs	For most specialty drugs, the copayments listed above will apply. Some specialty drugs are SaveonSP specialty drugs (listed at www.saveonsp.com/adventistris	Not covered	Pre-certification required. Deductible does not apply. Mail order through Accredo is required, and some drugs are available only through the Medical Channel Management Program. Any coinsurance paid for the SaveonSP specialty drugs will not apply to your out-of-pocket limit

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)	
		k). For these drugs, coinsurance is 30%, but if you sign up for the SaveonSP Program, your out-of-pocket cost will be $0.		(but the out-of-pocket will be reduced to $0 if you sign up for the SaveonSP Program).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Pre-certification required.
	Physician/surgeon fees	20% coinsurance	Not covered	Pre-certification required.
If you need immediate medical attention	Emergency room care	20% after $100 copayment/visit	20% after $100 copayment/visit. Please note NO COVERAGE for a Non-Emergency visit to an emergency room.	Copayment waived if admitted to hospital. Emergency hospital admission covered out-of-network at 20% coinsurance. Deductible does not apply when there is no hospital admission.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Pre-certification required for air transport unless failure to provide air transport would have endangered the life of the enrollee.
	Urgent care	$25 copayment/visit if billed as an office visit; or 20% after $100 copayment/visit if billed as an emergency room visit	$25 copayment/ visit if billed as an office visit; or 20% after $100 copayment/visit if billed as an emergency room visit	May be paid as an office visit or as an emergency room visit according to provider contract. Facility fees for office visits not paid. Deductible does not apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Pre-certification required. Emergency hospital admission covered out-of-network at 20% coinsurance.
	Physician/surgeon fees	20% coinsurance	Not covered	Surgical pre-certification required.

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	$25 copayment/visit for office visits; 20% coinsurance for other services.	$25 copayment/ visit for office visits; other services not covered.	Pre-certification required for inpatient services, intensive outpatient, partial hospitalization, and residential care. Deductible does not apply to counseling sessions. $0 copayment for telehealth counseling sessions, regardless of network status.
	Inpatient services	20% coinsurance	Not covered	
If you are pregnant	Office visits	$25 copayment/visit	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, copayment, 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	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Coverage limited to 120 visits/year.
	Rehabilitation services	20% coinsurance	Not covered	Therapeutic services include physical therapy, occupational therapy, and speech therapy. Visits beyond 60 visits/year for any single therapeutic service will require prior approval via additional medical necessity review. Vision therapy has a maximum of 30 visits/year. Vision therapy and any inpatient services require pre-certification. Habilitation services require pre-certification.
	Habilitation services	20% coinsurance	Not covered	
	Skilled nursing care	20% coinsurance	Not covered	Pre-certification required.
	Durable medical equipment	20% coinsurance	Not covered	Pre-certification required for any CPM devices/machines, CGM, Dynasplints, insulin pumps, and all billed charges above $2,000 or more.
	Hospice services	No charge	No charge if unavailable in-network	Deductible does not apply. Inpatient services require pre-certification.

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 your child needs dental or eye care	Children's eye exam	20% coinsurance	20% coinsurance	$450 maximum payable per plan year per person for vision care benefits. Maximum does not apply to one pediatric (under age 19) annual eye exam and one pair of standard, clear-lens prescription glasses per child per plan year. Deductible does not apply.
	Children's glasses	20% coinsurance	20% coinsurance	
	Children's dental check-up	No charge for preventive services; 20% coinsurance for restorative care in-network	No charge for preventive services; 25% for restorative care out-of-network.	Maximum payable per plan year for dental care is $2,500/individual and $7,500/family. Separate dental deductible applies. Deductible and maximum do not apply to pediatric preventive dental care.

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 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
- Hearing aids, covered with some limitations
- Infertility treatment, covered with some limitations
- Private-duty nursing, covered with some limitations
- Routine eye care (Adult and Children), covered with some limitations
- Routine foot care

Your Rights to Continue Coverage: There are state agencies that can help if you want to continue your coverage after it ends. The contact information for those state agencies can be found at www.HealthCare.gov/marketplace-in-your-state.
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 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 or your employer's human resources department.

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 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, kwiijigo 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	$375
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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$375
Copayments	$20
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,855**

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

The plan's overall deductible	$375
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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$1000
Coinsurance	$0
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	$375
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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$375
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$975**

Your employer may further subsidize your benefits under this plan (e.g., reduce/waive deductibles/copayments). Please contact your human resources department or call 888-276-4732 for details about any such subsidy.
* Please note that, because the plan is self-funded and not insured, the term "premiums" actually means your employee-share contribution.