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, Boon-Chapman at 800-252-9653. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. For questions about your coverage or to view the Glossary, please visit www.boonchapman.com or call 800-252-9653 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers **$1,000**/individual or **$3,000**/family. For out-of-network providers **$2,000**/individual or **$6,000**/family. Doesn't apply to most Preventive care.	Generally, you must pay all of the costs from provider up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes, outpatient prescription drugs, office visits and some Preventive care services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. **$450** per hospital confinement for out-of-network hospitals. 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?	For network providers **$1,000**/individual or **$3,000**/family. For out-of-network providers **$3,750**/individual or **$11,250**/family.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Copayments, deductibles, premiums, balance billed charges 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 800-252-9653 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	$25 co-pay/visit	50% coinsurance	——————none——————
	Specialist visit	$25 co-pay/visit	50% coinsurance	——————none——————
	Immunizations (Birth to 6 years)	No charge	No charge	
	Immunizations (Age 6 to the later 18th birthday or 12th grade)	No charge	50% coinsurance	
	Preventive care/screening/	$25 co-pay/visit	Not covered	Coverage limited to $750 per calendar year. 90% coinsurance applies thereafter. Adult immunizations are not a covered benefit.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	50% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	10% coinsurance	50% coinsurance	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.maxorplus.com	Generic drugs	The greater of 10% coinsurance or $15 co-pay for retail or $15 co-pay for mail order	Not covered	Retail prescriptions are limited to a 30-day supply. Mail order prescriptions are limited to a 90-day supply.
	Preferred brand drugs	The greater of 20% coinsurance or $25 co-pay for retail or $25 co-pay for mail order	Not covered	
	Non-preferred brand drugs/Compound drugs	The greater of 30% coinsurance or $35 co-pay for retail or $35 co-pay for mail order	Not covered	
	Specialty drugs	Coinsurance aligns with above category of generic, preferred brand, or non-preferred brand drugs	Not covered	Specialty drugs are limited to 90 day supply and must be filled by the Maxor Specialty Pharmacy (800) 687-0707.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	Preauthorization required at Prime Dx 800-477-4625. Failure to do so will result in 50%

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)	
				penalty.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	————————none————————
If you need immediate medical attention	Emergency room care	$150 co-pay/visit 10% coinsurance	50% coinsurance	Co-pay waived if admitted to in-patient hospital.
	Emergency medical transportation	10% coinsurance	50% coinsurance	————————none————————
	Urgent care	$25 co-pay/visit 10% coinsurance	50% coinsurance	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance	Preauthorization required at Prime Dx 800-477-4625. Failure to do so will result in 50% penalty.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	————————none————————
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	20% coinsurance	Not covered	Coverage is limited to $80 per visit. EAP benefits must be accessed before benefits will be paid.
	Mental/Behavioral health inpatient services	20% coinsurance	Not covered	EAP benefits must be accessed before benefits will be paid. Pre-authorization required at Prime Dx 800-477-4625.
	Substance use disorder outpatient services	20% coinsurance	Not covered	Coverage is limited to $80 per visit. EAP benefits must be accessed before benefits will be paid.
	Substance use disorder inpatient services	20% coinsurance	Not covered	EAP benefits must be accessed before benefits will be paid. Preauthorization required at Prime Dx 800-477-4625.
If you are pregnant	Office visits	$25 co-pay/visit 10% coinsurance	50% coinsurance	————————none————————
	Childbirth/delivery professional services	10% coinsurance	50% coinsurance	————————none————————
	Childbirth/delivery facility services	10% coinsurance	50% coinsurance	————————none————————
If you need help recovering or have other special health	Home health care	10% coinsurance	50% coinsurance	Coverage is limited to 120 days per calendar year.
	Rehabilitation services	10% coinsurance	50% coinsurance	————————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)	
needs	Habilitation services	10% coinsurance	50% coinsurance	Certain learning disabilities not covered. Refer to your plan document for full list of covered services.
	Skilled nursing care	10% coinsurance	50% coinsurance	Coverage is limited to 120 days per calendar year.
	Durable medical equipment	10% coinsurance	50% coinsurance	————————none————————
	Hospice services	10% coinsurance	50% coinsurance	Coverage is limited to 180 days per calendar year.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

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
- Adult Immunizations
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency services when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Allergy Treatment
- Bariatric surgery (with a morbid obesity diagnosis)
- Chiropractic care
- TMJ treatment

Monthly Employee Premiums:

	ACTIVE EMPLOYEES	RETIREES (with 15 years of continuous service)	RETIREES (without 15 years of continuous service)	COBRA*
Employee Only	$-0-	$-0-	$567.00	$444.80
Employee & Spouse	$80.00	$81.00	$648.00	$854.02
Employee & Child/ren	$70.00	$71.00	$638.00	$1,049.73
Employee & Family	$150.00	$152.00	$719.00	$1,481.19

*Other premium levels for spouse only or child only coverage are available to COBRA participants.

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 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 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: Boon-Chapman at 800-252-9653 or PO Box 9201, Austin, TX 78766-9201.

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 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 800-252-9653.

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	$1,000
Specialist *[copayment]*	$25
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$110
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,170**

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

The plan's overall deductible	$1,000
Specialist *[copayment]*	$25
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$1,040
Coinsurance	$186
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,281**

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

The plan's overall deductible	$1,000
Specialist *[copayment]*	$25
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$75
Coinsurance	$163
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,238**

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