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, contact your employer. 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 1-800-840-9496 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 Individual / $1,500 Family for In-Network $1,000 Individual / $3,000 Family for Out-of-Network Deductible is embedded	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. In-Network preventive care and services covered at "No charge". The following services are covered as deductible waived: Allergy testing, serum and injections, birthing centers, chiropractic treatment/spinal manipulations, hearing aids, home health care, hospice care, the injectable contraceptive benefit, medical records requests, office visits, outpatient lab and x-ray, preventive care skilled nursing facility, rehabilitation facility removal of wisdom teeth, and urgent care facility.	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?	Medical: $3,000 Individual / $9,000 Family for In-Network $10,000 Individual / $25,000 Family for Out-of-Network Medical Out-Of-Pocket Limit is embedded Prescription Drug: $3,600 Individual / $4,200 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, balance-billing charges, penalty amounts, health care this plan doesn't cover, and prescription drug charges. Prescription drug charges apply toward their own Out-of-Pocket limit.	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. North Carolina and South Carolina: Med Cost Call 1-800-824-7406 or go to www.medcost.com. All Other Locations: Aetna Signature Administrators Call 1-866-504-6813 or go to www.aetna.com/asa for Aetna network.	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, unless otherwise stated.

Benefits and cost sharing accumulate on a Calendar Year basis from 1/1 through 12/31 each year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	$5 copay per visit	50% coinsurance after deductible	None
	Specialist visit	$10 copay per visit	50% coinsurance after deductible	None
	Preventive care/screening/ immunization	No charge	50% coinsurance after deductible No charge for colon cancer screenings, breast pumps and supplies.	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	50% coinsurance after deductible	Pre-Certification is required. 50% penalty up to a maximum of $500 if genetic testing and sleep studies are not Pre-Certified. Laboratory, diagnostic, and x-ray services that are provided by an Out-of-Network Provider through a referral on an In-Network Physician will be paid at the In-Network rate.
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible TopCare Incentive: $250 copay if TopCare Provider is utilized	50% coinsurance after deductible	Pre-Certification is required. Failure to pre-certify will subject you to a 50% penalty up to a maximum of $500 for any resulting claims.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.WellDyneRx.com	Generic drugs	Retail: No charge 30-day supply Mail Order: No charge 90-day supply	Not covered	Prescription Drug: $3,600 Individual / $4,200 Family Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.WellDyneRx.com Retail covered up to a 30-day supply. Mail order covered up to a 90-day supply. Birth control pills and devices covered at no charge.
	Preferred brand drugs	Retail: $10 copay/prescription, 30-day supply Mail Order: $20 copay/prescription, 90-day supply	Not covered	
	Non-preferred brand drugs	Retail: $20 copay/prescription, 30-day supply Mail Order: $40 copay/prescription, 90-day supply	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	Retail: $100 copay/prescription, 30-day supply	Not covered	Prior authorization may be required on certain prescription drugs. If you purchase your prescription drugs from a non-participating pharmacy, you will have to pay the full price of the prescription and then submit a claim for reimbursement. Reimbursement will be according to the network price, so your total Out-of-Pocket cost may likely be greater than the co-payment you would have paid if you had used a network pharmacy. Prescriptions drugs that have "Orphan Status" are excluded.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance, after deductible TopCare Incentive: Inpatient/Outpatient Surgeries; $500 copay then No charge; Deductible waived. 2nd surgical opinion required to receive the benefit above. TopCare Incentive: Second Surgical Opinion: Copay waived, when TopCare provider is utilized.	50% coinsurance, after deductible	Pre-Certification is required except when rendered in the emergency room. Failure to pre-certify will subject you to a 50% penalty up to a maximum of $500 for any resulting claims. 2nd Surgical Opinion not required if surgery is done by TopCare provider.
	Physician/surgeon fees	30% coinsurance, after deductible TopCare Incentive: Inpatient/Outpatient Surgeries; $500 copay then No charge; Deductible waived. Second surgical opinion required to receive the benefit above. TopCare Incentives: Second Surgical Opinion: Copay waived, when TopCare provider is utilized.	50% coinsurance, after deductible	2nd Surgical Opinion is not required when TopCare provider is utilized.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	30% coinsurance after deductible	Same as In-Network	Diagnostic services performed in the emergency room are paid at the outpatient diagnostic service, lab and x-ray benefit level. An additional $350 copay applies for Non-True Emergency
	Emergency medical transportation	30% coinsurance after deductible	Same as In-Network	None
	Urgent care	$5 copay per visit	50% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible	50% coinsurance after deductible	50% penalty up to a maximum of $500 for any resulting claims if not Pre-Certified.
	Physician/surgeon fees	30% coinsurance after deductible	50% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient: 30% coinsurance after deductible Office: $10 copay per visit	50% coinsurance after deductible	None
	Inpatient services	30% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification is required. 50% penalty up to a maximum of $500 for any resulting claims.
If you are pregnant	Office visits	$5 copay per visit	50% coinsurance after deductible	Depending on the type of services, a co-insurance or deductible may apply. Pre-Certification is required for a hospital stay that exceed forty-eight (48) hours for a vaginal birth and ninety-six (96) hours for a cesarean section birth. $50% penalty up to a maximum of $500 for any admissions exceeding 48/96 hours if not Pre-Certified.
	Childbirth/delivery professional services	30% coinsurance after deductible Birthing Center: No Charge	50% coinsurance after deductible Birthing Center: No Charge	
	Childbirth/delivery facility services	Birthing Center: No Charge All Other Inpatient Facilities 30% coinsurance, after deductible	Birthing Center: No Charge All Other Inpatient Facilities 50% coinsurance, after deductible	
If you need help recovering or have other	Home health care	No charge	No charge	$50% penalty up to a maximum of $500 for any admissions exceeding 48/96 hours if not Pre-Certified. Limited to an annual maximum of forty (40) visits per plan participant

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
special health needs	Rehabilitation services	Inpatient Facilities: No Charge Outpatient Facilities: 30% coinsurance after deductible	Inpatient Facilities: No Charge Outpatient Facilities: 50% coinsurance after deductible	Pre-Certification is required for Inpatient rehabilitation facilities. Failure to pre-certify will subject you to a 50% penalty up to a maximum of $500 for any resulting claims. 60 days/calendar year when combined with Skilled Nursing Facility.
	Habilitation services	30% coinsurance after deductible Inpatient Facilities: No Charge Outpatient Facilities: 30% coinsurance after deductible	50% coinsurance after deductible Inpatient Facilities: No Charge Outpatient Facilities: 30% coinsurance after deductible	Pre-Certification is required. Failure to pre-certify 50% penalty up to a maximum of $500 for any resulting claims. 60 days/calendar year when combined with Skilled Nursing Facility.
	Skilled nursing care	No charge	No charge	Pre-Certification is required. Failure to pre-certify 50% penalty up to a maximum of $500 for any resulting claims. 60 days/calendar year when combined with Rehabilitation Facility.
	Durable medical equipment	30% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification is required. 50% penalty up to a maximum of $500 penalty if electric/motorized scooters, wheelchairs or pneumatic compression devices not Pre-Certified.
	Hospice services	No Charge	No Charge	Hospice care plan must certify life expectancy of six (6) months or less
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	No charge up to $300 annually: Includes exams, lenses, frames, contacts and hardware.
	Children's glasses	No Charge	No Charge	
	Children's dental check-up	No Charge	No Charge	One (1) visit every six (6) months up to age nineteen (19).

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)
- Non-emergency care when traveling outside the U.S.
- Infertility treatment
- Routine foot care

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

- Acupuncture ($500/calendar year)
- Bariatric surgery (as defined in the plan document for Morbid Obesity. (Limited to one (1) surgical procedure/lifetime. (Pre-Certification is required).
- Chiropractic care ($500/calendar year)
- Hearing aids ($2,000/calendar year)
- Long-term care
- Private duty nursing
- Routine eye care ($300/calendar year)
- Weight loss programs

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 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 your employer or 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**

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 1-800-840-9496.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-840-9496

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-840-9496

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-840-9496

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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist copayment	$10
Hospital (facility) coinsurance	30%
Other copayment or coinsurance	30%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$2,430
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,000**

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

The plan's overall deductible	$500
Specialist copayment	$10
Hospital (facility) coinsurance	30%
Other copayment or coinsurance	30%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$180
Coinsurance	$359
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,039**

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

The plan's overall deductible	$500
Specialist copayment	$10
Hospital (facility) coinsurance	30%
Other copayment or coinsurance	30%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$270
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$780**

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