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, visit www.heretrust.com or call 1-844-411-0786. 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.healthcare.gov/sbc-glossary or call 1-844-411-0786 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred Providers: **$0** individual; Non-Preferred Providers: **$500** individual / **$1,500** family.	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 and primary care services by a Preferred Provider 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.
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?	For Preferred Providers $2,500 individual / $7,500 family; for Non-Preferred Providers $10,000 individual / $30,000 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, balance-billing charges, deductibles, copayments, health care this plan doesn't cover, prescription drugs, penalties for failure to obtain preauthorization, charges in excess of allowed amounts, physical, occupational or speech therapy, repair of teeth following accidental injury, and neurodevelopmental therapy.	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 vision providers visit www.eyemedvisioncare.com or call 1-866-289-0614.	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
		Preferred Provider (You will pay the least)	Non-Preferred 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	$20 copay/office visit plus 10% coinsurance	$20 copay/office visit plus 40% coinsurance	All services must be medically necessary. Prescription required for massage therapy.
	Specialist visit	$20 copay/office visit plus 10% coinsurance	$20 copay/office visit plus 40% coinsurance	
	Preventive care/screening/ immunization	No charge	Not Covered	No coverage for routine preventive care tests performed by a Non-Preferred Provider, except mammograms at 40% coinsurance. 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)	10% coinsurance	40% coinsurance	
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.savrx.com** or by calling 800-228-3108	Generic drugs (Tier 1)	$12 copay/prescription (retail & mail order)	$12 copay/prescription (retail & mail order)	Covers up to a 34-day supply at a retail pharmacy or up to a 90-day supply through Walk-In-Mail or mail order. Brand drugs when a generic is available require you to pay the difference in cost between the generic and brand, plus the copay. If you fill your prescription at a non-network pharmacy, you must pay the full cost of prescription and file a claim for reimbursement with Sav-Rx. Contraceptive coverage provided for female member, spouse and female dependent children.
	Preferred brand drugs (Tier 2)			
	Non-preferred brand drugs (Tier 3)			
	Specialty drugs (Tier 4)			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	All services must be medically necessary. Preauthorization is required for certain procedures. Failure to do so will result in a $250 benefit reduction (not to exceed $500) for
	Physician/surgeon fees	$20 copay/visit plus 10% coinsurance	$20 copay/visit plus 40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
				all related expenses incurred in excess of the deductible for each surgery that is not preauthorized when required.
If you need immediate medical attention	Emergency room care	$75 copay/visit plus 10% coinsurance	$75 copay/visit plus 10% coinsurance	Copay waived if admitted to hospital. Emergency room physician requires $20 copay.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$20 copay/visit plus 10% coinsurance	$20 copay/visit plus 40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	All services must be medically necessary. Preauthorization is required. Failure to do so will result in a $250 benefit reduction (not to exceed $500) for all related expense incurred in excess of the deductible for each hospitalization that is not preauthorized.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit plus 10% coinsurance	$20 copay/visit plus 40% coinsurance	None
	Inpatient services	10% coinsurance	40% coinsurance	All services must be medically necessary. Preauthorization is required. Failure to do so will result in a $250 benefit reduction (not to exceed $500) for all related expense incurred in excess of the deductible for each hospitalization that is not preauthorized.
If you are pregnant	Office visits	$20 copay/office visit plus 10% coinsurance	$20 copay/office visit plus 40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment /coinsurance may apply. No Coverage for a dependent or child of dependent child.
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	$20 copay/visit plus 10% coinsurance	$20 copay/visit plus 40% coinsurance	Limited to 130 visits per calendar year.
	Rehabilitation services	10% coinsurance	40% coinsurance	All services must be medically necessary. Preauthorization is required for inpatient. If preauthorization is not obtained there will be a $250 benefit reduction (not to exceed $500) for

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
				all related expenses incurred in excess of the deductible. Outpatient rehabilitation services require $20 copay/visit.
	Habilitation services	Not Covered	Not Covered	Neurodevelopmental therapy available to dependent children age 6 and under, $20 copay and PPO/Non-PPO coinsurance levels and deductible apply.
	Skilled nursing care	10% coinsurance	40% coinsurance	Limited to 90 days/year. Preauthorization is required, failure to do so will result in a $250 benefit reduction (not to exceed $500) for all related expense incurred in excess of the deductible.
	Durable medical equipment	10% coinsurance	40% coinsurance	Requires a prescription. Excludes equipment whose primary purpose is preventing illness or injury, for exercise, comfort, or hygiene. Special equipment and supplies 20% coinsurance.
	Hospice services	10% coinsurance	40% coinsurance	$20 copay applies to professional services. Inpatient care limited to 14 days within benefit period of 6 months.
If your child needs dental or eye care	Children's eye exam	No charge	Fees in excess of $72 and over UCR	Limited to one exam every 12 months.
	Children's glasses	No charge for single vision lenses and fees in excess of $120 for frames	Fees in excess of $60 for single vision lenses and fees in excess of $60 for frames	Lenses limited to one pair each 12 months. Frames are limited to once each 24 months.
	Children's dental check-up	Charges in excess of fee schedule	Charges in excess of fee schedule	Limited to 2 exams per calendar year. $2,000 annual maximum waived for children under age 18.

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.)

- Bariatric Surgery
- Cosmetic Surgery (except to correct congenital anomalies or following mastectomy)
- Habilitation Services (except for treatment of neurodevelopmental conditions in children age 6 and under)
- Infertility treatment
- Long-term care
- Pregnancy for a dependent child
- 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.)		
• Acupuncture (limited to 12 visits/year) • Chiropractic care (limited to 12 visits/year) • Dental care (Adult)	• Hearing Aids • Non-emergency care when traveling outside the US.	• Private-duty nursing • Routine eye care (Adult)

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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 x 61565 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or contact the Administration Office at 1-844-411-0786.
Additionally, a consumer assistance program can help you file your appeal. Contact Washington Consumer Assistant Program at 1-800-562-6900 or www.insurance.wa.gov.

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 1-844-411-0786.

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** $0
- **Specialist copayment + coinsurance** $20 + 10%
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$1,250
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,330**

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

- **The plan's overall deductible** $0
- **Specialist copayment + coinsurance** $20 + 10%
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$720**

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

- **The plan's overall deductible** $0
- **Specialist copayment + coinsurance** $20+10%
- **Hospital (facility) coinsurance** 10%+$75
- **Other coinsurance** 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	**$2,800**

In this example, Mia would pay:

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

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