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 1-800-205-7002 or visit us at www.UA598benefits.org. 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 1-866-444-3272 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$750/individual or $2,250/family The Plan includes a Health Reimbursement Account (HRA). This can be used to pay for or reimburse you for certain, qualified medical expenses (including copays and coinsurance) up to the balance available in your HRA.	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 services, copays from in-network preferred providers, ambulance and prescription drugs.	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 in-network 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. $50 individual / $150 family for dental coverage.	You must pay all of the costs for dental services up to the specific deductible amount before this plan begins to pay for dental services.
What is the out-of-pocket limit for this plan?	For medical: $3,000 individual / $6,000 family For prescription drugs: $1,500 individual / $3,000 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. Prescription drug out-of-pocket limits apply to in-network only.
What is not included in the out-of-pocket limit?	Premiums, balance-billing 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 http://www.aetna.com/docfind or call 1-800-205-7002 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

Important Questions	Answers	Why This Matters:
		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 copay/office visit; deductible does not apply. 20% coinsurance for other outpatient services.	40% coinsurance	None.
	Specialist visit	$25 copay/office visit; deductible does not apply. 20% coinsurance for other outpatient services.	40% coinsurance	None.
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$5 copay/prescription (retail) $10 copay/prescription (mail order)	Purchases from a non-CVS Caremark network pharmacy: Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Prior authorization required for some drugs.
	Preferred brand drugs	$20 copay/prescription (retail) $40 copay/prescription (mail order)		

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)	
	Non-preferred brand drugs	$40 copay/prescription (retail) $80 copay/prescription (mail order)	Purchases from a non-CVS Caremark network pharmacy: Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Prior authorization required for some drugs.
	Specialty drugs	10% coinsurance, deductible does not apply	Not covered	Covers up to a 30-day supply. Only covered at CVS Caremark specialty pharmacy. Prior authorization required for some drugs. PrudentRx affects your coinsurance for certain drugs. See https://www.prudentrx.com/prudentexs for more information.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization for out-of-network providers recommended.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization for out-of-network providers recommended.
If you need immediate medical attention	Emergency room care	$75 copay/visit then 20% coinsurance	$75 copay/visit then 20% coinsurance	Emergency room copay waived if admitted to hospital.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Deductible does not apply.
	Urgent care	$25 copay/visit, deductible does not apply	40% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization for out-of-network providers recommended.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization for out-of-network providers recommended.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit, deductible does not apply. 20% coinsurance for other outpatient services.	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization for out-of-network providers recommended.

* For more information about limitations and exceptions, see the plan or policy document at www.UA598benefits.org.

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 are pregnant	Office visits	No charge; deductible does not apply.	40% coinsurance	Cost sharing does not apply for preventive services as recommended by the U.S. Preventive Services Taskforce. Depending upon the type of services, a 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	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 130 visits per calendar year. Preauthorization for out-of-network providers recommended.
	Rehabilitation services	20% coinsurance	40% coinsurance	Limited to 60 outpatient visits per calendar year. Limited to 60 inpatient days per calendar year. Preauthorization for out-of-network providers recommended.
	Habilitation services	20% coinsurance	40% coinsurance	None.
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 100 days per calendar year. Preauthorization for out-of-network providers recommended.
	Durable medical equipment	20% coinsurance	40% coinsurance	None.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization for out-of-network providers recommended.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limited to 1 exam every 12 months. Limited to $50 reimbursement every 12 months from out-of-network providers.
	Children's glasses	No charge	No charge	Limited to 1 pair every 12 months. Frames limited to $150 every 12 months from network providers. Frames and lenses limited to scheduled reimbursement amounts from out-of-network providers.
	Children's dental check-up	No charge	No charge	Limited to 2 exams per calendar year.

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 as allowed by the Plan
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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
- Chiropractic care
- Dental care (Adult)
- Infertility treatment
- 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: the Plan Administrator at 1-800-205-7002 or the Employee Benefits Security Administration at 1-866-444-EBSA. 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 on how 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: Plan Administrator, BeneSys,Inc., PMB #116, 5331 S Macadam Avenue Suite 258, Portland OR 97239 or at 1-800-205-7002. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA or www.dol.gov/ebsa/healthreform.

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 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 1-800-205-7002.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-205-7002.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-205-7002

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-205-7002.

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 and before HRA dollars are applied. The Plan has an HRA option which can be used to pay for or reimburse you for certain, qualified medical expenses (including copays and coinsurance) up to the balance available in your HRA.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$750
Specialist copayment	$0
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	$750
Copayments	$10
Coinsurance	$1,840
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,660**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$750
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	$125
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$22
The total Joe would pay is	**$647**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$750
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	$750
Copayments	$80
Coinsurance	$340
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,170**

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