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, https://www.boonchapman.com/. 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.dol.gov/ebsa/healthreform or call 1-800-252-9653 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000** individual / **$3,000** family combined for Network and Out-of-Network Providers	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your deductible may also be waived if services are received at a Houston Methodist Hospital facility.
Are there services covered before you meet your deductible?	Yes. Preventive care services 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. **$50** for Prescription Deductible: Individual. **$100** for Prescription Deductible: Family. 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?	**$4,500** individual / **$10,000** family for network provider **$50,000** individual / **N/A** family for out-of-network provider Prescription drug coverage out-of-pocket-limit of **$2,000** Individual / **$4,000** Family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. Your out-of-pocket limit may be waived if services are received from a Houston Methodist Hospital facility. The out-of-pocket limit includes deductibles and medical and prescription copay.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan does not 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 **1-800-252-9653** for a list of participating 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 don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

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	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/office visit, deductible waived	40% coinsurance	Includes Chiropractor visits. Limited to 35 visits per year.
	Specialist visit	$40 copay/office visit, deductible waived	40% coinsurance	None
	Preventive care/screening/immunization	No charge, deductible waived	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	Pre-certification is required with PrimeDx at (512) 454-5112.
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	Retail: 20% coinsurance ($10 minimum) Mail Order: 20% coinsurance ($25 minimum)	Not Covered	Retail prescriptions limited to 90-day supply. Retail minimums noted here are for a 30-day supply. Mail order limited to 90-day supply. Mail order minimums noted here are for a 31-90-day supply. Certain generic prescriptions for the treatment of asthma, high blood pressure, high cholesterol, diabetes, and proton pump inhibitors are available for no charge. Contact your prescription drug administrator for specific information.
	Preferred Brand Drugs	Retail: 20% coinsurance ($55 minimum) Mail Order: 20% coinsurance ($137.50 minimum)	Not Covered	
	Non Preferred Brand Drugs	Retail: 20% coinsurance ($80 minimum)	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-of-Network Provider	
		Mail Order: 20% coinsurance ($200. minimum)		
	Specialty drugs	Coinsurance aligns with above category of generic, preferred brand, or non-preferred brand drugs:	Not Covered	Specialty drugs limited to 30-day supply and must be obtained from Accredo Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Some services require pre-certification with PrimeDx at (512) 454-5112.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	40% coinsurance	Claims for out-of-network providers are paid toward the Maximum Allowable Charges.
	Emergency medical transportation	20% coinsurance	40% coinsurance	Claims for out-of-network providers are paid toward the Maximum Allowable Charges
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-certification is required with PrimeDx at (512) 454-5112
	Physician/surgeon fee	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay/visit, deductible waived or 20% coinsurance	40% coinsurance	There is no charge for Mental Health services received through the EAP. Supplemental Counseling Benefit will allow up to 50 counseling sessions per calendar year at $25 copay/visit, deductible waived. The Plan pays up to $95 max per office visit. Coverage included for marriage and family counseling.
	Inpatient services	20% coinsurance	40% coinsurance	Pre-certification is required with PrimeDx at (512) 454-5112.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-of-Network Provider	
If you are pregnant	Office visits	$30 copay/visit, deductible waived	40% coinsurance	In-network copay coverage is limited to initial visit only to determine pregnancy. 20% coinsurance applies thereafter. A covered person must notify PrimeDx at (512) 454-5112 within 30 days of learning that she is pregnant.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Pre-certification is required with PrimeDx at (512) 454-5112.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Pre-certification is required with PrimeDx at (512) 454-5112.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 60 visits per calendar year. Pre-certification is required with PrimeDx at (512) 454-5112.
	Rehabilitation services	$30 copay/visit, deductible waived	40% coinsurance	Limited to 60 visits per condition per calendar year. All care must be pre-certified with PrimeDx at (512) 454-5112.
	Habilitation services	$30 copay/visit, deductible waived	40% coinsurance	Limited to 60 visits per condition per calendar year. All care must be pre-certified with PrimeDx at (512) 454-5112.
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 60 visits per calendar year. Pre-certification is required with PrimeDx at (512) 454-5112.
	Durable medical equipment	20% coinsurance	40% coinsurance	Pre-certification is required with PrimeDx at (512) 454-5112 for Durable Medical Equipment if the cost exceeds $1,000
	Hospice services	20% coinsurance	40% coinsurance	Pre-certification is required with PrimeDx at (512) 454-5112.
If your child needs dental or eye care	Children's eye exam	No charge, deductible waived	No charge, deductible waived	One annual exam only covered, per plan participant through age 19.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge, deductible waived	No charge, deductible waived	One annual exam only covered, per plan participant through age 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.)		
• Acupuncture • Cosmetic Surgery • Dental Care (Adult) • Hearing Aids (not covered for dependents)	• Infertility Treatment • Long Term Care • Non-emergency care when traveling outside the U.S.	• Routine Eye Care (Adult) • Routine Foot Care • Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Chiropractic Care • Bariatric surgery	• Hearing Aids (available to participating employees only as a stand alone benefit)	• Private-duty Nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the **plan** at 1-800-252-9653. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services 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 the plan at 1-800-252-9653. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Does this Coverage 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 Coverage Meet the Minimum Value Standard? 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: 1-800-252-9653
Spanish (Español): Para obtener asistencia en Español, llame al
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa
Chinese (中文): 如果需要中文的帮助，请拨打这个号码
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'

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 copay**	**$40**
▪ **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	$1,000
Copayments	$10
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,370**

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 copay**	**$40**
▪ **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	$900
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,120**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
▪ **The plan's overall deductible**	**$1,000**
▪ **Specialist copay**	**$40**
▪ **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	$1,000
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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