 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 ?	\$1,850 individual / \$3,700 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 .
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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$4,500 individual / \$10,000 family for Network Providers \$50,000 individual / N/A family for Out-of-Network Providers	This is the out-of-pocket limit 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. The out-of-pocket limit includes deductibles
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	20% coinsurance	40% coinsurance	Includes Chiropractor visits. Limited to 35 visits per year.
	Specialist visit	20% coinsurance	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: & Mail Order: 20% coinsurance	Not Covered	Retail prescriptions limited to 90-day supply.
	Preferred Brand Drugs	Retail: & Mail Order: 20% coinsurance	Not Covered	Mail order limited to 90-day supply.
	Non Preferred Brand Drugs	Retail: & Mail Order: 20% coinsurance	Not Covered	Certain generic preventive prescriptions for the treatment of asthma, high blood pressure, high cholesterol, and diabetes are available for no charge. Contact your prescription drug administrator for specific information.
	Specialty drugs	20% coinsurance	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	Pre-certification is required 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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-of-Network Provider	
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	20% coinsurance	40% coinsurance	There is no charge for Mental Health services received through the EAP.
	Inpatient services	20% coinsurance	40% coinsurance	Pre-certification is required with PrimeDx at (512) 454-5112.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	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	
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	20% coinsurance	40% coinsurance	Limited to 60 visits per condition per calendar year. Pre-certification is required with PrimeDx at (512) 454-5112.
	Habilitation services	20% coinsurance	40% coinsurance	Limited to 60 visits per condition per calendar year. Pre-certification is required 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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-of-Network Provider	
	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](#).)

<ul style="list-style-type: none"> Acupuncture Cosmetic Surgery Dental Care (Adult) Hearing Aids (not covered for dependents) 	<ul style="list-style-type: none"> Infertility Treatment Long Term Care Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> Routine Eye Care (Adult) Routine Foot Care Weight Loss Programs
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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.)

<ul style="list-style-type: none"> Chiropractic Care Bariatric surgery 	<ul style="list-style-type: none"> Hearing Aids (available to participating employees only as a stand alone benefit) 	<ul style="list-style-type: none"> Private-duty Nursing
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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

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: January 01, 2021 - December 31, 2021

Texas Annual Conference of the United Methodist Church: High Deductible Health Plan

Coverage for: Individual, Family | Plan Type: High-deductible

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, kwijigo 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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
▪ The plan's overall deductible	\$1,850	▪ The plan's overall deductible	\$1,850	▪ The plan's overall deductible	\$1,850
▪ Specialist coinsurance	20%	▪ Specialist coinsurance	20%	▪ Specialist coinsurance	20%
▪ Hospital (facility) coinsurance	20%	▪ Hospital (facility) coinsurance	20%	▪ Hospital (facility) coinsurance	20%
▪ Other coinsurance	20%	▪ Other coinsurance	20%	▪ Other coinsurance	20%
This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$1,850	Deductibles	\$1,850	Deductibles	\$1,850
Copayments	\$0	Copayments	\$0	Copayments	\$0
Coinsurance	\$2,100	Coinsurance	\$700	Coinsurance	\$200
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$4,010	The total Joe would pay is	\$2,570	The total Mia would pay is	\$2,050

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.