

**⚠** 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, go to [www.boonchapman.com](http://www.boonchapman.com) or call 1-800-252-9653. 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 1-800-252-9653 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	For <u>network providers</u> , <b>\$1,250</b> /person or <b>\$3,750</b> /family. For <u>non-network providers</u> , <b>\$2,000</b> /person or <b>\$6,000</b> /family.	You must pay all the costs up to the <u>deductible</u> amount before this <u>plan</u> begins to pay for covered services you use. Check your policy or <u>plan</u> document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes, the deductible does not apply to <u>prescription drugs</u> , <u>network</u> colonoscopies, immunizations, labs performed by Quest, diabetic supplies by MedWise and outpatient surgeries.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other <u>deductibles</u> for specific services?	Yes. An additional <b>\$100</b> for <u>network providers</u> or <b>\$500</b> for <u>non-network providers</u> per hospital confinement. <b>\$500</b> for non-compliance. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<b>\$4,500</b> /person for <u>network providers</u> ; <b>\$13,500</b> /family for <u>network providers</u> . Unlimited for <u>non-network providers</u> .	The <u>out-of-pocket limit</u> 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 <u>plan</u> for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billed</u> charges, compliance penalties and services this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.aetna.com/asa">www.aetna.com/asa</a> or call <b>1-800-252-9653</b> for a list of participating <u>providers</u> .	If you use an <u>in-network</u> doctor or other health care <u>provider</u> , this <u>plan</u> will pay some or all of the costs of covered services. Be aware, your <u>in-network</u> doctor or hospital may use an out-of-network <u>provider</u> for some services. <u>Plans</u> use the term <u>in-network</u> , <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this <u>plan</u> pays different kinds of <u>providers</u> .
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No. You don't need a referral to see a <u>specialist</u> .	You can see the <u>specialist</u> you choose without permission from this <u>plan</u> .

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$25/visit	50% <a href="#">coinsurance</a>	The <a href="#">copay</a> only applies to the office visit itself. All other applies to <a href="#">deductible</a> and <a href="#">coinsurance</a>
	<a href="#">Specialist</a> visit	\$25/visit	50% <a href="#">coinsurance</a>	
	Other practitioner office visit	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Immunizations	No charge	Not Covered	
	<a href="#">Preventive care/screening/immunization</a>	No charge up to \$500	Not Covered	<a href="#">Deductible</a> waived up to \$500 then subject to <a href="#">deductible</a> and <a href="#">coinsurance</a> . Routine colonoscopies are paid at 100%, not subject to the annual limit.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	CareHere and Quest Laboratories –No charge for covered services.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic drugs	\$16/prescription up to 30 day supply \$30/prescriptions 31-60 day supply \$38/prescription 61-90 day supply	Not Covered	None
	Brand drugs/Generic Available	\$53/prescription up to 30 day supply \$106/prescriptions 31-60 day supply \$134/prescription 61-90 day supply	Not Covered	None
	Brand drugs/No Generic Available	\$68/prescription up to 30 day supply \$137/prescriptions 31-60 day supply \$170/prescription 61-90 day supply	Not Covered	None
	<a href="#">Specialty drugs</a>	10% <a href="#">coinsurance</a> up to \$152	Not Covered	30-day supply only; specialty pharmacy required
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Deductible</a> waived for network services. Facility and surgery related charges performed on the same day.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Medical Tourism Program	No charge	Not applicable	Tel: 1- 833-864-4316 PDX Care Bravo Email: <a href="mailto:nurseadvocate@boonchapman.com">nurseadvocate@boonchapman.com</a>
<b>If you need immediate medical</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> for true emergencies/	None

\* For more information about limitations and exceptions, see the plan or policy document at [www.boonchapman.com](http://www.boonchapman.com).

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)	
attention			50% <u>coinsurance</u> for non-emergencies	
	<a href="#">Emergency medical transportation</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u> for true emergencies/ 50% <u>coinsurance</u> for non-emergencies	None
	<a href="#">Urgent care</a>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Requires precertification
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Mental/Behavioral health inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Requires precertification
	Substance use disorder outpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Substance use disorder inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Requires precertification
If you are pregnant	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Requires precertification
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Requires precertification
	<a href="#">Rehabilitation services</a>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Chiropractic care \$1,500/annual maximum
	<a href="#">Habilitation services</a>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<a href="#">Skilled nursing care</a>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Requires precertification
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Dialysis	N/A	No charge up to MEC	Requires precertification. Also requires enrollment in Medicare Part A and B.
	Sleep Disorder	20% <u>coinsurance</u>	50% <u>coinsurance</u>	\$4,000 Lifetime maximum benefit
	TMJ Treatment	20% <u>coinsurance</u>	50% <u>coinsurance</u>	\$2,500 Lifetime maximum benefit
<a href="#">Hospice services</a>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limit 6 mo. maximum/Must comply w/utilization review to be covered.	
If your child needs	Children's eye exam	Not Covered	Not Covered	None

\* For more information about limitations and exceptions, see the plan or policy document at [www.boonchapman.com](http://www.boonchapman.com).

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)	
dental or eye care	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

**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)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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 (if administered by an MD or DO)
- Bariatric surgery
- Chiropractic care

**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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](http://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: Boon-Chapman Benefit Administrators, Inc. at 1-800-252-9653.

**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 1-800-252-9653.

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next section.* —————

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,250
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,840</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,250
Copayments	\$114
Coinsurance	\$2,480
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,904</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,250
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$7,460</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,250
Copayments	\$1,435
Coinsurance	\$372
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$3,113</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,250
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,010</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,250
Copayments	\$75
Coinsurance	\$326
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,651</b>