

**!** 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>\$3,000</b> /person or <b>\$6,000</b> /family. For <u>non-network providers</u> , <b>\$6,000</b> /person or <b>\$12,000</b> /family. Doesn't apply to preventive care.	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	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. <b>\$1,400</b> for the Medical Tourism Benefit. 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>\$6,450</b> /person for <u>network providers</u> ; <b>\$12,900</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 <u>out-of-network</u> <u>provider</u> for some services. <u>Plans</u> use the term <u>in-network</u> , preferred, 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)	
If you visit a health care <a href="#">provider's</a> office or clinic	<a href="#">Primary care</a> visit to treat an injury or illness	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Other practitioner office visit	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not Covered	
If you have a test	<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, after calendar year deductible.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic drugs	After <a href="#">deductible</a> , \$10/ <a href="#">prescription</a> up to 30 day supply \$20/ <a href="#">prescription</a> 31-60 day supply \$25/ <a href="#">prescription</a> 61-90 day supply	Not Covered	Prescriptions for preventive care medications are covered at 100%, <a href="#">deductible</a> waived.
	Preferred brand drugs	After <a href="#">deductible</a> , \$35/ <a href="#">prescription</a> up to 30 day supply \$70/ <a href="#">prescription</a> 31-60 day supply \$88/ <a href="#">prescription</a> 61-90 day supply	Not Covered	
	Non-preferred brand drugs	After <a href="#">deductible</a> , \$45/ <a href="#">prescription</a> up to 30 day supply \$90/ <a href="#">prescription</a> 31-60 day supply \$112/ <a href="#">prescription</a> 61-90 day supply	Not Covered	
	<a href="#">Specialty drugs</a>	10% <a href="#">coinsurance</a> up to \$100	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	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)	
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Medical Tourism Program	No charge after deductible	Not applicable	Tel: 1- 833-864-4316 PDX Care Bravo; Email: <a href="mailto:nurseadvocate@boonchapman.com">nurseadvocate@boonchapman.com</a>
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u> for true emergencies/ 50% <u>coinsurance</u> for non-emergencies	None
	<a href="#">Emergency medical transportation</a>	20% <u>coinsurance</u>		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.

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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)	
	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.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not Covered	None
	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.

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

**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.* [\\_\\_\\_\\_\\_](#)

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](#) \$3,000
- [Specialist coinsurance](#) 20%
- 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*)

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

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$40
Coinsurance	\$2,520
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,620</b>

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

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist coinsurance](#) 20%
- 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*)

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

<i>Cost Sharing</i>	
Deductibles	\$2,341
Copayments	\$765
Coinsurance	\$585
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$3,746</b>

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

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist coinsurance](#) 20%
- 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*)

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

<i>Cost Sharing</i>	
Deductibles	\$1,540
Copayments	\$0
Coinsurance	\$385
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,925</b>