
 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, Boon-Chapman at 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. For questions about your coverage or to view the Glossary, please visit [www.boonchapman.com](http://www.boonchapman.com) or call 800-252-9653 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	For <a href="#">network providers</a> <b>\$250</b> /individual. For <a href="#">out-of-network providers</a> <b>\$500</b> /individual. Doesn't apply to most <a href="#">Preventive care</a> .	Generally, you must pay all of the costs from <a href="#">provider</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes, outpatient <a href="#">prescription drugs</a> , office visits and some <a href="#">Preventive care</a> services.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. <b>\$450</b> per hospital confinement for <a href="#">out-of-network</a> hospitals. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">network providers</a> <b>\$2,000</b> /individual. For <a href="#">out-of-network providers</a> <b>\$7,500</b> /individual.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Copayments</a> , <a href="#">deductibles</a> , <a href="#">premiums</a> , <a href="#">balance billed</a> charges and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.aetna.com/asa">www.aetna.com/asa</a> or call 800-252-9653 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">co-pay</a> /visit	50% <a href="#">coinsurance</a>	—————none—————
	<a href="#">Specialist</a> visit	\$25 <a href="#">co-pay</a> /visit	50% <a href="#">coinsurance</a>	—————none—————
	Immunizations (Birth to 6 years)	No charge	No charge	
	Immunizations (Age 6 to the later 18 <sup>th</sup> birthday or 12 <sup>th</sup> grade)	No charge	50% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/</a>	\$25 <a href="#">co-pay</a> /visit	Not covered	Coverage limited to \$750 per calendar year. 90% <a href="#">coinsurance</a> applies thereafter. Adult immunizations are not a covered benefit.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	—————none—————
	Imaging (CT/PET scans, MRIs)	10% <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.maxorplus.com">www.maxorplus.com</a>	Generic drugs	The greater of 10% <a href="#">coinsurance</a> or \$15 <a href="#">co-pay</a> for retail or \$15 <a href="#">co-pay</a> for mail order	Not covered	Retail prescriptions are limited to a 30-day supply. Mail order prescriptions are limited to a 90-day supply.
	Preferred brand drugs	The greater of 20% <a href="#">coinsurance</a> or \$25 <a href="#">co-pay</a> for retail or \$25 <a href="#">co-pay</a> for mail order	Not covered	
	Non-preferred brand drugs/Compound drugs	The greater of 30% <a href="#">coinsurance</a> or \$35 <a href="#">co-pay</a> for retail or \$35 <a href="#">co-pay</a> for mail order	Not covered	
	<a href="#">Specialty drugs</a>	<a href="#">Coinsurance</a> aligns with above category of generic, preferred brand, or non-preferred brand drugs	Not covered	<a href="#">Specialty drugs</a> are limited to 90 day supply and must be filled by the Maxor Specialty Pharmacy (800) 687-0707.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required at Prime Dx 800-477-4625. Failure to do so will result in 50% penalty.

\* 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	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	—————none—————
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150 <a href="#">co-pay</a> /visit 10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Co-pay</a> waived if admitted to in-patient hospital.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	—————none—————
	<a href="#">Urgent care</a>	\$25 <a href="#">co-pay</a> /visit 10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required at Prime Dx 800-477-4625. Failure to do so will result in 50% penalty.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	—————none—————
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	20% <a href="#">coinsurance</a>	Not covered	Coverage is limited to \$80 per visit. EAP benefits must be accessed before benefits will be paid.
	Mental/Behavioral health inpatient services	20% <a href="#">coinsurance</a>	Not covered	EAP benefits must be accessed before benefits will be paid. <a href="#">Pre-authorization</a> required at Prime Dx 800-477-4625.
	Substance use disorder outpatient services	20% <a href="#">coinsurance</a>	Not covered	Coverage is limited to \$80 per visit. EAP benefits must be accessed before benefits will be paid.
	Substance use disorder inpatient services	20% <a href="#">coinsurance</a>	Not covered	EAP benefits must be accessed before benefits will be paid. <a href="#">Preauthorization</a> required at Prime Dx 800-477-4625.
If you are pregnant	Office visits	\$25 <a href="#">co-pay</a> /visit 10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	—————none—————
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	—————none—————
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	—————none—————
If you need help recovering or have other special health	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Coverage is limited to 120 days per calendar year.
	<a href="#">Rehabilitation services</a>	10% <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)	
<b>needs</b>	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Certain learning disabilities not covered. Refer to your <a href="#">plan</a> document for full list of covered services.
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Coverage is limited to 120 days per calendar year.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	—————none—————
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Coverage is limited to 180 days per calendar year.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	Not covered
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

**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         | • Hearing aids   | • Private-duty nursing     |
| • Adult Immunizations | • Infertility treatment                                  | • Routine eye care (Adult) |
| • Cosmetic surgery    | • Long-term care   | • Routine foot care        |
| • Dental care (Adult) | • Non-emergency services when traveling outside the U.S. | • Weight loss programs     |

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- |   |                     |                 |
|---|---------------------|-----------------|
| • Allergy Treatment                                   | • Chiropractic care | • TMJ treatment |
| • Bariatric surgery (with a morbid obesity diagnosis) |                     |                 |

**Monthly Employee Premiums:**

	ACTIVE EMPLOYEES	RETIREES (with 15 years of continuous service)	RETIREES (without 15 years of continuous service)	COBRA*
<b>Employee Only</b>	\$75.00	\$76.00	\$685.00	\$562.13
<b>Employee &amp; Spouse</b>	\$220.00	\$224.00	\$833.00	\$1,079.29
<b>Employee &amp; Child/ren</b>	\$210.00	\$213.00	\$823.00	\$1,326.63
<b>Employee &amp; Family</b>	\$355.00	\$361.00	\$970.00	\$1,871.90

\*Other premium levels for spouse only or child only coverage are available to COBRA participants.

**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: 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 at 800-252-9653 or PO Box 9201, Austin, TX 78766-9201.

**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 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist</a> [copayment]	\$25
■ Hospital (facility) [cost sharing]	10%
■ Other [cost sharing]	10%

#### 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	\$250
Copayments	\$110
Coinsurance	\$1,240
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,660</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>	\$250
■ <a href="#">Specialist</a> [copayment]	\$25
■ Hospital (facility) [cost sharing]	10%
■ Other [cost sharing]	10%

#### 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	\$250
Copayments	\$1,040
Coinsurance	\$186
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1,531</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>	\$250
■ <a href="#">Specialist</a> [copayment]	\$25
■ Hospital (facility) [cost sharing]	10%
■ Other [cost sharing]	10%

#### 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	\$250
Copayments	\$75
Coinsurance	\$163
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$488</b>