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, visit www.soundhealthwellness.com or call 1-800-225-7620. 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.soundhealthwellness.com or call 1-800-225-7620 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred providers: **$250** person/**$500** family. Non-preferred providers: **$500** person/**$1,000** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. **Note:** If you (and your enrolled spouse) fail to take steps to earn maximum HRA funding during the available time period, your deductible may be increased by as much as $500 person/$1,000 family.
Are there services covered before you meet your deductible?	Yes. Preventive care by a preferred provider, home health care, hospice services, and prescription drugs.	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 http://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?	In-network Medical: **$2,250** person/**$4,500** family Out-of-network Medical: **$4,500** person/**$9,000** family Overall in-network out-of-pocket limit on Essential Health Benefits: **$9,100** person / **$18,200** family --Medical portion of limit: $5,000 person/$10,000 family --Prescription portion of limit: $4,100 person/$8,200 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. See **Note** above: Medical out-of-pocket limit may increase for the same reasons as the deductible above, by as much as $500 person/$1,000 family due to unearned HRA funding.
What is not included in the out-of-pocket limit?	Emergency room copays, Rx copays, premiums, balance billing charges (except for chiropractic) and health care this plan doesn't	Even though you pay these expenses, they don't count toward the Medical out-of-pocket limit. However, expenses you incur for in-network essential health benefits will count toward the overall in-network out-of-pocket limit on Essential Health Benefits.

	cover.	
Will you pay less if you use a network provider?	Yes. See http://www.aetna.com/dse/search?site_id=soundhealth or call 1-800-225-7620 for a list of network 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 can see the specialist you choose without a referral.

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 provider's office or clinic	Primary care visit to treat an injury or illness	15% coinsurance	40% coinsurance	None
	Specialist visit	15% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	40% coinsurance	See page 55 under "Preventive Care-PPO Providers" and "Preventive Care-Non-PPO Providers" in the plan document for the specific well care schedule. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	40% coinsurance	Chiropractic x-rays limited to one set from one chiropractic visit, per calendar year.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	40% coinsurance	Preauthorization required on PET scan.

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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.soundhealthwellness.com or call 1-800-225-7620.	Most Generic drugs - Tier 1	$6/prescription retail (30-day supply) $18/prescription mail order (90-day supply)	$16/prescription (30-day supply)	Tier 0 in-network has a $0 copayment.
	Some Generic and most Preferred brand drugs - Tier 2	$22/prescription retail (30-day supply) $66 mail order copayment (90-day supply)	$42/prescription (30-day supply)	None
	Mostly Non-preferred brand drugs – Tier 3	$35/prescription retail (30-day supply) $70/prescription mail order (90-day supply)	$55/prescription (30-day supply)	Maintenance mail at retail at the "Trust Network" pharmacies $66 for 90-day supply.
	Specialty drugs	$35/prescription (30-day supply)	Not covered	Must use specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	40% coinsurance	None
	Physician/surgeon fees	15% coinsurance	40% coinsurance	See page 42 under "Other Services" in the plan document for a list of surgeries requiring preauthorization.
If you need immediate medical attention	Emergency room care	$100/visit plus 15% coinsurance	$100/visit plus 15% coinsurance	$100 copayment is waived if admitted.
	Emergency medical transportation	15% coinsurance	15% coinsurance	To nearest hospital.
	Urgent care	15% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	40% coinsurance	Benefits will be reduced by $250 for failure to preauthorize hospitalization.
	Physician/surgeon fees	15% coinsurance	40% coinsurance	None

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 need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	15% coinsurance	40% coinsurance	None
	Mental/Behavioral health inpatient services	15% coinsurance	40% coinsurance	Benefits will be reduced by $250 for failure to preauthorize hospitalization.
	Substance abuse disorder outpatient services	15% coinsurance	40% coinsurance	None
	Substance abuse disorder inpatient services	15% coinsurance	40% coinsurance	Benefits reduced by $250 for failure to preauthorize hospitalization.
If you are pregnant	Office visits	15% coinsurance	40% coinsurance	Benefits for employee or spouse only. Cost sharing does not apply for preventive services by a network provider. Depending on the type of services, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	15% coinsurance	40% coinsurance	Benefits for employee or spouse only.
	Childbirth/delivery facility services	15% coinsurance	40% coinsurance	Benefits for employee or spouse only. Benefits will be reduced by $250 for failure to preauthorize hospitalization.
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Preauthorization required.
	Rehabilitation services	15% coinsurance	40% coinsurance	Outpatient maximum of 45 visits per condition per calendar year, inpatient is subject to maximum of 30 days per condition per calendar year. Referral from physician, ARNP or PA required.
	Habilitation services	Not covered	Not covered	No coverage for Habilitation services.
	Skilled nursing care	15% coinsurance	40% coinsurance	Must be medically necessary for treatment of an illness or injury.
	Durable medical equipment	15% coinsurance	40% coinsurance	If purchase price exceeds $2,000 or the rental price exceeds $500, a preauthorization is required.
	Hospice services	No charge	No charge	60 visits lifetime maximum payable, preauthorization required
If your child needs	Children's eye exam	$10.00/visit	Charges over $50	Once every 12 months from last date of

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				service.
	Children's glasses	No charge for lenses For frames, charges over $95	Single vision-charges over $50 Bifocal-charges over $75 Trifocal-charges over $100 Lenticular-charges over $125 Frames-charges over $70	Lenses covered once every 12 months from last date of services. Frames covered once every 24 months from last date of service.
	Children's dental check-up	See dental plan	See dental plan	Dental benefits vary depending on plan choice.

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 (Adults)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Weight loss programs

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

- Acupuncture
- Bariatric Surgery
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot 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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. 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 Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

* For more information about limitations and exceptions, see the plan or policy document at www.soundhealthwellness.com.

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 [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** [insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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

* For more information about limitations and exceptions, see the plan or policy document at www.soundhealthwellness.com.

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. Note: These numbers assume the patient has completed HRA funding requirements listed on page 1 and earned credit of $500.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$250
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$250
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,120**

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

The plan's overall deductible	$250
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$250
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$970**

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

The plan's overall deductible	$250
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$250
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$650**

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