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, 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.healthcare.gov/sbc-glossary or call 1-800-252-9653 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1500** individual / **$3000** family for Network **$3000** individual / **$6000** family for Out of Network	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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive 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?	**$5500** individual / **$11000** family for Network **$17000** individual / **$32000** family Out of Network	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges preauthorization penalties, Morbid obesity copay, 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	70% coinsurance	None
	Specialist visit	20% coinsurance	70% coinsurance	None
	Preventive care/screening/immunization	No charge	70% coinsurance	You may have to pay for services that aren't preventive services. 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	70% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	70% coinsurance	Preauthorization is required. Without preauthorization benefits reduced by 20%.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at CVS Caremark https://www.caremark.com/	Generic Brand Drugs	Retail: $15 copay	Not covered	Retail: Limited to 30-day supply Mail Order: Limited to 90-day supply See Prescription Drug Card Program for more details.
	Preferred Brand Drugs	Retail: 20% coinsurance	Not covered	None
	Other	Retail: $25 copay	Not covered	Brand Step Therapy drugs Add to copay: following step therapy program Why tis Matters: Brand name asthma, cholesterol, diabetic and high blood pressure medications will be allowed at copay following step therapy program at Victoria County Employee Clinic. See Prescription Drug Card Program for more details.
	Specialty drugs	Not applicable	Not applicable	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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance No charge **at Citizens Medical Center**	70% coinsurance	Preauthorization is required for some services. Without preauthorization benefits reduced by 20%. If services are performed in Victoria, TX, Network benefits will only be applied for Citizens Medical Center. All other hospitals are considered Out of Network.
	Physician/surgeon fees	20% coinsurance	70% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copay applies per visit at **Citizens Medical Center/visit** then 20% coinsurance	$500 copay applies to all other providers/visit then 20% coinsurance	Copay is waived if admitted. Claims for out of network providers are paid toward the Maximum Allowable Charges. Non-Emergency care = Network 20% coinsurance. after deductible, Out of Network 70 % coinsurance after deductible The copay is waived if patient is admitted or visit is for Emergency Care as defined by the plan. 50% coinsurance for non-emergencies both Network & Out of Network.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Maximum Allowable Charges apply to Out of Network Providers
	Urgent care	20% coinsurance	70% 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 **No charge at Citizens Medical Center**	70% coinsurance	If services are performed in Victoria, TX, only **Citizens Medical Center** is considered Network; All other hospitals will be considered Out of network. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20%.
	Physician/surgeon fee	20% coinsurance	70% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	70% coinsurance	Limited to: 52 visits per Calendar Year.
	Inpatient services	20% coinsurance	70% coinsurance	Limited to: 30 days per Calendar year. 2 Days of partial hospitalization is equivalent to 1 inpatient day. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20%
If you are pregnant	Office visits	20% coinsurance	70% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	70% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	70% coinsurance	If services are performed in Victoria, TX, only Citizens **Medical Center** is considered Network; All other hospitals will be considered Out of network. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20%
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20%.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-of-Network Provider	
	Rehabilitation services	20% coinsurance	70% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20%.
	Habilitation services	20% coinsurance	70% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20%.
	Skilled nursing care	20% coinsurance	70% coinsurance	Limited to 90 days per confinement per Calendar Year Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20%.
	Durable medical equipment	20% coinsurance	70% coinsurance	Preauthorization is required in excess of $1,000. If you don't get preauthorization, benefits could be reduced by 20%.
	Hospice services	20% coinsurance	70% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20%.
If your child needs dental or eye care	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.)		
• Abortion (except in cases of rape, incest, or when the life of the mother is endangered) • Acupuncture • Cosmetic Surgery	• Dental Care (Adult) • Hearing Aids • Infertility Treatment • Long Term Care • Non-emergency care when traveling outside the U.S.	• Routine Eye Care (Adult) • Routine Foot Care • Weight Loss Programs

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.)		
• Bariatric Surgery	• Chiropractic Care	• Private-duty Nursing

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** x**61565** 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 on how 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**.

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
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)		**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**	**$1,500**	▪ **The plan's overall deductible**	**$1,500**	▪ **The plan's overall deductible**	**$1,500**
▪ **Specialist *copay***	**$50**	▪ **Specialist *copay***	**$50**	▪ **Specialist *copay***	**$50**
▪ **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:		**This EXAMPLE event includes services like:**		**This EXAMPLE event includes services like:**	
Specialist office visits (*prenatal care)*		Primary care physician office visits (*including disease education)*		Emergency room care *(including medical supplies)*	
Childbirth/Delivery Professional Services		Diagnostic tests *(blood work)*		Diagnostic test *(x-ray)*	
Childbirth/Delivery Facility Services		Prescription drugs		Durable medical equipment *(crutches)*	
Diagnostic tests (*ultrasounds and blood work)*		Durable medical equipment *(glucose meter)*		Rehabilitation services *(physical therapy)*	
Specialist visit *(anesthesia)*					
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:**	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$1,500	Deductibles	$900	Deductibles	$1,500
Copayments	$10	Copayments	$1,000	Copayments	$200
Coinsurance	$2,200	Coinsurance	$0	Coinsurance	$200
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$60	Limits or exclusions	$20	Limits or exclusions	$0
The total Peg would pay is	**$3,770**	**The total Joe would pay is**	**$1,920**	**The total Mia would pay is**	**$1,900**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-252-9653. *Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.