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, contact Aither Health at 833-420-1910 or aitherhealth.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.dol.gov/ebsa/healthreform or call 833-420-1910 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In Network:** Individual: $7,000 Family: $14,000 **Out-Of-Network:** Individual: $10,000 Family: $20,000	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 care 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 do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**In Network:** Individual: $14,000 Family: $28,000 **Out-Of-Network:** Individual: $20,000 Family: $40,000	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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, and penalties for failure to obtain pre-authorization for services.	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. For a list of Aetna Providers please visit https://www.aetna.com/ or call 1-800-872-3862.	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 **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 All Providers		Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	Deductible then 50% coinsurance	Virtual visits and telephonic visits are the same copay as in-office visits. Virtual visits and telephonic are available through Recuro at No Charge.
	Specialist visit	$60 copay/visit	Deductible then 50% coinsurance	None.
	Preventive care/screening/ immunization	No charge	Not Covered	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. Limited to 1 per Calendar Year.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible then 20% coinsurance	Deductible then 50% coinsurance	Preauthorization is required for inpatient and outpatient imaging (MRI, MRA, PET Scans, CT Scans and Nuclear Medicine). Failure to obtain preauthorization may result in a reduction of benefits. Contact an Aither Health advocate at 833-420-1910 for potential cost saving options.
	Imaging (CT/PET scans, MRIs)	Deductible then 20% coinsurance	Deductible then 50% coinsurance	
If you need drugs to treat your illness or condition More information about your prescription drug coverage is available at RX. Judi.Health 833-641-5318	Generic drugs	Retail: $10 copay/ prescription (Generics under $10-No Charge) Mail Order: $30 copay/ prescription	Retail: $10 copay/ prescription (Generics under $10-No Charge) Mail Order: $30 copay/ prescription	Covers up to a 30-day supply at retail and up to a 90-day supply through mail order. Drugs required as part of evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, as required by the Affordable Care Act are covered at 100% not subject to any copay, coinsurance or deductible.
	Preferred brand drugs (Formulary)	Retail: $40 copay/ prescription Mail Order: $120 copay/ prescription	Retail: $40 copay/ prescription Mail Order: $120 copay/ prescription	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		All Providers		
	Non-preferred brand drugs (Non-Formulary)	Retail: $80 copay/ prescription Mail Order: $240 copay/ prescription	Retail: $80 copay/ prescription Mail Order: $240 copay/ prescription	
	Specialty drugs	Retail: Deductible then 25% coinsurance Mail Order: Deductible then 25% coinsurance	Retail: Deductible then 25% coinsurance Mail Order: Deductible then 25% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 20% coinsurance	Deductible then 50% coinsurance	Preauthorization is required for outpatient surgeries and procedures. Failure to obtain pre-authorization may result in a reduction of benefits. Contact an Aither Health advocate at 833-420-1910 for potential cost saving options.
	Physician/surgeon fees	Deductible then 20% coinsurance	Deductible then 50% coinsurance	
If you need immediate medical attention	Emergency room care	Deductible then, $250 copay and 20% coinsurance	Deductible then, $250 copay and 20% coinsurance	Emergency room care covered for true emergencies only.
	Emergency medical transportation	Deductible then 20% coinsurance	Deductible then 50% coinsurance	
	Urgent care	$75 copay/visit	Deductible then 50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 20% coinsurance	Deductible then 50% coinsurance	Preauthorization may be required based on the services and location of those services being rendered. Failure to obtain preauthorization may result in a reduction of benefits.
	Physician/surgeon fees	Deductible then 20% coinsurance	Deductible then 50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Office Services	$30 copay/visit	Deductible then 50% coinsurance	Preauthorization may be required based on the services and location of those services being rendered. Failure to obtain preauthorization may result in a reduction of benefits.
	Outpatient services	$30 copay/visit	Deductible then 50% coinsurance	
	Inpatient services	Deductible then 20% coinsurance	Deductible then 50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay All Providers		Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	$60 copay/visit.	Deductible then 50% coinsurance	Preventive Care services, as required under the Affordable Care Act, may be covered at no charge. Preauthorization is required for inpatient hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs. (c-section).
	Childbirth/delivery professional services	Deductible then 20% coinsurance	Deductible then 50% coinsurance	
	Childbirth/delivery facility services	Deductible then 20% coinsurance	Deductible then 50% coinsurance	
If you need help recovering or have other special health needs	Home health care	Deductible then 20% coinsurance	Deductible then 50% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in a reduction of benefits. Limited to 20 visits per Calendar Year.
	Rehabilitation services	$75 copay/visit.	Deductible then 50% coinsurance	Limited to 20 visits per Calendar Year.
	Habilitation services	$75 copay/visit.	Deductible then 50% coinsurance	
	Skilled nursing care	Not Covered	Not Covered	None.
	Durable medical equipment	Deductible then 20% coinsurance	Deductible then 50% coinsurance	None.
	Hospice services	Deductible then 20% coinsurance	Deductible then 50% coinsurance	None.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	A vision screening is covered as part of your child's wellness visit with his or her family Physician under preventive care.
	Children's glasses	Not Covered	Not Covered	Not covered.
	Children's dental check-up	Not Covered	Not Covered	Oral health check-ups are covered as part of your child's wellness visit with his or her family Physician under preventive care.

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
- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Hearing Aids
- Long Term Care
- Non-emergency care outside the U.S.
- Private-duty nursing
- Routine Eye Care
- Routine Foot Care
- Weight Loss Programs

For more information about limitations and exceptions, see the plan or policy document.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic Care (Limited to 10 per Calendar Year)		

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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (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**
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 833-420-1910 .
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 833-420-1910 .
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 833-420-1910 .
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 833-420-1910 .

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** **$7,000**
- **Specialist copayment** **$60**
- **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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$7,000
Copayments	$10
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$8,170**

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

- **The plan's overall deductible** **$7,000**
- **Specialist copayment** **$60**
- **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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$4,600
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4,620**

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

- **The plan's overall deductible** **$7,000**
- **Specialist copayment** **$60**
- **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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,400**

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