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, [insert contact information]. 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.[insert].com or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $400 Individual/$800 Family Out-of-Network: $800 Individual/$1,600 Family Does not apply to prescription drugs and preventive care.	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. In-Network preventive care is 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 deductible for specific services.
What is the out-of-pocket limit for this plan?	Annual Salary <$75,000: Network $1,800 Individual / $3,000 Family. Out-of-Network $3,600 Individual / $6,000 Family. Annual Salary >$75,000: Network $2,500 Individual/$4,500 Family. Out-of-Network $5,000 Individual/$9,000 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.

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. See www.aetna.com/docfind or call 1-800-334-0299 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.

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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	20% coinsurance	30% coinsurance	None
	Specialist visit	20% coinsurance	30% coinsurance	None
	Preventive care/screening/ immunization	No charge	30% coinsurance, except deductible doesn't apply to preventive mammograms, gynecological exams, prostate specific antigen tests & digital rectal exams	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)	10% coinsurance for hospital; 20% coinsurance for free standing facility	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance for hospital; 20% coinsurance for free standing facility	30% coinsurance	

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 provided by Express Scripts, to treat your illness or condition. More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	Retail: up to a $10 copay for up to a 30 day supply Mail: up to a $10 copay for up to a 30 day supply; up to a $20 copay for a 31 to 90 day supply	Members will only be reimbursed the amount Oxy would have paid had an In-network provider been used (members are responsible for the cost difference)	Members are required to pay the cost difference when choosing a brand drug when a generic is available regardless of member or physician request Members are required to use the mail order pharmacy for maintenance medications after three retail fills Annual OOP $1,500 per person (Retail & Mail). See Plan Provisions for additional information
	Preferred brand drugs	Retail: 25% coinsurance w/$10 min and a $50 max for up to a 30 day supply Mail: 25% coinsurance w/$10 min and a $50 max for up to a 30 day supply; 25% coinsurance w/$20 min and a $100 max for 31 to 90 day supply	Members will only be reimbursed the amount Oxy would have paid had an In-network provider been used (members are responsible for the cost difference)	
	Non-preferred brand drugs	Retail: 25% coinsurance w/$25 min and a $100 max for up to a 30 day supply Mail: 25% coinsurance w/$25 min and a $100 max for up to a 30 day supply; 25% coinsurance w/$50 min and a $200 max for 31 to 90 day supply	Members will only be reimbursed the amount Oxy would have paid had an In-network provider been used (members are responsible for the cost difference)	

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)	
	Specialty drugs	See Generic, Preferred Brand and Non-Preferred Brand Chart	Members will only be reimbursed the amount Oxy would have paid had an In-network provider been used (members are responsible for the cost difference)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Preauthorization is required. If you don't get preauthorization, you could be subject to a penalty of up to $500.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	No coverage for non-emergency use. 30% coinsurance for non-emergency transport. None
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Preauthorization is required. If you don't get preauthorization, you could be subject to a penalty of up to $500.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit and other outpatient services 20% coinsurance	Office & other outpatient services: 25% coinsurance for first 50 visits; 30% coinsurance thereafter	None Penalty of up to $500 for failure to obtain preauthorization.
	Inpatient services	10% coinsurance	30% coinsurance	
If you are pregnant	Office visits	No charge	30% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help	Home health care	20% coinsurance	30% coinsurance	120 days/calendar year combined with private-

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)	
recovering or have other special health needs				duty nursing. Penalty of up to $500 for failure to obtain preauthorization.
	Rehabilitation services	20% coinsurance	30% coinsurance	None
	Habilitation services	20% coinsurance	30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	120 days/calendar year. Penalty of up to $500 for failure to obtain preauthorization for out-of-network care.
	Durable medical equipment	20% coinsurance	30% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	10% coinsurance	30% coinsurance	Penalty of up to $500 for failure to obtain preauthorization for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	30% coinsurance	1 routine eye exam/12 months.
	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
- Cosmetic Surgery
- Dental Care
- Glasses (Child)
- Hearing aids
- Long Term Care
- 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.)

- Bariatric Surgery
- Chiropractic Care 25 visits/calendar year
- Infertility treatment – Limited to the diagnosis & treatment of underlying medical condition
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing – 120 visits/calendar year combined with home health care.
- Routine eye care (Adult) – 1 routine eye exam/12 months.

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

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 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:

For language assistance in your language call 1-800-334-0299 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-800-334-0299.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-800-334-0299 በነጻ ይደውሉ
Arabic -	1-800-334-0299 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-334-0299 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-334-0299 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-334-0299 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-334-0299-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-334-0299 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-334-0299 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-800-334-0299.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-800-334-0299 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᏕᏬᏂᎯᏍᏗ ᏗᏂᏍᏕᏢᏍᎩ ᎾᏓᎢ (ᏣᎳᎩ) ᎮᏏᎳᏛᎢᏎ 1-800-334-0299 ᎤᎾᎢ Ꮭ ᎪᎱᏍᏗ ᏧᎬᏩᎶᏗ ᏂᎨᏒᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-800-334-0299，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-800-334-0299.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-334-0299 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-334-0299.
French -	Pour une assistance linguistique en français appeler le 1-800-334-0299 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-334-0299 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-334-0299 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-334-0299 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-334-0299 પર કૉલ કરો.

Questions: Call **1-800-334-0299** or visit us at **www.HealthReformPlanSBC.com** If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.HealthReformPlanSBC.com** or call **1-800-334-0299** to request a copy.

Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-800-334-0299. Kāki ʻole ʻia kēia kōkua nei.
Hindi -	हिन्दी में भाषा सहायता के लिए, 1-800-334-0299 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-334-0299.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-800-334-0299 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-334-0299 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-334-0299.
Japanese -	日本語で援助をご希望の方は、1-800-334-0299 まで無料でお電話ください。
Karen -	လာတ်မၤစၢတ်ကတိၤကျိာ်အဂီၢ် ကျိာ် ကိး 1-800-334-0299 လာတအိာ်ဒီးတၢ်လၢာ်ဘျာ်လၢာ်စုဟဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-334-0299번으로 전화해 주십시오.
Kru-Bassa -	Bɛ́m`ké gbo-kpá-kpá dyé pídyi dé Bǎsɔ́ɔ̀-wùdùǔ̌n wɛ̃ɛ, dá 1-800-334-0299
Kurdish -	.به خۆرایی پەیوەندی بکەن 1-800-334-0299 برای راهنمایی به زبان فارسی با شماره
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-334-0299 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-800-334-0299 क्रमांकावरकोणत्याहीखर्चाशवियकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-334-0299 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-334-0299 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-800-334-0299 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-334-0299
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-334-0299 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ col 1-800-334-0299 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-800-334-0299 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-334-0299 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-800-334-0299 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-800-334-0299 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-334-0299.

Questions: Call **1-800-334-0299** or visit us at **www.HealthReformPlanSBC.com** If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.HealthReformPlanSBC.com** or call **1-800-334-0299** to request a copy.

Portuguese -	Para obter assistência linguística em português ligue para o 1-800-334-0299 gratuitamente.
Romanian -	Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-334-0299
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-334-0299.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-334-0299 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-334-0299.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-800-334-0299.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-334-0299. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-334-0299 bila malipo.
Syriac -	1-800-334-0299 ...
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-334-0299 nang walang bayad.
Telugu -	1-800-334-0299 (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-334-0299 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ʻoku fiema'u hā tokoni ʻi he lea faka-Tonga telefoni 1-800-334-0299 ʻo ʻikai hā tōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-334-0299 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-334-0299.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-334-0299.
Urdu -	1-800-334-0299
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-334-0299.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-800-334-0299 פריי פון אפצאל.
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-800-334-0299 lái san owó kankan rárá.

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

Questions: Call **1-800-334-0299** or visit us at **www.HealthReformPlanSBC.com** If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.HealthReformPlanSBC.com** or call **1-800-334-0299** to request a copy.

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	$500
Specialist copayment	$50
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$300
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,160**

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

The plan's overall deductible	$500
Specialist copayment	$50
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$800
Copayments	$1,200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,360**

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

The plan's overall deductible	$500
Specialist copayment	$50
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$700
Copayments	$50
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,050**

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: [insert].
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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