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, please visit www.ua-benefits-wa.org. 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 1-888-406-3246 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300** person/**$900** family per calendar year	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, they have to meet their own individual deductible until the overall family deductible amount has been met.
Are there services covered before you meet your deductible?	Yes. The deductible does not apply to chemical dependency, pre-admission/surgery related testing done on an outpatient basis, immunizations, preventive care services performed by a PPO provider and physical exams by a non-PPO provider.	This plan covers some items and services even if you haven't yet met the annual 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?	**Medical** coinsurance: $2,000 per person/$4,000 per family in-network $5,000 per person/$10,000 per family out-of-network **Medical** overall out-of-pocket maximums (coinsurance, deductible and copays): $5,600 per person/$10,200 per family in-network **Prescription Drug:** $1,000 per person/$3,000 per 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.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Balance-billed charges, prescription penalties and health care this plan doesn't 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. For a list of preferred providers, see www.Aetna.com\docfind	Yes. For a list of preferred providers, see www.Aetna.com\docfind
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	$20 copay plus 20% coinsurance	$40 copay plus 40% coinsurance	---none---
	Specialist visit	$20 copay plus 20% coinsurance	$40 copay plus 40% coinsurance	---none---
	Preventive care/screening/ immunization	No charge	$40 copay plus 40% coinsurance	See plan document for specific preventive benefits. $400 annual limit on non-PPO physicals. Non-PPO well child exams limited to 7 exams during the first two years of the child's life. Immunizations paid at 100% for both PPO and non-PPO per immunization schedules found at www.cc.gov/vaccines.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Plan pays 100% for tests performed in advance of a covered surgery.
	Imaging (CT/PET scans, MRIs)	20% 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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com or call 1-866-818-6911.	Generic drugs	$8/Rx at retail for 30 day supply. $20/Rx at CVS pharmacy or mail order for 90 day supply.	Same as in-network. Penalty may apply for maintenance drugs.	Coverage limited to drugs on formulary list. Maintenance drugs not purchased at CVS pharmacy or mail order subject to a penalty of $15 per 30 day supply.
	Preferred brand drugs	$40/Rx at retail for 30 day supply. $100/Rx at CVS pharmacy or mail order for 90 day supply.	Same as in-network. Penalty may apply for maintenance drugs.	Coverage limited to drugs on formulary list. Maintenance drugs not purchased at CVS pharmacy or mail order subject to a penalty of $20 per 30 day supply. Penalty may apply if generic alternative is available.
	Non-preferred brand drugs	$55/Rx at retail for 30 day supply. $137.50/Rx at CVS pharmacy or mail order for 90 day supply.	Same as in-network. Penalty may apply for maintenance drugs.	Coverage limited to drugs on formulary list. Maintenance drugs not purchased at CVS pharmacy or mail order subject to a penalty of $30 per 30 day supply. Penalty may apply if generic alternative is available.
	Specialty drugs	Same as above	Not covered.	Coverage limited to drugs on formulary list. Limited to participating pharmacies. Second and future fills must be made through specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	---none---
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Benefit for the medically necessary services of an assistant surgeon limited to 20% of the plan's allowed amount.
If you need immediate medical attention	Emergency room care	$100 copay plus 20% coinsurance	$100 copay plus 40% coinsurance	Copay is waived if directly admitted to the hospital.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Coverage limited to transportation to nearest hospital.
	Urgent care	20% coinsurance	40% coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	$100 copay plus 40% coinsurance	Preauthorization required. No coverage for hospitalization primarily for diagnostic tests.

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	20% coinsurance	40% coinsurance	Benefit for the medically necessary services of an assistant surgeon limited to 20% of the plan's allowed amount.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	---none---
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization required.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Routine prenatal visits with an in-network provider are covered at 100%.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	---none---
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance plus $100 copay	---none---
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Preauthorization required. 100 visit maximum per calendar year
	Rehabilitation services	20% coinsurance	40% coinsurance	Must be prescribed by an ARNP/APRN, DC, PA, DPM, ND, MD or DO. Reviewed for continued medical necessity after 25 visits.
	Habilitation services	20% coinsurance	40% coinsurance	Limited to speech, OT and PT for mental health illnesses. Must be prescribed by an ARNP/APRN , DC, PA, DPM, ND, MD or DO. Reviewed for continued medical necessity after 25 visits.
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Covered charges are limited to the purchase price of the rented equipment.
	Hospice services	20% coinsurance	40% coinsurance	---none---
If your child needs dental or eye care	Children's eye exam	$10 copay	$101	No charge up to allowed amount
	Children's glasses	Covered in full	$39 single, $62 lined bifocal, $80 lined Trifocal, $112 Lenticular	Lenses covered twice each calendar year, frames covered twice each two calendar years.
	Children's dental check-up	20% coinsurance	30% coinsurance	Annual dental limit of $2,000 applies to children age 19 and over.

*For more information about limitations and exceptions, see the plan or policy document at www.ua-benefits-wa.org.

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
- Non-ER treatment outside the U.S.
- Infertility treatments
- Long-term care
- Weight loss programs

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

- Acupuncture
- Chiropractic
- Naturopaths
- Dental care (adult)
- Habilitation services
- Routine eye care (adult)
- 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: [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 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: 206-694-1374.

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 1-888-406-3246 (TTY: 711).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-406-3246 (TTY: 711).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-406-3246 (TTY: 711).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-406-3246 (TTY: 711).

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 ua-benefits-wa.org.

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	$300.00
Specialist *[cost sharing]*	$7,540.00
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$7,540.00

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300.00
Copayments	$180.00
Coinsurance	$1,406.00
What isn't covered	
Limits or exclusions	$30.00
The total Peg would pay is	$1,916.00

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

The plan's overall deductible	$300.00
Specialist *[cost sharing]*	$5,400.00
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$5,400.00

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300.00
Copayments	$240.00
Coinsurance	$964.00
What isn't covered	
Limits or exclusions	$40.00
The total Joe would pay is	$1,544.00

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

The plan's overall deductible	$300.00
Specialist *[cost sharing]*	$3,480.00
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$3,480.00

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300.00
Copayments	$100.00
Coinsurance	$608.00
What isn't covered	
Limits or exclusions	$40.00
The total Mia would pay is	$1,048.00

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