




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, call 1-800-544-5085 . 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](http://www.dol.gov/ebsa/healthreform) or call 1-800-544-5085 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<u>In-Network</u> : \$1,500 individual / \$3,000 family. <u>Out-of-Network</u> : \$2,500 individual/ \$5,000 family.	Generally, you must pay all of the costs from <a href="#">provider</a> up to the <a href="#">deductible</a> amount before this plan begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. PPO office visits, <a href="#">preventive care</a> in-network, and PPO Urgent care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this plan covers certain <a href="#">preventive</a> services without cost sharing and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<u>In-Network Provider</u> : 5,000 individual / \$10,000 family; <u>Out-of-Network Provider</u> \$10,000 individual / \$20,000 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">copays</a> , <a href="#">balance-billing</a> charges, prescription drugs, penalties for failure to obtain preauthorization for services and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> and select "Aetna Choice® POS II (Open Access) Network for a list of <a href="#">network providers</a> . For Teladoc see <a href="http://Teladoc.com/Aetna">Teladoc.com/Aetna</a> or call 1-800-835-2362.	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to</b>	No.	You can see the <a href="#">specialist</a> you choose without a referral.

Important Questions	Answers	Why This Matters:
see a <a href="#">specialist</a> ?		

 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 <a href="#">provider's office</a> or <a href="#">clinic</a>	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	Includes Internist, General Physician, Family Practitioner or Pediatrician. Spinal treatment limited to \$2,000 per calendar year, includes Chiropractic services. <a href="#">Coinsurance</a> and <a href="#">deductible</a> apply to Teladoc visits.
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a> /visit	40% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening</a> /immunization	No charge <a href="#">Deductible does not apply</a> .	40% <a href="#">coinsurance</a>	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Diagnostic services provided by an out-of-network provider at an in-network facility will be covered as though in-network.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.maxorplus.com">www.maxorplus.com</a>	Generic drugs	\$10 <a href="#">copay</a> /prescription for retail; \$20 <a href="#">copay</a> /prescription for mail order.	Not covered	Non-formulary drugs may not be covered without approval through the prior-authorization process. Covers up to a 30-day supply for a retail prescription and a 31- to 90-day supply for a mail order prescription.
	Preferred brand drugs	\$25 <a href="#">copay</a> /prescription for retail; \$50 <a href="#">copay</a> /prescription for mail order.	Not covered	
	Non-preferred brand drugs	\$50 <a href="#">copay</a> /prescription for retail; \$100 <a href="#">copay</a> /prescription for mail order.	Not covered	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.southbayheretrust.com](http://www.southbayheretrust.com).

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)	
	<a href="#">Specialty drugs</a>	\$50 <a href="#">copay</a> /prescription for retail; \$100 <a href="#">copay</a> /prescription for mail order.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	If you receive services from a non-network provider at an in-network facility, the Plan will provide benefits as though the provider was in-network.
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a> after \$100 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a> after \$100 <a href="#">copay</a> /visit	No coverage for non-emergency use. Emergency services provided in response to an emergent condition will be covered the same at in-network or out-of-network facilities.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit	40% <a href="#">coinsurance</a>	No coverage for non-urgent use. Emergency services provided at an out-of-network Urgent Care facility will be covered as though in-network.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for <u>out-of-network</u> care. \$400 penalty for failure to comply.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	If you receive services from a non-network provider at an in-network facility, the Plan will provide benefits as though the provider was in-network.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	If you receive services from a non-network provider at an in-network facility, the Plan will provide benefits as though the provider was in-network.
	Inpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for <u>out-of-network</u> care. \$400 penalty for failure to comply.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.southbayheretrust.com](http://www.southbayheretrust.com).

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 receive services from a non-network provider at an in-network facility, the Plan will provide benefits as though the provider was in-network
If you are pregnant	Office visits	\$10 <u>copay</u> /visit <u>deductible</u> does not apply	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, a <u>copay</u> or <u>coinsurance</u> may apply.
	Childbirth/delivery professional services	No charge	40% <u>coinsurance</u>	If you receive services from a non-network provider at an in-network facility, the Plan will provide benefits as though the provider was in-network.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Includes outpatient postnatal care. <u>Preauthorization</u> may be required. If you receive services from a non-network provider at an in-network facility, the Plan will provide benefits as if the provider was in-network.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required for <u>out-of-network</u> care
	<u>Rehabilitation services</u>	\$20 <u>copay</u> /visit	40% <u>coinsurance</u>	Coverage is limited to 30 visits per calendar year for Physical, Occupational, and Speech Therapy combined.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Benefit limitations may apply.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Coverage is limited to 60 days per calendar year. <u>Preauthorization</u> is required. \$400 penalty for failure to comply.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to \$10,000 per calendar year.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required for <u>out-of-network</u> care. \$400 penalty for failure to comply.
If your child needs dental or eye care	Children's eye exam	\$20 <u>copay</u> /exam	Fees in excess of \$45	Vision coverage is provided through Vision Service Plan (VSP). Limited to 1 routine eye exam every 12 months. Your child is only covered if you have elected dependent coverage and paid the appropriate premiums (if required).

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.southbayheretrust.com](http://www.southbayheretrust.com).

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)	
	Children's glasses	Fees in excess of \$175	Fees in excess of \$70 for frames and \$30 for single vision lenses	VSP allows 1 pair of frames once every 24 months and 1 set of lenses once every 12 months.
	Children's dental check-up	No charge	No charge	Dental coverage is provided through MetLife. Your child is only covered if you have elected dependent coverage and paid the appropriate premiums (if required).

## 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
- Bariatric surgery
- Cosmetic Surgery (unless medically necessary)
- Hearing aids
- Long-term care
- Massage therapy
- Pregnancy for a dependent child
- Private-duty nursing
- Routine foot care
- Weight loss programs
- Work related injury or illness

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

- Chiropractic Care
- Dental Care (Adult)
- Infertility treatment (diagnosis and treatment of underlying medical condition)
- Non-emergency care when traveling outside the U.S. when medically necessary and is considered standard of care
- Routine eye care (Adult) – Vision Service Plan

**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](http://www.dol.gov/ebsa/healthreform) and Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](http://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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). You may also contact the Trust Administration Office at 1-800-544-5085 .

### 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 1-800-544-5085.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-544-5085.

*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](#) \$1,500
- [Specialist copayment](#) \$20
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,900
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,470</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$20
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	1,100
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,720</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$20
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$90
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,690</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.