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 Customer Service at 1-855-485-8551. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provm ider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-855-485-8551 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network - $1,000/Individual or $2,000/Family Out-of-Network - $2,000/Individual or $4,000/Family	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. Note: Any amount applied to your Individual or Family deductible under the previous plan year for medical services rendered through 6/30/25 will be credited to the July 1, 2025 – June 30, 2026 plan year.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary 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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$5,000/Individual or $10,000/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. Note: Any amount applied to your Individual or Family Out-of-Pocket under the previous plan year for medical services rendered through 6/30/25 will be credited to the July 1, 2025 – June 30, 2026 plan year.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, 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. See www.aetna.com/asa	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	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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	$30 copay/office visit	50% coinsurance after deductible	None
	Specialist visit	$50 copay/visit	50% coinsurance after deductible	None
	Preventive care/screening/ immunization	No charge	No charge	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)	$50 copay/test - Xray No charge - Lab	50% coinsurance after deductible	If performed as a part of a physician office visit and billed by the Physician, expenses are covered subject to the applicable Physician's office visit member cost sharing.
	Imaging (CT/PET scans, MRIs)	$100 copay/test	50% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.us-rxcare.com 1-877-200-5533	Tier 1 - Preferred Generic	$15 copay/prescription 30-day supply retail $30 copay/prescription 90-day supply mail order	N/A	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Tier 2 - Preferred Brand Drugs and Some Generic Drugs	$35 copay/prescription 30-day supply retail $70 copay/prescription 90-day supply mail order	N/A	
	Tier 3 - Non-Preferred Brand Drugs, Some Generic Drugs	$75 copay/prescription 30-day supply retail $150 copay/prescription 90-day supply mail order	N/A	
	Specialty drugs (Tier 4)	$150 copay	N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required.
	Physician/surgeon fees	0% coinsurance after deductible	50% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	$100 copay	$100 copay	Emergency Room Copay Waived if Admitted
	Emergency medical transportation	0% coinsurance	0% coinsurance	
	Urgent care	$50 copay	50% coinsurance after deductible	

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 have a hospital stay	Facility fee (e.g., hospital room)	$200 copay	50% coinsurance after deductible	Preauthorization is required.
	Physician/surgeon fees	0% coinsurance	50% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay	50% coinsurance after deductible	Preauthorization required for inpatient services.
	Inpatient services	$200 copay	50% coinsurance after deductible	
If you are pregnant	Office visits	0% coinsurance	50% coinsurance after deductible	Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	$10 copay	50% coinsurance after deductible	
	Childbirth/delivery facility services	$200 copay	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	$50 copay	50% coinsurance after deductible	Maximum 60 visits/plan year.
	Rehabilitation services	$20 copay	50% coinsurance after deductible	Maximum 60 visits/plan year. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	$20 copay	50% coinsurance after deductible	
	Skilled nursing care	$200 copay	50% coinsurance after deductible	Maximum 120 In-Network/Out-of-Network Inpatient days
	Durable medical equipment	50% coinsurance after deductible	50% coinsurance after deductible	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	$200 copay -Inpatient 0% coinsurance after deductible - Outpatient	50% coinsurance after deductible	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	0% coinsurance	0% coinsurance	Coverage limited to one exam per 12 months.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	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.)

- Cosmetic Surgery
- Dental Care
- Routine Foot Care
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing

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

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Weight Loss Programs

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 855-458-8551. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 612565 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 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: INDECS, Appeals Department at 888-446-3327 or the Department of Labor Employee Benefits Security Administration at 1-866-444-EBSA or www.dol.gov/ebsa/healthreform.

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:
Spanish (Español): Para obtener asistencia en Español, llame al 855-458-8551.

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 hs-plans.com/woods.

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	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Copayments	$420
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$420***

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

The plan's overall deductible	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$1,000
Copayments	$260
Coinsurance	$100
What isn't covered	
Limits or exclusions	$100
The total Joe would pay is	**$1,460***

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

The plan's overall deductible	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$1,000
Copayments	$340
Coinsurance	$50
What isn't covered	
Limits or exclusions	$80
The total Mia would pay is	**$1,470***

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