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 Benefits at 800-690-7655 ext. 3012, option 5 or hrsolutions@dcsg.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.healthcare.gov/health-care-law-protections/summary-of-benefits-and-coverage/ or call 800-690-7655 ext. 3012, option 5 to request a copy.

Important Questions	Answers PPO1	PPO2	PPO3	Why This Matters:
What is the overall deductible?	$3,200 individual / $6,400 family in-network $6,000 individual / $12,000 family out-of-network	$1,350 individual / $2,700 family in-network $2,300 individual / $4,600 family out-of-network	$850 individual / $1,700 family in-network $1,300 individual / $2,600 family out-of-network	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes. The deductible doesn't apply to preventative care, office visits, and prescription drug benefits.	Yes. The deductible doesn't apply to preventative care, office visits, and prescription drug benefits.	Yes. The deductible doesn't apply to preventative care, office visits, and prescription drug benefits.	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.
Are there other deductibles for specific services?	No	No	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,750 individual / $7,500 family in-network $12,000 individual / $24,000 family out-of-network	$2,800 individual / $6,100 family in-network $4,500 individual / $9,600 family out-of-network	$2,300 individual / $5,000 family in-network $3,500 individual / $7,800 family out-of-network	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

What is not included in the out-of-pocket limit?	Premiums, balance-billed charges and services this plan doesn't cover.	Premiums, balance-billed charges and services this plan doesn't cover.	Premiums, balance-billed charges and services 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 participating providers see: -www.aetna.com or call 1-800-635-3364 (use the Choice POS II plan) -www.highmarkbcbs.com or call 1-800-572-1460 (use the BCBS PPO plan)	Yes. For a list of participating providers see: -www.aetna.com or call 1-800-635-3364 (use the Choice POS II plan) -www.highmarkbcbs.com or call 1-800-572-1460 (use the BCBS PPO plan)	Yes. For a list of participating providers see: -www.aetna.com or call 1-800-635-3364 (use the Choice POS II plan) -www.highmarkbcbs.com or call 1-800-572-1460 (use the BCBS PPO plan)	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 3 for how this plan pays different kinds of providers.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist	No. You don't need a referral to see a specialist	No. You don't need a referral to see a specialist	You can see the specialist you choose without permission from this plan.

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* For more information about limitations and exceptions, see the plan or policy document at www.BenefitYourLifeResources.com.

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)	
		PPO1, PPO2 & PPO3		
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/office visit	40% coinsurance	None
	Specialist visit	$40 copay/visit	40% coinsurance	None
	Other practitioner office visit	20% coinsurance for chiropractor	40% coinsurance for chiropractor	Combined network and out-of-network: 25 visits per benefit period.
	Preventive care/screening/ immunization	No charge	No coverage for preventive care visits 40% coinsurance for screening services and immunizations	None
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.BenefitYourLifeResources.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)	
		PPO1, PPO2 & PPO3		
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com/DCSG	Generic drugs	$10 copay (retail) $20 copay (mail order)	Not covered	Up to 30-day supply retail prescription; 31 - 90-day supply (mail order prescription)
	Preferred brand drugs	$30 copay (retail) $60 copay (mail order)	Not covered	Up to 30-day supply retail prescription; 31 - 90-day supply (mail order prescription)
	Non-preferred brand drugs	$65 copay (retail) $130 copay (mail order)	Not covered	Up to 30-day supply retail prescription; 31 - 90-day supply (mail order prescription)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	Deductible plus $150 copay/visit	Deductible plus $150 copay/visit	Copay waived if admitted as an inpatient.
	Emergency medical transportation	20% coinsurance	40% coinsurance	None
	Urgent care	$40 copay/visit	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.BenefitYourLifeResources.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)	
		PPO1, PPO2 & PPO3		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit 20% coinsurance for other outpatient services	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Combined network and out-of-network: 100 visits per benefit period.
	Rehabilitation services	20% coinsurance	40% coinsurance	None
	Habilitation services	20% coinsurance	40% coinsurance	None
	Skilled nursing care	20% coinsurance	40% coinsurance	Combined network and out-of-network: 100 days per benefit period.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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 (adult)
- Hearing Aids
- Long Term Care
- Private Duty Nursing.
- Routine eye care (adult)
- Routine foot care
- Weight loss program

* For more information about limitations and exceptions, see the plan or policy document at www.BenefitYourLifeResources.com.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric surgery	• Chiropractic Care • Infertility (Counseling, testing and treatment covered all plans; PPO3 has a 6 attempts limit for assisted fertilization)	• Non-emergency care when traveling outside the U.S.

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: your applicable 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 x61565 or www.cciio.cms.gov. You may also contact the plan at 800-690-7655 ext. 3012, option 5. 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: Benefits at 1-800-690-7655 ext. 3012, option 5.

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 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 [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** [insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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 www.BenefitYourLifeResources.com.

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)
PPO1

- The plan's overall deductible $3,200
- Specialist copayment $40
- 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 (minus HRA)	$2,700
Copayments	$120
Coinsurance	$430
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$3,250

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)
PPO2

- The plan's overall deductible $1,350
- Specialist copayment $40
- 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	$1,350
Copayments	$120
Coinsurance	$1,330
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$2,800

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)
PPO3

- The plan's overall deductible $850
- Specialist copayment $40
- 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	$850
Copayments	$120
Coinsurance	$1,330
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$2,300

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

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)
PPO1

- The plan's overall deductible $3,200
- Prescription out-of-pocket limit $1,000
- Specialist copayment $40
- 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 (minus HRA)	$2,700
Copayments (includes prescription out-of-pocket limit)	$1,080
Coinsurance	$470
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$4,250

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)
PPO2

- The plan's overall deductible $1,350
- Prescription out-of-pocket limit $1,000
- Specialist copayment $40
- 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	$1,350
Copayments (includes prescription out-of-pocket limit)	$1,080
Coinsurance	$1,370
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$3,800

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)
PPO3

- The plan's overall deductible $850
- Prescription out-of-pocket limit $1,000
- Specialist copayment $40
- 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	$850
Copayments (includes prescription out-of-pocket limit)	$1,080
Coinsurance	$1,370
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$3,300

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

Mia's Simple Fracture
(in-network emergency room visit and follow up care)
PPO1

- The plan's overall deductible $3,200
- Specialist copayment $40
- 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 (minus HRA)	$1,750
Copayments	$150
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,900

Mia's Simple Fracture
(in-network emergency room visit and follow up care)
PPO2

- The plan's overall deductible $1,350
- Specialist copayment $40
- 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	$1,350
Copayments	$150
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,900

Mia's Simple Fracture
(in-network emergency room visit and follow up care)
PPO3

- The plan's overall deductible $850
- Specialist copayment $40
- 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	$850
Copayments	$150
Coinsurance	$900
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,900

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