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, 1-844-380-4554. 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.webtpa.com or call 1-844-380-4554 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 person/family - WFM Medical Clinic $1,875 person/$2,125 family - *Preferred Network (EHN) $3,750 person/$4,250 family - *Expanded Network (Aetna) $7,500 person/$8,500 family Out-of-Network Providers *In-network deductibles cross-apply	Generally, you must pay all of the costs from providers up to the individual deductible amount before this plan begins to pay benefits. 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. Preventive care, and primary and urgent care 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, there are no other deductibles.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	$3,325 person/$6,650 family – *Preferred Network (EHN) and WFM Medical Clinic.$6,650 person/$13,300 family- *Expanded Network (Aetna) $13,300 person/$26,200 family -Out-of-Network Providers *In-network out-of-pocket limits cross-apply	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 preauthorization 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. Preferred Network-www.employershealthnetwork.com Expanded Network www.aetna.com/asa or call 1-844-380-4554 for assistance with network providers.	You pay the least if you use a provider at the WFM Medical Clinic. You pay more if you use a Preferred or Expanded Network provider. You will pay most if you use an out-of-network provider. You may 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.

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
		WFM Medical Clinic (You will pay the least)	Preferred Network (EHN)	Expanded Network (Aetna)	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	No Charge Not subject to deductible*	25% coinsurance Not subject to deductible	25% coinsurance	60% coinsurance	*Virtual visits are available for Team Members who are established patients of the WFM Medical Center. Primary care visits provided by an EHN provider that will not be subject to the deductible include Family Medicine, Internal Medicine, Pediatrics and OB-GYN.
	Specialist visit	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	None
	Preventive care/screening/ immunization	No Charge Not subject to deductible	No Charge Not subject to deductible	No Charge Not subject to deductible	60% coinsurance	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)	25% coinsurance Not subject to deductible	25% coinsurance Not subject to deductible	25% coinsurance	60% coinsurance	Any services (including lab services) performed as part of a primary care visit with the WFM Medical Clinic or an EHN provider such as Family Medicine, Pediatrics, OB-GYN and Internal Medicine are not subject to the deductible, with the exception of CT/MRI/MRA/PET and Nuclear scans. Other services performed by an EHN provider that are not part of a primary care visit are subject to 25% coinsurance after deductible is satisfied.
	Imaging (CT/PET scans, MRIs)	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		WFM Medical Clinic (You will pay the least)	Preferred Network (EHN)	Expanded Network (Aetna)	Out-of-Network Provider (You will pay the most)	
						Preauthorization is required for CT/ MRI/MRA/PET scans. CT/MRI/MRA/PET and Nuclear scans are subject to the deductible. If you don't get preauthorization, a $500 penalty will apply.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.southernscripts.net (800)710-9341 Lists of drugs and prior authorization can be found at: http://employershealthnetwork.com/resource/wfm/	Generic drugs and insulin	Not Applicable	25% coinsurance	25% coinsurance	Not Covered	Covers up to a 30-day supply (from in-network retail pharmacy) or up to 90-day supply (from in-network retail or mail order pharmacy). Certain medications may require preauthorization from Southern Scripts at 1-800-710-9341. Generic preventive drugs included on the ACA Drug List (Basic ACA Preventive), including generic contraceptives, are covered at 100% (and no deductible applies) if filled at an in-network pharmacy.
	Preferred brand drugs	Not Applicable	25% coinsurance	25% coinsurance	Not Covered	Non-generic preventive drugs included on the ACA Drug List (Expanded ACA Preventive) are covered at 100% (and no deductible applies) if prescribed by the WFM Medical Clinic and filled at an in-network retail pharmacy. Additional non-generic preventive drugs (Expanded Preventive) are covered at 100%, after the deductible, if prescribed by the WFM Medical Clinic and filled at an in-network retail pharmacy. If you are eligible to receive a subsidy through a manufacturer copay program, your copayment under the Variable Copay™ Program will be equal to the maximum subsidy available through that manufacturer copay program. Any manufacturer copay subsidy obtained under the Variable Copay™ Program will not accumulate toward your deductible or out of pocket costs.
	Non-preferred brand drugs	Not Applicable	50% coinsurance	50% coinsurance	Not Covered	
	Specialty drugs	Not Applicable			Not Covered	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		WFM Medical Clinic (You will pay the least)	Preferred Network (EHN)	Expanded Network (Aetna)	Out-of-Network Provider (You will pay the most)	
						If you are receiving a prescription drug through a manufacturer free drug program and you enroll in the Manufacturer Free Drug Initiative, that drug will not be covered under the plan. Certain medications may require preauthorization from Southern Scripts at 1-800-710-9341. Specialty drugs are limited to a 30-day, specialty formulary and specialty network only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	Certain procedures require preauthorization. If you don't get preauthorization, a $500 penalty will apply. For a list please go to: http://employershealthnetwork.com/resource/wfm/
	Physician/surgeon fees	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	Certain procedures require preauthorization. If you don't get preauthorization, a $500 penalty will apply. For a list please go to: http://employershealthnetwork.com/resource/wfm/
If you need immediate medical attention	Emergency room care	Not Applicable	25% coinsurance	25% coinsurance	25% coinsurance	Certain non-emergent procedures require preauthorization. If you don't get preauthorization, a $500 penalty will apply. For a list please go to: http://employershealthnetwork.com/resource/wfm/
	Emergency medical transportation	Not Applicable	25% coinsurance	25% coinsurance	25% coinsurance	Non emergent air and ground ambulance require preauthorization. If you don't get preauthorization, a $500 penalty will apply.
	Urgent care	No charge Not subject to deductible*	25% coinsurance Not subject to deductible	25% coinsurance	60% coinsurance	*You must be an established patient at the WFM Medical Clinic to receive urgent care at the WFM Medical Clinic (including by virtual visit); otherwise, normal plan benefits apply as indicated in Preferred Network tier. Services in person after hours or weekends are not free even for established patients.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		WFM Medical Clinic (You will pay the least)	Preferred Network (EHN)	Expanded Network (Aetna)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	Preauthorization is required. If you don't get preauthorization, a $500 penalty will apply.
	Physician/surgeon fees	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	Preauthorization is required. If you don't get preauthorization, a $500 penalty will apply.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	None
	Inpatient services	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	Preauthorization is required. If you don't get preauthorization, a $500 penalty will apply.
If you are pregnant	Office visits	Not Applicable	No Charge Not subject to deductible	No Charge Not subject to deductible	60% coinsurance	Non-routine pre-natal (non-preventive) is subject to 25% coinsurance after deductible if services provided in-network.
	Childbirth/delivery professional services	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	
	Childbirth/delivery facility services	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	
If you need help recovering or have other special health needs	Home health care	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	Preauthorization is required. If you don't get preauthorization, a $500 penalty will apply. Home health visits limited to 1 visit per day/100 visits per calendar year maximum. In and out of network combined.
	Rehabilitation services	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	
	Habilitation services	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		WFM Medical Clinic (You will pay the least)	Preferred Network (EHN)	Expanded Network (Aetna)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	Preauthorization is required. If you don't get preauthorization, a $500 penalty will apply. Limited to 30 days per calendar year. In and out of network combined.
	Durable medical equipment	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	Preauthorization is required for durable medical equipment that is over $1000; $500 penalty applies for failure to preauthorize. Hearing aids limited to single purchase every 3 years.
	Hospice services	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	Preauthorization is required. If you don't get preauthorization, a $500 penalty will apply. 6 month maximum for in and out of network combined.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	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.)

- Bariatric Surgery
- Chiropractic Care (outside of the Medical Center)
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment (diagnostic testing only)
- Long Term Care
- Non-Emergency Care when Traveling outside the U.S.
- Private Duty Nursing
- Routine Eye Care (Adult)
- 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.)	
• Acupuncture	• Hearing Aids

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-833-682-6480 or www.dol.gov/agencies/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 X61565 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, you can contact: Whole Foods Market (512) 542-0433 or WebTPA at 1-844-380-4554 and you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa.

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 1-844-380-4554
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-380-4554
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-380-4554
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-380-4554

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	$ 1,875
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1875
Copayments	$0
Coinsurance	$1450
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,385**

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

The plan's overall deductible	$1,875
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,875
Copayments	$0
Coinsurance	$1450
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,380**

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

The plan's overall deductible	$1,875
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,446
Copayments	$0
Coinsurance	$479
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

Note: These numbers assume the patient is using a Preferred provider. If you obtain services from an out-of-network provider, your costs may be higher.

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