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 1-844-380-4554. 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?	$1,700/person $3,400 /family - * Preferred Primary Care providers and Preferred network (EHN) and $3,200/person $5,000/family - *Expanded Network (Aetna) $7,500/person $10,500/family Out-of-Network providers *In-network deductibles cross-apply.	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, the overall family deductible must be met before the plan begins to pay. See the chart starting on page 2 for a description of when the deductible does not apply.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered 100% before you meet your deductible when using a network provider.	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 Primary Care providers and Preferred network (EHN) $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. Once an individual meets his or her out-of-pocket limit, the plan will pay 100% of the covered expenses for that individual.
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: https://members.ehnconnects.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 Preferred Primary Care 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.

* For more information about limitations and exceptions, see the plan or policy document at www.webtpa.com
Contact WebTPA for a list of Preferred Primary Care Providers at 1-844-380-4554.

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
		Preferred Primary Care Providers (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	*deductible then paid at 100%.	25% coinsurance	25% coinsurance	60% coinsurance	Virtual visits are contracted through the WFM Medical + Wellness Center (WFMMWC) and are available during regular business hours for Team Members who are established patients of the WFM MWC *Primary care visits provided by a Preferred Primary Care provider that include Family Medicine, Internal Medicine, Pediatrics.
	Specialist visit	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	None
	Preventive care screening immunization	No Charge	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	25% coinsurance	25% coinsurance	60% coinsurance	*Any Diagnostic service (including lab services) performed as part of a primary care visit with a Preferred Primary Care provider such as Family Medicine, Pediatrics, Internal Medicine are subject to the deductible.
	Imaging (CT/PET Scans, MRIs)	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	

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Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Preferred Primary Care Providers (You will pay the least)	Preferred Network (EHN)	Expanded Network (Aetna)	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.myprime.com. 1-877-278-5206.	Generic drugs	No charge for Standard Preventive drugs and not subject to deductible. 10% coinsurance with $2 min/$25 max	No charge for Standard Preventive drugs and not subject to deductible 10% coinsurance	No charge for Standard Preventive drugs and not subject to deductible 10% 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). Specialty drugs are limited to a 30-day, specialty formulary and specialty network only. Certain medications may require preauthorization from Prime Therapeutics at 1-877-278-5206. If you are eligible to receive a subsidy through a manufacturer copay program, your copayment under the FlexAccess program will be equal to the maximum subsidy available through that manufacturer copay program. Any manufacturer copay subsidy obtained under FlexAccess program will not accumulate toward your deductible or out of pocket costs.
	Preferred brand drugs	25% coinsurance $50 Maximum	25% coinsurance	25% coinsurance	Not Covered	
	Non-preferred brand drugs	50% coinsurance	50% coinsurance	50% coinsurance	Not Covered	
	Specialty drugs	50% coinsurance	50% coinsurance	50% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	Not Applicable	25% coinsurance	25% coinsurance	25% coinsurance	Certain procedures require preauthorization. If you don't get preauthorization, a $250 penalty will apply.

* For more information about limitations and exceptions, see the plan or policy document at webtpa.com. Contact WebTPA for a list of Preferred Primary Care Providers at 1-844-380-4554.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Preferred Primary Care Providers (You will pay the least)	Preferred Network (EHN)	Expanded Network (Aetna)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	Certain procedures require preauthorization. If you don't get preauthorization, a $250 penalty will apply.
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 $250 penalty will apply. Non emergent air and ground ambulance require preauthorization. If you don't get preauthorization, a $250 penalty will apply. .
	Emergency medical transportation	Not Applicable	25% coinsurance	25% coinsurance	25% coinsurance	
	Urgent care	(MDLive) deductible applies then paid at 100%.	25% coinsurance	25% coinsurance	60% coinsurance	
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 $250 penalty will apply.
	Physician/surgeon fees	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	Preauthorization is required. If you don't get preauthorization, a $250 penalty will apply.

* For more information about limitations and exceptions, see the plan or policy document at webtpa.com.
Contact WebTPA for a list of Preferred Primary Care Providers at 1-844-380-4554.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Preferred Primary Care Providers (You will pay the least)	Preferred Network (EHN)	Expanded Network (Aetna)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	Preauthorization is required for some services. If you don't get preauthorization, a $250 penalty will apply.
	Inpatient services	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	Preauthorization is required. If you don't get preauthorization, a $250 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) services are subject to 25% coinsurance after deductible if services provided in-network.
	Childbirth/delivery professional services	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	None
	Childbirth/delivery facility services	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	None
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 $250 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	Preauthorization is required for inpatient rehabilitation. If you don't get preauthorization, a $250 penalty will apply. Outpatient therapies limited to 20 visits per year, in and out of network combined. Therapies with a diagnosis code of autism will not have yearly limits.
	Habilitation services	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at webtpa.com.
Contact WebTPA for a list of Preferred Primary Care Providers at 1-844-380-4554.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Preferred Primary Care Providers (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 $250 penalty will apply.
	Durable medical equipment	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	Hearing aids limited to single purchase every 3 years. Preauthorization is required for Custom Fabricated Orthotics and Prosthetics (including for lower extremities, helmets, extremity prosthetic additions, electric prosthetic joints, facial prosthetics provided by non-physician, voice amplifiers, cranial remodeling orthosis, lower extremity orthosis, knee brace). If you don't get preauthorization, a $250 penalty will apply.
	Hospice services	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	
	Applied Behavioral Therapy (ABA Therapy)	Not Applicable	25% coinsurance	25% coinsurance	60% coinsurance	Preauthorization is required, reviewed every 4 months. If you don't get preauthorization, a $250 penalty will apply.
If your child needs dental or eye care	Children's eye exam	25% coinsurance	25% coinsurance	25% coinsurance	60% coinsurance	Preventive care is covered 100% before you meet your deductible.
	Children's glasses	Not covered	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	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.)

- Bariatric Surgery
- 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 Foot Care
- Weight Loss Programs

* For more information about limitations and exceptions, see the plan or policy document at webtpa.com. Contact WebTPA for a list of Preferred Primary Care Providers at 1-844-380-4554.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (20 visit limit) • Chiropractic Care (20 visit limit)	• Hearing Aids • Routine Eye Care (Adults)	• ABA Therapy (No Limitations, precertification is required)

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.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, 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**.
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 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.

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time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

* For more information about limitations and exceptions, see the plan or policy document at webtpa.com.
Contact WebTPA for a list of Preferred Primary Care Providers at 1-844-380-4554.

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	$1700
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,460**

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

The plan's overall deductible	$1700
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,620**

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

The plan's overall deductible	$1700
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

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