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, visit www.mycoresource.com or call 1-866-280-4120. 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.cciio.cms.gov or call 1-877-267-2323 X61565 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**EPO Network Providers**: **$0** person/**$0** family **Non-Network Providers**: **$500** person	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.
Are there services covered before you meet your deductible?	Yes. True medical emergency services and the prescription drug program.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**EPO Network Providers**: **N/A** **Non-Network Providers**: **$12,500** person	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Deductibles, copayments, penalties for failure to pre-certify services, premiums, balance-billing charges (unless balanced billing is prohibited), 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.myCoreSource.com or call 1-866-280-4120 for a list of network providers.	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).
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
		EPO Network Provider (You will pay the least)	Non-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	$13 copay/visit	50% coinsurance	Copays don't count toward the out–of–pocket limit.
	Specialist visit	$13 copay/visit	50% coinsurance	
	Preventive care/screening/ immunization	No charge	50% coinsurance	Coverage is limited to one routine physical exam/calendar year. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$13 copay	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$13 copay	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	$10 copay for retail and $10 copay mail order/ prescription		Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). Specialty drugs are limited to a 30 day supply. First 2 fills allowed at retail; thereafter, additional fills must be made through the CVS Caremark Specialty Pharmacy Program. Compound drugs over $300 and all specialty drugs require prior authorization.
	Preferred brand drugs	Retail: The greater of a $20 copay or 15%, up to a maximum copay of $200/prescription Mail Order: The greater of a $20 copay or 15%, up to a maximum copay of $300/prescription		
	Non-preferred brand drugs			
	Specialty drugs	Same as above, as applicable		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$130 copay	$130 copay, then 50% coinsurance	None
	Physician/surgeon fees	No charge	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$65 copay	$65 copay	Copay waived if admitted
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$13 copay	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay	$300 copay, then 50% coinsurance	Pre-certification is required. If the covered person fails to pre-certify services, the plan's benefit percentage will be reduced to 50%.
	Physician/surgeon fees	No charge	50% coinsurance	None

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		EPO Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: $13 copay; Other outpatient services: No charge	50% coinsurance	None
	Inpatient services	$300 copay	$300 copay, then 50% coinsurance	Pre-certification is required. If the covered person fails to pre-certify services, the plan's benefit percentage will be reduced to 50%.
If you are pregnant	Office visits	First prenatal visit: $13 copay; Thereafter: No charge	50% coinsurance	None
	Childbirth/delivery professional services	No charge	50% coinsurance	Depending on the type of services, a copay, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (*i.e.*, ultrasound.)
	Childbirth/delivery facility services	$300 copay	$300 copay, then 50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	No charge	50% coinsurance	Coverage is limited to 100 visits/calendar year. Pre-certification is required. If the covered person fails to pre-certify services, the plan's benefit percentage will be reduced to 50%.
	Rehabilitation services	Physical, speech & occupational therapy: $13 copay; Other therapies: No charge	50% coinsurance	None
	Habilitation services	Not covered	Not covered	No coverage for habilitation services.
	Skilled nursing care	No charge	50% coinsurance	Coverage is limited to 60 visits/confinement. Room and board is limited to 50% of the semi-private room charge of the transferring hospital. Pre-certification is required. If the covered person fails to pre-certify services, the plan's benefit percentage will be reduced to 50%.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		EPO Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Durable medical equipment	No charge	50% coinsurance	None
	Hospice services	No charge	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage for eye exams under medical.
	Children's glasses	Not covered	Not covered	No coverage for glasses under medical.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-ups under medical.

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;
- Habilitation services;
- Hearing aids (unless required as a result of illness, surgery or injury);
- Infertility treatment;
- Long-term care;
- Routine eye care;
- Routine foot care, and
- Weight-loss programs.

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;
- Non-emergency care when traveling outside the U.S. (limited to employees traveling on the business of the employer), and
- Private-duty nursing.

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. 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: CoreSource at 1-866-280-4120, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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

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 1-866-280-4120.

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	$0
Specialist copayment	$25
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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$660**

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

The plan's overall deductible	$0
Specialist copayment	$25
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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$910
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$970**

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

The plan's overall deductible	$0
Specialist copayment	$25
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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$100**

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

Aerovironment, Inc.
Medical Plans - Summary of Benefits

Medical Benefits:	PPO - In Network	PPO - Out of Network	EPO - In Network	EPO - Out of Network
Individual Annual Deductible	None	$300 Individual $900 Family	N/A; Co-pays apply	$500
Individual Out-Of-Pocket Maximum (Annual Deductible, Co-Pay, benefits paid at 50% (PPO), network benefits paid at 50% (EPO), and amounts due for failure to comply with requirement of the Utilization Management Program do not apply)	Not Applicable	$6000 per Insured per calendar year	Not Applicable	$12,500 per Insured per calendar year
Lifetime Maximum	$2,000,000		$2,000,000	
Physician Services				
Office Visits , per visit	$20 Co-pay	80%	$10 Co-pay	50%
Outpatient Surgery	$100/surgery copay, then plan pays 100%	$100/surgery copay, then plan pays 80% (UCR)	$100/surgery copay, then plan pays 100%	$100/surgery copay, then plan pays 50% (UCR)
Hospital Services				
Ambulance	100%	100%	100%	100%
Inpatient Care	$250/admission copay, then plan pays 100%	$250/admission copay, then plan pays 80%	$250/admission copay, then plan pays 100%	$250/admission copay, then plan pays 50%
Emergency Room, per use:	$50 Co-pay	80%	$50 Co-pay	50%
Preventive Care & Physical Exams:				
Colonoscopy	100%	80%	100%	50%
Mammography	100%	80%	100%	50%
Pap Smears	100%	80%	100%	50%
Physical Exams:	100% (no Co-pay); $250 annual maximum benefit	80%, $250 annual maximum benefit	100% (no Co-pay); $250 annual maximum benefit	50%, $250 annual maximum benefit
Well Child Care (up to 2 years of age)	100%	80%	100%	50%
Prescription Drug Benefit				
Generic - 30 day supply	$10	Not covered	$10	Not Covered
Brand - 30 day supply	Greater of $20 OR 15% Co-pay	Not covered	Greater of $20 OR 15% Co-pay	Not Covered
Mail Order - Generic - 90 day supply	$10	Not covered	$10	Not Covered
Mail Order - Brand - 90 day supply	Greater of $20 OR 15% Co-pay	Not covered	Greater of $20 OR 15% Co-pay	Not Covered
Other Services				
Diagnostic Lab & X-ray, Outpatient	$20 Co-pay	80%	$10 Co-pay	50%
Home Health Care	100%	80%	100%	50%
	Limited to 100 visits per Calendar Year COMBINED		Limited to 100 visits per Calendar Year COMBINED	
Allergy Testing & Treatment	$20 Co-pay	80%	$10 Co-pay	50%
Chiropractic -type Care / Acupuncture	$20 Co-pay	80%	$10 Co-pay	50%
	Limited to $1000 per Calendar Year COMBINED		Limited to $1000 per Calendar Year COMBINED	
Skilled Nursing Facility/ Rehabilitation Center				
Skilled Nursing Facility/ Rehabilitation Center	100%	80%	100%	50%
	Limited to 60 days per confinement		Limited to 60 days per confinement	

1. Important: Certain services may require authorization to avoid benefit reduction. See the Utilization Management Program section of the Summary Plan Description. Also, Benefits may be reduced or denied for pre-existing conditions. See special restrictions for Pre-existing conditions for more information.

2. This is a summary of benefits only. If there are differences in this summary and the actual plan documents, the plan documents will prevail.

3. UCR - The Usual, Customary, and Reasonable charges that the plan allows. You will be responsible for your share of the UCR allowed amount, PLUS any amounts the provider bills above that amount.