Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.HealthReformPlanSBC.com** or by calling **1-800-367-6276**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For each Calendar Year, Network: Individual **$500** / Family of 2 **$1,000** / Fam of 3 or more **$1,500**. Out-of-network: Ind **$1,500** / Fam of 2 **$3,000** / Fam of 3 or more / **$4,500**. Does not apply to prescription drugs, emergency care, and preventive care in-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 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	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.
Is there an out-of-pocket limit on my expenses?	Yes. Network: Individual **$3,000** / Family of 2 **$6,000** / Family of 3 or more **$9,000**. Out-of-network: Individual **$6,000** / Family of 2 **$12,000** / Family of 3 or more **$18,000**.	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, bariatric surgery expenses, penalties for failure to obtain pre-authorization for service, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.aetna.com** or call 1-800-367-6276 for a list of network **providers**.	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 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	40% coinsurance	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	$45 copay/visit	40% coinsurance	——————none——————
	Other practitioner office visit	$30 copay/visit for primary care visit; $45 copay/visit for specialist visit	40% coinsurance	Coverage is limited to 20 visits per calendar year for Chiropractic care.
	Preventive care /screening /immunization	No charge	Not covered	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	40% coinsurance	Physician office visit applies for in-network services rendered in a physician's office.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	Physician office visit applies for in-network services rendered in a physician's office.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetna.com/pharmacy-insurance/individuals-families	Generic drugs	Copay/prescription: $10 (retail), $20 (mail order)	Not covered	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Includes contraceptive drugs and devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for formulary generic FDA-approved women's contraceptives in-network. Covers a 180 day supply of certain Smoking Cessation Medications and 8 counseling sessions every 12 months. Includes weight loss drugs at applicable copay. No charge for generic drugs & 20% coinsurance for brand drugs purchased overseas.
	Preferred brand drugs	Copay/prescription: $35 (retail), $70 (mail order)	Not covered	
	Non-preferred brand drugs	35% coinsurance with a $60 minimum and up to a $125 maximum/ prescription (retail), 35% coinsurance with a $120 minimum and up to a $250 maximum/ prescription (mail order)	Not covered	
	Specialty drugs	40% coinsurance with a $60 minimum and up to a $125 maximum/ prescription	Not covered	Aetna Specialty CareRx℠ - First Prescription must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy®. Subsequent fills must be through Aetna Specialty Pharmacy®.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	————————none————————
	Physician/surgeon fees	10% coinsurance	40% coinsurance	————————none————————
If you need immediate medical attention	Emergency room services	10% coinsurance after $350 copay/visit, deductible waived	10% coinsurance after $350 copay/visit, deductible waived	50% coinsurance after $350 copay per visit, after deductible for non-emergency use.
	Emergency medical transportation	20% coinsurance	20% coinsurance	————————none————————
	Urgent care	$30 copay/visit	40% coinsurance	No coverage for non-urgent use.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after $200 copay/stay	40% coinsurance after $400 copay/stay	Pre-authorization required for out-of-network care.
	Physician/surgeon fee	10% coinsurance	40% coinsurance	————————none————————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$45 copay/visit	40% coinsurance	Coverage is limited to 45 visits per calendar year.
	Mental/Behavioral health inpatient services	20% coinsurance after $200 per stay	40% coinsurance after $400 copay/stay	Pre-authorization required for out-of-network care.
	Substance use disorder outpatient services	$45 copay/visit	40% coinsurance	Coverage is limited to 45 visits per calendar year.
	Substance use disorder inpatient services	20% coinsurance after $200 per stay	40% coinsurance after $400 copay/stay	Coverage is limited to 45 days per calendar year. Pre-authorization required for out-of-network care.
If you are pregnant	Prenatal and postnatal care	No charge	40% coinsurance	————————none————————
	Delivery and all inpatient services	20% coinsurance after $200 per stay	40% coinsurance after $400 copay/stay	Includes outpatient postnatal care. Pre-authorization may be required for out-of-network care.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	Coverage is limited to 90 visits per calendar year. Pre-authorization required for out-of-network care.
	Rehabilitation services	20% coinsurance	20% coinsurance	Coverage is limited to 60 visits per course of treatment for Physical, Occupational, and Speech Therapy combined.
	Habilitation services	20% coinsurance	20% coinsurance	Coverage is limited to 60 visits per course of treatment for developmental delays, combined with rehabilitation services.
	Skilled nursing care	10% coinsurance	40% coinsurance	Coverage is limited to 90 days per calendar year. Pre-authorization required for out-of-network care.
	Durable medical equipment	20% coinsurance	20% coinsurance	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
	Hospice service	No charge	No charge	Pre-authorization required for out-of-network care.
If your child needs dental or eye care	Eye exam	No charge	Not covered	Coverage is limited to 1 routine eye exam per calendar year.
	Glasses	No charge	No charge	Benefit limitations may apply.
	Dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care - Coverage is limited to 20 visits per calendar year.
- Hearing aids - Coverage is limited to 1 hearing aid to a maximum of $3,000 per 36 months.
- Infertility treatment - Coverage is limited to the diagnosis and treatment of underlying medical condition, artificial insemination & ovulation induction limited to 6 separate attempts per lifetime.
- Private-duty nursing - Coverage is limited to 70 - 8 hour visits per calendar year.
- Routine eye care (Adult) - Coverage is limited to 1 routine eye exam per calendar year for in-network only.

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 1-800-367-6276. 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 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

Questions: Call 1-800-367-6276 or visit us at www.HealthReformPlanSBC.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.HealthReformPlanSBC.com or call 1-800-367-6276 to request a copy.

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact us by calling the toll free number on your Medical ID Card. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
Additionally, a consumer assistance program can help you file an **appeal**. Contact information is at http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-367-6276.
如果需要中文的帮助，请拨打这个号码 1-800-367-6276.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-367-6276.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-367-6276.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,200
- **Patient pays:** $1,340

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$220
Coinsurance	$470
Limits or exclusions	$150
Total	**$1,340**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,960
- **Patient pays:** $1,440

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$650
Coinsurance	$210
Limits or exclusions	$80
Total	**$1,440**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.