

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



**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](http://www.HealthReformPlanSBC.com) or by calling 1-888-982-3862.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For each Calendar Year: In-network Individual <b>\$300</b> / Family of 2 <b>\$600</b> / Family of 3 or more <b>\$900</b> ; Out-of-network Individual <b>\$900</b> / Family of 2 <b>\$1,800</b> / Family of 3 or more <b>\$2,700</b>	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> 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 <b>deductible</b> .
Are there other deductibles for specific services?	No.	You don't have to meet <b>deductibles</b> 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, In-network: Individual <b>\$3,000</b> / Family of 2 <b>\$6,000</b> / Family of 3 or more <b>\$9,000</b> ; Out-of-network Individual <b>\$4,000</b> / Family of 2 <b>\$8,000</b> / Family of 3 or more <b>\$12,000</b> .	The <b>out-of-pocket limit</b> 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, copays, pharmacy copays, confinement fees, penalties for failure to obtain preauthorization for services, expenses covered at 50% and non-covered expenses.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
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. For a list of <b>preferred providers</b> , see <a href="http://www.aetna.com">www.aetna.com</a> or call 1-888-982-3862.	If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a specialist?	No.	You can see the <b>specialist</b> 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 <b>excluded services</b> .

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- **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 in-network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	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	\$20 copay per visit	40% coinsurance	Includes services of an Internist, Pediatrician, Family Practitioner or General Practitioner. No additional charge for diagnostic test (x-ray, blood work when part of office visit.
	Specialist visit	\$35 copay per visit	40% coinsurance	No additional charge for diagnostic test (x-ray and blood work) when part of office visit.
	Other practitioner office visit	\$35 copay per visit	40% coinsurance	Maximum 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 at an independent facility	40% coinsurance	Applicable copay when billed as a separate primary care physician or specialist visit.
	Imaging (CT/PET scans, MRIs)	10% coinsurance at an independent facility	10% coinsurance	Applicable copay when billed as a separate primary care physician or specialist visit.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	You Use an Out-Of-Network Provider	Limitations & Exceptions
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about prescription drug coverage is at <a href="http://www.aetna.com/pharmacy-insurance/individuals-families">www.aetna.com/pharmacy-insurance/individuals-families</a></p>	Generic drugs	\$10 copay/prescription (retail), \$20 copay/prescription (mail order)	Not covered	<p>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 and injectable fertility drugs. No charge for formulary generic FDA-approved women's contraceptives in-network. Also covers 180 day supply of certain Smoking Cessation Medications and 8 counseling sessions every 12 months. No charge for Generic drugs purchased overseas, 20% coinsurance for Brand-name drugs purchased overseas.</p>
	Preferred brand drugs	\$20 copay/prescription (retail), \$40 copay/prescription (mail order)	Not covered	
	Non-preferred brand drugs	35% coinsurance/prescription (retail), with a minimum \$35 and maximum \$100, 35% coinsurance/prescription (mail order) \$70 minimum and \$200 maximum	Not covered	
	Specialty drugs	\$10 copay (generic), \$20 copay (preferred), 35% coinsurance with a minimum \$35 and maximum \$100, (non-preferred), no mail order	Not covered	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40%	————— None —————
	Physician/surgeon fees	10% coinsurance	40%	————— None —————

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<b>If you need immediate medical attention</b>	Emergency room services	10% coinsurance after \$350 copay	10% coinsurance after \$350 deductible	50% coinsurance after deductible; \$350 emergency room copay for non-emergency.
	Emergency medical transportation	20% coinsurance	20% coinsurance	————— None —————
	Urgent care	\$20 copay per visit	40% coinsurance	————— None —————
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% coinsurance after \$200 per confinement fee	40% coinsurance after \$400 per confinement fee	Precertification required for out-of-network care. Benefits will be reduced by \$500 if pre-authorization is not obtained.
	Physician/surgeon fee	10% coinsurance	40% coinsurance	————— None —————
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$35 copay	40% coinsurance	Coverage is limited to 45 visits per calendar year.
	Mental/Behavioral health inpatient services	20% coinsurance after \$200 per confinement fee	40% coinsurance after \$400 per confinement fee	Coverage is limited to 45 visits per calendar year. Precertification required for out-of-network care. Benefits will be reduced by \$500 if pre-authorization is not obtained.
	Substance use disorder outpatient services	\$35 copay	40% coinsurance	Coverage is limited to 45 visits per calendar year.
	Substance use disorder inpatient services	20% coinsurance after \$200 per confinement fee	40% coinsurance after \$400 per confinement fee.	Coverage is limited to 45 visits per calendar year Precertification required for out-of-network care. Benefits will be reduced by \$500 if pre-authorization is not obtained.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	You Use an Out-Of-Network Provider	Limitations & Exceptions
<b>If you are pregnant</b>	Prenatal and postnatal care	No charge	40% coinsurance	————— None —————
	Delivery and all inpatient services	10% coinsurance after \$200 per confinement fee	40 % coinsurance	Per confinement fee waived for newborns.
<b>If you need help recovering or have other special health needs</b>	Home health care	10% coinsurance	40% coinsurance	Limited to 90 visits per calendar year.
	Rehabilitation services	20% coinsurance	20% coinsurance	Limited to 60 day maximum per course of treatment.
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	10% coinsurance	40% coinsurance	Limited to 90 days per calendar year. Precertification required for out-of-network care. Benefits will be reduced by \$500 if pre-authorization is not obtained.
	Durable medical equipment	20% coinsurance	20% coinsurance	————— None —————
	Hospice service	No charge	No charge	Precertification required for out-of-network care. Benefits will be reduced by \$500 if pre-authorization is not obtained.
<b>If your child needs dental or eye care</b>	Eye exam	No charge	Not covered	Limited to one exam per calendar year.
	Glasses	No charge	No charge	Up to \$150 reimbursement maximum per person per calendar year.
	Dental check-up	No charge	No charge	————— None —————

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**Excluded Services & Other Covered Services:**

<b>Services Your Plan Does NOT Cover</b> (This isn't a complete list. Check your policy or plan document for other <b>excluded services</b> .)		
• Acupuncture	• Habilitation services	• Non-emergency care when traveling outside the U.S.
• Cosmetic Surgery	• Infertility treatment	• Routine Foot Care
• Dental Care (Adult)	• Long-Term Care	• Weight Loss Programs
<b>Other Covered Services</b> (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric Surgery	• Hearing Aids (\$3,000 maximum every 3 years)	• Routine Eye Care (Adult)
• Chiropractic care (Limited to 20 visits per calendar year)	• Private-Duty Nursing: (Limited to 70 eight hour shifts per calendar year)	

**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](http://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](http://www.cciio.cms.gov).

**Your Grievance and Appeals Rights:**

- 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: Aetna at 1-800-367-6276, the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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/member-guidelines/complaints-grievances-appeals.html>.

**Language Access Services:**

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-982-3862.  
 Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-888-982-3862.

如果需要中文的帮助, 请拨打这个号码 1-888-982-3862.  
 Para obtener asistencia en Español, llame al 1-888-982-3862.

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

**Coverage Examples**

**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 will also 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: \$ 5,890
- Patient pays: \$ 1,650

**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	\$ 300
Copays	\$ 300
Coinsurance	\$ 900
Limits or exclusions	\$ 150

**Total \$ 1,650**

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

- Amount owed to providers: \$ 5,400
- Plan pays: \$ 4,240
- Patient pays: \$ 1,160

**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	\$ 300
Copays	\$ 540
Coinsurance	\$ 240
Limits or exclusions	\$ 80

**Total \$ 1,160**

## Coverage Examples

## Questions and answers about 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.