

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



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 1-888-982-3862.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For each Calendar Year Individual \$300 / Family \$600 (2 or more) \$900 (3 or more) Does not apply to 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, Individual \$3,000 / Family \$6,000 (2 or more) \$9,000 (3 or more)	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, copays, expenses covered at 50%, balance-billed charges, penalties for failure to obtain pre-authorization for services and health care this plan doesn't 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 <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	No.	This plan treats providers the same in determining payment for the same services.
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 .

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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**.)
- Your cost sharing does not depend on whether a **provider** is in a **network**.

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance except 100% for office surgery	Office surgery covered at 100% of first \$1,000, no deductible; then 80% after deductible.
	Specialist visit	20% coinsurance	————— None —————
	Other practitioner office visit	20% coinsurance	Coverage is limited to 20 visits per calendar year for chiropractic care.
	Preventive care /screening /immunization	No charge	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	————— None —————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	————— None —————

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Common Medical Event	Services You May Need	Your Cost	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	\$10 copay/ prescription (retail), \$20 copay/ prescription (mail order)	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 fertility drugs. Includes 180 day supply of certain smoking cessation medications and 8 counseling sessions every 12 months. No charge for formulary generic FDA-approved women's contraceptives in-network. No coverage for drugs on the Medication Formulary Exclusions List. No charge for Generic drugs purchased overseas, 20% coinsurance for Brand-name drugs purchased overseas.
	Preferred brand drugs	\$20 copay/ prescription (retail), \$40 copay/ prescription (mail order)	
	Non-preferred brand drugs	35% copay \$35 - \$100 (retail), 35% copay \$70 - \$200 (mail order)	
	Specialty drugs	Same as retail	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	None
	Physician/surgeon fees	20% coinsurance	None
If you need immediate medical attention	Emergency room services	20% coinsurance	Non-emergency use covered at 50%.
	Emergency medical transportation	20% coinsurance	None
	Urgent care	20% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Precertification required for care. Benefits will be reduced by \$500 if pre-authorization is not obtained.
	Physician/surgeon fee	20% coinsurance	None

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Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	Coverage is limited to 45 visits.
	Mental/Behavioral health inpatient services	20% coinsurance except 40% coinsurance after 60 days	Precertification required for care. Benefits will be reduced by \$400 if pre-authorization is not obtained.
	Substance use disorder outpatient services	20% coinsurance	Coverage is limited to 45 visits.
	Substance use disorder inpatient services	20% coinsurance	Coverage is limited to 45 days per calendar year. Precertification required for care. Benefits will be reduced by \$500 if pre-authorization is not obtained.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	None
	Delivery and all inpatient services	20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Coverage is limited to 90 visits per calendar year.
	Durable medical equipment	20% coinsurance	None
	Hospice service	No charge, deductible waived	Precertification required for care. Benefits will be reduced by \$500 if pre-authorization is not obtained.
If your child needs dental or eye care	Eye exam	No charge	1 exam per calendar year
	Glasses	\$150 allowance	Allowance once per calendar year.
	Dental check-up	Not covered	Not covered

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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 .)		
<ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery 	<ul style="list-style-type: none"> • Dental care (Adult & Child) • Long-term care 	<ul style="list-style-type: none"> • 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.)		
<ul style="list-style-type: none"> • Bariatric surgery (50% coinsurance) • Hearing aids (\$3,000 maximum every 3 years) 	<ul style="list-style-type: none"> • Infertility treatment (Diagnosis and treatment of underlying cause and 6 cycles of Artificial Insemination and Ovulation Induction) • Private-duty nursing (Limited to 70 shifts per calendar year) 	<ul style="list-style-type: none"> • Routine eye care

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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 1-888-982-3862. 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:

- 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 1-888-982-3862, 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/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: \$ 6,030
- Patient pays: \$ 1,510

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	\$ 20
Coinsurance	\$ 1,040
Limits or exclusions	\$ 150

Total \$ 1,510

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

- Amount owed to providers: \$ 5,400
- Plan pays: \$ 4,510
- Patient pays: \$ 890

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	\$ 200
Coinsurance	\$ 310
Limits or exclusions	\$ 80

Total \$ 890

Note: Your plan may have both **copays** and **coinsurance** for covered services; if so, these examples use **copays** only. Your costs may be higher.

Coverage Examples

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?

x 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?

x 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.