

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

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

**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:
<b>What is the overall deductible?</b>	Network: Individual <b>\$500</b> / Family <b>\$1,500</b> . Out-of-Network: Individual <b>\$1,000</b> / Family <b>\$3,000</b> . Does not apply to office visits, prescription drugs, emergency care, and preventive care in-network.	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> .
<b>Are there other deductibles for specific services?</b>	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.
<b>Is there an out-of-pocket limit on my expenses?</b>	Yes. Network: Individual <b>\$3,500</b> / Family <b>\$10,500</b> . Out-of-Network: Individual <b>\$7,000</b> / Family <b>\$21,000</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.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billed charges, 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 <b>out-of-pocket limit</b> .
<b>Is there an overall annual limit on what the plan pays?</b>	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.
<b>Does this plan use a network of providers?</b>	Yes. See <a href="http://www.aetna.com">www.aetna.com</a> or call 1-888-982-3862 for a list of network <b>providers</b> .	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> .
<b>Do I need a referral to see a specialist?</b>	No.	You can see the <b>specialist</b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	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 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	\$25 copay/visit	50% coinsurance	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	\$40 copay/visit	50% coinsurance	—————none—————
	Other practitioner office visit	\$40 copay/visit	50% coinsurance	Coverage is limited to 20 visits per calendar year for Chiropractic care.
	Preventive care /screening /immunization	No charge	50% coinsurance	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	—————none—————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	—————none—————

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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
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b>prescription drug coverage</b> is available at <a href="http://www.aetna.com/pharmacy-insurance/individuals-families">www.aetna.com/pharmacy-insurance/individuals-families</a></p> <p>Value Three Tier Open Formulary</p>	Generic drugs	Copay/prescription: \$10 (retail), \$20 (mail order)	30% coinsurance after copay/prescription: \$10 (retail)	<p>Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs &amp; devices obtainable from a pharmacy, oral fertility drugs. No charge for formulary generic FDA-approved women's contraceptives in-network. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written. Maintenance drugs - after two retail fills, members are required to fill a 90-day supply at Aetna Rx Home Delivery or CVS/pharmacy.</p> <p>First prescription must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy Networks. Subsequent fills must be through Aetna Specialty Pharmacy Networks.</p>
	Preferred brand drugs	Copay/prescription: \$30 (retail), \$60 (mail order)	30% coinsurance after copay/prescription: \$30 (retail)	
	Non-preferred brand drugs	Copay/prescription: \$60 (retail), \$120 (mail order)	30% coinsurance after copay/prescription: \$60 (retail)	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs.	Not covered	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after \$100 copay/visit	50% coinsurance	—————none—————
	Physician/surgeon fees	20% coinsurance	50% coinsurance	—————none—————
<p><b>If you need immediate medical attention</b></p>	Emergency room services	\$150 copay/visit	\$150 copay/visit	No coverage for non-emergency use.
	Emergency medical transportation	20% coinsurance	20% coinsurance	50% coinsurance for non-emergency transport.
	Urgent care	\$40 copay/visit	50% coinsurance	No coverage for non-urgent use.
<p><b>If you have a hospital stay</b></p>	Facility fee (e.g., hospital room)	\$150 copay/day first 5 days per stay; 0% coinsurance thereafter	50% coinsurance	Maximum of 3 confinement copays per individual per calendar year. Pre-authorization required for out-of-network care.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	—————none—————

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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
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$40 copay/visit	50% coinsurance	—————none—————
	Mental/Behavioral health inpatient services	\$150 copay/day first 5 days per stay; 0% coinsurance thereafter	50% coinsurance	Maximum of 3 confinement copays per individual per calendar year. Pre-authorization required for out-of-network care.
	Substance use disorder outpatient services	\$40 copay/visit	50% coinsurance	—————none—————
	Substance use disorder inpatient services	\$150 copay/day first 5 days per stay; 0% coinsurance thereafter	50% coinsurance	Maximum of 3 confinement copays per individual per calendar year. Pre-authorization required for out-of-network care.
<b>If you are pregnant</b>	Prenatal and postnatal care	No charge	50% coinsurance	—————none—————
	Delivery and all inpatient services	\$150 copay/day first 5 days per stay; 0% coinsurance thereafter	50% coinsurance	Includes outpatient postnatal care. Maximum of 3 confinement copays per individual per calendar year. Pre-authorization may be required for out-of-network care.
<b>If you need help recovering or have other special health needs</b>	Home health care	20% coinsurance	50% coinsurance	Coverage is limited to 120 visits per calendar year, including up to 70 - 8 hour shifts for private-duty nursing. Pre-authorization required for out-of-network care.
	Rehabilitation services	20% coinsurance	50% coinsurance	Coverage is limited to 60 visits per calendar year for Physical, Occupational & Speech Therapy combined.
	Habilitation services	Not covered	Not covered	Not covered.
	Skilled nursing care	20% coinsurance	50% coinsurance	Coverage is limited to 100 days per calendar year. Pre-authorization required for out-of-network care.
	Durable medical equipment	20% coinsurance	50% coinsurance	—————none—————

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	Hospice service	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
<b>If your child needs dental or eye care</b>	Eye exam	Not covered	Not covered	Not covered.
	Glasses	Not covered	Not covered	Not covered.
	Dental check-up	Not covered	Not covered	Not covered.

**Excluded Services & Other Covered Services:**

<b>Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u>.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult &amp; Child)</li> <li>• Glasses (Child)</li> </ul>	<ul style="list-style-type: none"> <li>• Habilitation services</li> <li>• Hearing aids</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult &amp; Child)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>
<b>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.)</b>		
<ul style="list-style-type: none"> <li>• Chiropractic care - Coverage is limited to 20 visits per calendar year.</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment - Coverage is limited to the diagnosis and treatment of underlying medical condition.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing - Coverage is limited to 70 - 8 hour shifts per calendar year combined with home health care.</li> </ul>

**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](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).

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs****Coverage for: Individual + Family | Plan Type: POS****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 us by calling the toll free number on your Medical ID Card. If your group health plan is subject to ERISA, 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](http://www.dol.gov/ebsa/healthreform).

Additionally, a consumer assistance program can help you file your **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 1-888-982-3862.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-982-3862.

如果需要中文的帮助, 请拨打这个号码 1-888-982-3862.

Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-982-3862.

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

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Coverage Examples

Coverage for: Individual + Family | Plan Type: POS

## 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: \$6,500
- Patient pays: \$1,040

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$500
Copays	\$300
Coinsurance	\$40
Limits or exclusions	\$200
<b>Total</b>	<b>\$1,040</b>

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

- Amount owed to providers: \$5,400
- Plan pays: \$4,020
- Patient pays: \$1,380

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$500
Copays	\$600
Coinsurance	\$200
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,380</b>

## Coverage Examples

Coverage for: Individual + Family | Plan Type: POS

## 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.

**Supplemental Information**

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<p><b>How is the overall deductible or out-of-pocket limit met?</b></p>	<p>Individual <b>deductible</b> and <b>out-of-pocket limit</b> payments apply to the family <b>deductible</b> and <b>out-of-pocket limit</b>.</p>	<p>The family <b>deductible</b> and family <b>out-of-pocket limit</b> are cumulative for all family members. The family <b>deductible</b> and <b>out-of-pocket limit</b> can be met by a combination of family members; however no single individual within the family will be subject to more than the individual <b>deductible</b> or <b>out-of-pocket limit</b> amount.</p>
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**How your out-of-network care is reimbursed:**

We cover the cost of services based on whether doctors are “in-network” or “out-of-network.” We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

You may choose a **provider** (doctor or hospital) in our **network**. You may choose to visit an out-of-network **provider**. If you choose a doctor who is out-of-network, your Aetna health **plan** may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "**allowed**" **amount**.

Professional Services: 105% of Medicare

Facility Services: 140% of Medicare

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna **plan** "recognizes." Your doctor may bill you for the dollar amount that your **plan** doesn't "recognize." You must also pay any **copayments**, **coinsurance** and **deductibles** under your **plan**. No dollar amount above the "recognized charge" counts toward your **deductible** or **out-of-pocket limit**. To learn more about how we pay out-of-network benefits, visit [www.aetna.com](http://www.aetna.com). Type “how Aetna pays” in the search box.

You can avoid these extra costs by getting your care from Aetna's **network** of health care **providers**. Go to [www.aetna.com](http://www.aetna.com) and click on “Find a Doctor” on the left side of the page. If you are already a member, sign on to your Aetna Navigator® member site.

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applies when you *choose* to get care out-of-network. When you have no choice (for example: emergency room visit after a car accident or for other **emergency services**), we will pay the bill as if you got care in-network. You pay cost sharing and **deductibles** for your in-network level of benefits. Contact Aetna if your health care **provider** asks you to pay more. You are not responsible for any outstanding **balance billed** by your **providers** for **emergency services** beyond your cost sharing and **deductibles**.

**Other important information about your plan:**

This **plan** does not cover all health care expenses and includes exclusions and limitations. Members should refer to their **plan** documents to determine which health care services are covered and to what extent.

Additional information regarding your **plan** is available in the Disclosure Document on [www.aetna.com](http://www.aetna.com).

Information includes:

- “Knowing what is covered” which describes how we review a request for coverage for a service or supply
- “**Prescription drug** benefit” which describes procedures we use to manage **prescription drug** benefits. These procedures include how to obtain a list of covered drugs and the exception policy for receiving coverage of a drug that is not on a closed formulary

**Plans** are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and **health insurance plans** contain exclusions and limitations. Not all health services are covered.

See **plan** documents for a complete description of benefits, exclusions, limitations and conditions of coverage. **Plan** features and availability may vary by location and are subject to change. You may be responsible for the health care **provider's** full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the **plan**. **Providers** are independent contractors and are not agents of Aetna. **Provider** participation may change without notice. We do not provide care or guarantee access to health services.

The following is a partial list of services and supplies that are generally not covered. However, your **plan** documents may contain exceptions to this list based on state mandates or the **plan** design or rider(s) purchased by you or your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your **plan** documents
- Donor egg retrieval
- Non-**medically necessary** services or supplies
- Orthotics except diabetic orthotics

**Supplemental Information**

- Experimental and investigational procedures, except for coverage for **medically necessary** routine patient care costs for members participating in a cancer clinical trial with respect to the treatment of cancer or other life-threatening disease or condition.
- Home births
- Immunizations for travel or work except where **medically necessary** or indicated
- Implantable drugs and certain injectable drugs including injectable infertility drugs
- Long-term rehabilitation therapy

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

We consider your personal information to be private. We have policies and procedures in place to protect your personal information from unlawful use and disclosure. For a summary of our policy, go to [www.aetna.com](http://www.aetna.com). You'll find the Privacy Notices link at the bottom of the page.

**Plan** features and availability may vary by location and group size.

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- Outpatient **prescription drugs** (except for treatment of diabetes), unless covered by a prescription **plan** rider and over-the-counter medications (except as provided in a hospital) and supplies
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling or **prescription drugs**
- Therapy or rehabilitation other than those listed as covered