

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 or by calling 1-800-370-4526.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For each Calendar Year, Network: Individual \$500 / Family \$1,000 . Out-of-Network: Individual \$2,500 / Family \$5,000 . Does not apply to office visits, preventive care, and emergency care.	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 \$2,000 / Family \$4,000 . Out-of-Network: Individual \$5,000 / Family \$10,000 .	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, 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 <i>specific</i> covered services, such as office visits.
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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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 <u>provider's</u> office or clinic (continued on next page)	Primary care visit to treat an injury or illness	Custom Network PCP \$0 copay per visit; \$20 copay per visit for all others	40% coinsurance after calendar year deductible	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	\$25 copay per visit	40% coinsurance after calendar year deductible	Routine eye exams (Network Provider) are covered 100% no copay, no deductible once per calendar year.
	Other practitioner office visits (see below):			
	Spinal manipulation (e.g. Chiropractic)	\$25 copay per visit	40% coinsurance after calendar year deductible	Limited to 25 visits per calendar year, no medical necessity
	Acupuncture	20% coinsurance after \$25 copay per visit	40% coinsurance after calendar year deductible	
	Nutritional Counseling	\$0 copay, no deductible	Not Covered	Limited to 2 visits per 12 months (non-diagnosis). \$25 copay (Network Provider) after limit is exhausted.

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	Preventive care /screening /immunization	\$0 copay, no deductible	40% coinsurance after deductible, except no charge for: Routine GYN Exam, & Routine Mammogram. Not covered: Routine Physical Exam & Routine Prostate Specific Antigen, Lung Cancer Screening, Tobacco Cessation Counseling	Age and frequency schedules may apply. Two diagnostic mammograms covered 100% no deductible (Network Provider) per calendar year. Tobacco cessation counseling visits (Network Provider) limited to 8 visits per 12 months. One lung cancer screening covered 100% no deductible (Network Provider) per 12 months for eligible members. See Summary Plan Description booklet for eligibility.
If you have a test	Diagnostic test	10% coinsurance	40% coinsurance after calendar year deductible	(includes x-ray, blood work, ultrasound)
	Imaging (CT/PET scans, MRIs)	\$50 copay per visit	\$50 copay per visit	————— None —————
If you need drugs to treat your illness or condition (continued on next page) More Information about prescription drug coverage is available at www.aetna.com/pharmacy-insurance/individuals-families	Generic drugs <i>*Note: Retail pharmacy or mail order available in-network</i>	\$10 copay/ prescription for a 30 day supply, \$15 copay/ prescription for a 90 day supply	\$10 copay/ prescription for a 30 day supply (retail), \$15 copay/ prescription for a 90 day supply (retail)	Covers up to a 90 day supply (retail prescription), 90 day supply (mail order prescription). Includes performance enhancing medication (6 tablets per 30 days for retail or 18 tablets per 90 days for mail order or retail)*Infertility and Erectile Dysfunction drugs: \$50.00 copay for 30 day supply or \$75.00 copay for 90 day supply, 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. \$0 copay for first two 90-day treatment regimens for certain tobacco cessation prescription drugs and over-the-counter (“OTC”) medications.
	Preferred brand drugs <i>*Note: Retail pharmacy or mail order available in-network</i>	\$30 copay/ prescription for a 30 day supply, \$45 copay/ prescription for a 90 day supply	\$30 copay/ prescription for a 30 day supply (retail), \$45 copay/ prescription for a 90 day supply (retail)	
	Non-preferred brand drugs <i>*Note: Retail pharmacy or mail order available in-network</i>	\$45 copay/ prescription for a 30 day supply, \$70 copay/ prescription for a 90 day supply	\$45 copay/ prescription for a 30 day supply (retail), \$70 copay/ prescription for a 90 day supply (retail)	

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	Specialty drugs	Applicable cost as noted above for generic or brand drugs.	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Preferred Network Facility 10% coinsurance, after deductible. All others 20% coinsurance, after deductible; Non-free standing hospital: 5% coinsurance, after deductible	40% coinsurance after calendar year deductible	None
	Physician/surgeon fees	Preferred Network 10% coinsurance, after deductible. All others 20% coinsurance, after deductible.	40% coinsurance after calendar year deductible	None
If you need immediate medical attention	Emergency room services	\$300 copay per visit	\$300 copay per visit	None
	Emergency medical transportation	0% coinsurance	0% coinsurance	None
	Urgent care	\$25 copay per visit	40% coinsurance after calendar year deductible	None

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If you have a hospital stay	Facility fee (e.g., hospital room)	Preferred 10% coinsurance. All other Facilities 20% coinsurance	40% coinsurance after calendar year deductible	Pre-authorization required for out-of-network care.
	Physician/surgeon fee	Preferred 10% coinsurance. All other Facility 20% coinsurance	40% coinsurance after calendar year deductible	————— None —————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$25 copay per visit	40% coinsurance after calendar year deductible	————— None —————
	Mental/Behavioral health inpatient services	10% coinsurance	40% coinsurance after calendar year deductible	Pre-authorization required for out-of-network care.
	Substance use disorder outpatient services	\$25 copay per visit	40% coinsurance after calendar year deductible	————— None —————
	Substance use disorder inpatient services	10% coinsurance	40% coinsurance after calendar year deductible	Pre-authorization required for out-of-network care.
If you are pregnant	Prenatal and postnatal care	No charge	40% coinsurance after calendar year deductible	————— None —————
	Delivery and all inpatient services	0% coinsurance	40% coinsurance after calendar year deductible	Includes outpatient postnatal care. Pre-authorization required for out-of-network care.

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If you need help recovering or have other special health needs	Home health care	0% coinsurance	40% coinsurance after calendar year deductible	Pre-authorization required for out-of-network care.
	Rehabilitation services	\$25 copay per visit	40% coinsurance after calendar year deductible	————— None —————
	Habilitation services	\$25 copay per visit	40% coinsurance after calendar year deductible	Benefit limitations may apply.
	Skilled nursing care	0% coinsurance	40% coinsurance after calendar year deductible	Coverage is limited to 100 days per calendar year. Pre-authorization required for out-of-network care.
	Durable medical equipment	0% coinsurance	40% coinsurance after calendar year deductible	————— None —————
	Hospice service	0% coinsurance	40% coinsurance after calendar year deductible	Pre-authorization required for out-of-network care.
If your child needs dental or eye care	Eye exam	No charge	40% coinsurance after calendar year deductible	Coverage is limited to 1 routine eye exam per calendar year.
	Glasses	Not covered	Not covered	Not covered.
	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 .)		
<ul style="list-style-type: none"> ◦ Cosmetic surgery ◦ Dental care (Adult & Child) ◦ Glasses (Child) 	<ul style="list-style-type: none"> ◦ Long-term care ◦ Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> ◦ Private-duty nursing ◦ 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"> • Acupuncture • Bariatric surgery • Chiropractic care 	<ul style="list-style-type: none"> • Hearing aids - Coverage is limited to 1 hearing aid to a maximum of \$1,400 per 36 months up to age 19. 	<ul style="list-style-type: none"> • Infertility treatment - Benefit limitations may apply. • Routine eye care (Adult) - Coverage is limited to 1 routine eye exam per calendar year.

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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 1-800-370-4526. 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 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 Provide 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 1-800-370-4526.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-370-4526.

如果需要中文的帮助, 请拨打这个号码 1-800-370-4526.

Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 1-800-370-4526.

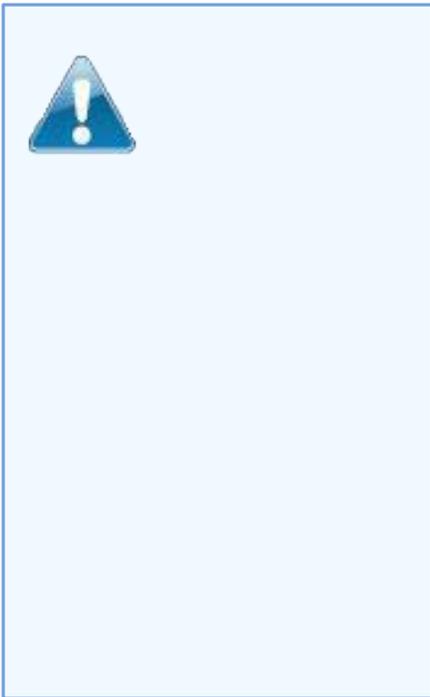
-----*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*-----

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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.



- **Amount owed to providers:** \$7,540
- **Plan pays:** \$6,410
- **Patient pays:** \$1,130

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	\$20
Coinsurance	\$460
Limits or exclusions	\$150
Total	\$1,130



- **Amount owed to providers:** \$5,400
- **Plan pays:** \$4,450
- **Patient pays:** \$950

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	\$360
Coinsurance	\$10
Limits or exclusions	\$80
Total	\$950

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.