

**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 1-877-292-2480.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: Individual <b>\$100</b> / Family <b>\$300</b> ; Out-of-network: Individual <b>\$450</b> / Family <b>\$1,350</b> Does not apply to inpatient services and emergency 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> .
Are there other deductibles for specific services?	Yes.	A per confinement <b>deductible</b> applies to all confinements except hospice or for newborns. The inpatient per confinement <b>deductible</b> is \$200.
Is there an out-of-pocket limit on my expenses?	Yes, In-network: Individual <b>\$2,000</b> / Family <b>\$4,000</b> ; Out-of-network: Individual <b>\$3,000</b> / Family <b>\$6,000</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, 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 <b>out-of-pocket limit</b> . *Precertification is required for out-of-network providers of inpatient services, hospitals, treatment facility, skilled nursing, home health care, hospice and private duty expenses or a penalty applies.
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?	Yes. For a list of in-network and Aexcel <sup>®</sup> designated <b>providers</b> , see <a href="http://www.Aetna.com">www.Aetna.com</a> or call 1-877-292-2480.	If you use an in-network doctor, Aexcel designated <b>specialist</b> 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 6. 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** and Aexcel designated **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts. A designated **provider** is an in-network **provider** who meets additional criteria and is identified with an icon in the **provider** directory.
- Aexcel designated specialties are: cardiology, cardiothoracic surgery, gastroenterology, general surgery, obstetrics and gynecology, orthopedics, otolaryngology, neurology, neurosurgery, plastic surgery, urology and vascular surgery.

Common Medical Event	Services You May Need	Your Cost If You Use an In-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	\$15 copay per visit	40% coinsurance	Diagnostic x-ray and lab services covered at 10% coinsurance.
	Specialist visit	\$15 copay per visit	40% coinsurance	20% coinsurance for non-designated providers in Aexcel specialties.
	Other practitioner office visit	\$15 copay per visit	40% coinsurance	Coverage is limited to 20 visits per calendar year for Chiropractic care.
	Preventive care /screening /immunization	No charge, except \$15 copay for hearing exam.	Not covered, except 40% coinsurance for mammograms, routine gynecology, pap smear, and hearing exam.	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	40% coinsurance	———— None —————
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	———— None —————

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Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
<b>If you need drugs to treat your illness or condition</b>  More information about prescription drug coverage is available at <a href="http://www.aetna.com/pharmacy-insurance/individuals-families">www.aetna.com/pharmacy-insurance/individuals-families</a>	Generic drugs	30% copay with \$10 min and \$100 max (retail)/30% copay \$20 min and \$200 max (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 fertility drugs. PPI and NSA medication classes are limited to a \$20 monthly benefit allowance. Amounts in excess of the \$20 allowance is the responsibility of the member.
	Preferred brand drugs	40% copay with \$10 min and \$100 max (retail)/40% copay with \$20 min and \$200 max (mail order)	Not covered	
	Non-preferred brand drugs	40% copay with \$10 min and \$100 max (retail) /40% copay with \$20 min and \$200 max (mail order)	Not covered	
	Specialty drugs	30% copay with \$10 min and \$100 max (generic)/ 40% copay with \$10 min and \$100 max (brand)	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	None
	Physician/surgeon fees	10% coinsurance	40% coinsurance	20% coinsurance for non-designated providers in Aexcel specialties.
<b>If you need immediate medical attention</b>	Emergency room services	10% coinsurance after \$150 copay per visit, deductible waived	10% coinsurance after \$150 copay per visit, deductible waived	Non-emergency use of emergency room covered at 40% coinsurance after \$150 copay.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Precertification required for non-emergency use.
	Urgent care	\$15 copay per visit	40% coinsurance	Covered for both urgent and non-urgent care.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% coinsurance after \$200 per confinement copay	40% coinsurance after \$200 per confinement copay	None
	Physician/surgeon fee	10% coinsurance	40% coinsurance	20% coinsurance for non-designated providers in Aexcel specialties.
<b>If you have mental health, behavioral health or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$15 copay per visit	40% coinsurance	None
	Mental/Behavioral health inpatient services	10% coinsurance after \$200 per confinement copay	40% coinsurance after \$200 per confinement copay	None
	Substance use disorder outpatient services	\$15 copay per visit	40% coinsurance.	None
	Substance use disorder inpatient services	10% coinsurance after \$200 per confinement copay	40% coinsurance after \$200 per confinement copay	None
<b>If you are pregnant</b>	Prenatal and postnatal care	10% coinsurance	40% coinsurance	20% coinsurance for non-designated providers in Aexcel specialties.
	Delivery and all inpatient services	10% coinsurance after \$200 per confinement copay	40% coinsurance	20% coinsurance for non-designated providers in Aexcel specialties.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
<b>If you need help recovering or have other special health needs</b>	Home health care	10% coinsurance	40% coinsurance	Coverage is limited to 130 visits. Precertification required for out-of-network care.
	Rehabilitation services	\$15 copay per visit	40% coinsurance	Subject to review for medical necessity.
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	10% coinsurance after a \$200 per confinement deductible	40% coinsurance after \$200 per confinement deductible	Coverage is limited to 120 days per calendar year.
	Durable medical equipment	10% coinsurance	40% coinsurance	————— None —————
	Hospice service	10% coinsurance	Not covered	————— None —————
<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

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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**.)

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

**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  | • Chiropractic care (Limited to 20 visits per calendar year)      | • Infertility treatment (Diagnosis & treatment of underlying medical condition) |
| • Bariatric surgery (only covered if performed at an Institute of Quality) | • Hearing aids - 10% coinsurance. \$1,000 per ear every 36 months | • Private-duty nursing  |

**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 1-877-292-2480. 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 1-877-292-2480, 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 1-877-292-2480.  
 Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-292-2480.

如果需要中文的帮助, 请拨打这个号码 1-877-292-2480.  
 Para obtener asistencia en Español, llame al 1-877-292-2480.

*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: \$ 6,570
- Patient pays: \$ 970

**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	\$ 100
Copays	\$ 0
Coinsurance	\$ 720
Limits or exclusions	\$ 150
<b>Total</b>	<b>\$ 970</b>

Note: These numbers assume that patient received all care from in-network Aexcel designated providers (including hospitals), where appropriate. To pay the lowest out-of-pocket costs, in-network Aexcel designated providers should be used.

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

- Amount owed to providers: \$ 5,400
- Plan pays: \$ 4,080
- Patient pays: \$ 1,320

**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	\$ 100
Copays	\$ 150
Coinsurance	\$ 990
Limits or exclusions	\$ 80
<b>Total</b>	<b>\$ 1,320</b>

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.