

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?	Network: Individual \$0 / Family \$0 . Out-of-Network: Individual \$500 / Family \$1,000 . Does not apply to 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 \$1,500 / Family \$3,000 . Out-of-Network: Individual \$2,000 / Family \$4,000 .	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.
Does this plan use a network of providers?	Yes. See www.aetna.com or call 1-800-370-4526 for a list of network providers .	If you use an in-network doctor or other health care provider , 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 provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
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**.)
- 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$10 copay/visit	30% coinsurance	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	\$35 copay/visit	30% coinsurance	—————none—————
	Other practitioner office visit	\$35 copay/visit	30% coinsurance	Coverage is limited to 20 visits per calendar year for Chiropractic care.
	Preventive care /screening /immunization	No charge	30% coinsurance, except adult routine physicals & immunizations, hearing exams, and gynecological exams not covered	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	\$35 copay/visit	30% coinsurance	—————none—————
	Imaging (CT/PET scans, MRIs)	\$50 copay/visit	30% coinsurance	—————none—————

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If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.aetna.com/pharmacy-insurance/individuals-families Premier Plus Three Tier Open Formulary	Generic drugs	Copay/prescription: \$10 (retail), No charge/ prescription (mail order)	Not covered	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for formulary generic FDA-approved women's contraceptives in-network. First prescription must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy Networks. Subsequent fills must be through Aetna Specialty Pharmacy Networks.
	Preferred brand drugs	Copay/prescription: \$20 (retail), \$40 (mail order)	Not covered	
	Non-preferred brand drugs	Copay/prescription: \$35 (retail), \$70 (mail order)	Not covered	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$200 copay/visit	Not covered	—————none—————
	Physician/surgeon fees	No charge	30% coinsurance	—————none—————
If you need immediate medical attention	Emergency room services	\$150 copay/visit	\$150 copay/visit	No coverage for non-emergency use.
	Emergency medical transportation	No charge	No charge	—————none—————
	Urgent care	\$50 copay/visit	30% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 copay/stay	30% coinsurance after \$500 copay/stay	Pre-authorization required for out-of-network care.
	Physician/surgeon fee	No charge	30% coinsurance	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$35 copay/visit	30% coinsurance	—————none—————
	Mental/Behavioral health inpatient services	\$500 copay/stay	30% coinsurance after \$500 copay/stay	Pre-authorization required for out-of-network care.

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	Substance use disorder outpatient services	\$35 copay/visit	30% coinsurance	—————none—————
	Substance use disorder inpatient services	\$500 copay/stay	30% coinsurance after \$500 copay/stay	Pre-authorization required for out-of-network care.
If you are pregnant	Prenatal and postnatal care	No charge	30% coinsurance	—————none—————
	Delivery and all inpatient services	\$500 copay/stay	30% coinsurance after \$500 copay/stay	Includes outpatient postnatal care. Pre-authorization may be required for out-of-network care.
If you need help recovering or have other special health needs	Home health care	No charge	50% coinsurance	Coverage is limited to 120 visits per calendar year. Pre-authorization required for out-of-network care.
	Rehabilitation services	\$35 copay/visit	30% coinsurance	Coverage is limited to 80 visits per calendar year for Physical, Occupational & Speech Therapy combined.
	Habilitation services	\$35 copay/visit	30% coinsurance	Coverage is limited to children up to age 18 for Autism.
	Skilled nursing care	\$500 copay/stay	30% coinsurance after \$500 copay/stay	Coverage is limited to 120 days per calendar year. Pre-authorization required for out-of-network care.
	Durable medical equipment	No charge	30% coinsurance	—————none—————
	Hospice service	\$500 copay/stay for inpatient; no charge for outpatient	30% coinsurance after \$500 copay/stay for inpatient; 30% coinsurance for outpatient	Pre-authorization required for out-of-network care.
If your child needs dental or eye care	Eye exam	No charge	Not covered	Coverage is limited to 1 routine eye exam per 12 months.
	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.)

- | | | |
|---|---|--|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult & Child) | <ul style="list-style-type: none"> • Glasses (Child) • Hearing aids • Long-term care | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Routine foot care • Weight loss programs - Except for required preventive services. |
|---|---|--|

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"> • Chiropractic care - Coverage is limited to 20 visits per calendar year. | <ul style="list-style-type: none"> • Infertility treatment - Coverage is limited to the diagnosis and treatment of underlying medical condition, artificial insemination & ovulation induction to 6 separate attempts per lifetime. | <ul style="list-style-type: none"> • Private-duty nursing - Coverage is limited to 70 - 8 hour shifts per calendar year. • Routine eye care (Adult) - Coverage is limited to 1 routine eye exam per 12 months. |
|---|--|--|

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. 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.

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>

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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 1-800-370-4526.

如果需要中文的帮助, 请拨打这个号码 1-800-370-4526.

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

Dinek'ehgo shika at'ohwol ninisingo, kwijigo 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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Coverage Examples

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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.



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: \$6,440
- Patient pays: \$1,100

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	\$0
Copays	\$900
Coinsurance	\$0
Limits or exclusions	\$200
Total	\$1,100

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

- Amount owed to providers: \$5,400
- Plan pays: \$4,720
- Patient pays: \$680

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	\$0
Copays	\$600
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$680

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.

Submission: Combo ASC-NA-PL-1-14_Part3_fix.xlsx

Imported: 9/9/2016 2:14:00 PM

Analysis:

Last Error Analysis: 9/9/2016 3:59:52 PM

Recalculate

There are no Validation Errors