Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** HMO

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 **1-855-586-6960**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: Individual **$5,750** / Family **$11,500**. Does not apply to network for certain office visits and preventive 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 **$6,600** / Family **$13,200**.	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 and health care this plan doesnt' 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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.aetna.com** or call 1-855-586-6960 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?	Yes, for network **specialists**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
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**.

- **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	$20 copay/visit, deductible waived	Not covered	————————none————————
	Specialist visit	$50 copay/visit	Not covered	————————none————————
	Other practitioner office visit	$50 copay visit for Chiropractic care	Not covered	Coverage is limited to 20 visits for Chiropractic care.
	Preventive care /screening /immunization	No charge	Not covered	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	Lab: 0% coinsurance, X-ray: $100 copay/visit	Not covered	————————none————————
	Imaging (CT/PET scans, MRIs)	$250 copay/visit	Not covered	————————none————————

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** HMO

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 need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.aetna.com/pharmacy-insurance/individuals-families	Preferred generic drugs	$15 copay (retail), $30 copay (mail order)	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Applicable cost share plus difference (brand minus generic cost) applies for brand when generic available. No charge for preferred generic FDA-approved women's contraceptives network. Precertification and step therapy required.
	Preferred brand drugs	$45 copay (retail), $112.50 copay (mail order)	Not covered	
	Non-preferred generic/brand drugs	$75 copay (retail), $225 copay (mail order)	Not covered	
	Specialty drugs	Preferred: 40% coinsurance for up to a 30 day supply; Non-preferred: 50% coinsurance for up to a 30 day supply	Not covered	Aetna Specialty CareRx℠ – First Prescription must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy®. Subsequent fills must be through Aetna Specialty Pharmacy®.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/visit	Not covered	——————none——————
	Physician/surgeon fees	0% coinsurance	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	$250 copay/visit	$250 copay/visit	Copay waived if admitted. OON Emergency Room(ER) cost share same as network. No coverage for non-emergency care.
	Emergency medical transportation	$250 copay/trip	$250 copay/trip	OON services cost share same as network.
	Urgent care	$60 copay/visit	Not covered	No coverage for non-urgent care.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/admission	Not covered	——————none——————
	Physician/surgeon fee	0% coinsurance	Not covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50 copay/visit	Not covered	——————none——————
	Mental/Behavioral health inpatient services	$250 copay/admission	Not covered	——————none——————

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** HMO

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
	Substance use disorder outpatient services	$50 copay/visit	Not covered	——————none——————
	Substance use disorder inpatient services	$250 copay/admission	Not covered	——————none——————
If you are pregnant	Prenatal and postnatal care	Prenatal: No charge; Postnatal: 0% coinsurance	Not covered	——————none——————
	Delivery and all inpatient services	$250 copay/admission	Not covered	——————none——————
If you need help recovering or have other special health needs	Home health care	$250 copay/visit	Not covered	Coverage is limited to 60 visits.
	Rehabilitation services	$50 copay/visit	Not covered	Coverage is limited to 30 visits for Physical Therapy(PT)/Occupational Therapy(OT) combined, and 30 visits for Speech Therapy(ST). Benefit limits are shared between rehabilitation and habilitation services.
	Habilitation services	$50 copay/visit	Not covered	Coverage limited to 30 visits for PT/OT combined, and 30 visits for ST. Benefit limits are shared between rehabilitation and habilitation services.
	Skilled nursing care	$250 copay/admission	Not covered	Coverage is limited to 120 days.
	Durable medical equipment	50% coinsurance	Not covered	——————none——————
	Hospice service	Inpatient: $250 copay/admission, Outpatient: $250 copay/visit	Not covered	——————none——————
If your child needs dental or eye care	Eye exam	No charge	Not covered	Coverage is limited to 1 exam per calendar year.
	Glasses	No charge	Not covered	Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per calendar year.

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
	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.)

- Acupuncture - except as form of anesthesia.
- Bariatric surgery
- Cosmetic surgery - except when medically necessary.
- Dental care (Adult & Child) - except accidental injury.
- Hearing aids
- Infertility treatment - except the diagnosis and surgical treatment of underlying conditions.
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Chiropractic care - limited to 20 visits.

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-586-6960. You may also contact your state insurance department at Commonwealth of Pennsylvania, (717) 783-0442, **www.insurance.pa.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 Insurance Department, Commonwealth of Pennsylvania, (717) 783-0442, **www.insurance.pa.gov**.

Additionally, a consumer assistance program can help you file an **appeal**. Contact: Pennsylvania Consumer Assistance Program, Pennsylvania Insurance Department, Bureau of Consumer Services, 1209 Strawberry Square, Harrisburg, PA 17111, (877) 881-6388, **http://www.pahealthoptions.com**

Language Access Services:

Para obtener asistencia en Español, llame al 1-855-586-6960.

如果需要中文的帮助，请拨打这个号码 1-855-586-6960.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-586-6960.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-586-6960.

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

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:** $2,190
- **Patient pays:** $5,350

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	$5,200
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$5,350**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $50
- **Patient pays:** $5,350

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	$5,270
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$5,350**

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.