

**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 <https://www.aetna.com/sbcsearch/getpolicydocs?u=070100-070020-031646> or by calling 1-888-982-3862.

Important Questions	Answers	Why this Matters:
<b>What is the overall <u>deductible</u>?</b>	In-Network: Individual <b>\$6,350</b> / Family <b>\$12,700</b> . Does not apply to office visits, prescription drugs, and preventive care in-network.	You must pay all the costs up to the <b><u>deductible</u></b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b><u>deductible</u></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><u>deductible</u></b> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <b><u>deductibles</u></b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an <u>out-of-pocket limit</u> on my expenses?</b>	Yes. In-Network: Individual <b>\$6,350</b> / Family <b>\$12,700</b> .	The <b><u>out-of-pocket limit</u></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 <u>out-of-pocket limit</u>?</b>	Premiums, balance-billed charges, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <b><u>out-of-pocket limit</u></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 <u>network of providers</u>?</b>	Yes. See <a href="http://www.aetna.com">www.aetna.com</a> or call 1-888-982-3862 for a list of in-network <b><u>providers</u></b> .	If you use an in-network doctor or other health care <b><u>provider</u></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><u>provider</u></b> for some services. Plans use the term in-network, <b><u>preferred</u></b> , or participating for <b><u>providers</u></b> in their <b><u>network</u></b> . See the chart starting on page 2 for how this plan pays different kinds of <b><u>providers</u></b> .
<b>Do I need a referral to see a <u>specialist</u>?</b>	No.	You can see the <b><u>specialist</u></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><u>excluded services</u></b> .

**Questions:** Call 1-888-982-3862 or visit us at [www.HealthReformPlanSBC.com](http://www.HealthReformPlanSBC.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.HealthReformPlanSBC.com](http://www.HealthReformPlanSBC.com) or call 1-888-982-3862 to request a copy.

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

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



- **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** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

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 visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$30 copay/visit	Not covered	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	\$60 copay/visit	Not covered	—————none—————
	Other practitioner office visit	0% coinsurance	Not covered	Coverage is limited to 20 visits per calendar year for Chiropractic care.
	Preventive care /screening /immunization	No charge	Not covered	Age and frequency schedules may apply.
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	0% coinsurance	Not covered	—————none—————
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not covered	—————none—————

**Questions:** Call 1-888-982-3862 or visit us at [www.HealthReformPlanSBC.com](http://www.HealthReformPlanSBC.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.HealthReformPlanSBC.com](http://www.HealthReformPlanSBC.com) or call 1-888-982-3862 to request a copy.

**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 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 <u>prescription drug coverage</u> is available at <a href="http://www.aetna.com/pharmacy-insurance/individuals-families">www.aetna.com/pharmacy-insurance/individuals-families</a>  Value Plus Four Tier Open Formulary	Preferred generic drugs	Copay/prescription: \$10 (retail), \$20 (mail order)	Not covered	Cover 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for formulary generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written.  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: \$30 (retail), \$60 (mail order)	Not covered	
	Non-preferred generic/brand drugs	Copay/prescription: \$60 (retail), \$120 (mail order)	Not covered	
	Specialty drugs	30% coinsurance up to a \$250 maximum/prescription	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not covered	—————none—————
	Physician/surgeon fees	0% coinsurance	Not covered	—————none—————
<b>If you need immediate medical attention</b>	Emergency room services	0% coinsurance	0% coinsurance	No coverage for non-emergency use.
	Emergency medical transportation	0% coinsurance	0% coinsurance	No coverage for non-emergency transport.
	Urgent care	0% coinsurance	Not covered	No coverage for non-urgent use.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	—————none—————
	Physician/surgeon fee	0% coinsurance	Not covered	—————none—————
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$60 copay/visit	Not covered	—————none—————
	Mental/Behavioral health inpatient services	0% coinsurance	Not covered	—————none—————
	Substance use disorder outpatient services	\$60 copay/visit	Not covered	—————none—————

**Questions:** Call 1-888-982-3862 or visit us at [www.HealthReformPlanSBC.com](http://www.HealthReformPlanSBC.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.HealthReformPlanSBC.com](http://www.HealthReformPlanSBC.com) or call 1-888-982-3862 to request a copy.



**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 an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Substance use disorder inpatient services	0% coinsurance	Not covered	—————none—————
<b>If you are pregnant</b>	Prenatal and postnatal care	No charge	Not covered	—————none—————
	Delivery and all inpatient services	No charge for physician maternity services; 0% coinsurance for facility services	Not covered	Includes outpatient postnatal care.
<b>If you need help recovering or have other special health needs</b>	Home health care	0% coinsurance	Not covered	Coverage is limited to 3 visits per day and 60 visits per calendar year.
	Rehabilitation services	0% coinsurance	Not covered	Coverage is limited to 30 visits per calendar year for Physical, Occupational & Speech Therapy combined.
	Habilitation services	0% coinsurance	Not covered	Coverage is limited to Autism Physical, Occupational & Speech Therapy for children up to age 22; 30 visits per calendar year after age 22, combined with rehabilitation services.
	Skilled nursing care	0% coinsurance	Not covered	Coverage is limited to 60 days per calendar year.
	Durable medical equipment	0% coinsurance	Not covered	—————none—————
	Hospice service	0% coinsurance for inpatient; 20% coinsurance for outpatient	Not covered	—————none—————
<b>If your child needs dental or eye care</b>	Eye exam	No charge	Not covered	Coverage is limited to 1 routine eye exam per 24 months.
	Glasses	Not covered	Not covered	Not covered.
	Dental check-up	Not covered	Not covered	Not covered.

**Questions:** Call 1-888-982-3862 or visit us at [www.HealthReformPlanSBC.com](http://www.HealthReformPlanSBC.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.HealthReformPlanSBC.com](http://www.HealthReformPlanSBC.com) or call 1-888-982-3862 to request a copy.



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

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

**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                 | • Hearing aids                                       | • Routine foot care    |
| • Bariatric surgery           | • Long-term care                                     | • Weight loss programs |
| • Cosmetic surgery            | • Non-emergency care when traveling outside the U.S. |                        |
| • Dental care (Adult & Child) | • Private-duty nursing                               |                        |
| • Glasses (Child)             |  |                        |

**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 - Coverage is limited to 20 visits per calendar year. | • Infertility treatment - Coverage is limited to the diagnosis and treatment of underlying medical condition. | • Routine eye care (Adult) - Coverage is limited to 1 routine eye exam per 24 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 1-888-982-3862. 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).

**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). You may also contact the Florida Department of Financial Services, Division of Consumer Services, (877) 693-5236, <http://www.floir.com/consumers>

**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.**

**Questions:** Call 1-888-982-3862 or visit us at [www.HealthReformPlanSBC.com](http://www.HealthReformPlanSBC.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.HealthReformPlanSBC.com](http://www.HealthReformPlanSBC.com) or call 1-888-982-3862 to request a copy.



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

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

**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.

如果需要中文的帮助, 请拨打这个号码 1-888-982-3862.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 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.*-----

**Questions:** Call 1-888-982-3862 or visit us at [www.HealthReformPlanSBC.com](http://www.HealthReformPlanSBC.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.HealthReformPlanSBC.com](http://www.HealthReformPlanSBC.com) or call 1-888-982-3862 to request a copy.

Coverage Examples

Coverage for: Individual + Family | Plan Type: HMO

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: \$2,120
- Patient pays: \$5,420

**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	\$5,200
Copays	\$20
Coinsurance	\$0
Limits or exclusions	\$200
<b>Total</b>	<b>\$5,420</b>

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

- Amount owed to providers: \$5,400
- Plan pays: \$2,520
- Patient pays: \$2,880

**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	\$2,400
Copays	\$400
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,880</b>

## Coverage Examples

Coverage for: Individual + Family | Plan Type: HMO

## 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.