

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

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


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=082400-010020-081883> or by calling 1-866-253-8885.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	In-network: Individual \$2,500 / Family \$5,000 . Does not apply to certain office visits, preventive care and prescription drugs in-network.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. In-network: Individual \$5,500 / Family \$11,000.	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u>?	Premiums and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <u>network of providers</u>?	Yes. See www.aetna.com or call 1-866-253-8885 for a list of in-network <u>providers</u> .	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u>?	Yes. A written referral is required for most <u>specialist</u> visits.	This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the plan's permission before you see the <u>specialist</u> .
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call 1-866-253-8885 or visit us at 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 or call 1-866-253-8885 to request a copy.

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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** 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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$50 copay/visit, deductible waived	Not covered	_____none_____
	Specialist visit	20% coinsurance	Not covered	_____none_____
	Other practitioner office visit	20% coinsurance for Chiropractic care	Not covered	Coverage is limited to 30 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)	20% coinsurance	Not covered	_____none_____
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	_____none_____
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/Non-preferred generic drugs	\$13 copay for up to a 90 day supply	Not covered	Covers up to a 30 day supply (retail prescription), 31-90 day supply (retail & mail order prescription). Applicable cost share plus difference (brand minus generic cost) applies for brand when generic available unless Dispense as Written. No charge for preferred generic FDA-approved women's contraceptives in-network. Precertification required.
	Preferred brand drugs	50% coinsurance up to a \$100 maximum for up to a 90 day supply	Not covered	
	Non-preferred brand drugs	50% coinsurance up to a \$150 maximum for up to a 90 day supply	Not covered	
	Preferred/non-preferred specialty drugs	Applicable cost as noted above for generic or brand drugs	Not covered	_____none_____

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If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	—————none—————
	Physician/surgeon fees	20% coinsurance	Not covered	—————none—————
If you need immediate medical attention	Emergency room services	20% coinsurance after \$100 copay/visit	20% coinsurance after \$100 copay/visit	Copay waived if admitted. Out-of-network emergency room services cost-share same as in-network. No coverage for non-emergency care.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network cost-share same as in-network.
	Urgent care	20% coinsurance after \$100 copay/visit	20% coinsurance after \$100 copay/visit	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	—————none—————
	Physician/surgeon fee	20% coinsurance	Not covered	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	Not covered	—————none—————
	Mental/Behavioral health inpatient services	20% coinsurance	Not covered	—————none—————
	Substance use disorder outpatient services	20% coinsurance	Not covered	—————none—————
	Substance use disorder inpatient services	20% coinsurance	Not covered	—————none—————
If you are pregnant	Prenatal and postnatal care	Prenatal: No charge; Postnatal: 20% coinsurance	Not covered	—————none—————
	Delivery and all inpatient services	20% coinsurance	Not covered	—————none—————

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If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	—————none—————
	Rehabilitation services	20% coinsurance	Not covered	Coverage is limited to 30 visits each for Physical Therapy, Occupational Therapy, & Speech Therapy.
	Habilitation services	20% coinsurance	Not covered	Other than autism, coverage is limited to 30 visits each for Physical Therapy, Occupational Therapy & Speech Therapy, rehabilitation & habilitation separate.
	Skilled nursing care	20% coinsurance	Not covered	—————none—————
	Durable medical equipment	20% coinsurance	Not covered	—————none—————
	Hospice service	20% coinsurance	Not covered	—————none—————
If your child needs dental or eye care	Eye exam	No charge	Not covered	Coverage is limited to 1 exam every 12 months, through the end of the month after the person attains age 19.
	Glasses	No charge	Not covered	Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses every 12 months, through the end of the month after the person attains age 19.
	Dental check-up	No charge	Not covered	Coverage is limited to 1 exam every 6 months.

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 <u>excluded services</u>.)		
• Abortion - except in cases of rape, incest, or when the life of the mother is endangered. • Acupuncture - except as form of anesthesia. • Cosmetic surgery - except when medically necessary.	• Dental care (Adult) - except accidental injury. • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Routine foot care • Weight loss programs - except for required preventive services.

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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"> • Bariatric surgery • Chiropractic care - Coverage is limited to 30 visits. • Hearing aids - Coverage is limited to 1 per ear every 24 months age 0-16. | <ul style="list-style-type: none"> • Private-duty nursing - Coverage is limited to services provided under home health care benefit. • Routine eye care (Adult) - Coverage is limited to 1 exam every 12 months. |
|---|--|

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 1-866-253-8885. You may also contact your state insurance department at (800) 446-7467, <http://www.state.nj.us/dobi/consumer.htm>

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 New Jersey State Insurance Department, (800) 446-7467, <http://www.state.nj.us/dobi/consumer.htm>

Additionally, a consumer assistance program can help you file your **appeal**. Contact New Jersey State Insurance Department, Office of Consumer Protection Services, NJ Department of Banking and Insurance, P.O. Box 329, Trenton, NJ 08625-0329, (800) 446-7467, <http://www.state.nj.us/dobi/consumer.htm>

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.**

-----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:** \$4,320
- **Patient pays:** \$3,220

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	\$2,500
Copays	\$20
Coinsurance	\$500
Limits or exclusions	\$200
Total	\$3,220

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

- **Amount owed to providers:** \$5,400
- **Plan pays:** \$2,420
- **Patient pays:** \$2,980

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	\$2,400
Copays	\$500
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$2,980

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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.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-253-8885.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 1-859-425-3379, CRCoordinator@aetna.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.

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TTY: 711

Language Assistance:

For language assistance in your language call 1-866-253-8885 at no cost.

Arabic -	1-866-253-8885 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني
Chinese -	欲取得繁體中文語言協助，請撥打 1-866-253-8885，無需付費。
French -	Pour une assistance linguistique en français appeler le 1-866-253-8885 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-866-253-8885 gratis.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-866-253-8885 પર કોલ કરો.
Hindi -	हन्दी में भाषा सहायता के लएि, 1-866-253-8885 पर मुफ्त कॉल करें।
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-866-253-8885.
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-253-8885 번으로 전화해 주십시오.
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-253-8885
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-866-253-8885.
Portuguese -	Para obter assistência linguística em português ligue para o 1-866-253-8885 gratuitamente.
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-253-8885.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-866-253-8885.
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-253-8885 nang walang bayad.
Urdu -	اےریکل گفتفم رپ 1-866-253-8885 میں یکتنو اعامین لیل ریم ودر
Vietnamese -	Đề`được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số` 1-866-253-8885.