



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, you can visit [www.HealthReformPlanSBC.com](http://www.HealthReformPlanSBC.com) or call 1-877-542-3862. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.HealthReformPlanSBC.com](http://www.HealthReformPlanSBC.com) or call 1-877-542-3862 to request a copy

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$0 individual / \$0 family	See the common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <u>deductible</u> ?	Not applicable	You do not have to meet a <u>deductible</u> before services are covered under this <a href="#">plan</a> . But a <u>copayment</u> may apply.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <a href="#">plan</a> ?	<u>Network provider</u> Medical: \$4,500 individual/\$9,000 family; <u>Network provider</u> Prescription Drug: \$2,100 individual/ \$4,200 family. <u>Out-of-Network provider</u> : Not Applicable.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <u>out-of-pocket</u> limits until the overall family <u>out-of-pocket</u> limit has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance billing charges</u> , health care this <a href="#">plan</a> does not cover, <u>copayments</u> and <u>coinsurance</u> on certain services and penalties for failure to obtain precertification.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.aetna.com">www.aetna.com</a> or call 1-877-542-3862 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services, but only if you have a <u>referral</u> before you see the <u>specialist</u> .

Common Medical Event	Services You May Need	What Will You Pay		Limitations, Exceptions & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$15 <u>copay</u> /visit	Not covered	<u>Preauthorization</u> is required for certain services. If you don't get <u>preauthorization</u> , benefits will be denied. Telemedicine is covered at \$0 <u>copay</u> /visit.
	<u>Specialist</u> visit	\$25 <u>copay</u> /visit	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge for x-ray at non-hospital affiliated freestanding facility; \$50 <u>copay</u> /visit at hospital-based facilities \$10 <u>copay</u> /visit at preferred lab; \$50 <u>copay</u> /visit at other lab	Not covered	Preferred laboratories: Quest Diagnostics or LabCorp. All <u>cost-sharing</u> for COVID-19 diagnostic testing, and for health care provider visits ( <u>in and out-of-network</u> ), urgent care visits, and emergency room visits that result in an order for or administration of the test, is waived.
	Imaging (CT/PET scans, MRIs)	No charge at non-hospital affiliated freestanding facility; \$75 <u>copay</u> /visit at hospital-based facilities	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.

Common Medical Event	Services You May Need	What Will You Pay		Limitations, Exceptions & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b>  More information about <u><a href="http://www.express-scripts.com">prescription drug coverage</a></u> is available at <u><a href="http://www.express-scripts.com">www.express-scripts.com</a></u> or call 1-800-939-2142	Generic drugs	\$8 <u>copay</u> /prescription for 30-day supply (retail or mail order); \$16 <u>copay</u> /prescription for 90-day supply (participating retail or mail order)	Reimbursement limited to in- <u>network</u> allowable amount minus applicable <u>copay</u>	Up to 30-day fills at retail or mail order for non-maintenance drugs; 90-day fills for maintenance drugs available at participating pharmacies or mail order only, maintenance drugs filled as 30-day supply incur penalty at fourth fill; under Choice Program, you pay applicable <u>copay</u> plus difference between generic and brand when preferred generic equivalent is available. Erectile dysfunction (ED) drugs are not covered unless medically necessary for conditions other than ED. Prescription drugs with an over-the-counter equivalent are not covered, except for emergency contraception. Qualified members ages 40 - 75 receive generic low to moderate dose statins at no cost. No charge for diabetic supplies purchased through the prescription plan. One copay applies for multiple diabetic medications filled at a 90-day participating retail pharmacy or Express Scripts Pharmacy, if purchased at the same time.
	Preferred brand drugs	\$28 <u>copay</u> /prescription for 30-day supply (retail or mail order); \$56 <u>copay</u> /prescription for 90-day supply (participating retail or mail order)	Reimbursement limited to in- <u>network</u> allowable amount minus applicable <u>copay</u>	
	Non-preferred brand drugs	\$50 <u>copay</u> /prescription for 30-day supply (retail or mail order); \$100 <u>copay</u> /prescription for 90-day supply (participating retail or mail order)	Reimbursement limited to in- <u>network</u> allowable amount minus applicable <u>copay</u>	
	<u>Specialty drugs</u>	<u>Copay</u> based on whether drug is generic, preferred, or non-preferred	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$100 <u>copay</u> /visit outpatient hospital; \$50 <u>copay</u> /visit ambulatory surgery center	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied. Additional benefits for non-emergency, planned surgeries are available through SurgeryPlus.

Common Medical Event	Services You May Need	What Will You Pay		Limitations, Exceptions & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	Physician/surgeon fees	No charge	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> /visit	\$200 <u>copay</u> /visit	In- <u>network</u> provider <u>copayment</u> is waived if admitted. No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	\$50 <u>copay</u> /visit	\$50 <u>copay</u> /visit	No coverage for non-emergency use.
	<u>Urgent care</u>	\$15 <u>copay</u> /visit	Not covered	No coverage for non-urgent use. Telemedicine is covered at \$0 <u>copay</u> /visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 <u>copay</u> /day; \$200 maximum/admission \$100 <u>copay</u> /day; \$200 maximum/admission for elective orthopedic & spine procedures performed at preferred Institutes of Quality (IOQ) or \$500 <u>copay</u> /admission at other facilities \$100 <u>copay</u> /day; \$200 maximum/admission for bariatric surgery performed at preferred IOQ or 25% <u>coinsurance</u> at other facilities	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied. Copayments and coinsurance for bariatric surgery do not accumulate towards the out-of-pocket maximum. Additional benefits for non-emergency, planned surgeries are available through SurgeryPlus. All <u>cost-sharing</u> for COVID-19 treatment provided during an inpatient <u>hospitalization</u> with an in- <u>network</u> provider is waived.
	Physician/surgeon fee	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> /visit	Not covered	None

Common Medical Event	Services You May Need	What Will You Pay		Limitations, Exceptions & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	Inpatient services	\$100 <u>copay</u> /per day; \$200 maximum/ admission	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
If you are pregnant	Office visits	\$25 <u>copay</u> /initial visit; No charge for subsequent prenatal visits	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$100 <u>copay</u> /day; \$200 maximum/admission	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	Not covered	Limited to 45 visits per condition for physical and occupational therapy combined. No visit-limit on physical therapy for treatment of back pain. Coverage is limited to 45 visits per condition for speech therapy. Subject to medical necessity review at 25 visits.
	<u>Habilitation services</u>	Covered same as any other expense based on the type of service performed	Not covered	None
	<u>Skilled nursing care</u>	No charge	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	None
	<u>Hospice services</u>	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	\$15 <u>copay</u> /visit	Not covered	Limited to 1 exam per 24 months. Coverage may be available through EyeMed Vision.

Common Medical Event	Services You May Need	What Will You Pay		Limitations, Exceptions & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	Children's glasses	Not covered	Not covered	You must pay 100% of these expenses. Coverage may be available through EyeMed Vision.
	Children's dental check-up	No charge under Delta Dental or Dominion Dental	20% <u>coinsurance</u> under Delta Dental; not covered under Dominion Dental	Delta Dental: \$1,500 maximum per person per <u>plan</u> year; Dominion Dental: no maximum.

**Excluded Services & Other Covered Services:**

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Glasses
- Long-term care (non-hospice)
- Non-emergency care when traveling outside the U. S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture (in lieu of anesthesia)
- Bariatric surgery
- Chiropractic care, except for treatment of back pain
- Dental care (bone fractures, removal of bony impacted teeth, tumors and odontogenic cysts)
- Hearing aids (3 hearing aids within 36 months for children to age 24; 1 initial hearing aid, 1 replacement and 1 additional if needed due to growth)
- Infertility treatment (lifetime maximum: \$30,000 medical and \$15,000 prescription drug)
- Routine eye care (1 exam per 24 months)
- Employee assistance services through Health Advocate

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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), or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). You can also contact the plan at 1-877-542-3862. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, 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), or Aetna by calling the toll free number on your Medical ID Card. Additionally, a



consumer assistance program can help you file your [appeal](#). Contact information is at <https://www.aetna.com/individuals-families/member-rights-resources/complaints-grievances-appeals.html>

### Does this Coverage Provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the premium tax credit.

### Does this Coverage Meet the Minimum Value Standard? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

### Language Access Services:

Arabic (العربية): إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-489-8933.

Chinese (繁體中文): 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-489-8933.

French (Français): Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-489-8933.

French Creole (Kreyòl Ayisyen): Si w pale Kreyòl Ayisyen, gen sèvis ed pou lang ki disponib gratis pou ou. Rele 1-800-489-8933.

German (Deutsch): Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 1-800-489-8933.

Italian (Italiano): In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-489-8933.

Japanese (日本語): 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-489-8933 まで、お電話にてご連絡ください。

Korean (한국어): 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-489-8933 번으로 전화해 주십시오.

Persian-Farsi (فارسی): اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-489-8933 تماس بگیرید.

Polish (Polski): Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-489-8933.

Portuguese (Português): Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-489-8933.

Russian (Русский): Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-489-8933.

Spanish (Español): Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-489-8933.

Tagalog (Tagalog): Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-489-8933.

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

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The **plan's overall deductible**: \$0
- **Specialist copayment**: \$25
- **Hospital (facility) copayment**: \$100 per day, Maximum \$200 per admission
- **Obstetric care copayment**:

Based on type of service\*

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

#### Cost Sharing

Deductibles	\$0
Copayments	\$400
Coinsurance	\$0

#### What isn't covered

Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$460</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The **plan's overall deductible**: \$0
- **Specialist copayment**: \$25
- **Hospital (facility) copayment**: \$100 per day, Maximum \$200 per admission
- **Diagnostic test (blood work) copayment**: \$10\*\*

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

#### Cost Sharing

Deductibles	\$0
Copayments	\$900
Coinsurance	\$300

#### What isn't covered

Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,260</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The **plan's overall deductible**: \$0
- **Specialist copayment**: \$25
- **Hospital (facility) copayment**: \$100 per day, Maximum \$200 per admission
- **Diagnostic test (x-ray) copayment**: No charge\*\*\*

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

#### Cost Sharing

Deductibles	\$0
Copayments	\$300
Coinsurance	\$50

#### What isn't covered

Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$350</b>

\* \$25 copay/initial visit; no charge for subsequent prenatal visits.

\*\* Assumes member elects a preferred lab.

\*\*\* Assumes member elects a freestanding facility.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.