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 1-866-253-8885.

Important Questions	Answers	Why this Matters
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes, **$550** Individual /**$1500** Family for brand prescription drug coverage. There are no other specific **deductibles**.	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?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out-of-pocket limit?	This plan has no **out-of-pocket limit**.	Not applicable because there's no **out-of-pocket limit** on your expenses.
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 the plan use a network of providers?	Yes. For a list of in-network **providers**, see www.Aetna.com or call 1-866-253-8885.	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.	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 6. 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 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 co-pay per visit	Not covered	——— None ———
	Specialist visit	$60 co-pay per visit	Not covered	——— None ———
	Other practitioner office visit	Not covered	Not covered	Not covered
	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)	$60 co-pay per visit.	Not covered	——— None ———
	Imaging (CT/PET scans, MRIs)	$250 co-pay per visit	Not covered	——— None ———

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 need drugs to treat your illness or condition **More information about prescription drug coverage is available at http://www.aetna.com/pharmacy-insurance/individuals-families/index.html**	Formulary generic drugs	$15 co-pay for up to a 30 day supply, $30 co-pay for up to a 60 day supply; deductible waived	Not covered	Covers up to a 30-day supply (retail or mail order prescription or); 31-60 day supply (retail or mail order prescription). Includes diabetic supplies and contraceptive drugs and devices obtainable from a pharmacy. Includes Mandatory Generics with Dispense as Written (DAW) override. No charge for FDA-approved women's contraceptives in-network. Precertification and Step Therapy required.
	Formulary brand drugs	$40 co-pay for up to a 30 day supply, $80 co-pay for up to a 60 day supply	Not covered	
	Non-formulary drugs	$60 co-pay for up to a 30 day supply, $120 co-pay for up to a 60 day supply	Not covered	
	Specialty drugs (e.g., self-injectable)	25% co-insurance after deductible	Not covered	———— None ————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$550 co-pay per procedure	Not covered	———— None ————
	Physician/surgeon fees	No charge	Not covered	———— None ————
If you need immediate medical attention	Emergency room services	$250 co-pay per visit	Paid as in-network	Copay is waived if admitted. No coverage for non-emergency care.
	Emergency medical transportation	No charge	Paid as in-network	———— None ————
	Urgent care	$200 co-pay per visit.	Not covered	No coverage for non-urgent care.

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 have a hospital stay	Facility fee (e.g., hospital room)	$600 copay per day for the first 5 days per admission	Not covered	——— None ———
	Physician/surgeon fee	No charge	Not covered	——— None ———
If you have mental health, behavioral health or substance abuse needs	Mental/Behavioral health outpatient services	Not covered	Not covered	Not covered
	Mental/Behavioral health inpatient services	Not covered	Not covered	Not covered
	Substance use disorder outpatient services	Not covered	Not covered	Not covered
	Substance use disorder inpatient services	Not covered	Not covered	Not covered
If you are pregnant	Prenatal and postnatal care	Prenatal care:No charge; Postnatal care: $50 co-pay	Not covered	——— None ———
	Delivery and all inpatient services	$600 co-pay per day for the first 5 days per admission	Not covered	——— None ———

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 need help recovering or have other special health needs	Home health care	$60 co-pay per visit	Not covered	Coverage is limited to 60 visits
	Rehabilitation services	$60 co-pay per visit	Not covered	Coverage is limited to 60 day consecutive period per incident of illness/injury for PT/OT/ST combined.
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	$600 co-pay per day for the first 5 days per admission	Not covered	Coverage is limited to 60 days. Copay is waived if a member is transferred from a hospital to a skilled nursing facility.
	Durable medical equipment	50% of cost per item	Not covered	Coverage is limited to $1000 annual maximum.
	Hospice service	Inpatient:$600 co-pay per day for the first 5 day per admission; Outpatient:$60 co-pay per visit	Not covered	Coverage is limited to 60 days. Copay is waived if a member is transferred from a hospital to a hospice facility.
If your child needs dental or eye care	Eye exam	No charge	Not covered	Coverage is limited to one exam per 24 months.
	Glasses	No charge	Not covered	Coverage is limited to $100 reimbursement maximum per 24 months.
	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	• Bariatric surgery	• Chiropractic care
• Cosmetic surgery	• Dental care (Adult & Child)	• Habilitation services
• Infertility treatment	• Long-term care	• Mental/Behavioral services (IP/OP)
• Non-emergency care when traveling outside the U.S.	• Private-duty nursing	• Routine foot care
• Substance use disorder services (IP/OP)	• 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.)		
• Hearing Aid (Adult) is limited to 1 hearing aid per ear every 36 months up to $200 per hearing aid; no coverage first 12 months.	• Hearing Aid (Children Under 24) is limited to 1 hearing aid, per ear every 3 years up to a maximum of $1,000 per hearing aid.	• Routine eye care (Adult) coverage is limited to one exam per 24 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, Pennsylvania Insurance Department 1326 Strawberry Square Harrisburg, Pennsylvania 17120, 717-783-0442, Toll Free In State Only 877-881-6388

Your Grievance and Appeals Rights:

- If you have a complaint or are dissatisfied with a denial or 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: Aetna at 1-866-253-8885, you may also contact Pennsylvania Insurance Department 1326 Strawberry Square Harrisburg, Pennsylvania 17120, 717-783-0442, Toll Free In State Only 877-881-6388
- Additionally, a consumer assistance program can help you file your **appeal**. Contact: Pennsylvania Department of Insurance at (877) 881-6388 or www.insurance.pa.gov

Language Access Services:

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-253-8885.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-253-8885.
如果需要中文的帮助，请拨打这个号码 1-866-253-8885.
Para obtener asistencia en Español, llame al 1-866-253-8885.

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 will also 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:** $ 5,490
- **Patient pays:** $ 2,050

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	$ -
Co-pays	$ 1,900
Co-insurance	$ -
Limits or exclusions	$ 150
Total	**$ 2,050**

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

- **Amount owed to providers:** $ 5,400
- **Plan pays:** $ 3,440
- **Patient pays:** $ 1,960

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	$ -
Co-pays	$ 1,240
Co-insurance	$ 640
Limits or exclusions	$ 80
Total	**$ 1,960**

Note: Your plan may have both **copayments** and **coinsurance** for covered services, if so, these examples use **copayments** only. Your costs may be higher.

Questions and answers about 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 policy 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 these conditions 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 for 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 also should 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.