

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

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



**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](http://www.HealthReformPlanSBC.com) or by calling 1-888-982-3862.

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	Maximum Savings: Individual <b>\$250</b> / Family <b>\$500</b> . Standard Savings: Individual <b>\$1,500</b> / Family <b>\$3,000</b> . Out-of-Network: Individual <b>\$3,000</b> / Family <b>\$6,000</b> . Does not apply to office visits, prescription drugs, emergency care, and preventive care in-network.	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</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>deductible</b> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an out-of-pocket limit on my expenses?</b>	Yes. Maximum Savings: Individual <b>\$1,000</b> / Family <b>\$2,000</b> . Standard Savings: Individual <b>\$3,000</b> / Family <b>\$6,000</b> . Out-of-Network: Individual <b>\$5,000</b> / Family <b>\$10,000</b> .	The <b>out-of-pocket limit</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 out-of-pocket limit?</b>	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for service, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</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 network of providers?</b>	Yes. See <a href="http://www.aetna.com">www.aetna.com</a> or call 1-888-982-3862 for a list of Maximum Savings <b>providers</b> .	If you use an in-network doctor or other health care <b>provider</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>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
<b>Do I need a referral to see a specialist?</b>	No.	You can see the <b>specialist</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>excluded services</b> .

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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 Maximum Savings **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Maximum Savings Provider	Your Cost If You Use a Standard Savings 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	\$30 copay/visit	20% coinsurance	—————none—————
	Specialist visit	\$25 copay/visit	\$40 copay/visit	20% coinsurance	Includes Internist, General Physician, Family Practitioner or Pediatrician if the physician is not the member's selected PCP.
	Other practitioner office visit	\$25 copay/visit	\$40 copay/visit	20% coinsurance	Coverage is limited to 40 visits per calendar year for Chiropractic care.
	Preventive care/ screening/ immunization	No charge	No charge	20% coinsurance, except deductible waived for gynecological exams	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for laboratory; \$25 copay/visit for x-ray	No charge for laboratory; \$40 copay/visit for x-ray	20% coinsurance	—————none—————
	Imaging (CT/PET scans, MRIs)	\$25 copay/visit	\$40 copay/visit	20% coinsurance	—————none—————

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Common Medical Event	Services You May Need	Your Cost If You Use a Maximum Savings Provider	Your Cost If You Use a Standard Savings 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>  Premier Plus Three Tier Open Formulary	Generic drugs	Not applicable	Copay/prescription: \$10 for 30 day supply (retail), \$20 for 31-90 day supply (retail & mail order)	20% coinsurance (retail)	Covers 30 day supply (retail), 31-90 day supply (participating retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for formulary generic FDA-approved women's contraceptives in-network.
	Preferred brand drugs	Not applicable	Copay/prescription: \$25 for 30 day supply (retail), \$50 for 31-90 day supply (retail & mail order)	20% coinsurance (retail)	
	Non-preferred brand drugs	Not applicable	Copay/prescription: \$40 for 30 day supply (retail), \$80 for 31-90 day supply (retail & mail order)	20% coinsurance (retail)	
	Specialty drugs	Not applicable	Applicable cost as noted above for generic or brand drugs.	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	0% coinsurance	20% coinsurance	—————none—————
	Physician/surgeon fees	0% coinsurance	0% coinsurance	20% coinsurance	—————none—————
<b>If you need immediate medical attention</b>	Emergency room services	\$100 copay/visit	\$150 copay/visit	\$150 copay/visit	No coverage for non-emergency use.
	Emergency medical transportation	No charge	No charge	No charge	No coverage for non-emergency transport.
	Urgent care	\$100 copay/visit	\$150 copay/visit	20% coinsurance	No coverage for non-urgent use.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	0% coinsurance	\$150 copay/stay, after deductible	20% coinsurance	Pre-authorization required for out-of-network care.
	Physician/surgeon fee	0% coinsurance	0% coinsurance	20% coinsurance	—————none—————

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<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$25 copay/visit	\$25 copay/visit	20% coinsurance	—————none—————
	Mental/Behavioral health inpatient services	0% coinsurance	\$150 copay/stay, after deductible	20% coinsurance	Pre-authorization required for out-of-network care.
	Substance use disorder outpatient services	\$25 copay/visit	\$25 copay/visit	20% coinsurance	—————none—————
	Substance use disorder inpatient services	0% coinsurance	\$150 copay/stay, after deductible	20% coinsurance	Pre-authorization required for out-of-network care.
<b>If you are pregnant</b>	Prenatal and postnatal care	No charge	No charge	20% coinsurance	—————none—————
	Delivery and all inpatient services	\$25 copay for physician maternity services; 0% coinsurance for facility services	\$40 copay for physician maternity services; \$150 copay/stay, after deductible for facility services	20% coinsurance	Includes outpatient postnatal care. Pre-authorization may be required for out-of-network care.
<b>If you need help recovering or have other special health needs</b>	Home health care	No charge	0% coinsurance	20% coinsurance	Pre-authorization required for out-of-network care.
	Rehabilitation services	\$25 copay/visit	\$40 copay/visit	20% coinsurance	Coverage is limited to treatment for 60 consecutive days per incident for Physical, Occupational & Speech Therapy combined.
	Habilitation services	\$25 copay/visit	\$40 copay/visit	20% coinsurance	Coverage is limited to treatment of Autism.
	Skilled nursing care	0% coinsurance	\$150 copay/stay, after deductible	20% coinsurance	Pre-authorization required for out-of-network care.
	Durable medical equipment	No charge	No charge	20% coinsurance	Pre-authorization required for out-of-network services over \$1,500.

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	Hospice service	0% coinsurance for inpatient; no charge for outpatient	\$150 copay/stay, after deductible for inpatient; 0% coinsurance for outpatient	20% coinsurance	Pre-authorization required for out-of-network care.
<b>If your child needs dental or eye care</b>	Eye exam	No charge	No charge	20% coinsurance	Coverage is limited to 1 routine eye exam per 24 months.
	Glasses	Not applicable	Not covered	Not covered	Not covered.
	Dental check-up	Not applicable	Not covered	Not covered	Not covered.

**Excluded Services & Other Covered Services:**

<b>Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u>.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult &amp; Child)</li> <li>• Glasses (Child)</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>

<b>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.)</b>		
<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Chiropractic care - Coverage is limited to 40 visits per calendar year.</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids - Coverage is limited to 1 hearing aid to a maximum of \$1,400 per ear per 36 months for children under age 19.</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment - Coverage is limited to the diagnosis and treatment of underlying medical condition.</li> <li>• Routine eye care (Adult) - Coverage is limited to 1 routine eye exam per 24 months.</li> </ul>

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs****Coverage for: Individual + Family | Plan Type: POS****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 Department of Professional & Financial Regulation, Bureau of Insurance, (207) 624-8475, [www.maine.gov/pfr/insurance](http://www.maine.gov/pfr/insurance).

Additionally, a consumer assistance program can help you file your **appeal**. Contact Maine Health Insurance Consumer Assistance Program (MHICAP), PO Box 2490, Augusta, ME 04338, (800) 965-7476, <http://www.maineahc.org>

**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.**

**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.-----

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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: \$7,020
- Patient pays: \$520

#### 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	\$300
Copays	\$20
Coinsurance	\$0
Limits or exclusions	\$200
<b>Total</b>	<b>\$520</b>

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

- Amount owed to providers: \$5,400
- Plan pays: \$4,520
- Patient pays: \$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	\$300
Copays	\$500
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$880</b>

## 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.