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

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

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 **1-855-586-6963**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: Individual **$750** / Family **$1,500**. Out–of–Network: Individual **$1,000** / Family **$2,000**. Does not apply to office visits, prescription drugs, emergency care, and preventive care in-network.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**.
Are there other deductibles for specific services?	No.	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?	Yes. In-Network: Individual **$2,000** / Family **$4,000**. Out–of–Network: Individual **$3,000** / Family **$6,000**.	The **out-of-pocket limit** 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 out-of-pocket limit?	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 **out-of pocket limit**.
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 this plan use a network of providers?	Yes. See **www.aetna.com** or call 1-855-586-6963 for a list of in-network **providers**.	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?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	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 **excluded services**.

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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	$25 copay/visit	20% coinsurance	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	$35 copay/visit	20% coinsurance	——————none——————
	Other practitioner office visit	$35 copay/visit	20% coinsurance	Coverage is limited to 20 visits per calendar year for acupuncture.
	Preventive care /screening /immunization	No charge	20% coinsurance	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	$50 copay/visit	20% coinsurance	——————none——————

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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 www.aetna.com/pharmacy-insurance/individuals-families Premier Plus Four Tier Open Formulary	Generic drugs	Copay/prescription: $10 for 30 day supply (retail), $20 for 31-90 day supply (retail & mail order)	20% coinsurance after copay/prescription: $10 (retail)	Covers 30 day supply (retail), 31-90 day supply (participating retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for formulary generic FDA-approved women's contraceptives in-network.
	Preferred brand drugs	Copay/prescription: $35 for 30 day supply (retail), $70 for 31-90 day supply (retail & mail order)	20% coinsurance after copay/prescription: $35 (retail)	
	Non-preferred brand drugs	Copay/prescription: $50 for 30 day supply (retail), $100 for 31-90 day supply (retail & mail order)	20% coinsurance after copay/prescription: $50 (retail)	
	Specialty drugs	Copay/prescription: $75 (retail), $150 (mail order)	Not covered	Precertification required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	$100 copay/visit	$100 copay/visit	No coverage for non-emergency use.
	Emergency medical transportation	20% coinsurance	20% coinsurance	No coverage for non-emergency transport.
	Urgent care	$25 copay/visit	20% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	——————none——————

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

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 mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 copay/visit	20% coinsurance	————————none————————
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
	Substance use disorder outpatient services	$35 copay/visit	20% coinsurance	————————none————————
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	————————none————————
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Includes outpatient postnatal care. Pre-authorization may be required for out-of-network care.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Coverage is limited to 120 visits per calendar year. Pre-authorization required for out-of-network care.
	Rehabilitation services	$35 copay/visit	20% coinsurance	————————none————————
	Habilitation services	$35 copay/visit	20% coinsurance	Coverage is limited to treatment of Autism.
	Skilled nursing care	20% coinsurance	40% coinsurance	Coverage is limited to 100 days per calendar year. Pre-authorization required for out-of-network care.
	Durable medical equipment	No charge	20% coinsurance	————————none————————
	Hospice service	20% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
If your child needs dental or eye care	Eye exam	No charge	20% coinsurance	Coverage is limited to 1 routine eye exam per 12 months.
	Glasses	Not covered	Not covered	Not covered.
	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.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- 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.)

- Acupuncture - Coverage is limited to 20 visits per calendar year.
- Bariatric surgery
- Chiropractic care
- Hearing aids - Coverage is limited to 1 hearing aid to a maximum of $1,400 per ear per 36 months for children up to age 19.
- Infertility treatment - Coverage is limited to the diagnosis and treatment of underlying medical condition, artificial insemination, ovulation induction, and advanced reproductive technology.
- Routine eye care (Adult) - Coverage is limited to 1 routine eye exam per 12 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 1-855-586-6963. 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**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **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**. You may also contact the Department of Professional & Financial Regulation, Bureau of Insurance, (207) 624-8475, **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.mainecahc.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 1-855-586-6963.

如果需要中文的帮助，请拨打这个号码 1-855-586-6963.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-586-6963.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-586-6963.

----------*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 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:** $5,820
- **Patient pays:** $1,720

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	$800
Copays	$20
Coinsurance	$700
Limits or exclusions	$200
Total	**$1,720**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,020
- **Patient pays:** $1,380

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	$800
Copays	$500
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,380**

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.

Supplemental Information **Coverage for:** Individual + Family | **Plan Type:** PPO

How is the overall deductible or out-of-pocket limit met?	Individual **deductible** and **out-of-pocket limit** payments apply to the family **deductible** and **out-of-pocket limit**.	The family **deductible** and family **out-of-pocket limit** are cumulative for all family members. The family **deductible** and **out-of-pocket limit** can be met by a combination of family members; however no single individual within the family will be subject to more than the individual **deductible** or **out-of-pocket limit** amount.

How your out-of-network care is reimbursed:

We cover the cost of services based on whether doctors are "in-network" or "out-of-network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

You may choose a **provider** (doctor or hospital) in our **network**. You may choose to visit an out-of-network **provider**. If you choose a doctor who is out-of-network, your Aetna health **plan** may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "**allowed**" **amount**.

Professional Services: 105% of Medicare	Facility Services: 140% of Medicare

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna **plan** "recognizes." Your doctor may bill you for the dollar amount that your **plan** doesn't "recognize." You must also pay any **copayments**, **coinsurance** and **deductibles** under your **plan**. No dollar amount above the "recognized charge" counts toward your **deductible** or **out-of-pocket limit**. To learn more about how we pay out-of-network benefits, visit www.aetna.com. Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's **network** of health care **providers**. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator® member site.

Supplemental Information **Coverage for:** Individual + Family | **Plan Type:** PPO

This applies when you *choose* to get care out-of-network. When you have no choice (for example: emergency room visit after a car accident or for other **emergency services**), we will pay the bill as if you got care in-network. You pay cost sharing and **deductibles** for your in-network level of benefits. Contact Aetna if your health care **provider** asks you to pay more. You are not responsible for any outstanding **balance billed** by your **providers** for **emergency services** beyond your cost sharing and **deductibles**.

Other important information about your plan:

This **plan** does not cover all health care expenses and includes exclusions and limitations. Members should refer to their **plan** documents to determine which health care services are covered and to what extent.

Additional information regarding your **plan** is available in the Disclosure Document on www.aetna.com.

Information includes:

- "Knowing what is covered" which describes how we review a request for coverage for a service or supply
- "**Prescription drug** benefit" which describes procedures we use to manage **prescription drug** benefits. These procedures include how to obtain a list of covered drugs and the exception policy for receiving coverage of a drug that is not on a closed formulary

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and **health insurance plans** contain exclusions and limitations. Not all health services are covered.

See **plan** documents for a complete description of benefits, exclusions, limitations and conditions of coverage. **Plan** features and availability may vary by location and are subject to change. You may be responsible for the health care **provider's** full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the **plan**. **Providers** are independent contractors and are not agents of Aetna. **Provider** participation may change without notice. We do not provide care or guarantee access to health services.

The following is a partial list of services and supplies that are generally not covered. However, your **plan** documents may contain exceptions to this list based on state mandates or the **plan** design or rider(s) purchased by you or your employer.

Supplemental Information

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

- All medical and hospital services not specifically covered in, or which are limited or excluded by your **plan** documents
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for **medically necessary** routine patient care costs for members participating in a cancer clinical trial with respect to the treatment of cancer or other life-threatening disease or condition.
- Home births
- Immunizations for travel or work except where **medically necessary** or indicated
- Implantable drugs and certain injectable drugs including injectable infertility drugs
- Long-term rehabilitation therapy
- Non-**medically necessary** services or supplies
- Orthotics except diabetic orthotics
- Outpatient **prescription drugs** (except for treatment of diabetes), unless covered by a prescription **plan** rider and over-the-counter medications (except as provided in a hospital) and supplies
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling or **prescription drugs**
- Therapy or rehabilitation other than those listed as covered

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

We consider your personal information to be private. We have policies and procedures in place to protect your personal information from unlawful use and disclosure. For a summary of our policy, go to www.aetna.com. You'll find the Privacy Notices link at the bottom of the page.

Plan features and availability may vary by location and group size.

Colorado Supplement to the Summary of Benefits and Coverage Form

Aetna Life Insurance Company
Name of Carrier

Open Choice®
Name of Plan

Large Employer Group Policy
Policy Type

TYPE OF COVERAGE

1. TYPE OF PLAN	PPO
2. OUT-OF-NETWORK CARE COVERED?[1]	Yes; but patient pays more for out-of-network care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado.

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits and Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description	What this means.
4. Deductible Period	Calendar Year	Calendar year deductibles restart each January
5. Annual Deductible Type	Individual/Family	Individual means the deductible amount you and each individual covered by the plan will have to pay for allowable covered expenses before the carrier will cover those expenses. Family is the maximum deductible amount that is required to be met for all family members covered by the plan. It may be an aggregated amount (e.g., $3,000 per family) or specified as the number of individual deductibles that must be met (e.g., 3 deductibles per family).
6. What cancer screenings are covered?	Prostate Cancer Screening Cervical Cancer Screening Breast Cancer Screening Colorectal Cancer Screening	• Age and Frequency schedule may apply • Age and Frequency schedule may apply • Age and Frequency schedule may apply • Age and Frequency schedule may apply

LIMITATIONS AND EXCLUSIONS

7. Period during which pre-existing conditions are not covered for covered person age 19 and older [2]	Not applicable, plan does not impose limitation periods for pre-existing conditions.
8. How does the policy define a "pre-existing condition"?	Not applicable, Plan does not exclude coverage of pre-existing conditions.
9. Exclusionary Riders. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No

USING THE PLAN

	IN-NETWORK	**OUT-OF-NETWORK**
10. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, refer to your certificate of coverage for details.
11. Does the plan have a binding arbitration clause?	No	

Questions: Call 1-888-982-3862, TDD 1-800-628-3323 (hearing impaired only) or visit www.Aetna.com.

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance
Consumer Affairs Section
1560 Broadway, Suite 850, Denver, CO 80202
Call 303-894-7490 (in state, toll free: 800-930-3745)
Email: insurance@dora.state.co.us

Endnotes:

1 "Network"refers to a specified group of physicians, hospitals, medical clinics and other health care providers this plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).
2 Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

Colorado Access Disclosure:

Aetna maintains and makes available to interested parties upon request a managed care network access plan on its business premises. The managed care network access plan demonstrates the managed care network contains an adequate number of accessible acute care hospitals, primary care providers, and specialists available to provide covered health care services. Among other things, the access plan describes Aetna's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of plan enrollees.

This document is available in other languages. Do you need this in another language? Call us.
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-877-287-0117.

Si necesita asistencia lingüistica en español, llámenos al número que figura en su tarjeta de identificación (ID) médica.
Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-877-287-0117.