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SCHOOLS HEALTH INSURANCE FUND: QPOS® - Burlington Twp BOE \$10

Coverage for: Individual + Family | Plan Type: POS



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-370-4526 to request a copy.

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	Participating: Individual \$0 / Family \$0. Non-Participating: Individual \$200 / Family \$400.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Emergency care, inpatient hospital services & outpatient hospital services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	Participating: Individual \$4,000 / Family \$8,000. Non-Participating: Individual \$1,000 / Family \$2,000.	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 <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of <u>participating 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 charge</u> and what your <u>plan pays (balance billing)</u> . Be aware, your <u>network provider might</u> use an <u>out-of-network provider for some services (such as lab work). Check with your <u>provider before you get services</u>.</u>
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> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

		What You	Will Pay	Limitations, Exceptions & Other Important Information	
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)		
	Primary care visit to treat an injury or illness	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	20% coinsurance	None	
If you visit a health care provider's office	<u>Specialist</u> visit	\$15 <u>copay/</u> visit, <u>deductible</u> doesn't apply	20% coinsurance	None	
or clinic	Preventive care / screening / immunization	No charge	No charge up to \$150; 20% coinsurance thereafter	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed 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 laboratory; \$15 <u>copay</u> /visit for x-ray, <u>deductible</u> doesn't apply	No charge	None	
	Imaging (CT/PET scans, MRIs) \$15 copay/visit, deductible doesn't apply No charge		None		
If you need drugs to	Generic drugs	Not covered	Not covered	Not covered.	
treat your illness or condition	Preferred brand drugs	Not covered	Not covered	Not covered.	
	Non-preferred brand drugs	Not covered	Not covered	Not covered.	
More information about prescription drug coverage is available at www.aetna.com/pharma cy-insurance/individuals-families	Specialty drugs	Not covered	Not covered	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	None	
Surgery	Physician/surgeon fees	No charge	No charge	None	
If you need immediate medical attention	Emergency room care	\$50 <u>copay/</u> visit, <u>deductible</u> doesn't apply	\$50 <u>copay/</u> visit, <u>deductible</u> doesn't apply	No coverage for non-emergency use.	
modical attorition	Emergency medical transportation	No charge	No charge	No coverage for non-emergency transport.	

		What You	Will Pay		
Common Medical Event Services You May Need		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information	
	<u>Urgent care</u>	\$15 <u>copay/</u> visit, <u>deductible</u> doesn't apply	20% coinsurance	None	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	<u>Pre-authorization</u> required for <u>out-of-network</u> care.	
otay	Physician/surgeon fees	No charge	No charge	None	
If you need mental health, behavioral health, or substance	Outpatient services	Office & other outpatient services: \$15 copay/visit, deductible doesn't apply	Office & other outpatient services: 20% coinsurance	None	
abuse services	Inpatient services	No charge	No charge	<u>Pre-authorization</u> required for <u>out-of-network</u> care.	
	Office visits	No charge	20% coinsurance	Cost sharing doesn't apply to certain	
If you are pregnant	Childbirth/delivery professional services	\$15 copay/pregnancy, deductible doesn't apply	20% coinsurance	preventive services. Maternity care may include tests & services described elsewhere in	
	Childbirth/delivery facility services	No charge	No charge	the SBC (i.e. ultrasound). <u>Pre-authorization</u> required for out-of-network care may apply.	
If you need help recovering or have other special health needs	Home health care	No charge	No charge	60 visits/calendar year for <u>out-of-network</u> . <u>Pre-authorization</u> required for <u>out-of-network</u> care.	
	Rehabilitation services	\$15 copay/visit, deductible doesn't apply	No charge	Limited to treatment for 60 consecutive days/condition in-network for Physical, Occupational & Speech Therapy combined.	
	<u>Habilitation services</u>	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	No charge	Limited to treatment of Autism.	
	Skilled nursing care	No charge	No charge	120 days/calendar year. <u>Pre-authorization</u> required for <u>out-of-network</u> care.	
	Durable medical equipment	20% coinsurance after out-of-network deductible	20% coinsurance	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.	
	Hospice services	No charge	No charge for inpatient; 20% <u>coinsurance</u> for outpatient	Pre-authorization required for out-of-network care.	

			Will Pay		
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information	
If your child needs	Children's eye exam	\$15 <u>copay/</u> visit, <u>deductible</u> doesn't apply	Not covered	1 routine eye exam/12 months up to age 19 & 1 routine eye exam/24 months after age 19.	
dental or eye care	Children's glasses	No charge	No charge	\$70 maximum/24 months.	
	Children's dental check-up	Not covered	Not covered	Not covered.	

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
- Dental care (Adult & Child)
- Long-term care

- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- Private-duty nursing

- Routine foot care
- Weight loss programs Except for required preventive services.

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

- Acupuncture Limited to medical necessity.
- Bariatric surgery Limited to in-network only.
- Chiropractic care 20 visits/calendar year for

in-network

Hearing aids - 1 hearing aid to \$1,000 maximum per ear/24 months for children under age 16 for in-network only.

 Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, artificial insemination & ovulation induction. Advanced reproductive technology: 4 complete egg

retrievals/lifetime.

Routine eye care (Adult) - 1 routine eye exam/12 months up to age 19 & 110utine eye exam/24 months after age 19 in-network only.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends.

- For more information on your rights to continue coverage, contact the **plan** at 1-800-370-4526.
- If your group health coverage 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.
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.
- If your coverage is a church <u>plan</u>, church <u>plans</u> are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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 or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact us directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.

- If your group health coverage 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.
- For non-federal governmental group health **plans**, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan Meet Minimum Value Standard? No.

If your <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$0
Specialist copayment	\$15
Hospital (facility) copayment	\$0
Other copayment	\$0

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)

Managing Joe's type 2 Diabetes

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

■ The <u>plan's overall deductible</u>	\$0
Specialist copayment	\$15
■ Hospital (facility) copayment	\$0
Other <u>copayment</u>	\$0

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)

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
Specialist copayment	\$15
■ Hospital (facility) <u>copayment</u>	\$0
Other copayment	\$0

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
Diagnostic test (x-ray)

Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

opodialist visit (arrostriosia)		Darable medical equipment (gracese m	7.01)		
Total Example Cost	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900
In this example, Peg would pay:	nis example, Peg would pay: In this example, Joe would pay:		In this example, Mia would pay:		
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$50	Copayments	\$100	Copayments	\$100
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$100	Limits or exclusions	\$6,000	Limits or exclusions	\$0
The total Peg would pay is	\$150	The total Joe would pay is	\$6,100	The total Mia would pay is	\$100

Note: If your <u>plan</u> has a wellness program and you choose to participate, you may be able to reduce your costs.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

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 859-425-3379, CRCoordinator@aetna.com.

California HMO/HNO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY 711, Fax 860-262-7705, 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 http://www.hhs.gov/ocr/office/file/index.html.

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TTY: 711

Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian -Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526. ለቋንቋ እንዛ በ አማርኛ በ 1-800-370-4526 በነጻ ይደውሉ Amharic -للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 4526-370-370-1-Arabic -Armenian -Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-370-4526 առանց գնով։ Bahasa Indonesia -Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya. Bantu-Kirundi -Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa Bengali-Bangala -Bisayan-Visayan -Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad. Burmese -número gratuït 1-800-370-4526. Chamorro -Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu. Cherokee -ΘοΌν Θ \$ (2h ΔοΌλ ΛΙΑΘΌ ΡΟΌν Θτ Τ (GWV) Φ b W6" \$ 1-800-370-4526 Ο ΘΤ L ΑΓΟΌλ ΔΕ GP ΛΙΑΡΑΘ. 欲取得繁體中文語言協助,請撥打1-800-370-4526,無需付費。 Chinese -Choctaw -(Chahta) anumpa ya apela a chi I paya hinla 1-800-370-4526. Cushite -Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa. Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526. Dutch -French -Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais. French Creole -Pou jwenn asistans nan lang Kreyòl Avisyen, rele nimewo 1-800-370-4526 gratis. German -Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an. Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση. Greek -Gujarati -

Hawaiian -	No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki 'ole 'ia kēia kōkua nei.			
Hindi -	=====================================			
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.			
Ibo -	Maka enyemaka asusu na Igbo kpọọ 1-800-370-4526 na akwughi ugwo o bula			
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.			
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.			
Japanese -	日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。			
Karen -	$v>w>frRp>Rw>fuwdRusd.ft*D>f\ usd.f\ ud;\ 1-800-370-4526\ v>wtd.f'D;w>fv>mfbl.fv>mfphRb.f$			
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526번으로 전화해 주십시오.			
Kru-Bassa -	Ɓέ m̀ ké gbo-kpá-kpá dyé pídyi dé Ɓǎsɔ́ɔ̀-wùdùǔn w̃εε, dá 1-800-370-4526			
Kurdish -	برای راهنمایی به زبان فارسی با شماره 4526-370-800 به خور ایی پهیوهندی بکهن.			
Laotian - 4526 Marathi -				
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.			
Micronesian- Pohnpeyan - Mon-Khmer, Cambodian -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.			
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526			
Nepali -	(
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-800-370-4526 kecïn aγöc.			
Norwegian -	For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.			
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।			
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.			
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.			
Persian -	برای راهنمایی به زبان فارسی با شماره فره -370-370 بدون هیچ هزینه ای تماس بگیرید. انگلیسی			

Portuguese - Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-370-4526

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-370-4526 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-370-4526. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.

ته شخد هِنُه به شَمْونهُ عَمِ مُنْفِلُت مُنْفُون مُص مُل مُحَفّه د معد المر 370-4526-370 نُحِم.

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-800-370-4526 'o 'ikai hā tōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.

ا رورک ل کتف م رب ₁₋₈₀₀₋₃₇₀₋₄₅₂₆ عول کتن و اعمون مل ل روم و در

Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-800-370-4526 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan rárá.