aetna **Aetna Value Network**

Coverage Period: 11/01/2012 - 10/31/2013

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

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

THE ROCK CHURCH AND THE ROCK ACADEMY

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 documents at www.HealthReformPlanSBC.com or by calling the toll free number on your ID card (1-888-982-3862 for prospective members).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For each Calendar Year, In-network: Individual **$0** / Family **$0**.	See the chart starting on page 2 for your costs for services this plan covers.
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 **$1,500** / Family **$3,000**.	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, and health care this plan doesn't 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. For a list of in-network **providers**, see www.aetna.com or call 1-888-982-3862.	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, for in-network **specialists**.	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 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	$10 copay per visit	Not covered	Includes services of an internist, general physician, family practitioner or pediatrician.
	Specialist visit	$10 copay per visit	Not covered	——— None ———
	Other practitioner office visit	$10 copay per visit for Spinal Manipulation	Not covered	Coverage is limited to 20 visits per calendar year for Spinal Manipulation.
	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)	No charge	Not covered	——— None ———
	Imaging (CT/PET scans, MRIs)	$100 copay per visit	Not covered	——— 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**	Generic drugs	$10 copay/ prescription (retail), $20 copay/ prescription (mail order)	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Includes performance enhancing medication, contraceptive drugs and devices obtainable from a pharmacy, oral fertility drugs. No charge for formulary generic FDA-approved women's contraceptives in-network. Precertification required. Step therapy required.
	Preferred brand drugs	$20 copay/ prescription (retail), $40 copay/ prescription (mail order)	Not covered	
	Non-preferred brand drugs	$35 copay/ prescription (retail), $70 copay/ prescription (mail order)	Not covered	
	Specialty drugs	$10 copay (Generic), $20 copay (Preferred), $35 copay (Non-preferred)/ prescription (retail)	Not covered	——— None ———
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	——— None ———
	Physician/surgeon fees	No charge	Not covered	——— None ———
If you need immediate medical attention	Emergency room services	$100 copay per visit	$100 copay per visit	No coverage for non-emergency use.
	Emergency medical transportation	$100 copay	$100 copay	No coverage for non-emergency use.
	Urgent care	$35 copay per visit	Not covered	No coverage for non-urgent procedures.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Precertification required for care.
	Physician/surgeon	No charge	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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	$10 copay per visit	Not covered	——— None ———
	Mental/Behavioral health inpatient	No charge	Not covered	Precertification required for care.
	Substance use disorder outpatient	$10 copay per visit	Not covered	——— None ———
	Substance use disorder inpatient	No charge	Not covered	Precertification required for care.
If you are pregnant	Prenatal and postnatal care	Prenatal: No charge; Postnatal: $10 copay	Not covered	——— None ———
	Delivery and all inpatient services	No charge	Not covered	——— None ———
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Coverage is limited to 100 visits per calendar year. Coverage is limited to three intermittent visits per day by a participating home health care agency; one visit equals a period of 4 hours or less. Precertification required for care.
	Rehabilitation services	$10 copay per visit	Not covered	Coverage is limited to treatment over a 60 day consecutive period per incident of illness or injury beginning with the first day of treatment. Includes speech, physical, occupational therapy.
	Habilitation services	$10 copay per visit	Not covered	Coverage includes for Applied Behavioral Analysis. Member cost sharing is based upon the type of service performed and the place of service where it is rendered.
	Skilled nursing care	No charge	Not covered	Coverage is limited to 100 days per calendar year. Precertification required for care.
	Durable medical equipment	No charge	Not covered	Coverage is limited to $2,000 per calendar year maximum.
	Hospice service	No charge	Not covered	Precertification required for care.

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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 your child needs dental or eye care	Eye exam	No charge	Not covered	Coverage is limited to one routine vision exam every 24 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**.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs
- Glasses

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.)

- Bariatric surgery
- Chiropractic care - Coverages is limited to 20 visits per calendar year.
- Infertility treatment - Coverage includes for diagnosis and treatment of underlying medical condition.
- Routine eye care (Adult) - Coverage is limited to one routine vision exam every 24 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 1-888-982-3862. 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, 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: Aetna at 1-888-982-3862, 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: California Department of Managed Health Care Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814, (888) 466-2219, www.healthhelp.ca.gov helpline@dmhc.ca.gov. Additionally, a consumer assistance program can help you file your appeal. Contact: California Department of Managed Health Care Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814, (888) 466-2219, or visit http://www.healthhelp.ca.gov or email helpline@dmhc.ca.gov.

Language Access Services:

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-982-3862.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-982-3862.

如果需要中文的帮助，请拨打这个号码 1-888-982-3862.

Para obtener asistencia en Español, llame al 1-888-982-3862.

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

Coverage Examples

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:** $5,890
- **Patient pays:** $1,650

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	$0
Copays	$0
Coinsurance	$1,500
Limits or exclusions	$150
Total	**$1,650**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,820
- **Patient pays:** $1,580

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	$0
Copays	$370
Coinsurance	$1,130
Limits or exclusions	$80
Total	**$1,580**

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

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

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.