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 **1-888-238-6258**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For each Calendar Year, In-network: Individual **$1,300** / Family **$2,600**. Out-of-network: Individual **$2,500** / Family **$5,000**. Does not apply to 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 **$6,450** / Family **$12,900**. Out-of-network: Individual **$6,450** / Family **$12,900**.	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 1-888-238-6258 for a list of 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 network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a 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	15% coinsurance	40% coinsurance	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	15% coinsurance	40% coinsurance	——————none——————
	Other practitioner office visit	15% coinsurance	40% coinsurance	Coverage is limited to 20 visits per calendar year for Chiropractic care.
	Preventive care /screening /immunization	No charge	40% coinsurance; deductible waived for mammograms & gynecological exams; hearing exams not covered	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	40% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	15% coinsurance	40% coinsurance	——————none——————

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Common Medical Event	Services You May Need	Your Cost If You Use a 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	After deductible: Copay/prescription: $10 (retail), $20 (mail order)	After deductible: 20% coinsurance after copay/prescription: $10 (retail), $20 (mail order)	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Includes performance enchancing medication limited to 6 tablets per month, 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 with 90 day Transition of Care. •Step therapy required with 90 day Transition of Care.
	Preferred brand drugs	After deductible: Copay/prescription: $30 (retail), $60 (mail order)	After deductible: 20% coinsurance after copay/prescription: $30 (retail), $60 (mail order)	
	Non-preferred brand drugs	After deductible: Copay/prescription: $60 (retail), $120 (mail order)	After deductible: 20% coinsurance after copay/prescription: $60 (retail), $120 (mail order)	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs.	Applicable cost as noted above for generic or brand drugs.	Aetna Specialty CareRx℠ - First Prescription must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy®. Subsequent fills must be through Aetna Specialty Pharmacy®.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fees	15% coinsurance	40% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	15% coinsurance	15% coinsurance	No coverage for non-emergency use.
	Emergency medical transportation	15% coinsurance	15% coinsurance	——————none——————
	Urgent care	15% coinsurance	40% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
	Physician/surgeon fee	15% coinsurance	40% coinsurance	——————none——————

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Common Medical Event	Services You May Need	Your Cost If You Use a 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	15% coinsurance	25% coinsurance for first 40 visits; 40% coinsurance thereafter	——————none——————
	Mental/Behavioral health inpatient services	15% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
	Substance use disorder outpatient services	15% coinsurance	25% coinsurance for first 40 visits; 40% coinsurance thereafter	——————none——————
	Substance use disorder inpatient services	15% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
If you are pregnant	Prenatal and postnatal care	No charge	40% coinsurance	——————none——————
	Delivery and all inpatient services	15% 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	15% coinsurance	40% coinsurance	Coverage is limited to 60 visits per calendar year. Pre-authorization required for out-of-network care.
	Rehabilitation services	15% coinsurance	40% coinsurance	Coverage is limited to 60 visits per calendar year for Physical, Occupational and Speech Therapy combined.
	Habilitation services	15% coinsurance	40% coinsurance	Coverage is limited to 60 visits per calendar year for Autism Physical, Occupational & Speech Therapy combined with rehabilitation services and congenital & genetic birth defects up to age 21.
	Skilled nursing care	15% coinsurance	40% coinsurance	Coverage is limited to 60 days per calendar year. Pre-authorization required for out-of-network care.
	Durable medical equipment	15% coinsurance	40% coinsurance	——————none——————

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
	Hospice service	15% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
If your child needs dental or eye care	Eye exam	No charge	40% coinsurance	Coverage is limited to 1 routine eye exam per 12 months.
	Glasses	No charge	Not covered	Coverage is limited to $100 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
- Cosmetic surgery
- Dental care (Adult & Child)
- Hearing aids
- 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.)

- Bariatric surgery
- Chiropractic care - Coverage is limited to 20 visits per calendar year.
- Infertility treatment - Coverage is limited to the diagnosis and treatment of underlying medical condition.
- 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 1-888-238-6258. 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:

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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 att 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**. You may also contact the Government of the District of Columbia, Dept. of Insurance, Securities, and Banking, (202) 727-8000, **http://disb.dc.gov**. Additionally, a consumer assistance program can help you file your **appeal**. Contact: District of Columbia Healthcare Finance, Office of the Ombudsman, 441 4th St, NW (9th and 10th Fl.), Washington, DC 20001,(877) 685-6391, **http://ombudsman.dc.gov**

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 not meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 1-888-238-6258.

如果需要中文的帮助，请拨打这个号码 1-888-238-6258.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-238-6258.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-238-6258.

----------*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:** $4,470
- **Patient pays:** $3,070

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	$2,500
Copays	$20
Coinsurance	$400
Limits or exclusions	$150
Total	**$3,070**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,410
- **Patient pays:** $2,990

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	$2,500
Copays	$240
Coinsurance	$170
Limits or exclusions	$80
Total	**$2,990**

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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.

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aetna Real-time Error

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Submission: Combo-FI-NA-PL-1-1_Part1_fix.xlsx

Imported: 9/2/2014 10:55:00 PM

Validation Errors (1)

Context	Message
Minimum Value Standard	[.]Plan does not meet Minimum Value Standard. Please review on Minimum Value Calculator tab of SBC Editor.