



Aetna Open Access® Managed Choice® - OOA PPO HDHP 2000

Coverage for: EE Only; EE+ Family | Plan Type: POS



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) 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,

<https://www.aetna.com/sbcsearch/getpolicydocs?u=080500-110020-022527> or by calling 1-866-547-2670. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-866-547-2670 to request a copy.

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	For each Calendar Year, In-Network: EE Only \$2,000; EE+ Family \$4,000. Out-of-Network: EE Only \$6,000; EE+ Family \$12,000.	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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
<u>Are there services covered before you meet your deductible?</u>	Yes. In-network <u>preventive care</u> is 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/ .
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	For each Calendar Year, In-Network: EE Only \$3,500; EE+ Family \$7,000. Out-of-Network: EE Only \$12,000; EE+ Family \$24,000.	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> , the overall family <u>out-of-pocket limit</u> must be met.
<u>What is not included in the out-of-pocket limit?</u>	Premiums, <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<u>Will you pay less if you use a network provider?</u>	Yes. See http://www.aetna.com/docfind or call 1-866-547-2670 for a list of in-network providers.	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</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<u>Do you need a referral to see a specialist?</u>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$60 <u>copay</u> /visit	50% <u>coinsurance</u>	None
	<u>Preventive care /screening</u> /immunization	No charge	50% <u>coinsurance</u> , except <u>deductible</u> doesn't apply to well child & child immunizations	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	Diagnostic test (x-ray, blood work)	0% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	\$250 <u>copay</u> /visit	50% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.aetnapharmacy.com/advancedcontrolaetna	Preferred generic drugs (Includes Tier 1A - Value Drugs and Tier 1 Preferred Generic <u>Prescription Drugs</u>)	<u>Copay</u> /prescription: Tier 1A \$3 for 30 day supply (retail), \$6 for 31-90 day supply (retail & mail order); Preferred Generic \$10 for 30 day supply (retail), \$20 for 31-90 day supply (retail & mail order)	50% <u>coinsurance</u> after <u>copay</u> /prescription: Tier 1A \$3 for 30 day supply (retail), \$6 for 31-90 day supply (retail); Preferred Generic \$10 for 30 day supply (retail), \$20 for 31-90 day supply (retail)	Covers 30 day supply (retail), 31-90 day supply (retail & participating mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> . Review your <u>formulary</u> for prescriptions requiring precertification or step therapy for coverage. <u>Copay</u> /prescription for preferred insulin, <u>deductible</u> doesn't apply: \$25 for each 30 day supply. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written. <u>Deductible</u> doesn't apply to certain preventive medications.
	Preferred brand drugs	<u>Copay</u> /prescription: \$45 for 30 day supply (retail), \$90 for 31-90 day supply (retail & mail order)	50% <u>coinsurance</u> after <u>copay</u> /prescription: \$45 for 30 day supply (retail), \$90 for 31-90 day supply (retail)	
	Non-preferred generic/brand drugs	<u>Copay</u> /prescription: \$70 for 30 day supply (retail), \$140 for 31-90 day supply (retail & mail order)	50% <u>coinsurance</u> after <u>copay</u> /prescription: \$70 for 30 day supply (retail), \$140 for 31-90 day supply (retail)	
	<u>Specialty</u> drugs	30% <u>coinsurance</u> (preferred), 50%	Not covered	All prescriptions must be filled through the Aetna Specialty Pharmacy Network. \$300

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		<u>coinsurance</u> (non-preferred)		(preferred) and \$500 (non preferred) maximum copay for each 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$300 <u>copay/visit</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	0% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$350 <u>copay/visit</u>	\$350 <u>copay/visit</u>	Out-of-network emergency use paid the same as in- <u>network</u> . No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	\$350 <u>copay/trip</u>	\$350 <u>copay/trip</u>	Out-of-network emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$85 <u>copay/visit</u>	50% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <u>copay/day</u> first 3 days per stay; 0% <u>coinsurance</u> thereafter	50% <u>coinsurance</u>	Penalty of \$400 for failure to obtain pre- <u>authorization</u> for out-of-network care.
	Physician/surgeon fees	0% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$60 <u>copay/visit</u> ; other outpatient services: 0% <u>coinsurance</u>	Office & other outpatient services: 50% <u>coinsurance</u>	None
	Inpatient services	\$500 <u>copay/day</u> first 3 days per stay; 0% <u>coinsurance</u> thereafter	50% <u>coinsurance</u>	Penalty of \$400 for failure to obtain pre- <u>authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge; except \$60 <u>copay</u> for initial visit to confirm pregnancy	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of \$400 for failure to obtain pre- <u>authorization</u> for out-of-network care may apply.
	Childbirth/delivery professional services	0% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$500 <u>copay/day</u> first 3 days per stay; 0% <u>coinsurance</u> thereafter	50% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	120 visits but not less than \$1,000/calendar year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Rehabilitation services</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.
	<u>Habilitation services</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	\$500 <u>copay/day</u> first 3 days per stay; 0% <u>coinsurance</u> thereafter	50% <u>coinsurance</u>	60 days/calendar year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	\$500 <u>copay/day</u> first 3 days per stay; 0% <u>coinsurance</u> thereafter for inpatient; 0% <u>coinsurance</u> for outpatient	50% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	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.)

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

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

- Acupuncture - 10 visits/calendar year for disease, injury & chronic pain.
- Chiropractic care
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, including artificial insemination.
- Private-duty nursing - 70-8 hour shifts/calendar year.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-866-547-2670.
- 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.
- If your coverage is a church plan, church plans 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 plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general toll free number at 1-866-547-2670. 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.
- Florida Department of Financial Services, Division of Consumer Services, 877-693-5236 (Toll-Free), 850-413-3089 (Out of State), Dial *711 (TDD), <http://www.myfloridacfo.com/Division/Consumers/>.
- 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.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.

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

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 plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. 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)

<u>The plan's overall deductible</u>	\$2,000
<u>Specialist copayment</u>	\$60
<u>Hospital (facility) copayment</u>	\$500
<u>Other coinsurance</u>	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)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
<u>Limits or exclusions</u>	\$60
The total Peg would pay is	\$3,060

Managing Joe's Type 2 Diabetes

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

<u>The plan's overall deductible</u>	\$2,000
<u>Specialist copayment</u>	\$60
<u>Hospital (facility) copayment</u>	\$500
<u>Other coinsurance</u>	0%

This EXAMPLE event includes services like:

Primary care provider office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Diabetic supplies (glucose meter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
<u>Limits or exclusions</u>	\$20
The total Joe would pay is	\$2,420

Mia's Simple Fracture

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

<u>The plan's overall deductible</u>	\$2,000
<u>Specialist copayment</u>	\$60
<u>Hospital (facility) copayment</u>	\$500
<u>Other coinsurance</u>	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)

Total Example Cost	\$2,800
In this example, Mia would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
<u>Limits or exclusions</u>	\$0
The total Mia would pay is	\$2,100

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-866-547-2670.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-547-2670.

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.

Persian-Farsi	هرامش اب ، ناگیار رو طب نابز تامد خ هب ی سرتسد یارب 1-866-547-2670 دیری گب سامت
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwono 1-866-547-2670.
Portuguese	Para acessar os serviços de idiomas sem custo para você, ligue para 1-866-547-2670.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਨਿਂ ਬਸਿ ਮਿਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਰਿਨ ਲਈ, 1-866-547-2670 'ਤੇ ਛੋਨ ਰਿ।
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-866-547-2670.
Samoan	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-866-547-2670.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite 1-866-547-2670.
Spanish	Para acceder a los servicios de idiomas sin costo, llame al 1-866-547-2670.
Syriac-Assyrian	جَلْ بِلْجِيَّةَ هَذِهِ حَلْقَةَ مُتَّكِّبَةٍ، مُنْبَحَّةٍ : 1-866-547-2670.
Tagalog	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-866-547-2670.
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-866-547-2670.
Ukrainian	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-866-547-2670.
Vietnamese	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, gọi số 1-866-547-2670.