Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** POS

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 **https://www.aetna.com/sbcsearch/getpolicydocs?u=073100-050020-241648** or by calling **1-866-529-2517**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For each Plan Year, In-network: Individual **$2,000** / Family **$4,000**. Out-of-network: Individual **$5,000** / Family **$10,000**. Does not apply to certain office visits, preventive care, emergency care, urgent care and prescription drugs 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 **$6,850** / Family **$13,700**. Out-of-network: Individual **$10,000** / Family **$20,000**.	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 services 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 1-866-529-2517 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**.

- **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	$30 copay/visit, deductible waived	50% coinsurance	————————none————————
	Specialist visit	$60 copay/visit, deductible waived	50% coinsurance	————————none————————
	Other practitioner office visit	25% coinsurance, deductible waived for Chiropractic care	25% coinsurance for Chiropractic care	Coverage is limited to 30 visits for Chiropractic care.
	Preventive care /screening /immunization	No charge	50% coinsurance, deductible waived for routine gynecological exams and childhood immunizations	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	$60 copay/visit, deductible waived	50% coinsurance	————————none————————
	Imaging (CT/PET scans, MRIs)	$500 copay/visit	50% coinsurance	Precertification required for out-of-network care. Benefits will be reduced by 50% up to $400 per service or supply if precertification is not obtained.

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	Preferred generic drugs	Copay/prescription: Tier 1A: $3 copay for up to a 30 day supply, $7.50 copay for up to a 90 day supply; Tier 1: $10 copay for up to a 30 day supply, $25 copay for up to a 90 day supply	Not covered	Covers up to a 90 day supply (retail & mail order prescription). Applicable cost share plus difference (brand minus generic cost) applies for brand when generic available. No charge for preferred generic FDA-approved women's contraceptives in-network. Precertification and step therapy required.
	Preferred brand drugs	$50 copay for up to a 30 day supply, $125 copay for up to a 90 day supply	Not covered	
	Non-preferred generic/brand drugs	$75 copay for up to a 30 day supply, $187.50 copay for up to a 90 day supply	Not covered	
	Specialty drugs	Preferred: 40% coinsurance up to a $150 maximum for up to a 30 day supply; Non-preferred: 50% coinsurance up to a $150 maximum for up to a 30 day supply	Not covered	Aetna Specialty CareRxSM – 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)	$500 copay/visit	50% coinsurance	————————none————————
	Physician/surgeon fees	0% coinsurance	50% coinsurance	————————none————————
If you need immediate medical attention	Emergency room services	$250 copay/visit, deductible waived	$250 copay/visit, deductible waived	Copay waived if admitted. Out-of-network cost-share same as in-network. No coverage for non-emergency care.
	Emergency medical transportation	0% coinsurance	0% coinsurance	Out-of-network cost-share same as in-network.

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
	Urgent care	$75 copay/visit, deductible waived	50% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/admission	50% coinsurance	Precertification required for out-of-network care. Benefits will be reduced by 50% up to $400 per service or supply if precertification is not obtained.
	Physician/surgeon fee	0% coinsurance	50% coinsurance	————————none————————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$60 copay/visit, deductible waived	50% coinsurance	————————none————————
	Mental/Behavioral health inpatient services	$500 copay/admission	50% coinsurance	Precertification required for out-of-network care. Benefits will be reduced by 50% up to $400 per service or supply if precertification is not obtained.
	Substance use disorder outpatient services	$60 copay/visit, deductible waived	50% coinsurance	————————none————————
	Substance use disorder inpatient services	$500 copay/admission	50% coinsurance	Precertification required for out-of-network care. Benefits will be reduced by 50% up to $400 per service or supply if precertification is not obtained.
If you are pregnant	Prenatal and postnatal care	Prenatal: No charge; Postnatal: 0% coinsurance	50% coinsurance	————————none————————
	Delivery and all inpatient services	$500 copay/admission	50% coinsurance	Precertification required for out-of-network care. Benefits will be reduced by 50% up to $400 per service or supply if precertification is not obtained.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	50% coinsurance	Coverage is limited to 100 visits.
	Rehabilitation services	$60 copay/visit, deductible waived	50% coinsurance	Coverage is limited to 30 visits for Physical Therapy & Occupational Therapy combined, 30 visits for Speech Therapy, rehabilitation & habilitation separate.

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
	Habilitation services	$60 copay/visit, deductible waived	50% coinsurance	Coverage is limited to 30 visits for Physical Therapy & Occupational Therapy combined and 30 visits for Speech Therapy, rehabilitation & habilitation separate.
	Skilled nursing care	$500 copay/admission	50% coinsurance	Coverage is limited to 120 days. Precertification required for out-of-network care. Benefits will be reduced by 50% up to $400 per service or supply if precertification is not obtained.
	Durable medical equipment	0% coinsurance	50% coinsurance	————————none————————
	Hospice service	Inpatient: $500 copay/admission; Outpatient: 0% coinsurance	50% coinsurance	Precertification required for out-of-network care. Benefits will be reduced by 50% up to $400 per service or supply if precertification is not obtained.
If your child needs dental or eye care	Eye exam	No charge	50% coinsurance	Coverage is limited to 1 exam every 12 months.
	Glasses	No charge	50% coinsurance	Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per year.
	Dental check-up	No charge	30% coinsurance	Coverage is limited to 2 exams every 12 months.

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 - except as form of anesthesia.
- Cosmetic surgery - except when medically necessary.
- Dental care (Adult) - except accidental injury.
- Infertility treatment - except the diagnosis and surgical treatment of underlying conditions.
- Long-term care
- 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 30 visits.
- Hearing aids - Coverage is limited to 1 per ear every 36 months age 0-24.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing - Coverage is limited to inpatient when medically necessary.
- Routine eye care (Adult) - Coverage is limited to 1 exam every 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 1-866-529-2517. 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 Insurance Commissioner and Department of Insurance, (800) 282-8611, **http://www.delawareinsurance.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 meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 1-866-529-2517.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-529-2517.

如果需要中文的帮助，请拨打这个号码 1-866-529-2517.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-529-2517.

----------*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:** $4,840
- **Patient pays:** $2,700

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	$2,000
Copays	$500
Coinsurance	$0
Limits or exclusions	$200
Total	**$2,700**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,120
- **Patient pays:** $2,280

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	$2,000
Copays	$200
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,280**

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.