aetna : LEE COUNTY BOARD OF COUNTY COMMISSIONERS : Aetna Open Access® Aetna SelectSM

Coverage for: Individual + Family | Plan Type: EPO



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>, <u>provider</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.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: Individual \$0 / Family \$0.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services.
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> ?	Network: Individual \$1,500 / Family \$3,000.	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?	<u>Premiums</u> , <u>balance-billing</u> charges & health care this <u>plan</u> 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 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 for</u> the difference between the <u>provider's charge</u> and what your <u>plan pays</u> (<u>balance billing</u>). Be aware, your <u>network provider might</u> use an <u>out-of-network provider for</u> some services (such as lab work). Check with your <u>provider before</u> you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All $\underline{\textbf{copayment}}$ and $\underline{\textbf{coinsurance}}$ costs shown in this chart are after your $\underline{\textbf{deductible}}$ has been met, if a $\underline{\textbf{deductible}}$ applies.

		What You Will Pay			
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information	
	Primary care visit to treat an injury or illness	\$10 copay/visit	Not covered	None	
If you visit a health	Specialist visit	\$25 <u>copay</u> /visit	Not covered	None	
care <u>provider's</u> office or clinic	Preventive care / screening / immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.	
If you have a test	Diagnostic test (x-ray, blood work)	\$25 <u>copay</u> /visit	Not covered	None	
ii you nave a test	Imaging (CT/PET scans, MRIs)	\$50 <u>copay</u> /visit	Not covered	None	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aetnapharmacy.co m/premierplus Premier Plus Formulary	Generic drugs	Copay/prescription: \$10 (retail), \$0 (mail order)	Not covered	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for	
	Preferred brand drugs	Copay/prescription: \$20 (retail), \$40 (mail order)	Not covered		
	Non-preferred brand drugs	Copay/prescription: \$35 (retail), \$70 (mail order)	Not covered	preferred generic FDA-approved women's contraceptives in- <u>network</u> .	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Not covered	All prescriptions must be filled through the Aetna Specialty Pharmacy Network.	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	\$200 copay/visit	Not covered	None	
surgery	Physician/surgeon fees	No charge	Not covered	None	
If you need immediate medical attention	Emergency room care	\$150 <u>copay</u> /visit	\$150 <u>copay</u> /visit	No coverage for non-emergency use.	
	Emergency medical transportation	No charge	No charge	No coverage for non-emergency transport.	
	<u>Urgent care</u>	\$50 <u>copay</u> /visit	Not covered	No coverage for non-urgent use.	
If you have a hospital	Facility fee (e.g., hospital room)	\$500 <u>copay</u> /stay	Not covered	None	
stay	Physician/surgeon fees	No charge	Not covered	None	

		What You		Limitations, Exceptions & Other Important Information	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)		
If you need mental health, behavioral	Outpatient services	Office & other outpatient services: \$25 <u>copay</u> /visit	Not covered	None	
health, or substance abuse services	Inpatient services	\$500 <u>copay</u> /stay	Not covered	None	
	Office visits	No charge	Not covered	Cost sharing doesn't apply to certain	
If you are pregnant	Childbirth/delivery professional services	No charge	Not covered	preventive services. Maternity care may	
ii you are pregnam	Childbirth/delivery facility services	\$500 <u>copay</u> /stay	Not covered	include tests & services described elsewhere in the SBC (i.e. ultrasound).	
	Home health care	No charge	Not covered	120 visits/calendar year, including up to 70 visits for private-duty nursing.	
	Rehabilitation services	\$25 <u>copay</u> /visit	Not covered	80 visits/calendar year for Physical, Occupational & Speech Therapy combined.	
If you need help	<u>Habilitation services</u>	\$25 <u>copay</u> /visit	Not covered	Limited to children up to age 18 for Autism.	
recovering or have other special health needs	Skilled nursing care	\$500 <u>copay</u> /stay	Not covered	120 days/calendar year.	
	<u>Durable medical equipment</u>	No charge	Not covered	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.	
	<u>Hospice services</u>	\$500 <u>copay</u> /stay for inpatient; no charge for outpatient	Not covered	None	
dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam/12 months.	
	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.)

- Acupuncture
- 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 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 plan document.)

- Chiropractic care 20 visits/calendar year.
- Infertility treatment Limited to the diagnosis & treatment of underlying medical condition. Artificial insemination & ovulation induction: 6 separate attempts/lifetime.
- Private-duty nursing 70- 8 hour shifts/calendar year combined with home health care.
- Routine eye care (Adult) 1 routine eye exam/12 months.

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 <u>plan</u> 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.
- 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 to submit a claim, <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:

- Aetna 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 appeal. 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? 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 <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	\$25
Hospital (facility) copayment	\$500
Other <u>copayment</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*)

The total Peg would pay is

Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
Specialist copayment	\$25
Hospital (facility) <u>copayment</u>	\$500
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 <u>plan's</u> overall <u>deductible</u>	\$0
Specialist copayment	\$25
Hospital (facility) copayment	\$500
Other <u>copayment</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)

The total Mia would pay is

Total Example Cost \$12,800		Total Example Cost \$7,400		Total Example Cost	\$1,900
In this 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	\$700	Copayments	\$1,100	Copayments	\$300
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0

\$1,120

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

\$760

The total Joe would pay is

\$300

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, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-800-370-4526.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030, Fresno, CA 93779)

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705)

Email: CRCoordinator@aetna.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

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.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-800-370-4526 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526

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 - 1–800–370–4526– ਰਗ ।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.

Burmese - ()

1-800-370-4526 Catalan - Per rebre assistència en (català), truqui al

número gratuït 1-800-370-4526.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu.

Chinese - 欲取得繁體中文語言協助,請撥打1-800-370-4526,無需付費。

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.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.

French - Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, 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.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.

Gujarati - પણ વર્ગાસ્ 800-370-4526 પર .

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 -. 1-800-370-4526 पर Hmong -Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526. Maka enyemaka asusu na Igbo kpoo 1-800-370-4526 na akwughi ugwo o bula lbo -Ilocano -Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo. Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526. Italian -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。 Japanese 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 Karen -한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526번으로 전화해 주십시오. Korean -Bέ m ké gbo-kpá-kpá dyé pídyi dé Bǎsɔ́ɔ̀-wùdùǔn w̃ε, dá 1-800-370-4526 Kru-Bassa -بر ای ر اهنمایی به زبان فارسی با شماره م4526-370-1800 به خورایی بهیومندی بکهن. Kurdish -Laotian -1-800-370-4526 Marathi -1-800-370-4526 Marshallese -Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān. Miçronesian-Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais. Pohnpeyan -Mon-Khmer, 1-800-370-4526 Cambodian -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 -1-800-370-4526 Nilotic-Dinka -Tën kupony ë thok ë Thuonjän col 1-800-370-4526 kecin ayöc. Norwegian -For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt. Panjabi -ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ. 1-800-370-4526 'ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ। Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix. بر ای ر اهنمایی به زبان فار سی با شمار ه <u>۹۶۵۰ ۵۶۵ محمد ۱ یون هیچ هزینه ای تماس بگیرید.</u> انگلیسی Persian -

Aby uzyskać pomoc w jezyku polskim, zadzwoń bezplatnie pod numer 1-800-370-4526.

Polish -

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.

- Syriac مُرْمَن بُرِ عَمْ الله عَلَى مُرْمَة سِمِعِلْم مُركَة سِمِعِلْم مُركَة عِلَى الله عَلَى ا

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

Telugu - 1-800-370-4526

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Thai - 500-370-4526

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 رپ ₁₋₈₀₀₋₃₇₀₋₄₅₂₆ عول کتن و اعمین 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.