# aetna DC Aetna Gold OAMC 90/50

**Coverage Period: 01/01/2014 - 12/31/2014**
**Coverage for:** Individual + Family | **Plan Type:** POS

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

**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 855-885-3289.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | For each Plan Year: In-network: Individual **$0** / Family **$0**; Out-of-network: Individual **$5,000** / Family **$10,000**. Does not apply to prescription drugs. | 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 **$5,000** / Family **$10,000**; 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 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 855-885-3289. | 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 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 per visit | 50% coinsurance | None |
| | Specialist visit | $50 copay per visit | 50% coinsurance | None |
| | Other practitioner office visit | 25% coinsurance for chiropractic care | 25% coinsurance for chiropractic care | None |
| | Preventive care /screening /immunization | No charge | 50% coinsurance, except routine gyn exam and routine mammograms, no charge | Age and frequency schedules may apply. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Lab: $15 copay per visit; X-ray: $50 copay per visit | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | $300 copay per visit | 50% coinsurance | Precertification required for out-of-network care. Benefits will be reduced by $400 per occurrence if precertification is not obtained. |

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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**<br>**More information about prescription drug coverage is available at www.aetna.com/pharmacy-insurance/individuals-families** | Preferred generic drugs | $15 copay (retail), $30 copay (mail order) | 30% coinsurance after $15 copay (retail) | Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). No coverage for 31-90 day supply for out-of-network. 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 with 90 day Transition of Care. |
| | Preferred brand drugs | $50 copay (retail), $100 copay (mail order) | 30% coinsurance after $50 copay (retail) | |
| | Non-preferred generic/brand drugs | $100 copay (retail), $200 copay (mail order) | 30% coinsurance after $100 copay (retail) | |
| | Specialty drugs (e.g., self-injectable, infused and oral specialty drugs) | $300 copay | Not covered | Covers up to a 30-day supply. 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) | 10% coinsurance | 50% coinsurance | ———— None ———— |
| | Physician/surgeon fees | 10% coinsurance | 50% coinsurance | ———— None ———— |
| **If you need immediate medical attention** | Emergency room services | $300 copay per visit | $300 copay per visit | Copay is waived if admitted. OON ER services cost share same as in-network. No coverage for non-emergency care. |
| | Emergency medical transportation | No charge | No charge | OON cost share same as in-network. |
| | Urgent care | $75 copay per visit | 50% coinsurance | No coverage for non-urgent care. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 50% coinsurance | Precertification required for out-of-network care. Benefits will be reduced by $400 per occurrence if precertification is not obtained. |
| | Physician/surgeon fee | 10% coinsurance | 50% coinsurance | ———— None ———— |

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

| 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 services | $25 copay per visit for visits 1-40; $40 copay per visit/visits 41+ | 25% coinsurance/visits 1-40; 40% coinsurance/visits 41+ | ———— None ———— |
| | Mental/Behavioral health inpatient services | 10% coinsurance | 50% coinsurance | Precertification required for out-of-network care. Benefits will be reduced by $400 per occurrence if precertification is not obtained. |
| | Substance use disorder outpatient services | $25 copay per visit for visits 1-40; $40 copay per visit/visits 41+ | 25% coinsurance/visits 1-40; 40% coinsurance/visits 41+ | ———— None ———— |
| | Substance use disorder inpatient services | 10% coinsurance | 50% coinsurance | Precertification required for out-of-network care. Benefits will be reduced by $400 per occurrence if precertification is not obtained. |
| **If you are pregnant** | Prenatal and postnatal care | Prenatal: No charge; Postnatal: 10% coinsurance | 50% coinsurance | ———— None ———— |
| | Delivery and all inpatient services | 10% coinsurance | 50% coinsurance | Precertification required for out-of-network care. Benefits will be reduced by $400 per occurrence if precertification is not obtained. |
| **If you need help recovering or have other special health needs** | Home health care | $50 copay per visit | 50% coinsurance | Coverage is limited to 90 visits. |
| | Rehabilitation services | $50 copay per visit | 50% coinsurance | ———— None ———— |
| | Habilitation services | $50 copay per visit | 50% coinsurance | ———— None ———— |
| | Skilled nursing care | 10% coinsurance | 50% coinsurance | Coverage is limited to 60 days. Precertification required for out-of-network care. Benefits will be reduced by $400 per occurrence if precertification is not obtained. |

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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 |
|---|---|---|---|---|
| | Durable medical equipment | 50% coinsurance | 50% coinsurance | ——————— None ——————— |
| | Hospice service | Inpatient: 10% coinsurance; Outpatient: $50 copay per visit | 50% coinsurance | Precertification required for out-of-network care. Benefits will be reduced by $400 per occurrence 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 per 12 months. |
| | Glasses | Preferred: No charge; Non-preferred: 50% coinsurance | 50% coinsurance | Coverage is limited to 1 pair glasses (lenses & frames) or contacts per 12 months. |
| | Dental check-up | No charge | 30% coinsurance, deductible waived | Coverage is limited to 2 exams. |

## 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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- 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.)

- Chiropractic care
- Routine eye care (Adult) limited to 1 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 855-885-3289. 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. 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 your State Department of Insurance at Securities, and Banking, (202) 727-8000, http://disb.dc.gov/.

- Additionally, a consumer assistance program can help you file an **appeal**. Contact: District of Columbia Healthcare Finance, Office of the Ombudsman, 899 North Capitol Street, NE, Room 6037, Washington, DC 20002, (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 Provide 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:

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-885-3289.

如果需要中文的帮助，请拨打这个号码 855-885-3289.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 855-885-3289.

Para obtener asistencia en Español, llame al 855-885-3289.

*----------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:** $6,620
- **Patient pays:** $920

### 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 preventative | $40 |
| **Total** | **$7,540** |

### Patient pays:

| | |
|---|---|
| Deductibles | $0 |
| Copays | $320 |
| Coinsurance | $450 |
| Limits or exclusions | $150 |
| **Total** | **$920** |

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,650
- **Patient pays:** $1,750

### Sample care costs:

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventative | $100 |
| **Total** | **$5,400** |

### Patient pays:

| | |
|---|---|
| Deductibles | $0 |
| Copays | $1,030 |
| Coinsurance | $640 |
| Limits or exclusions | $80 |
| **Total** | **$1,750** |

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 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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# Real-time Error Analysis

ABC

**Submission:** DC_SG_GOLD_OAMC_90_50_ON_010114_v090113.xlsm

Imported: 8/19/2013 6:23:00 PM

**Analysis:** Last Error Analysis: 8/22/2013 9:47:31 AM

Recalculate

| Validation Errors (26) | |
|---|---|
| **Context** | **Message** |
| **Version** | [.]The required attribute 'Document_ID' is missing. |
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| **AnalysisResult** | [.]The element 'AetnaSBCExcel2012' has invalid child element 'AnalysisResult'. |