aetna Aexcel® Plus Aetna Choice® POS II

Coverage Period: 01/01/2017- 12/31/2017

Coverage for: Individual + Family **Plan Type:** POS

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

SARASOTA COUNTY GOVERNMENT

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 1-888-982-3862.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: Individual **$500** / Family **$1,000** Out-of-network: Individual **$1,000** / Family **$2,000**	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 **$1,750** / Family **$3,500** Out-of-network: Individual **$3,500** / Family **$7,000**	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. *Precertification is required for out-of-network **providers** of inpatient services, hospitals, treatment facility, skilled nursing, home health care, hospice and private duty expenses or a penalty applies.
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 and Aexcel® designated **providers**, see www.Aetna.com or call 1-888-982-3862.	If you use an in-network doctor, Aexcel designated **specialist** 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 6. 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. You pay this plus any **deductible** amounts you owe under this health insurance plan. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000 and you've met your **deductible,** your **coinsurance** payment of 20% would be $200. If you haven't met any of the **deductible** and it's at least $1,000, you would pay the full cost of the hospital stay.
- 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** and Aexcel designated **providers** by charging you lower **deductibles, copayments,** and **coinsurance** amounts. A designated **provider** is an in-network **provider** who meets additional criteria and is identified with an icon in the **provider** directory. Aexcel designated specialties are: cardiology, cardiothoracic surgery, gastroenterology, general surgery, obstetrics and gynecology, orthopedics, otolaryngology, neurology, neurosurgery, plastic surgery, urology and vascular surgery.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network or an Aexcel Designated Provider	Your Cost If You Use an Aexcel Non-Designated 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	$20 copay	Not applicable	40% coinsurance	——— None ———
	Specialist visit	$30 copay	$40 copay	40% coinsurance	——— None ———
	Other practitioner office visit	$30 copay	Not applicable	40% coinsurance	Limited to 20 visits per calendar year for chiropractic care. Acupuncture is limited to office visit and 2 modalities per visit, 20 visits per calendar year
	Preventive care/ screening/ immunization	No charge	No charge	No charge	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	$20 copay	Not applicable	40% coinsurance	——— None ———
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not applicable	40% coinsurance	——— None ———

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.benecardpbf.com**	Generic drugs	$9 copay for up to a 30 day supply , $22.50 copay for up to a 90 day supply	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Includes contraceptive drugs and devices obtainable from a pharmacy, oral fertility drugs. Mandatory generics are not required. No charge for formulary generic FDA-approved women's contraceptives in-network.
	Preferred brand drugs	20% co-insurace ($25 minimum and $40 maximum) for up to a 30 day supply , 20% co-insurance ($62.50 minimum and $100 Maximum) for up to a 90 day	Not covered	
	Non-preferred brand drugs	40% co-insurance ($40 minimum and $55 maximum) for up to a 30 day supply , 40% co-insurance ($100 minimum and $137.50 maximum) for up to a 90 day supply	Not covered	

	Specialty drugs	Generic $9 copay for up to a 30 day supply, Preferred brand drugs 20% co-insurace ($25 minimum and $40 maximum) for up to a 30 day supply, Non-Preferred 40% co-insurance ($40 minimum and $55 maximum) for up to a 30 day supply	Not covered	Covers up to a 30 day supply. First Prescription may be filled at a participating retail pharmacy or BenCard Specialty mail order pharmacy. Subsequent fills must be through BeneCard Specialty Pharmacy.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network or an Aexcel Designated Provider	Your Cost If You Use an Aexcel Non-Designated Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not applicable	40% coinsurance	———————— None ————————
	Physician/surgeon fees	10% coinsurance	20% coinsurance	40% coinsurance	———————— None ————————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network or an Aexcel Designated Provider	Your Cost If You Use an Aexcel Non-Designated Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$150 copay	Not applicable	$150 copay	No coverage for non-emergency use.
	Emergency medical transportation	20% coinsurance	Not applicable	20% coinsurance	———— None ————
	Urgent care	$75 copay	Not applicable	40% coinsurance	No coverage for non-urgent care.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not applicable	40% coinsurance	Precertification required for out-of-network care or benefits will be reduced by $500.
	Physician/surgeon fee	10% coinsurance	20% coinsurance	40% coinsurance	———— None ————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay	Not applicable	40% coinsurance	———— None ————
	Mental/Behavioral health inpatient services	20% coinsurance	Not applicable	40% coinsurance	Precertification required for out-of-network care or benefits will be reduced by $500.
	Substance use disorder outpatient services	$30 copay	Not applicable	40% coinsurance	———— None ————
	Substance use disorder inpatient services	20% coinsurance	Not applicable	40% coinsurance	Precertification required for out-of-network care or benefits will be reduced by $500.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network or an Aexcel Designated Provider	Your Cost If You Use an Aexcel Non-Designated Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge, after copay. Deductible waived.	20% coinsurance	40% coinsurance	———— None ————
	Delivery and all inpatient services	20% coinsurance, deductible waived for healthy newborn expenses	Not applicable	40% coinsurance	Precertification required for out-of-network care or benefits will be reduced by $500.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not applicable	40% coinsurance	Limited to 120 visits per calendar year. Precertification required for out-of-network care or benefits will be reduced by $500.
	Rehabilitation services	20% coinsurance	Not applicable	40% coinsurance	Limited to 60 visits per calendar year.
	Habilitation services	20% coinsurance	Not applicable	40% coinsurance	Calendar year max $36,000, Life time max $200,000.
	Skilled nursing care	20% coinsurance	Not applicable	40% coinsurance	Limited to 90 days per calendar year. Precertification required for out-of-network care or benefits will be reduced by $500.
	Durable medical equipment	20% coinsurance, deductible waived	Not applicable	40% coinsurance	———— None ————
	Hospice service	20% coinsurance	Not applicable	40% coinsurance	Precertification required for out-of-network care or benefits will be reduced by $500.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered	Not covered
	Glasses	Not covered	Not applicable	Not covered	Not covered
	Dental check-up	Not covered	Not applicable	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**.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these

- Acupuncture-Limited to office visit and 2 modalities per visit, Limited to 20 visits per calendar year
- Bariatric surgery-Limited to in-network providers only, 1 surgery per lifetime.
- Chiropractic care-Limited to 20 visits per calendar year for chiropractic care
- Habilitation services
- Hearing aids-Limited to $1,500 every 5 years.
- Infertility treatment-Limited to 6 attempts per lifetime for artificial insemination and ovulation induction.
- Private-duty nursing-Limited to 70-8 hour shifts per calendar year.

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 1-888-982-3862. 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: Aetna at 1-888-982-3862, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Additionally, a consumer assistance program can help you file an appeal. Contact information is at http://www.aetna.com/individuals-families-health-insurance/member-guidelines/complaints-grievances-appeals

Language Access Services:

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-982-3862.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-982-3862.

如果需要中文的帮助，请拨打这个号码 1-888-982-3862.

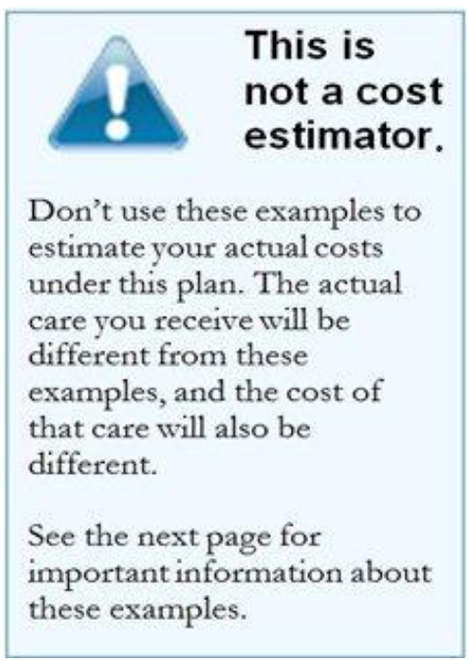
Para obtener asistencia en Español, llame al 1-888-982-3862.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Coverage Examples

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.



Having a baby
(normal delivery)

- **Amount owed to providers:** $ 7,510
- **Plan pays:** $ 5,700
- **Patient pays:** $ 1,810

Sample care costs:

Hospital charges (mother)	$ 2,700
Routine obstetric care	$ 2,100
Hospital charges (baby)	$ 900
Anesthesia	$ 900
Laboratory tests	$ 500
Prescriptions	$ 170
Radiology	$ 200
Vaccines, other preventive	$ 40
Total	**$ 7,510**

Patient pays:

Deductibles	$ 500
Copays	$ 420
Coinsurance	$ 890
Limits or exclusions	$ -
Total	**$ 1,810**

Note: These numbers assume that patient received all care from in-network Aexcel designated providers (including hospitals), where appropriate. To pay the lowest out-of-pocket costs, in-network Aexcel designated providers should be used.

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

- **Amount owed to providers:** $ 5,400
- **Plan pays:** $ 3,710
- **Patient pays:** $ 1,690

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	$ 0
Copays	$ 1,440
Coinsurance	$ 250
Limits or exclusions	
Total	**$ 1,690**

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.