



: STATE OF FLORIDA - DEPARTMENT OF MANAGEMENT SERVICES
(DMS): Aetna Open Access® Aetna SelectSM - Standard HMO Plan

Coverage for: Individual + Family | Plan Type: EPO



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, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. 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 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	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 <u>deductible</u> ?	Yes. This plan has no <u>deductible</u> .	This <u>plan</u> covers some items and services 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 plan covers certain preventive services without <u>cost-sharing</u> and before you meet your deductible.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services your plan covers.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Medical: Individual \$1,500 / Family \$3,000. Global: Individual \$7,350 / Family \$14,700. (met by medical and prescription copays or prescription copays only).	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 <u>out-of-pocket limit</u> ?	<u>Premiums</u> and services this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.aetna.com/docfind or call 1-877-858-6507 for a list of in- <u>network providers</u> .	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.
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 **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	\$20 copay/visit	Not covered	Additional charges may apply for non-preventive services performed in the Physician's office. Additional charges may apply for non-preventive services performed in the Physician's office. 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.
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit	Not covered	
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	Not covered	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	Charges for office visits may apply if services are performed in a Physician's office. Charge for office visits or Physician/professional services may also apply depending where services are received.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	

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)	
<p>If you need drugs to treat your illness or condition</p> <p><u>Prescription drug coverage is administered by CVS/Caremark</u></p> <p>More information about <u>prescription drug coverage</u> is available at www.caremark.com</p>	Generic drugs (Tier 1)	\$7 copay/prescription (retail); \$14 copay/prescription (participating retail pharmacy or mail order)	Not covered	<p>Prescription drug coverage is provided through CVS/Caremark. For a list of participating pharmacies, go to www.caremark.com/sofrxplan or call 1-888-766-5490.</p> <p>Generic & Brand drugs: covers up to a 90-day supply at retail pharmacies and a 60-90 day supply via mail order.</p> <p>Certain drugs in all tiers require prior authorization. Brand additional charge may apply.</p> <p>Specialty and cost-sharing drugs available in 30-day supply only; not available via mail order.</p>
	Preferred brand drugs (Tier 2)	\$30 copay/prescription (retail); \$60 copay/prescription (participating retail pharmacy or mail order)	Not covered	
	Non-preferred brand drugs (Tier 3)	\$50 copay/prescription (retail); \$100 copay/prescription (participating retail pharmacy or mail order)	Not covered	

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)	
	Specialty drugs (Tier 4)	Preferred brand Specialty drugs: \$30 copay/prescription (retail); \$60 copay/prescription (participating retail pharmacy or mail-order) Non-preferred brand Specialty drugs: \$50 copay/prescription (retail) \$100 copay/prescription (participating retail pharmacy or mail order)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Charges for office visits may also apply if services are performed in any Physician's office. Prior authorization required.
	Physician/surgeon fees	No charge	Not covered	Charges for office visits may also apply if services are performed in any Physician's office. Prior authorization required.
If you need immediate medical attention	<u>Emergency room care</u>	\$100 copay/ visit	\$100 copay/ visit	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	No charge	No charge	None
	<u>Urgent care</u>	\$25 copay/ visit	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 copay/ per admission	Not covered	Prior authorization required.
	Physician/surgeon fees	No charge	Not covered	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 copay/ visit \$250 copay/ per admission	Not covered	Prior authorization required.
	Inpatient services	Residential stay: No Charge	Not covered	Prior authorization required.

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 are pregnant	Office visits	No charge	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Prior authorization required.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$250 <u>copay/ per admission</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	None Rehabilitative physical, speech and occupational therapy to treat injuries is limited to 60 visits per injury. Chiropractic services is limited to 60 visits per injury.
	<u>Rehabilitation services</u>	\$40 <u>copay/</u> visit for physical, occupational, speech therapy, and chiropractic services	Not covered	
	<u>Habilitation services</u>	\$40 <u>copay/</u> visit	Not covered	Habilitative occupational therapy is limited to home health care, hospice care, treatment of Autism Spectrum Disorder, treatment of Developmental Disabilities, and Down syndrome. Limited to 60 Days post-hospitalization care per calendar year. Prior authorization required.
	<u>Skilled nursing care</u>	No charge	Not covered	
	<u>Durable medical equipment</u>	No charge	Not covered	
	<u>Hospice services</u>	No charge	Not covered	
If your child needs dental or eye care	Children's eye exam	\$20 copay/ visit at PCP; \$40 copay/ visit at Specialist	Not covered	Limited to 1 routine eye exam per calendar year.
	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
- Child Glasses
- Cosmetic surgery
- Dental Care (Adult & Child)
- Hearing Aids
- Long-term care
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Foot Care
- Private Duty Nursing
- Weight Loss Programs

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

- Chiropractic Care
- Routine Eye Care (Adult)

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 1-800-370-4526.
- 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, appeal, or a grievance for any reason to your plan. 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 **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)

- The **plan's** overall **deductible** \$0
- **Specialist copayment** \$40
- Hospital (facility) **copayment** \$250
- Other **copayment** \$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	\$12,800
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$998
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,058

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The **plan's** overall **deductible** \$0
- **Specialist copayment** \$40
- Hospital (facility) **copayment** \$250
- Other **copayment** \$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*)

Total Example Cost	\$7,400
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$847
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$902

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The **plan's** overall **deductible** \$0
- **Specialist copayment** \$40
- Hospital (facility) **copayment** \$250
- Other **copayment** \$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	\$1,925
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$355
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$355

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

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 the number on your ID card.

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).

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