♥aetnaCVSHealth:: 2023 DE Aetna CVS Bronze 2: QHDHP HMO OFF PD

Coverage for: Individual + Family | Plan Type: HMO



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, https://www.aetna.com/sbcsearch/getcbpolicydocs?P=0760801&Y=23, or by calling 1-844-365-7373. 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 1-844-365-7373 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In- <u>network</u> : Individual \$6,000 / Family \$12,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> in- <u>network</u> .	This <u>plan</u> covers some items and services even 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 <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>network</u> : Individual \$7,100 / Family \$14,200.	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>	Premiums and health care this plan 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 https://aet.na/providersearch_aetna or call 1-844-365-7373 for a list of in-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</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> .



		What You Will Pay			
Common Medical Event	Services You May Need	In-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	50% coinsurance	Not covered	None	
If you visit a health care	Specialist visit	50% coinsurance	Not covered	None	
provider's office or clinic	Preventive care /screening /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	50% coinsurance	Not covered	Applies to services received in office or in outpatient setting.	
ii you nave a test	Imaging (CT/PET scans, MRIs)	50% coinsurance	Not covered	Applies to services received in office or in outpatient setting.	
	Preferred generic drugs	50% coinsurance for up to a 90 day supply	Not covered	Covers up to a 30 day supply (retail prescription), 31-90 day supply (retail & mail	
If you need drugs to treat your illness or condition	Preferred brand drugs	50% coinsurance for up to a 90 day supply	Not covered	order prescription). Applicable cost share plus difference (brand minus generic cost) applies	
More information about prescription drug coverage is available at	Non-preferred generic/brand drugs	50% coinsurance for up to a 90 day supply	Not covered	for brand when generic available. No charge for preferred generic FDA-approved women's contraceptives in-network. All specialty prescription drug fills on initial fill must be filled at a network specialty pharmacy except for urgent situations. Your plan may include access to CVS retail pharmacies for certain specialty drugs.	
http://aet.na/deivl23	Preferred/non-preferred specialty drugs	50% coinsurance up to a \$150 maximum/ prescription for up to a 30 day supply	Not covered		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	Not covered	None	
our got y	Physician/surgeon fees	50% coinsurance	Not covered	None	
If you need immediate medical attention	Emergency room care	50% coinsurance	50% coinsurance	Out-of-network <u>emergency room care</u> cost-share same as in- <u>network</u> . No coverage for non-emergency care.	
modification of the state of th	Emergency medical transportation Urgent care	50% coinsurance 50% coinsurance	50% <u>coinsurance</u> Not covered	Out-of-network cost-share same as in-network. No coverage for non-urgent use.	
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		What You Will Pay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Importan Information
If you have a	Facility fee (e.g., hospital room)	50% coinsurance	Not covered	None
hospital stay	Physician/surgeon fees	50% coinsurance	Not covered	None
If you need mental health, behavioral health, or	Outpatient services	Office visits and all other outpatient services: 50% coinsurance	Not covered	None
substance abuse services	Inpatient services	50% coinsurance	Not covered	None
	Office visits	No charge	Not covered	Cost sharing does not apply for preventive
If you are pregnant	Childbirth/delivery professional services	50% coinsurance	Not covered	services. Maternity care may include tests and services described elsewhere in the SBC
	Childbirth/delivery facility services	50% coinsurance	Not covered	(i.e. ultrasound).
	Home health care	50% coinsurance	Not covered	Coverage is limited to 100 visits.
	Rehabilitation services	25% coinsurance for Physical Therapy and Occupational Therapy; 50% coinsurance for Speech Therapy	Not covered	Coverage is limited to 30 visits for Speech Therapy.
If you need help recovering or have other	Habilitation services	50% coinsurance	Not covered	None
special health needs	Skilled nursing care	50% coinsurance	Not covered	Coverage is limited to 120 days per confinement.
	Durable medical equipment	50% coinsurance	Not covered	Coverage is limited to 1 <u>durable medical</u> <u>equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	50% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	50% coinsurance	Not covered	Coverage is limited to 1 exam every 12 months up to age 19.
	Children's glasses	50% coinsurance	Not covered	Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per calendar year up to age 19.
	Children's dental check-up	0% coinsurance	Not covered	Coverage is limited to 2 exams every 12 months up to age 19.

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.)

- Abortion
- Cosmetic surgery
- Dental care (Adult)

- Long-term care
- Routine eye care (Adult)
- Routine foot care

Weight loss programs

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

- Acupuncture Coverage is limited to 10 visits.
- Bariatric surgery
- Chiropractic care

- Hearing aids Coverage is limited to 1 per ear every 36 months.
- Infertility treatment Benefit limitations may apply.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing Coverage is limited to inpatient when medically necessary.

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: Insurance Commissioner and Department of Insurance, Consumer Services Division, 302-674-7310 or In-State: 800-282-8611, http://www.delawareinsurance.gov.

• For more information on your rights to continue coverage, contact the plan at 1-844-365-7373.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance <u>Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596 or state health insurance <u>marketplace</u> or SHOP.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <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:

• Insurance Commissioner and Department of Insurance, Consumer Services Division, 302-674-7310 or In-State: 800-282-8611, http://www.delawareinsurance.gov.

Does this plan provide Minimum Essential Coverage? Yes.

<u>Minimum Essential Coverage</u> generally includes <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of <u>Minimum Essential Coverage</u>, you may not be eligible for the <u>premium tax credit</u>.

Does this plan meet Minimum Value Standards? Not Applicable.

If your <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

To see examples of how this <u>plan</u> 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>	\$6,000
Specialist coinsurance	50%
Hospital (facility) coinsurance	50%
Other coinsurance	50%

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	\$12,700	
In this example, Peg would pay:		
Cost Sharing		
<u>Deductibles</u>	\$6,000	
<u>Copayments</u>	\$0	
<u>Coinsurance</u>	\$1,100	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$7,160	

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>	\$6,000
Specialist coinsurance	50%
Hospital (facility) coinsurance	50%
Other <u>coinsurance</u>	50%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Total Example Cost	\$5,600	
In this example, Joe would pay:		
Cost Sharing		
<u>Deductibles</u>	\$5,400	
<u>Copayments</u>	\$0	
<u>Coinsurance</u>	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$5,420	

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$6,000
Specialist coinsurance	50%
■ Hospital (facility) coinsurance	50%
Other coinsurance	50%

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	\$2,800	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$2,800	
<u>Copayments</u>	\$0	
<u>Coinsurance</u>	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$2,800	

Note: These numbers assume the patient does not participate in the <u>plan's</u> wellness program. If you participate in the <u>plan's</u> wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-844-365-7373.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-844-365-7373.

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 unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide 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: P.O. Box 24030, Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), 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).

Health plans are offered or underwritten or administered by Aetna Health Inc. (Pennsylvania) (Aetna). Aetna is part of the CVS Health family of companies.

TTY: 711

Language Assistance:

For language assistance in your language call 1-844-365-7373 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-844-365-7373.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-844-365-7373 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 7373-365-1-844

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-844-365-7373 առանց գնով։

Bahasa-Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-844-365-7373 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-844-365-7373 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্য(1-844-365-7373-ত(কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-844-365-7373 nga walay bayad.

Burmese - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-844-365-7373 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-844-365-7373.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-844-365-7373 sin gåstu.

Chinese - 欲取得繁體中文語言協助,請撥打 1-844-365-7373,無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-844-365-7373.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-844-365-7373 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-844-365-7373.

French - Pour une assistance linguistique en français appeler le 1-844-365-7373 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-844-365-7373 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-844-365-7373 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-844-365-7373 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ય વગર 1-844-365-7373 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-844-365-7373. Kāki 'ole 'ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-844-365-7373 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-844-365-7373.

lbo - Maka enyemaka asusu na Igbo kpoo 1-844-365-7373 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-844-365-7373 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-844-365-7373.

Japanese - 日本語で援助をご希望の方は、1-844-365-7373 まで無料でお電話ください。

Karen - လာတာ်မာစားတာ်ကတိာကျိန်အင်္ဂ ကျိန် ကိုး 1-844-365-7373 လာတအိန်ဒီးတာ်လာ၁်ဘူန်လာ၁်စုးသာ

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-844-365-7373 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pidyi dé Bašsoó-wuduun wee, dá 1-844-365-7373

برای راهنمایی به زبان فارسی با شماره 7373-365-441-1 به خورایی پهیومندی بکهن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-844-365-7373 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - कोणत्याही शूल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-844-365-7373 वर फोन करा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-844-365-7373 ilo ejjelok wōnān.

Micronesian - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-844-365-7373 ni sohte isais.

Mon-Khmer, Cambodian - សម្ភាប់ជំនួយភាសាជា ភាសាខ្មមរៃ សូមទូរស័ព្**ទទ**ៅកាន់លខេ 1-844-365-7373 ដ**ោយឥតគិតថ្**ល។ៃ

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-844-365-7373

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-844-365-7373 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kuoony ë thok ë Thuonjän col 1-844-365-7373 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-844-365-7373 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵੀੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-844-365-7373 'ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-844-365-7373 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 7373-365-844 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-844-365-7373.

Portuguese - Para obter assistência linguística em português ligue para o 1-844-365-7373 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-844-365-7373

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-844-365-7373.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-844-365-7373 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-844-365-7373.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-844-365-7373.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-844-365-7373 Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-844-365-7373 bila malipo.

Syriac - R - 22 K K & D2.31 abr 21.2 K oai, or Ly iapr 361, 20, 1-844-365-7373 apr. .

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-844-365-7373 nang walang bayad.

Telugu - భషతో నయంకొరకు ఎలంటి ఖర్చు లేకుండా 1-844-365-7373 కు కల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-844-365-7373 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-844-365-7373 'o 'ikai hā tōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-844-365-7373 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-844-365-7373.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-844-365-7373.

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 7373-365-1-844. پر بات کریں

Vietnamese - Đê 'được hố' trợ ngôn ngư băng (ngôn ngư), hay gọi miến phi 'đên số '1-844-365-7373.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-844-365-7373 פריי פון אפצאל

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-844-365-7373 lái san owó kankan rárá.