aetna Aetna Choice® POS II

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

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

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

EMORY UNIVERSITY

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.hr.emory.edu or by calling your benefits department. Emory University: 404-727-7613; Emory Healthcare: 404-686-6044.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	EHN: Individual $850/Family $2,550. In-network: Individual $1,000 Family $3,000. Out-of-network: Individual $2,000/Family $6,000. Does not apply to preventive care.	Aside from office visit co-payments and 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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. EHN: Individual $2,750/Family $5,500.In-network: Individual $4,000/ Family $8,000. 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. *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 in-network designated providers, see www.aetna.com or call 1-800-982-3862	If you use an in-network doctor, 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. 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.

Questions: Call 1-888-982-3862 or visit us at www.HealthReformPlanSBC.com

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.HealthReformPlanSBC.com or call 1-888-982-3862 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $25) 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 15% would be $150. 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 Emory Healthcare Network (EHN) **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts than in-network providers. The EHN includes providers and facilities that are either owned or affiliated with Emory. This plan may encourage you to use in-network providers by charging you lower deductibles, copayments and coinsurance amounts than out-of-network providers.

Common Medical Event	Services You May Need	Your Cost If You Use Emory Healthcare Network (EHN)	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	$25 copay	$35 copay; $25 for pediatrician or Behavioral Health	50% coinsurance	Applies to all network physicians of Internal Medicine, Family Practice, and General Medicine.
	Specialist visit	$35 copay	$50 copay	50% coinsurance	Dermatologist $25 copay; Allergist $25 copay.
	Other practitioner office visit	Acupuncture $35 copay; Spinal manip. $50	$50 copay for both Acupuncture and Spinal manipulation	50% coinsurance	Coverage is limited to 20 visits per calendar year for spinal manipulations
	Preventive care/screening/immunization	No charge	No charge	50% coinsurance	Age and frequency schedules may apply
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	25% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance	25% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	Your Cost If You Use an Emory Healthcare Network (EHN)	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.caremark.com	Generic drugs	10% coinsurance Retail min. $10, max $25. Mail-order min. $25, max $62.50		Out-of-Network reimbursement is based on the discounted, in-network cost of the medication minus the applicable coinsurance.	You do not have to meet the deductible first. Certain items identified by your plan as preventive care are covered in full and not subject to the coinsurance amounts indicated. Covers up to a 30 day supply (retail prescription); up to 90 days supply (mail-order prescription). Some drugs may require preauthorization. To be covered, fill maintenance drugs through mail order or at CVS or Emory pharmacy.
	Preferred brand drugs	20% coinsurance Retail min. $30, max $75. Mail-order min. $75, max $187.50			
	Non-preferred brand drugs	30% coinsurance Retail min. $60, max $120. Mail-order min. $150, max $300			
	Specialty drugs	40% coinsurance Retail min. $90, max $150. Mail-order min. $225, max $375			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	25% coinsurance	50% coinsurance	None
	Physician/surgeon fees	15% coinsurance	25% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room services	$250 copay	$250 copay	$250 copay	None
	Emergency medical transportation	$75 copay	$75 copay	$75 copay	None
	Urgent care	$25 copay	$35 copay	$50 copay	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	25% coinsurance	50% coinsurance	Precertification required for out-of-network or $750 penalty applies.
	Physician/surgeon fee	15% coinsurance	25% coinsurance	50% coinsurance	
				50% coinsurance	Precertification required for out-of-

Common Medical Event	Services You May Need	Your Cost If You Use an Emory Healthcare Network (EHN)	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	$25 copay	50% coinsurance	None
	Mental/Behavioral health inpatient services	15% coinsurance	25% coinsurance	50% coinsurance	Precertification required for out-of-network or $750 penalty applies.
	Substance use disorder outpatient services	$25 copay	$25 copay	50% coinsurance	None
	Substance use disorder inpatient services	15% coinsurance	25% coinsurance	50% coinsurance	Precertification required for out-of-network or $750 penalty applies.
If you are pregnant	Prenatal and postnatal care	15% coinsurance	25% coinsurance	50% coinsurance	None
	Delivery and all inpatient services	15% coinsurance	25% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	15% coinsurance	25% coinsurance	50% coinsurance	Coverage is limited to 120 visits.
	Rehabilitation services	$25 copay	$35 copay	50% coinsurance	Coverage is limited to 90 visits combined for Physical, Speech, Occupational Therapies, including outpatient hospital facility services
	Habilitation services	$25 copay	$35 copay	50% coinsurance	Coverage is limited to 90 visits. Coverage includes Physical, Speech and Occupational Therapies for developmental delays. Speech Therapy covered with Autism diagnosis.
	Skilled nursing care	15% coinsurance	25% coinsurance	50% coinsurance	Coverage is limited to 120 visits.
	Durable medical equipment	15% no deductible	25% no deductible	50% coinsurance	None
	Hospice service	No charge	No charge	50% coinsurance	None
If your child needs dental or	Eye exam	No charge	No charge	50% coinsurance	1 routine eye exam every 12 months.

Common Medical Event	Services You May Need	Your Cost If You Use an Emory Healthcare Network (EHN)	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
eye care	Glasses	Not covered	Not covered	Not covered	Not covered
	Dental check-up	Not covered	Not covered	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
- Hearing aids
- Long-term care
- Weight loss programs
- Private-duty nursing
- 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 services.)

- Acupuncture all applicable copays and coinsurance apply
- Bariatric surgery covered the same as Hospitalization
- Chiropractic care
- Infertility treatment (Artificial insemination and ovulation induction is limited to 6 separate cycles per lifetime.)
- Routine eye care (Adult) 1 exam every 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.

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 404-727-7613.

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 Meet the 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:

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

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

(中文): 如果需要中文的帮助，**请拨打这个号码**1-888-982-3862

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

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 will also 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** $ 5,558
- **Patient pays** $ 1,982

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 preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$850
Copays	$0
Coinsurance	$982
Limits or exclusions	$150
Total	**$1,982**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,242
- **Patient pays** $ 1,158

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	$850
Copays	$150
Coinsurance	$78
Limits or exclusions	$80
Total	**$1,158**

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

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.