aetna VA Health Network Only CD 1.5 (2000 Ded)

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

Coverage Period: 03/01/2013 - 02/28/2014
Coverage for: Individual + Family **Plan Type:** HNonly

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 1-866-529-2517.

Important Questions	Answers	Why this Matters
What is the overall deductible?	For each Plan Year: Individual **$2,000** / Family **$4,000**. Does not apply to office visits, preventive care 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 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. Individual **$4,000** / Family **$8,000**	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, prescription drugs 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 the plan use a network of providers?	Yes. For a list of in-network **providers**, see www.aetna.com or call 1-866-529-2517.	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 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. 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	$25 co-pay per visit, deductible waived	Not covered	——— None ———
	Specialist visit	$50 co-pay per visit, deductible waived	Not covered	——— None ———
	Other practitioner office visit	$10 co-pay per visit for chiropractic care	Not covered	Coverage is limited to 20 visits for chiropractic care.
	Preventive care/screening/immunization	No charge, deductible waived	Not covered	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	Lab: $0 co-pay per visit; X-ray: $50 co-pay per visit	Not covered	——— None ———
	Imaging (CT/PET scans, MRIs)	$200 co-pay per visit	Not covered	——— 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 http://www.aetna.com/pharmacy-insurance/individuals-families/index.html**	Formulary generic drugs	$10 co-pay for up to a 30 day supply, $20 co-pay for up to a 90 day supply	Not covered	Covers up to a 30-day supply (retail or mail order prescription); 31-90 day supply (retail or mail order prescription). Includes diabetic supplies, oral fertility drugs and contraceptive drugs and devices obtainable from a pharmacy. No charge for formulary generic FDA-approved women's contraceptives in-network. Precertification required with 90 day Transition of Care.
	Formulary brand drugs	$35 co-pay for up to a 30 day supply, $70 co-pay for up to a 90 day supply	Not covered	
	Non-formulary brand and generic drugs	$60 co-pay for up to a 30 day supply, $120 co-pay for up to a 90 day supply	Not covered	
	Specialty drugs (e.g., self-injectable, infused and oral specialty drugs)	$200 co-pay for up to a 30 day supply, $400 co-pay for up to a 90 day supply	Not covered	Aetna Specialty CareRx℠ - First prescription for a specialty drug 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)	30% co-insurance	Not covered	———— None ————
	Physician/surgeon fees	30% co-insurance	Not covered	———— None ————
If you need immediate medical attention	Emergency room services	$200 co-pay per visit	Paid as in-network	Copay is waived if admitted. No coverage for non-emergency care.
	Emergency medical transportation	$0 co-pay per trip	Paid as in-network	———— None ————
	Urgent care	$75 co-pay per visit	Not covered	No coverage for non-urgent care.

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 a hospital stay	Facility fee (e.g., hospital room)	30% co-insurance	Not covered	None
	Physician/surgeon fee	30% co-insurance	Not covered	None
If you have mental health, behavioral health or substance abuse needs	Mental/Behavioral health outpatient services	$50 co-pay per visit, deductible waived	Not covered	None
	Mental/Behavioral health inpatient services	30% co-insurance	Not covered	None
	Substance use disorder outpatient services	$50 co-pay per visit, deductible waived	Not covered	None
	Substance use disorder inpatient services	30% co-insurance	Not covered	None
If you are pregnant	Prenatal and postnatal care	Prenatal: No charge, deductible waived; Postnatal: $50 co-pay	Not covered	None
	Delivery and all inpatient services	30% co-insurance	Not covered	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 help recovering or have other special health needs	Home health care	$0 co-pay per visit	Not covered	Coverage is limited to 60 visits.
	Rehabilitation services	$50 co-pay per visit	Not covered	Coverage is limited to 30 visits combined for PT/OT and 30 visits for ST.
	Habilitation services	$50 co-pay per visit	Not covered	Coverage is limited to early intervention services for children up to age 3, $5,000 maximum per year.
	Skilled nursing care	30% co-insurance	Not covered	Coverage is limited to 60 days.
	Durable medical equipment	50% co-insurance	Not covered	Coverage is limited to $5,000 maximum per year.
	Hospice service	Inpatient: 30% co-insurance; Outpatient: $0 co-pay per visit	Not covered	———— None ————
If your child needs dental or eye care	Eye exam	No charge, deductible waived	Not covered	Coverage is limited to 1 exam per 24 months.
	Glasses	Not covered	Not covered	Not covered
	Dental check-up	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**.)		
• Acupuncture	• Bariatric surgery	• Cosmetic surgery
• Dental care (Adult and Child)	• Glasses (Adult and Child)	• 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 limited to 20 visits	• Routine eye care (Adult) limited to 1 exam per 24 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 1-866-529-2517. 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 1-866-529-2517, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or your state insurance department at 1-804-371-9741 or http://www.scc.virginia.gov/boi.

- Additionally, a consumer assistance program can help you file your appeal. Contact: Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance, P.O. Box 1157, Richmond, VA 23218, 1-877-310-6560, http://www.scc.virginia.gov/boi, bureauofinsurance@scc.virginia.gov.

Language Access Services:

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-529-2517.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-529-2517.
如果需要中文的帮助，请拨打这个号码 1-866-529-2517.
Para obtener asistencia en Español, llame al 1-866-529-2517.

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:** $ 3,810
- **Patient pays:** $ 3,730

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	$ 2,000
Co-pays	$ 240
Co-insurance	$ 1,340
Limits or exclusions	$ 150
Total	**$ 3,730**

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

- **Amount owed to providers:** $ 5,400
- **Plan pays:** $ 2,500
- **Patient pays:** $ 2,900

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	$ 2,000
Co-pays	$ 380
Co-insurance	$ 440
Limits or exclusions	$ 80
Total	**$ 2,900**

Note: Your plan may have both **copayments** and **coinsurance** for covered services, if so, these examples use **copayments** 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 policy 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 these conditions 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 for 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 also should 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.