aetna® : DC Silver HMO 3000 100% HSA E

Coverage for: Employee + Family | **Plan Type:** HMO

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, https://www.aetna.com/sbcsearch/getpolicydocs?u=081400-020020-731855 or by calling 1-855-885-3289. 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 1-855-885-3289 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each Plan Year, In-network: Individual $3,000 / Family $6,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care in-network.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: Individual $6,500 / Family $13,000.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-855-885-3289 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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	$30 copay/visit	Not covered	None
	Specialist visit	$75 copay/visit	Not covered	None
	Preventive care /screening /immunization	No charge	Not covered	You may have to pay for services that are not preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	Not covered	Applies to services received in office or in outpatient setting.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not covered	Applies to services received in office or in outpatient setting.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetna.com/individuals-families/find-a-medication.html	Preferred generic drugs	$12 copay for up to a 30 day supply, $30 copay for up to a 90 day supply	Not covered	Covers up to a 30 day supply (retail prescription), 31-90 day supply (retail & mail order prescription). Applicable cost share plus difference (brand minus generic cost) applies for brand when generic available. No charge for preferred generic FDA-approved women's contraceptives in-network. Precertification and step therapy may be required.
	Preferred brand drugs	$55 copay for up to a 30 day supply, $137.50 copay for up to a 90 day supply	Not covered	
	Non-preferred generic/brand drugs	$95 copay for up to a 30 day supply, $237.50 copay for up to a 90 day supply	Not covered	
	Specialty drugs	Preferred: 40% coinsurance up to a $150 maximum for up to a 30 day supply; Non-preferred: 50% coinsurance up to a $150 maximum for up to a 30 day supply	Not covered	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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not covered	None
	Physician/surgeon fees	0% coinsurance	Not covered	None

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 need immediate medical attention	Emergency room care	$500 copay/visit	$500 copay/visit	Copay waived if admitted. Out-of-network emergency room care cost-share same as in-network. No coverage for non-emergency care.
	Emergency medical transportation	0% coinsurance	0% coinsurance	Out-of-network cost-share same as in-network.
	Urgent care	$60 copay/visit	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	None
	Physician/surgeon fees	0% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient office visits: $25 copay/visit for first 40 visits; $40 copay/visit thereafter; All other outpatient services: 0% coinsurance	Not covered	None
	Inpatient services	0% coinsurance	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance	Not covered	
	Childbirth/delivery facility services	0% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not covered	Coverage is limited to 90 visits/episode.
	Rehabilitation services	$75 copay/visit	Not covered	None
	Habilitation services	$75 copay/visit	Not covered	None
	Skilled nursing care	0% coinsurance	Not covered	Coverage is limited to 60 days.
	Durable medical equipment	50% coinsurance	Not covered	Coverage is limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	0% coinsurance	Not covered	None

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 your child needs dental or eye care	Children's eye exam	50% coinsurance	Not covered	Coverage is limited to 1 exam/plan year 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 plan year up to age 19.
	Children's dental check-up	0% coinsurance	Not covered	Coverage is limited to 2 exams per plan year 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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Routine eye care (Adult) - Coverage is limited to 1 exam.

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: District of Columbia Healthcare Finance, Office of the Ombudsman, (877) 685-6391, http://ombudsman.dc.gov.

- For more information on your rights to continue coverage, contact the plan at 1-855-885-3289.
- 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 1-855-885-3289.
- District of Columbia Healthcare Finance, Office of the Ombudsman, (877) 685-6391, http://ombudsman.dc.gov.
- 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 District of Columbia Healthcare Finance, Office of the Ombudsman, 441 4th St, NW (9th and 10th Fl.), Washington, DC 20001, (877) 685-6391, healthcareombudsman@dc.gov, http://ombudsman.dc.gov

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** **$3,000**
- **Specialist copayment** **$75**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **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:	
Cost Sharing	
Deductibles	$3,000
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,160**

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

- **The plan's overall deductible** **$3,000**
- **Specialist copayment** **$75**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **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:	
Cost Sharing	
Deductibles	$3,000
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4,120**

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

- **The plan's overall deductible** **$3,000**
- **Specialist copayment** **$75**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **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	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-855-885-3289.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-855-885-3289.

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 1-855-885-3289.

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).

TTY: 711

Language Assistance:

For language assistance in your language call 1-855-885-3289 at no cost.

Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-855-885-3289 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-855-885-3289
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-855-885-3289-তে কল করুন।
Chinese -	欲取得繁體中文語言協助，請撥打 1-855-885-3289，無需付費。
French -	Pour une assistance linguistique en français appeler le 1-855-885-3289 sans frais.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-855-885-3289 an.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-855-885-3289 na akwụghị ụgwọ ọ bụla
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-855-885-3289.
Japanese -	日本語で援助をご希望の方は、1-855-885-3289 まで無料でお電話ください。
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-855-885-3289 번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ́m`ké gbo-kpá-kpá dyé piɗyi ɖé Ɓaǎsɔ́-wuɖuǔn wɛ̀ɛ, ɖá 1-855-885-3289
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-855-885-3289
Portuguese -	Para obter assistência linguística em português ligue para o 1-855-885-3289 gratuitamente.
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-855-885-3289.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-855-885-3289.
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-855-885-3289 nang walang bayad.
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-855-885-3289 ฟรีไม่มีค่าใช้จ่าย
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy goị miễn phí đến số 1-855-885-3289.
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-855-885-3289 lái san owó kankan rárá.