

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services (HIGH PLAN)

Coverage Period: 07/01/2020-06/30/2021



DELAWARE VALLEY HEALTH TRUST: Open Choice® - Kent County
 Levy Court – PPO HRA \$5,000/\$10,000 with RX \$10/\$25/\$75
 Kent County pays full cost (100%) of Deductible through County funded HRA

Coverage for: EE Only; EE+ Family | Plan Type: PPO



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 deductible?	Network: EE Only \$5,000; EE+ Family \$10,000. Out-of-Network: EE Only \$5,000; EE+ Family \$10,000. <i>Inform your healthcare provider that deductible is paid by Kent County through HRA</i>	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 policy, the overall family deductible must be met before the plan begins to pay. Health Reimbursement Arrangement (HRA) is available that works with your medical plan, as described in your employer's Summary Plan Description.
Are there services covered before you meet your deductible?	Yes. In-network Preventive care, routine eye exam, prescription drugs and services with copayments are covered before you meet your in-network deductible.	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?	Network: EE Only \$7,150; EE+ Family: \$14,300. Out-of-Network: EE Only \$10,000; EE+ Family: \$20,000.	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, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	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 1-800-370-4526 for a list of 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?	No.	You can see the specialist you choose without a referral.



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
		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	\$10 <u>copay</u> /visit, deductible does not apply	20% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit, deductible does not apply	20% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	20% <u>coinsurance</u>	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)	0% coinsurance	20% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aetnapharmacy.com/premierplus <u>Premier Plus Formulary</u>	Generic drugs	<u>Copay/prescription</u> : \$10 (retail), \$20 (mail order), deductible does not apply	20% <u>coinsurance</u> after <u>copay/prescription</u> : \$10 (retail), deductible does not apply	Covers up to 34 supply (retail), up to 90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> . <u>Deductible</u> doesn't apply to preventive medications. Certain participating retail pharmacy <u>providers</u> may have agreed to make maintenance prescription drugs available at the same <u>cost-sharing</u> and quantity limits as the mail service coverage.
	Preferred brand drugs	<u>Copay/prescription</u> : \$25 (retail), \$50 (mail order), deductible does not apply	20% <u>coinsurance</u> after <u>copay/prescription</u> : \$25 (retail), deductible does not apply	
	Non-preferred brand drugs	<u>Copay/prescription</u> : \$75 (retail), \$150 (mail order), deductible does not apply	20% <u>coinsurance</u> after <u>copay/prescription</u> : \$75 (retail), deductible does not apply	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Specialty drugs</u>	Applicable cost as noted above for generic or brand drugs	Not covered	Certain drugs may require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% <u>coinsurance</u>	None
	Physician/surgeon fees	0% coinsurance	20% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay</u> /visit, deductible does not apply	\$150 <u>copay</u> /visit, deductible does not apply	No coverage for non-emergency use. Copay is waived if admitted. Observation stay is not considered inpatient admission.
	<u>Emergency medical transportation</u>	0% coinsurance	0% coinsurance	20% coinsurance for non-emergency out-of-network transport
	<u>Urgent care</u>	\$50 <u>copay</u> /visit, deductible does not apply	20% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% <u>coinsurance</u>	Penalty of \$200 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	0% coinsurance	20% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: \$10 <u>copay</u> /visit, deductible does not apply	Office & other outpatient services: 20% <u>coinsurance</u>	None
	Inpatient services	0% coinsurance	20% <u>coinsurance</u>	Penalty of \$200 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge, except \$20 copay for initial visit to confirm pregnancy, deductible does not apply	20% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of \$200 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery professional services	0% coinsurance	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	0% coinsurance	20% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	0% coinsurance	20% <u>coinsurance</u>	Up to 100 visits per benefit period.
	<u>Rehabilitation services</u>	\$20 <u>copay</u> /visit, deductible does not apply	20% <u>coinsurance</u>	Up to 30 visits per plan year for physical and occupational therapy combined. 30 visits per plan year for speech therapy.
	<u>Habilitation services</u>	Not covered	Not covered	Not covered.
	<u>Skilled nursing care</u>	0% coinsurance	20% <u>coinsurance</u>	120 days/calendar year.
	<u>Durable medical equipment</u>	0% coinsurance	20% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	0% coinsurance	20% <u>coinsurance</u>	None
If your child needs dental or eye care	Children's eye exam	No charge	20% <u>coinsurance</u>	Once every 24 months
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

NOTE: If your Healthcare Provider asks about the deductible, inform the physician/specialist/other provider that Kent County fully pays the cost of the \$5,000/\$10,000 deductible through an HRA. Aetna will pay the applicable deductible amount to the healthcare provider and Kent County will reimburse Aetna (DVHT).

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
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids (Adult)
- Long-term care
- Routine foot care
- Weight loss programs - Except for required preventive services.

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

- Bariatric surgery
- Chiropractic care - 30 visits/year.
- Non-emergency care when traveling outside the U.S.
- Infertility treatment – Including diagnosis & treatment of underlying medical condition, artificial insemination, ovulation induction and Advance Reproduction Technology.
- Routine eye care (Adult) - 1 routine eye exam/24 months, includes contact lens fitting & evaluation.
- Private Duty Nursing – up to 240 hours per year

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** \$5,000
- **Specialist Copayment** \$20
- **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	\$7,618
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles Paid by Kent County HRA	\$5,000
Copayments	\$60
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,120

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

- The **plan's** overall **deductible** \$5,000
- **Specialist Copayment** \$20
- **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	\$4,728
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles Paid by Kent County HRA	\$1,862
Copayments	\$755
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$2,672

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

- The **plan's** overall **deductible** \$5,000
- **Specialist Copayment** \$20
- **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	\$927
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$859
Copayments	\$140
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$999

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: 1-800-370-4526.

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 1-800-370-4526.

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).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - हनिदी में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwụghị ụgwọ ọ bụla
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.
- Japanese - 日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。
- Karen - လာဝတီမစာတီကတီကိတ်အိတ် ကိတ် ကိတ် 1-800-370-4526 လာဝတီအိတ်ဒီးတီလာဝတီကိတ်လာဝတီကိတ်
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.
- Kru-Bassa - Ɓe m'ké gbo-kpá-kpá dyé pídyi dé Ɓáwó-wuḍuŋ wɛɛ, dǎ 1-800-370-4526
- Kurdish - برائى راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خورایی یه یومندی بکهن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-800-370-4526 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.
- Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526
- Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- 800-370-4526 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tën kuwoɲy ë thok ë Thuɔŋjäŋ ɔɔl 1-800-370-4526 kecïn ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hefte in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.
- Persian - برائى راهنمایی به زبان فارسی با شماره 1-800-370-4526 بدون هیچ هزینه ای تماس بگیريد. انگلیسی
- Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.

