



Aetna “R” CDHP Silver

Plan Facts	Member Services	1-800-589-4811
	Hours of Operation	8:00 a.m. to 6:00 p.m. Local Time Monday – Friday
	Website	www.aetna.com
	Name of Physician Network	Aetna Choice POS II (Open Access)
	Minute Clinic	www.minuteclinic.com 1-866-389-2727
	Decision Support Tools	
	24-Hour Informed Health Line (Nurse-line)	1-800-556-1555
	Personal Health Advocate	
Cost Sharing	Annual Deductible: Single/Two-person or family See Notes Below	In Network \$2,600 single coverage; \$5,200 two-person or family coverage per plan year Out of Network \$5,000 single coverage; \$10,000 two-person or family coverage per plan year
	Out-of-pocket Maximum: Single/Two-person or family See Notes Below	In Network \$6,350 single coverage; \$12,700 two-person or family coverage; <u>includes</u> deductible; per plan year Out of Network \$12,700 single coverage; \$25,400 two-person or family coverage; <u>includes</u> deductible; per plan year
NOTES		Embedded Deductible AND Embedded OOP Max - each individual can satisfy their individual deductible for plan to pay at coinsurance level and OOP max at 100%. The balance of the family deductible and OOP Max can be met by the remaining family members
		The in and out of network deductibles and out-of-pocket amounts cross-apply
	Lifetime Coverage Limit	Limit does not apply
	In Network/ Out of Network	This plan covers care provided by in-network and out of network (participating) providers and facilities



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	Reasonable & Customary	<p>In Network Does not apply</p> <p>Out of Network Benefits are subject to reasonable & customary limits (R&C). Charges above R&C, if any, are not covered and do not count toward deductibles or out-of-pocket limits</p>
	Pre-Authorization	<p>In Network Does not apply to member. It is the provider's responsibility to secure pre-authorization</p> <p>Out of Network Surgeries and in-patient care must be pre-certified. Penalties may apply otherwise</p>
	Pre-existing Conditions	N/A
Access	Ability to Self-refer to OB/GYN	Yes
	Ability to Self-refer to Specialists	Yes
Preventive Care	Routine Preventive physical exam 1 exam per plan year ages 4 and older	<p>In Network 100% covered; no deductible</p> <p>Out of Network 50% covered; no deductible</p>
	Well-woman exam (includes pap) 1 exam per plan year	
	Mammogram 1 per plan year	
	Pediatric Exams Up to 7 exams until age 1; 3 exams between ages 1 and 2; 3 exams between ages 2 and 3 1 exam per plan year thereafter	
	Immunizations - child and adult	
Office Visits	Primary Doctor Office Visit and Specialist Office Visit	<p>In Network 70% covered after deductible is met</p> <p>Out of Network 50% covered after deductible is met</p>



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Family Planning / Maternity Care	Pre/post-natal office visit	<p>In Network 100% covered, no deductible</p> <p>Out of Network 50% covered after deductible is met</p>
	In-hospital Delivery Services	<p>In Network 70% covered after deductible is met</p> <p>Out of Network 50% covered after deductible is met</p>
	Newborn Nursery Services	<p>In Network 70% covered after deductible is met</p> <p>Out of Network 50% covered after deductible is met</p> <p>Team member must add newborn within 30 days of birth in order to be covered</p>
	Lactation Consultation – up to 6 visits per plan year	<p>In Network 100% covered, no deductible</p> <p>Out of Network 50% covered after deductible is met</p>
	Breast Pump and Supplies – electric breast pump limited to 1 per 36 months	<p>In Network 100% covered, no deductible</p> <p>Out of Network 50% covered after deductible is met</p>



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	Fertility Services	<p>In Network 70% covered after deductible is met</p> <p>Out of Network 50% covered after deductible is met</p> <p>Covers diagnosis/treatment of underlying medical condition; artificial insemination/ovulation induction and ART \$15,000 medical lifetime maximum and \$5,000 prescription lifetime maximum</p>
	In Vitro Fertilization	<p>In Network 70% covered after deductible is met</p> <p>Out of Network 50% covered after deductible is met</p> <p>Included in Fertility Services as part of \$15,000 medical lifetime maximum and \$5,000 prescription lifetime maximum. Not a separate benefit</p>
Autism Spectrum Disorder	Outpatient Physical Therapy, Occupational Therapy and Speech Therapy	<p>In Network 70% covered after deductible is met; limited to 30 visits per plan year</p> <p>Out of Network 50% covered after deductible is met; limited to 30 visits per plan year</p> <p>Combined in- and out-of-network visit limit with non-Autism Spectrum Disorder diagnosis</p>
Autism – Behavior Therapy	Outpatient Behavior Therapy	<p>In Network 70% covered after deductible is met; unlimited visits per plan year</p> <p>Out of Network 50% covered after deductible is met; unlimited visits per plan year</p>
Autism - Applied Behavior Analysis		<p>In Network 70% covered after deductible is met; unlimited visits per plan year</p> <p>Out of Network 50% covered after deductible is met; unlimited visits per plan year</p>



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Out-Patient Services	Out-Patient Surgery (see IOQ note below)	<p>In Network 70% covered after deductible is met</p> <p>Out of Network 50% covered after deductible is met</p>
	IOQ NOTES	<p>IOQ are Institutes of Quality network of hospitals and other facilities which specialize in certain Bariatric, Cardiac and Orthopedic surgeries. They have been chosen based on their quality of results and level of care. You will receive higher level of benefits than other in-network providers and facilities.</p> <p>If an IOQ facility is used: 95% covered after deductible</p>
	Out-Patient Laboratory Services and X-Ray	<p>In Network 70% covered after deductible is met</p> <p>Out of Network 50% covered after deductible is met</p>
	Out-Patient Physical Therapy	<p>In Network 70% covered after deductible is met; limited to 30 visits per plan year</p> <p>Out of Network 50% covered after deductible is met; limited to 30 visits per plan year</p> <p>Combined in- and out-of-network visit limit</p>
	Out-Patient Occupational Therapy	<p>In Network 70% covered after deductible is met; limited to 30 visits per plan year</p> <p>Out of Network 50% covered after deductible is met; limited to 30 visits per plan year</p> <p>Combined in- and out-of-network visit limit</p>
	Out-Patient Speech Therapy	<p>In Network 70% covered after deductible is met; limited to 30 visits per plan year</p> <p>Out of Network 50% covered after deductible is met; limited to 30 visits per plan year</p> <p>Combined in- and out-of-network visit limit; Exclusions may apply; Check with Plan for details</p>



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Inpatient Services	Hospital Co-insurance (see IOQ Note Below)	<p style="text-align: center;">In Network 70% covered after deductible is met</p> <p style="text-align: center;">Out of Network 50% covered after deductible is met</p>
	IOQ Notes	<p>IOQ are Institutes of Quality network of hospitals and other facilities which specialize in certain Bariatric, Cardiac and Orthopedic surgeries. They have been chosen based on their quality of results and level of care. You will receive higher level of benefits than other in-network providers and facilities.</p> <p style="text-align: center;">If an IOQ facility is used: 95% covered after deductible is met</p>
	Hospital Co-insurance (semi-private room)	<p style="text-align: center;">In Network 70% covered after deductible is met</p> <p style="text-align: center;">Out of Network 50% covered after deductible is met</p>
	Newborn Nursery Services	<p style="text-align: center;">In Network 70% covered after deductible is met</p> <p style="text-align: center;">Out of Network 50% covered after deductible is met</p> <p style="text-align: center;">Team member must add newborn within 30 days of birth in order to be covered</p>
	In-Patient Services: Nursing Services, medications and ancillary charges	<p style="text-align: center;">In Network 70% covered after deductible is met</p> <p style="text-align: center;">Out of Network 50% covered after deductible is met</p>
Trans-gender Reassignment Benefit	Behavioral Services, Hormone Therapy* and Surgery	<p style="text-align: center;">In Network 70% covered after deductible is met</p> <p style="text-align: center;">Out of Network 50% covered after deductible is met</p>
	* NOTE	Hormone Therapy is through CVS Caremark – applicable coinsurance levels apply. See Prescription Drug information by Plan below.



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Emergency Care	Urgent Care Clinic Visit	<p>In Network 70% covered after deductible is met</p> <p>Out of Network 50% covered after deductible is met</p>
	Emergency room (not followed by admission)	<p>In Network 70% covered after deductible; if non-emergency, 50% covered after deductible is met</p> <p>Out of Network 70% covered after deductible; if non-emergency, 50% covered after deductible is met</p>
	Ambulance Service	<p>In Network 70% covered after deductible is met</p> <p>Out of Network Emergency ambulance covered at 50% after deductible is met; non-emergency ambulance paid at 50% after deductible is met</p>
Prescription Drugs		Prescription drugs for Aetna medical plans are administered by CVS Caremark. CVS Caremark Customer Care: 877-209-3213; available 24/7
Retail Prescription Drugs	Retail Generic	<p>\$10 co-pay after deductible is met; up to 30-day supply</p> <p>Certain generics may be filled for \$3.33 plus a dispensing fee (May vary by location)</p>
	Generic Surcharge	If you or your physician requests a brand name drug when a generic is available, you must pay the difference in cost between the two, in addition to the applicable co-pay or coinsurance.
	Retail Formulary Brand	70% covered up to a maximum co-pay of \$200 after deductible is met; up to 30-day supply
	Retail Non-formulary	50% covered up to a maximum co-pay of \$400 after deductible is met; up to 30-day supply



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Mail Order / Mail Service Prescription Drugs	Home Delivery Generic	\$20 co-pay after deductible is met up to 90-day supply Certain generics may be filled for \$9.99 for up to a 90-day supply.
	Generic Surcharge	If you or your physician requests a brand name drug when a generic is available, you must pay the difference in cost between the two, in addition to the applicable co-pay or coinsurance
	Home Delivery Formulary Brand	70% covered up to a maximum co-pay of \$200 after deductible is met; up to 90-day supply
	Home Delivery Non-formulary Brand	50% covered up to \$400 maximum co-pay after deductible is met; up to 90-day supply
Preventive Drugs	Applies to both retail and home delivery	Certain Preventive Drugs may not be subject to the deductible and/or copay. Check with CVS/Caremark whether the condition you are being treated for qualifies.
Required Home Delivery of Prescription Drugs	Home Delivery Required for Maintenance Drugs	Up to a 1-month supply of a maintenance medication may be filled up to two times from a participating retail pharmacy; then medication covered only if ordered from the CVS Caremark Pharmacy. Alternatively, a 90-day prescription may be filled at a CVS Retail Pharmacy at the same cost as Home Delivery.
Prescription Drug Step Therapy	Medication for a Chronic Condition	Required procedure - List of drugs that require Step Therapy are available by calling CVS Caremark Member Services at 1-877-209-3213.
Prescription Drug Prior Authorization		Certain medications require prior authorization. Your doctor or pharmacist must obtain authorization from Caremark first or medication will not be covered.
Specialty Drugs	High-cost biomedical drugs	Requires exclusive use of CVS Caremark Specialty Pharmacy for filling specialty drugs up to a 1-month supply.
Injectable Fertility Products		Covered; infertility benefit maximum \$5,000



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Mental Health / Substance Abuse	Mental Health: Out-Patient Coverage	<p>In Network 70% covered after deductible is met</p> <p>Out of Network 50% covered after deductible is met</p>
	Mental Health: In-Patient Coverage	<p>In Network 70% covered after deductible is met</p> <p>Out of Network 50% covered after deductible is met; 1st \$300 of hospital expenses are not covered if not pre-certified</p>
	Detox: Out-Patient Coverage	<p>In Network 70% covered after deductible is met</p> <p>Out of Network 50% covered after deductible is met</p>
	Detox: In-Patient Coverage	<p>In Network 70% covered after deductible is met</p> <p>Out of Network 50% covered after deductible is met; 1st \$300 of hospital expenses are not covered if not pre-certified</p>
	Rehab: Out-Patient Coverage	<p>In Network 70% covered after deductible</p> <p>Out of Network 50% covered after deductible is met</p>
	Rehab: In-Patient Coverage	<p>In Network 70% covered after deductible is met</p> <p>Out of Network 50% covered after deductible is met; 1st \$300 of hospital expenses are not covered if not pre-certified</p>
Alternative Care	Chiropractic	<p>In Network 70% covered after deductible is met; limited to 30 visits per plan year</p> <p>Out of Network 50% covered after deductible is met; limited to 30 visits per plan year</p> <p>Combined in- and out-of-network visit limit</p>



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	Non-custodial Home Health Care	<p>In Network 70% covered after deductible; limited to 60 visits per plan year</p> <p>Out of Network 50% covered after deductible is met; limited to 30 visits per plan year</p> <p>Combined in- and out-of-network visit limit</p>
	Hospice Care	<p>In Network 70% covered after deductible</p> <p>Out of Network 50% covered after deductible</p>
	Prescribed Care in Non-custodial Skilled Nursing Facility	<p>In Network 70% covered after deductible</p> <p>Out of Network 50% covered after deductible</p>
	Institutes of Quality (IOQ)	IOQ are a network of hospitals and other facilities which specialize in gastric bypass, heart and knee replacement surgeries. They have been chosen based on their quality of results and level of care. You will receive higher level of benefits than other in-network providers and facilities. In-Network only. All non-IOQ services are out of network.
	Durable Medical Equipment (DME)	<p>In Network 70% covered after deductible is met; foot orthotics limited to \$250 per plan year</p> <p>Out of Network 50% covered after deductible is met; foot orthotics limited to \$250 per plan year</p>
	Hearing Evaluations	<p>In Network 100% covered; limited to 1 visit every 24 months</p> <p>Out of Network 50% covered; limited to 1 visit every 24 months</p> <p>Combined in- and out-of-network limit</p>
	Hearing Aids	<p>In Network/Out of Network 100% covered up to \$1,000 per 36 months; after deductible is met (combined in and out-of-network)</p>