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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; includes deductible; per plan year **Out of Network** **$12,700** single coverage; **$25,400** two-person or family coverage; includes 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	**In Network** Does not apply **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
	Pre-Authorization	**In Network** Does not apply to member. It is the provider’s responsibility to secure pre-authorization **Out of Network** Surgeries and in-patient care must be pre-certified. Penalties may apply otherwise
	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	**In Network** 100% covered; no deductible **Out of Network** 50% covered; no deductible
	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	**In Network** 70% covered after deductible is met **Out of Network** 50% covered after deductible is met

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Family Planning / Maternity Care	Pre/post-natal office visit	**In Network** 100% covered, no deductible **Out of Network** 50% covered after deductible is met
	In-hospital Delivery Services	**In Network** 70% covered after deductible is met **Out of Network** 50% covered after deductible is met
	Newborn Nursery Services	**In Network** 70% covered after deductible is met **Out of Network** 50% covered after deductible is met **Team member must add newborn within 30 days of birth in order to be covered**
	Lactation Consultation – up to 6 visits per plan year	**In Network** 100% covered, no deductible **Out of Network** 50% covered after deductible is met
	Breast Pump and Supplies – electric breast pump limited to 1 per 36 months	**In Network** 100% covered, no deductible **Out of Network** 50% covered after deductible is met
	Fertility Services	**In Network** 70% covered after deductible is met **Out of Network** 50% covered after deductible is met Covers diagnosis/treatment of underlying medical condition; artificial insemination/ovulation induction and ART $15,000 medical lifetime maximum and $5,000 prescription lifetime maximum

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

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Out-Patient Services	Out-Patient Surgery (see IOQ note below)	**In Network** 70% covered after deductible is met **Out of Network** 50% covered after deductible is met
	IOQ NOTES	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. **If an IOQ facility is used**: 95% covered after deductible
	Out-Patient Laboratory Services and X-Ray	**In Network** 70% covered after deductible is met **Out of Network** 50% covered after deductible is met
	Out-Patient Physical Therapy	**In Network** 70% covered after deductible is met; limited to 30 visits per plan year **Out of Network** 50% covered after deductible is met; limited to 30 visits per plan year **Combined in- and out-of-network visit limit**
	Out-Patient Occupational Therapy	**In Network** 70% covered after deductible is met; limited to 30 visits per plan year **Out of Network** 50% covered after deductible is met; limited to 30 visits per plan year **Combined in- and out-of-network visit limit**
	Out-Patient Speech Therapy	**In Network** 70% covered after deductible is met; limited to 30 visits per plan year **Out of Network** 50% covered after deductible is met; limited to 30 visits per plan year **Combined in- and out-of-network visit limit; Exclusions may apply; Check with Plan for details**

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Inpatient Services	Hospital Co-insurance (see IOQ Note Below)	**In Network** 70% covered after deductible is met **Out of Network** 50% covered after deductible is met
	IOQ Notes	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. **If an IOQ facility is used:** 95% covered after deductible is met
	Hospital Co-insurance (semi-private room)	**In Network** 70% covered after deductible is met **Out of Network** 50% covered after deductible is met
	Newborn Nursery Services	**In Network** 70% covered after deductible is met **Out of Network** 50% covered after deductible is met **Team member must add newborn within 30 days of birth in order to be covered**
	In-Patient Services: Nursing Services, medications and ancillary charges	**In Network** 70% covered after deductible is met **Out of Network** 50% covered after deductible is met
Trans-gender Reassign-ment Benefit	Behavioral Services, Hormone Therapy* and Surgery	**In Network** 70% covered after deductible is met **Out of Network** 50% covered after deductible is met
	*** 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	**In Network** 70% covered after deductible is met **Out of Network** 50% covered after deductible is met
	Emergency room (not followed by admission)	**In Network** 70% covered after deductible; if non-emergency, 50% covered after deductible is met **Out of Network** 70% covered after deductible; if non-emergency, 50% covered after deductible is met
	Ambulance Service	**In Network** 70% covered after deductible is met **Out of Network** Emergency ambulance covered at 50% after deductible is met; non-emergency ambulance paid at 50% after deductible is met
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	$10 co-pay after deductible is met; up to 30-day supply Certain generics may be filled for $3.33 plus a dispensing fee (May vary by location)
	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
Mail Order / Mail Service	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.

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Prescription Drugs	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 Authori-zation		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
Mental Health / Substance Abuse	Mental Health: Out-Patient Coverage	**In Network** 70% covered after deductible is met **Out of Network** 50% covered after deductible is met

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	Mental Health: In-Patient Coverage	**In Network** 70% covered after deductible is met **Out of Network** 50% covered after deductible is met; 1st $300 of hospital expenses are not covered if not pre-certified
	Detox: Out-Patient Coverage	**In Network** 70% covered after deductible is met **Out of Network** 50% covered after deductible is met
	Detox: In-Patient Coverage	**In Network** 70% covered after deductible is met **Out of Network** 50% covered after deductible is met; 1st $300 of hospital expenses are not covered if not pre-certified
	Rehab: Out-Patient Coverage	**In Network** 70% covered after deductible **Out of Network** 50% covered after deductible is met
	Rehab: In-Patient Coverage	**In Network** 70% covered after deductible is met **Out of Network** 50% covered after deductible is met; 1st $300 of hospital expenses are not covered if not pre-certified
Alternative Care	Chiropractic	**In Network** 70% covered after deductible is met; limited to 30 visits per plan year **Out of Network** 50% covered after deductible is met; limited to 30 visits per plan year **Combined in- and out-of-network visit limit**
	Non-custodial Home Health Care	**In Network** 70% covered after deductible; limited to 60 visits per plan year **Out of Network** 50% covered after deductible is met; limited to 30 visits per plan year **Combined in- and out-of-network visit limit**

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	Hospice Care	**In Network** 70% covered after deductible **Out of Network** 50% covered after deductible
	Prescribed Care in Non-custodial Skilled Nursing Facility	**In Network** 70% covered after deductible **Out of Network** 50% covered after deductible
	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)	**In Network** 70% covered after deductible is met; foot orthotics limited to $250 per plan year **Out of Network** 50% covered after deductible is met; foot orthotics limited to $250 per plan year
	Hearing Evaluations	**In Network** 100% covered; limited to 1 visit every 24 months **Out of Network** 50% covered; limited to 1 visit every 24 months **Combined in- and out-of-network limit**
	Hearing Aids	**In Network/Out of Network** 100% covered up to $1,000 per 36 months; after deductible is met (combined in and out-of-network)