



**PLAN DESIGN AND BENEFITS**  
**Savings Plus OA Managed Choice POS Bronze**  
**CA 50/50 6800 Ded (2019)**

**CA Group Business 1-100 Employees**

| PLAN FEATURES  | NETWORK CARE  | OUT-OF-NETWORK CARE  |
|--|---|--|
| <b>Primary Care Physician Selection</b>  | Optional  | Optional   |
| <b>Deductible</b> (per calendar year)  | \$6,800 Individual<br>\$13,600 Family   | \$13,600 Individual<br>\$27,200 Family                       |
| Unless otherwise indicated, the deductible must be met before benefits can be paid.  |   |  |
| Claims from in-network and out-of-network providers do not cross-accumulate to satisfy the deductible.   |   |  |
| As indicated in the plan, member cost sharing for certain services are excluded from the charges to meet the deductible.   |   |  |
| No one family member may contribute more than the individual deductible amount to the family deductible.   |   |  |
| <b>Member Coinsurance</b><br>(applies to all expenses unless otherwise stated)   | 50%   | 50%  |
| <b>Payment Limit</b><br>(per calendar year, includes deductible)   | \$7,700 Individual<br>\$15,400 Family   | \$15,100 Individual<br>\$30,200 Family                       |
| Claims from in-network and out-of-network providers do not cross-accumulate to satisfy the out-of-pocket maximums.   |   |  |
| Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and copays (except any penalty amounts) may be used to satisfy the Payment Limit.   |   |  |
| No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum.   |   |  |
| <b>Payment for Non-Preferred Care*</b>   | Not applicable  | Professional: 100% of Medicare<br>Facility: 100% of Medicare |
| <b>Certification Requirements</b>  |   |  |
| Certification for certain types of non-preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for hospital admissions, treatment facility admissions, skilled nursing facility admissions, home health care, and hospice care is required. If the necessary certification is not received, payment for services will be reduced by \$400 per occurrence  |   |  |
| <b>Referral Requirement</b>  | Not Required  | Not applicable   |
| PHYSICIAN SERVICES   | NETWORK CARE  | OUT-OF-NETWORK CARE  |
| <b>Office Visits to Non-Specialist</b>   | \$60 copay deductible waived  | 50% after deductible   |
| Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illness or injury.   |   |  |
| <b>Specialist Office Visits</b>  | \$95 copayment after deductible   | 50% after deductible   |
| <b>Walk-in Clinics</b>   | \$60 copay deductible waived  | Not covered  |
| Walk-in clinics are network, free-standing health care facilities. They are an alternative to a doctor's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor an outpatient department of a hospital, is considered a walk-in clinic. |   |  |
| <b>Maternity - Delivery and Post-Partum Care</b>   | 50% after deductible  | 50% after deductible   |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay.   |   |  |
| <b>Allergy Testing</b>   | Member cost sharing is based on the type of service performed and the place rendered. | 50% after deductible   |
| <b>Allergy Injections</b>  | Covered in full   | 50% after deductible   |
| PREVENTIVE CARE  | NETWORK CARE  | OUT-OF-NETWORK CARE  |
| Preventive care services are covered in accordance with Health Care Reform.  |   |  |
| <b>Routine Adult Physical Exams and Immunizations</b><br>Coverage is limited to 1 exam every 12 months.  | Covered in full   | 50% after deductible   |
| <b>Routine Well Child Exams and Immunizations</b><br>Coverage is limited 7 exams in the first 12 months of life; 3 exams in the second 12 months of life; 3 exams in the third 12 months of life; 1 exam every 12 months thereafter to age 22.   | Covered in full   | 50% after deductible   |

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| <b>Routine Gynecological Exams</b><br>Includes Pap smear, HPV screening and related lab fees. Coverage is limited to 1 exam every 12 months.   | Covered in full                        | 50% after deductible   |
| <b>Routine Mammograms</b><br>For covered females age 40 and over. Frequency schedule applies.  | Covered in full                        | 50% after deductible   |
| <b>Women's Health</b><br>Includes: Screening for gestational diabetes; HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted infections; counseling and screening for human immunodeficiency virus; screening and counseling for interpersonal and domestic violence; breastfeeding support, supplies and counseling; Limitations may apply. | Covered in full                        | Member cost sharing is based on the type of service performed and the place of service where it is rendered. |
| <b>Prenatal Maternity</b>  | Covered in full                        | 50% after deductible   |
| <b>Routine Digital Rectal Exam / Prostate-Specific Antigen Test</b><br>For covered males age 40 and over. Frequency schedule applies.  | Covered in full                        | 50% after deductible   |
| <b>Colorectal Cancer Screening</b><br>Sigmoidoscopy and Double Contrast Barium Enema - 1 every 5 years for all members age 50 and over. Preventive Colonoscopy - 1 every 10 years for all members age 50 and over. Fecal Occult Blood Testing - 1 every year for all members age 50 and over.  | Covered in full                        | 50% after deductible   |
| <b>Routine Eye and Hearing Screenings</b>  | Paid as part of routine physical exam. | Paid as part of routine physical exam.   |
| <b>HEARING SERVICES</b>  | <b>NETWORK CARE</b>                    | <b>OUT-OF-NETWORK CARE</b>   |
| <b>Hearing Exam</b> (by Specialist)  | \$95 copayment after deductible        | 50% after deductible   |
| <b>Hearing Aid</b>   | Not covered                            | Not covered  |
| <b>VISION SERVICES</b>   | <b>NETWORK CARE</b>                    | <b>OUT-OF-NETWORK CARE</b>   |
| <b>Adult Routine Eye Exams (Refraction)</b>  | Not covered                            | Not covered  |
| <b>Pediatric Routine Eye Exams (Refraction)</b><br>Coverage is limited to age 0-19.  | \$60 copay deductible waived           | Not covered  |
| <b>Adult Vision Hardware</b>   | Not covered                            | Not covered  |
| <b>Pediatric Vision Hardware</b><br>Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per calendar year age 0-19.  | Covered in full                        | Not covered  |
| <b>DIAGNOSTIC PROCEDURES</b>   | <b>NETWORK CARE</b>                    | <b>OUT-OF-NETWORK CARE</b>   |
| <b>Outpatient Diagnostic Laboratory</b>  | \$75 copay deductible waived           | 50% after deductible   |
| <b>Outpatient Diagnostic X-ray (except for Complex Imaging Services)</b>   | 50% after deductible                   | 50% after deductible   |
| <b>Outpatient Diagnostic X-ray for Complex Imaging Services</b><br>Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required.   | 50% after deductible                   | 50% after deductible   |
| <b>Outpatient Diagnostic Laboratory Performed in a PCP Office Visit</b>  | Included in OV Copay                   | 50% after deductible   |
| <b>Outpatient Diagnostic X-ray Performed in a PCP Office Visit (except for Complex Imaging Services)</b>   | Included in OV Copay                   | 50% after deductible   |

| <b>Outpatient Diagnostic X-ray for Complex Imaging Services Performed in a PCP Office Visit</b><br>Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required.        | 50% after deductible  | 50% after deductible  |
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| <b>Outpatient Diagnostic Laboratory Performed in a Specialist Office Visit</b>  | Included in OV Copay  | 50% after deductible  |
| <b>Outpatient Diagnostic X-ray Performed in a Specialist Office Visit (except for Complex Imaging Services)</b>   | Included in OV Copay  | 50% after deductible  |
| <b>Outpatient Diagnostic X-ray for Complex Imaging Services Performed in a Specialist Office Visit</b><br>Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required. | 50% after deductible  | 50% after deductible  |
| EMERGENCY MEDICAL CARE  |   |   |
| EMERGENCY MEDICAL CARE  | NETWORK CARE  | OUT-OF-NETWORK CARE   |
| <b>Urgent Care Provider</b><br>(Benefit Availability may vary by location.)   | \$100 copay deductible waived   | Paid as in-network  |
| <b>Non-Urgent Use of Urgent Care Provider</b>   | Not covered   | Not covered   |
| <b>Emergency Room</b>   | 50% after deductible  | Paid as in-network  |
| <b>Non-Emergency care in an Emergency Room</b>  | Not covered   | Not covered   |
| <b>Emergency Ambulance</b>  | 50% after deductible  | Paid as in-network  |
| <b>Non-Emergency Ambulance</b>  | 50% after deductible  | Paid as in-network  |
| HOSPITAL CARE   |   |   |
| HOSPITAL CARE   | NETWORK CARE  | OUT-OF-NETWORK CARE   |
| <b>Inpatient Coverage</b><br>Including maternity (prenatal, delivery and postpartum) and transplants.   | 50% after deductible  | 50% after deductible  |
| <b>Outpatient Surgery</b><br>Provided in an outpatient hospital department or freestanding surgical facility.   | 50% after deductible  | 50% after deductible  |
| <b>Colonoscopy</b><br>(non-preventive)  | Member cost sharing is based on the type of service performed and the place rendered. | Member cost sharing is based on the type of service performed and the place rendered. |
| <b>Transplants</b><br>Coverage is limited to IOE facilities only.   | 50% after deductible  | Not covered   |
| MENTAL HEALTH and SUBSTANCE USE SERVICES  |   |   |
| MENTAL HEALTH and SUBSTANCE USE SERVICES  | NETWORK CARE  | OUT-OF-NETWORK CARE   |
| <b>Inpatient Mental Health &amp; Substance Use Services</b>   | 50% after deductible  | 50% after deductible  |
| <b>Outpatient Office Visit Mental Health &amp; Substance Use Services</b>   | \$95 copay deductible waived  | 50% after deductible  |
| <b>Outpatient Other Mental Health &amp; Substance Use Services</b><br>(e.g.:partial hospitalization programs, intensive outpatient programs, applied behavior analysis)                         | 50% after deductible  | 50% after deductible  |
| OTHER SERVICES AND PLAN DETAILS   |   |   |
| OTHER SERVICES AND PLAN DETAILS   | NETWORK CARE  | OUT-OF-NETWORK CARE   |
| <b>Skilled Nursing Facility</b><br>Coverage is limited to 100 days per calendar year.   | 50% after deductible  | 50% after deductible  |
| <b>Home Health Care</b><br>Coverage is limited to 100 visits per calendar year. 1 visit equals a period of 4 hours or less.   | 50% after deductible  | 50% after deductible  |
| <b>Infusion Therapy</b><br>Provided in the home or physician's office.  | \$60 copay deductible waived  | 50% after deductible  |
| <b>Infusion Therapy</b><br>Provided in the outpatient hospital department or freestanding facility.   | 50% after deductible  | 50% after deductible  |

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| <b>Hospice Care - Inpatient</b>  | 50% after deductible  | 50% after deductible                       |
| <b>Hospice Care Outpatient</b>   | 50% after deductible  | 50% after deductible                       |
| <b>Private Duty Nursing -Outpatient</b>  | Not covered   | Not covered                                |
| <b>Outpatient Short-Term Rehabilitation - Physical Therapy</b><br>If provided in the outpatient hospital department, paid under outpatient hospital benefit.<br><br>Accumulation and Cost Share- No visit limits per calendar year PT, OT and ST, separate from habilitation and includes all outpatient places of service for PT, OT and ST.        | 50% after deductible  | 50% after deductible                       |
| <b>Outpatient Short-Term Rehabilitation - Occupational Therapy</b><br>If provided in the outpatient hospital department, paid under outpatient hospital benefit.<br><br>Accumulation and Cost Share- No visit limits per calendar year PT, OT and ST, separate from habilitation and includes all outpatient places of service for PT, OT and ST.    | 50% after deductible  | 50% after deductible                       |
| <b>Outpatient Short-Term Rehabilitation - Speech Therapy</b><br>If provided in the outpatient hospital department, paid under outpatient hospital benefit.<br><br>Accumulation and Cost Share- No visit limits per calendar year PT, OT and ST, separate from habilitation and includes all outpatient places of service for PT, OT and ST.          | 50% after deductible  | 50% after deductible                       |
| <b>Outpatient Chiropractic</b><br>If provided in the outpatient hospital department, paid under outpatient hospital benefit.<br><br>Accumulation and Cost Share- Coverage is limited to 20 visits per calendar year, separate from habilitation and includes all outpatient places of service for Chiro.   | 50% after deductible  | 50% after deductible                       |
| <b>Acupuncture</b>   | \$60 copay deductible waived  | 50% after deductible                       |
| <b>Durable Medical Equipment</b>   | 50% after deductible  | 50% after deductible                       |
| <b>Diabetic Supplies not obtainable at a pharmacy</b>  | Covered same as any other medical expense.  | Covered same as any other medical expense. |
| <b>FAMILY PLANNING</b>   | <b>NETWORK CARE</b>   | <b>OUT-OF-NETWORK CARE</b>                 |
| <b>Infertility Treatment - Diagnostic only</b><br>Covered only for the diagnosis and treatment of the underlying medical condition.  | Member cost sharing is based on the type of service performed and the place rendered. | 50% after deductible                       |
| <b>Infertility Treatment - Artificial Insemination or Ovulation Induction</b><br>Coverage is limited to \$2,000 maximum per lifetime, AI/OI & ART/ GIFT combined. Excludes ZIFT, IVF, ICSI, ovum microsurgery, cryopreserved embryo transfers and injectable medications.  | Member cost sharing is based on the type of service performed and the place rendered. | Not covered                                |
| <b>Advanced Reproductive Technology.</b> Including, but not limited to, GIFT, ZIFT, IVF, ICSI, ovum microsurgery and cryopreserved embryo transfers.<br><br>Coverage is limited to \$2,000 maximum per lifetime, AI/OI & ART/ GIFT combined. Excludes ZIFT, IVF, ICSI, ovum microsurgery, cryopreserved embryo transfers and injectable medications. | Member cost sharing is based on the type of service performed and the place rendered. | Not covered                                |
| <b>Voluntary Sterilization - Vasectomy</b>   | Member cost sharing is based on the type of service performed and the place rendered. | 50% after deductible                       |
| <b>Voluntary Sterilization - Tubal Ligation</b>  | Covered in full   | 50% after deductible                       |
| <b>PEDIATRIC DENTAL SERVICES</b>   | <b>NETWORK CARE</b>   | <b>OUT-OF-NETWORK CARE</b>                 |

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| <b>Preventive &amp; Diagnostic</b> (includes exams, cleanings, x-rays, fluoride, sealants)<br>Coverage is limited to age 0-19.  | Covered in full after deductible  | 30% after deductible   |
| <b>Basic</b> (includes space maintainers, fillings, anesthesia, denture adjustments)<br>Coverage is limited to age 0-19.  | 30% after deductible  | 50% after deductible   |
| <b>Major</b> (includes crowns, endodontics, periodontics, oral surgery, dentures, bridges)<br>Coverage is limited to age 0-19.  | 50% after deductible  | 50% after deductible   |
| <b>Orthodontia</b> (limited to medically necessary orthodontia)<br>Coverage is limited to age 0-19.   | 50% after deductible  | 50% after deductible   |
| <b>PHARMACY DEDUCTIBLE</b>  | <b>NETWORK CARE</b>   | <b>OUT-OF-NETWORK CARE</b>   |
| <b>Prescription drug calendar year deductible</b>   | Prescription drugs purchased at a network pharmacy are subject to the in-network medical deductible which must be satisfied before any prescription drug benefits are paid.                     | Prescription drugs purchased at a non-network pharmacy are subject to the non-network medical deductible which must be satisfied before any prescription drug benefits are paid. |
| <b>PHARMACY - PRESCRIPTION DRUG BENEFITS</b>  | <b>NETWORK CARE</b>   | <b>OUT-OF-NETWORK CARE</b>   |
| <b>Retail</b><br>Up to a 30 day supply  |   |  |
| <b>Generic Drugs</b>  | \$30 copay deductible waived  | Not covered  |
| <b>Preferred Brand Drugs</b>  | \$100 copayment after deductible  | Not covered  |
| <b>Non-Preferred Drugs</b><br>Deductible waived for generics on all tiers   | Brand: \$150 copayment after deductible   | Not covered  |
| <b>Specialty Drugs</b><br><b>Includes self-injectable, infused and oral specialty drugs</b> (retail and mail order up to a 30-day supply, excludes insulin).  | 50% up to \$500 after deductible  | Not covered  |
| <b>Mail Order Delivery</b>  | When you fill your prescription by mail order, you may save money 31-90 days – excludes specialty drugs when compared to the cost to purchase your prescriptions at your local retail pharmacy. |  |
| <b>Generic Drugs</b>  | \$60 copay deductible waived  | Not covered  |
| <b>Preferred Brand Drugs</b>  | \$200 copayment after deductible  | Not covered  |
| <b>Non-Preferred Drugs</b><br>Deductible waived for generics on all tiers   | Brand: \$300 copayment after deductible   | Not covered  |
| <b>Specialty Drugs</b><br><b>Includes self-injectable, infused and oral specialty drugs</b>   | Not covered   | Not covered  |
| <b>Specialty CareRx<sup>SM</sup></b> -First Prescription for a specialty drugs must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy®. Subsequent fills must be through Aetna Specialty Pharmacy®.<br>For more information, please go to <a href="http://www.aetnaspecialtycarerx.com">www.aetnaspecialtycarerx.com</a> |   |  |

**Choose Generic** - Included. See Aetna Formulary for details.

If the physician prescribes or the member requests a covered brand name prescription drug when a generic prescription drug equivalent is available, the member will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent plus the applicable cost-sharing. The cost difference between the generic and brand does not count toward the Out of Pocket Maximum.

**Precertification** - Included. See Aetna Formulary for details.

**Step Therapy** - Included. See Aetna Formulary for details.

**Pharmacy Plan includes:**

Diabetic supplies obtainable from a pharmacy (Including: needles, syringes, test strips, lancets and alcohol swabs - available at retail or mail order).

**Performance Enhancing Drugs** - Coverage is included for up to 30 pills per month or 27 pills per 90 days for lifestyle/performance drugs. See Aetna Formulary for details on precertification.

Formulary generic FDA-approved Womens Contraceptives covered 100% in network.

**In-Network and Out-of-Network Providers**

\*We cover the cost of services based on whether doctors are "in-network" or "out-of-network". We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a provider who is out-of-network, your Aetna health plan may pay some of that provider's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

Your doctor sets his or her own rate to charge you. It may be higher - sometimes much higher - than what your Aetna plan "recognizes". Your non-network doctor may bill you for the dollar amount that Aetna doesn't "recognize". You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums.

To learn more about how we pay out-of-network benefits visit [www.aetna.com](http://www.aetna.com). Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to [www.aetna.com](http://www.aetna.com) and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site.

This applies when you choose to get care out-of-network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in the network. You pay cost sharing and deductibles for your in-network level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

### **What's Not Covered**

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design purchased.

- All medical or hospital services not specifically covered in or which are limited or excluded in the plan documents
- Charges related to any eye surgery mainly to correct refractive errors
- Cosmetic surgery, including breast reduction
- Custodial care
- Adult dental care and x-rays
- Donor egg retrieval
- Experimental and investigational procedures
- Immunizations for travel or work
- Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents
- Non-medically necessary services or supplies
- Orthotics except as specified in the plan
- Over-the-counter medications and supplies
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs
- Special duty nursing
- Weight reduction programs, or dietary supplements

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. Precertification requirements may vary.

If your plan covers outpatient prescription drugs, your plan includes a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step therapy, please refer to our website at [www.aetna.com](http://www.aetna.com), or the Aetna Medication Formulary Guide. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates may not reduce the amount a member pays the pharmacy for covered prescriptions. In addition, in circumstances where your prescription plan uses copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage.

Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna, Inc., that is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated charge with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services.

While this information is believed to be accurate as of the print date, it is subject to change.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Plans are provided by Aetna Health Inc.

For more information about Aetna plans, refer to [www.aetna.com](http://www.aetna.com).

FORM #: 14.35.305.1 B (10/18) © 2018

Print Date:12-21-2018

TPID: 14042131