CITY OF OWASSO
Effective Date: 07-01-2021
Aetna Choice® POS II – ASC
Premium Plan

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit Limitations - For any service or supply that is subject to a maximum visit, day, or dollar limitation on a per year basis, the benefit year begins on January 1st unless otherwise mandated. Refer to your plan documents for more information.		
Deductible (per calendar year)	None Individual None Family	$1,000 Individual $3,000 Family
Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount.		
Member Coinsurance	Covered 100%	50%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$4,000 Individual $8,000 Family	$4,500 Individual $9,000 Family
All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. Pharmacy expenses apply towards the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum		
Unlimited except where otherwise indicated.		
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%	50%; after deductible
1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older		
Routine Well Child Exams/Immunizations	Covered 100%	50%; after deductible
7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%	50%; after deductible
1 exam and pap smear per calendar year, includes related fees.		
Routine Mammograms	Covered 100%	50%; after deductible
1 per year for covered females age 40 and over.		
Women's Health	Covered 100%	50%; after deductible
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. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		

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Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%	50%; after deductible
Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%	50%; after deductible
Colorectal Cancer Screening Recommended: For all members age 45 and over.	Covered 100%	50%; after deductible
Routine Eye Exams 1 routine exam per 12 months.	Covered 100%	50%; after deductible
Routine Hearing Screening	Covered 100%	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician.	$25 copay	50%; after deductible
Specialist Office Visits	$25 copay	50%; after deductible
Hearing Exams 1 routine exam per 24 months.	Covered 100%	50%; after deductible
Pre-Natal Maternity	Covered 100%	50%; after deductible
Walk-in Clinics Walk-in Clinics are free-standing health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be Walk-in Clinics.	$25 copay	50%; after deductible
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed. Covered 100% when an office visit charge is not applicable.	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray (other than Complex Imaging Services) If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	Covered 100%	50%; after deductible
Diagnostic Laboratory If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	Covered 100%	50%; after deductible
Diagnostic Complex Imaging If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	$50 copay	50%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$35 copay	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	$150 copay	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered

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HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	$150 per day for the first 2 days, thereafter Covered 100%	50% after $500 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	$150 per day for the first 2 days, thereafter Covered 100%	50% after $500 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	Covered 100%	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	$50 copay	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	$50 copay	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	$150 per day for the first 2 days, thereafter Covered 100%	50% after $500 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	Covered 100%	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%	50%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	$150 per day for the first 2 days, thereafter Covered 100%	50% after $500 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	$150 per day for the first 2 days, thereafter Covered 100%	50% after $500 copay; after deductible
Substance Abuse Office Visits	Covered 100%	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%	50%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	$150 per day for the first 2 days, thereafter Covered 100%	50% after $500 copay; after deductible
Limited to 90 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	$25 copay	50%; after deductible
Limited to 120 visits per year. Private Duty Nursing not included. Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.		
Hospice Care - Inpatient	Covered 100%	Covered 100%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	Covered 100%	Covered 100%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing	Covered 100%	50%; after deductible
Limited to 70 eight hour shifts per year. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.		
Spinal Manipulation Therapy	$25 copay	50%; after deductible
Limited to 15 visits per year		

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Outpatient Rehabilitative Speech Therapy Limited to 60 visits per year.	$25 copay	50%; after deductible
Outpatient Physical and Occupational Therapy Limited to 60 visits per year combined.	$25 copay	50%; after deductible
Habilitative Physical Therapy	Not Covered	Not Covered
Habilitative Occupational Therapy	Not Covered	Not Covered
Habilitative Speech Therapy	Not Covered	Not Covered
Autism Behavioral Therapy Combined with outpatient mental health visits	$25 copay	50%; after deductible
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health All Other benefit	Covered 100%	50%; after deductible
Autism Physical Therapy	Covered 100%	50%; after deductible
Autism Occupational Therapy	Covered 100%	50%; after deductible
Autism Speech Therapy	Covered 100%	50%; after deductible
Durable Medical Equipment	Covered 100%	50%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%	Covered same as any other expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%	Covered same as any other medical expense.
Infusion Therapy Administered in the home or physician's office	$25 copay	50%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Vision Eyewear	Not Covered	Not Covered
Transplants	$150 per day for the first 2 days, thereafter Covered 100% Preferred coverage is provided at an IOE contracted facility only.	50% after $500 copay; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery Limited to $10,000 per lifetime Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$150 per day for the first 2 days, thereafter Covered 100%	50% after $500 copay; after deductible
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered	Not Covered

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Vasectomy	Covered 100%	50%; after deductible
Tubal Ligation	Covered 100%	50%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Standard Open Formulary	
Generic Drugs		
Retail	$10 copay	50% of submitted cost; after applicable copay
Mail Order	$20 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$20 copay	50% of submitted cost; after applicable copay
Mail Order	$40 copay	Not Applicable
Non-Preferred Brand-Name Drugs		
Retail	$35 copay	50% of submitted cost; after applicable copay
Mail Order	$70 copay	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna National Network	
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	Up to a 30 day supply First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network. Aetna Specialty Performance Network Drug List	

Plan Includes: Diabetic supplies, blood glucose monitors, prescription weight loss drugs and contraceptive drugs and devices obtainable from a pharmacy.
Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).
Precertification for specialty drugs included
Seasonal Vaccinations covered 100% in-network
Preventive Vaccinations covered 100% in-network
Travel Vaccinations covered 100% in-network
Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.
Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

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The following is a 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 or rider(s) purchased by your employer.

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental X-rays.
• Donor egg retrieval
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Hearing aids
• Home births
• Immunizations for travel or work, except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Infertility services, including 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.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna, or its affiliate(s), receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates may reduce the amount a member pays the pharmacy for covered prescriptions.
CVS Caremark ® Mail Service Pharmacy refers to CVS Caremark ® Mail Service Pharmacy, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with CVS Caremark ® Mail Service Pharmacy may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.
In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.
Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**
Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**
Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com.**
Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.