Aetna Memorial Herman ACO (Accountable Care Organization)

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK CARE (Designated Memorial Herman ACO providers & facilities)
Deductible (per calendar year)	$750 Individual $2250 Family
All covered expenses accumulate simultaneously toward the deductible in in both preferred tiers. Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.	
Member Coinsurance Applies to all expenses unless otherwise stated.	20%
Payment Limit (per calendar year)	$3,000 Employee $6,000 Family
All covered expenses accumulate simultaneously toward the Payment Limit from application of coinsurance percentage, copays, pharmacy and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year.	
Lifetime Maximum All covered expenses accumulate simultaneously toward the Lifetime Maximum in each of the three benefit tiers.	Unlimited except where otherwise
Primary Care Physician Selection	**Optional**
Referral Requirement	**Optional**

PREVENTIVE CARE	IN-NETWORK TIER 1
Routine Adult Physical Exams/ Immunizations 1 exam per calendar year for members age 18 to age 65; 1 exam per calendar year for adults age 65 and older.	Covered 100%; deductible waived
Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 3 exams in the 13th-36th months of life; 1 exam per calendar year to age 18.	Covered 100%; deductible waived
Routine Gynecological Care Exams Routine tests & lab fees, 1 exam per calendar	Covered 100%; deductible waived
Routine Mammograms For covered females age 35 and over, 1 exam per calendar year. Member cost sharing is based on the type of service performed and the place of service where it is rendered	Covered 100%; deductible waived
Routine Digital Rectal Exam / Prostate-specific Antigen Test For covered males age 40 and over.	Covered 100%; deductible waived
Colorectal Cancer Screening For all members age 45 and over.	Covered 100%; deductible waived
Routine Hearing Exams 1 routine exam per 24 months	Covered as either PCP or specialist office visit.
Newborn Hearing Screening 1 in first 30 days of life and follow-up diagnostice care untill the age of 24 months	Covered 100%; deductible waived
PHYSICIAN SERVICES	**IN-NETWORK TIER 1**
Office Visits (non surgical) to PCP	$30 office visit copay

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Includes services of an internist, general physician, family practitioner or pediatrician.	
Specialist Office Visits Maternity OB visits: copay for initial visit only, there after covered 100%.	$40 office visit copay
Outpatient Surgery (hospital or other facility) The member cost sharing applies to all covered benefits incurred during a member's outpatient visit, however Aexcel specialist services performed in a hospital or other facility may be billed separately for the Aexcel product and covered as Physician	20% after Deductible
Physician Services for Non-Office Care Aexcel specialist services performed in a hospital or other facility may be billed separately for the Aexcel product.	20% after Deductible
Allergy Testing	Covered as either PCP or specialist office visit
Allergy Injections	Covered as either PCP or specialist office visit
DIAGNOSTIC PROCEDURES	**IN-NETWORK TIER 1**
Diagnostic Laboratory and X-ray except for 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	$40 copay
Complex Imaging Services (examples: MRI/CAT/PET scans)	$150 Copay
EMERGENCY MEDICAL CARE	**IN-NETWORK TIER 1**
Walk-in Clinic	$30 copay
Urgent Care Provider (benefit availability may vary by location)	$40 copay
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	20% after deductible
Non-Emergency care in an Emergency Room	Not Covered
Ambulance	20% after deductible
HOSPITAL CARE	**IN-NETWORK TIER 1**
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay, however Aexcel specialist services performed in a hospital or other facility may be billed separately for the Aexcel product and covered as Physician	20% after Deductible, after $300 per confinement copay
Inpatient Maternity Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay, however Aexcel specialist services performed in a hospital or other facility may be billed separately for the Aexcel product and covered as Physician	20% after Deductible, after $300 per confinement copay
Outpatient Hospital Expenses (including surgery) The member cost sharing applies to all covered benefits incurred during a member's outpatient visit, however Aexcel specialist services performed in a hospital or other facility may be billed separately for the Aexcel product and covered as Physician	20% after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK TIER 1**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	20% after Deductible, after $300 per confinement copay
Outpatient	20% after deductible

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The member cost sharing applies to all covered benefits incurred during a member's outpatient visit
Maximums are combined for Mental Health and Alcohol/Drug services

ALCOHOL/DRUG ABUSE SERVICES	IN-NETWORK TIER 1	
Inpatient	20% after Deductible, after $300 per confinement copay	
3 episodes per lifetime, Inpatient / outpatient combined.		
Outpatient	20% after deductible	

The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit
Maximums are combined for Mental Health and Alcohol/Drug services

OTHER SERVICES	IN-NETWORK TIER 1	
Convalescent Facility (Skilled Nursing) Limited to 100 days per calendar year.	20% after Deductible, after $300 per confinement copay	
The member cost sharing applies to all covered benefits incurring during a member's inpatient stay		
Home Health Care Includes Private Duty Nursing limited to 70 eight hour shifts per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.	20% after deductible	
Hospice Care - Inpatient	20% after Deductible, after $300 per confinement copay	
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Hospice Care - Outpatient	20% after deductible	
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
Private Duty Nursing- Outpatient	Not Covered	
Outpatient Short-Term Rehabilitation Includes Speech, Physical, Occupational Therapy Limited 60 visits per calendar year.	$40 copay	
Spinal Manipulation Therapy Limited to 20 visits per calendar year	$40 copay, dedutible waived	
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health, Other Services	Covered same as any other Outpatient Mental Health.
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health, Other Services	Covered same as any other Outpatient Mental Health.
Autism Physical Therapy	$40 copay, deductible waived	
Autism Ocupational Therapy	$40 copay, deductible waived	
Autism Speech Therapy	$40 copay, dedutible waived	
Durable Medical Equipment	20% after deductible	
Prosthetics	20% after deductible	
Orthotics	20% after deductible	
Diabetic Supplies	Covered 100% for supplies only.	
Prescription Drugs	Not Covered	
Contraceptive devices not obtainable at/under pharmacy (includes coverage for contraceptive visits)	Covered 100%; deductible waived	
Transplants Coverage is provided at an IOE contracted facility only.	20% after Deductible, after $300 per confinement copay	
Bariatric Surgery	Not Covered	

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Mouth, Jaws and Teeth (oral surgery procedures, whether medical or dental in nature)	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Out of Area Dependents	No coverage for non-emergency care received outside the service area.

FAMILY PLANNING	**IN-NETWORK TIER 1**
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Diagnosis and treatment of the underlying medical condition.	
Comprehensive Infertility Services	Not Covered
Vasectomy	Your cost sharing is based on the type of service and where it is performed.
Tubial Ligation	Covered 100%; deductible waived

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 19 or to age 26.
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Waived

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 or rider(s) purchased by your employer.

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; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; 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; Nonmedically necessary services or supplies; Orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing.

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.

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Some benefits are subject to limitations or visit maximums. 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. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary.

They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are administered by Aetna Life Insurance Company.