aetna

Grand View Hospital - CHOICE PLAN
Effective Date: 01-01-2016
Aetna Choice™ POS II - ASC

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	CUSTOMER PREFERRED CARE (Home Host)	AETNA PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	None Individual None Family	$200 Individual $600 Family	$1,000 Individual $3,000 Family
All covered expenses, excluding prescription drugs, accumulate toward both the preferred and non-preferred Deductible. Unless otherwise indicated, the Deductible must be met prior to benefits being payable. 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%	20%	50%
Applies to all expenses unless otherwise stated.			
Payment Limit (per calendar year)	$1,000 Individual $3000 Family	$1,500 Individual $4500 Family	$5,000 Individual $15000 Family
All covered expenses excluding prescription drugs accumulate toward both the preferred and non-preferred medical Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, and deductibles (except any penalty amounts) may be used to satisfy 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.			
Payment for Non-Preferred	Not applicable	Not applicable	Professional: 110% of Medicare Facility: 150% of Medicare
Primary Care Physician Selection	Optional	Optional	Not applicable
Certification Requirements -			
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, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is 50% of benefit up to $1000 maximum			
Referral Requirement	None	None	None
PREVENTIVE CARE	**CUSTOMER PREFERRED CARE (Home Host)**	**AETNA PREFERRED CARE**	**NON-PREFERRED CARE**
Routine Adult Physical Exams/ Immunizations	Covered 100%	Covered 100%; deductible waived	50% after deductible
1 exam per 12 months for adults age 22 and older.			
Routine Well Child Exams/Immunizations	Covered 100%	Covered 100%; deductible waived	50% after deductible
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 per 12 months thereafter to age 22			

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Routine Gynecological Care Exams Includes Pap smear and related lab fees	Covered 100%	Covered 100%; deductible waived	50% after deductible
Routine Mammograms	Covered 100%	Covered 100%; deductible waived	50% after deductible
Women's Health	Covered 100%	Covered 100%; deductible waived	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.			
Routine Digital Rectal Exam / Prostate-specific Antigen Test For covered males age 40 and over.	Covered 100%	Covered 100%; deductible waived	50% after deductible
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%	Covered 100%; deductible waived	50% after deductible
Routine Eye Exams 1 routine exam per 12 months.	Covered 100%	Covered 100%; deductible waived	50% after deductible
PHYSICIAN SERVICES	**CUSTOMER PREFERRED CARE (Home Host)**	**AETNA PREFERRED CARE**	**NON-PREFERRED CARE**
Office Visits to PCP	$15 office visit copay	$20 office visit copay; after deductible	50% after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.			
Specialist Office Visits	$25 office visit copay	$40 office visit copay after deductible	50% after deductible
Includes services of an internist, general physician, family practitioner or pediatrician, if the physician is not the member's selected PCP.			
Pre-Natal Maternity	Covered 100%; deductible waived	Covered 100%; deductible waived	Covered according to standard claim practice.
Allergy Testing	Covered as either PCP or specialist office visit	Covered as either PCP or specialist office visit	50% after deductible
Allergy Injections	Covered as either PCP or specialist office visit	Covered as either PCP or specialist office visit	50% after deductible
DIAGNOSTIC PROCEDURES	**CUSTOMER PREFERRED CARE (Home Host)**	**AETNA PREFERRED CARE**	**NON-PREFERRED CARE**
Diagnostic Laboratory and Xray	Covered 100%	20% after deductible	50% after deductible
Diagnostic X-ray for Complex Imaging Services	$25 copay	$40 copay after deductible	50% after deductible

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EMERGENCY MEDICAL CARE	CUSTOMER PREFERRED CARE (Home Host)	AETNA PREFERRED CARE	NON-PREFERRED CARE
Urgent Care Provider (benefit availability may vary by location)	Refer to Aetna Preferred Care	$50 copay after deductible	50% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered	Not Covered
Emergency Room	$50 copay	$100 copay after deductible	Same as preferred care.
Non-Emergency care in an Emergency Room	$150 copay	Not Covered	Not Covered
Urgent use of Ambulance	Covered 100%	Covered 100% after deductible	Same as preferred care.
HOSPITAL CARE	**CUSTOMER PREFERRED CARE (Home Host)**	**AETNA PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Coverage	$100 per admission copay	20% after deductible	50% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.			
Inpatient Maternity Coverage (includes delivery and postpartum care)	$25 for Physician Services; deductible waived; $100 per admission for Facility services	20% after deductible	50% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.			
Outpatient Surgery	$50 copay	20% after deductible	50% after deductible
Outpatient Hospital Expenses	Covered 100%	20% after deductible	50% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.			
MENTAL HEALTH SERVICES	**CUSTOMER PREFERRED CARE (Home Host)**	**AETNA PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	Refer to Aetna Preferred Care	20% after deductible	50% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.			
Outpatient	Refer to Aetna Preferred Care	$40 copay after deductible	50% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.			

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ALCOHOL/DRUG ABUSE SERVICES	CUSTOMER PREFERRED CARE (Home Host)	AETNA PREFERRED CARE	NON-PREFERRED CARE
Inpatient	Refer to Aetna Preferred Care	20% after deductible	50% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.			
Outpatient	Refer to Aetna Preferred Care	$40 copay after deductible	50% after deductible
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit.			

OTHER SERVICES	CUSTOMER PREFERRED CARE (Home Host)	AETNA PREFERRED CARE	NON-PREFERRED CARE
Convalescent Facility	Refer to Aetna Preferred Care	20% after deductible	50% after deductible
Limited to 120 days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay.			
Home Health Care	Covered 100%	20% after deductible	50% after deductible
Limited to 120 visits per calendar year. 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.			
Hospice Care - Inpatient	$100 per admission copay	20% after deductible	50% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay			
Hospice Care - Outpatient	Covered 100%	20% after deductible	50% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit			
Outpatient Short-Term Rehabilitation	$25 copay	$40 copay after deductible	50% after deductible
Includes Speech, Physical, and Occupational Therapy, limited to 60 combine visit per calendar year			
Spinal Manipulation Therapy	$25 copay	$40 copay after deductible	50% after deductible
Limited to 30 visits per calendar year			
Durable Medical Equipment	Covered 100%	20% after deductible	50% after deductible
Diabetic Supplies	Covered same as any other medical expense.	Covered same as any other medical expense.	Covered same as any other medical expense.
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%	Covered 100%; deductible waived	Covered same as any other medical expense.
Generic FDA-approved Women's Contraceptives	Covered 100%	Covered 100%; deductible waived	50% after deductible
Bariatric Surgery	Covered 100% after $100 copay; after deductible	20% after deductible	$240 per admission deductible after plan deductible
Transplants	Refer to Aetna Preferred Care	20% after deductible. Preferred coverage is provided at an IOE contracted facility only; after deductible	50% Non-Preferred coverage is provided at a Non-IOE facility after deductible

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	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan.		
FAMILY PLANNING	**CUSTOMER PREFERRED CARE (Home Host)**	**AETNA PREFERRED CARE**	**NON-PREFERRED CARE**
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered	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	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Coverage includes Artificial Insemination (limited to six courses of treatment per member's lifetime) and Ovulation Induction (limited to six courses of treatment per member's lifetime). Lifetime maximum applies to all procedures covered by any Aetna plan except where prohibited by law.			
Vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Tubal Ligation	Covered 100%	Covered 100%; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
PHARMACY	**CUSTOMER PREFERRED CARE (Home Host)**	**AETNA PREFERRED CARE**	**NON-PREFERRED CARE**
Pharmacy Plan Type	Aetna Premier Plus Open Formulary		
Retail	$5 copay for generic drugs, $20 copay for formulary brand-name drugs, and $35 copay for non-formulary brand-name drugs up to a 30 day supply at Grand View pharmacy	$20 copay for generic drugs, $40 copay for formulary brand-name drugs, and $80 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	Not Covered

	$10 copay for generic drugs, $40 copay for formulary brand-name drugs, and $70 copay for non-formulary brand-name drugs up to a 90 day supply at Grand View pharmacy		
Mail Order	Refer to Preferred Network	$40 copay for generic drugs, $80 copay for formulary brand-name drugs, and $160 copay for non-formulary brand-name drugs up to a 90 day supply from Aetna Rx Home Delivery®.	Not applicable
Aetna Premier Plus Specialty Drugs	The greater of 10% or $125 per prescription for a maximum 30 day supply for formulary drugs. The greater of 10% or $150 per prescription for a maximum 30 day supply for non-formulary drugs.	The greater of 10% or $125 per prescription for a maximum 30 day supply for formulary drugs. The greater of 10% or $150 per prescription for a maximum 30 day supply for non-formulary drugs.	

First prescription may be filled at Retail facility. Subsequent fills must be through either GVH or Aetna Specialty Pharmacy.

Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.

Premier Plus Specialty Drugs

Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs, Diabetic supplies.

Premier Plus Precert included.

Formulary Generic FDA-approved Women's Contraceptives covered 100% in network

Prescription drug calendar year Payment Limit (combined maximum for drugs received at a customer preferred or Aetna preferred pharmacy	$2,000 Individual	$2,000 Individual	Not applicable
	$4,000 Family	$4,000 Family	Not applicable

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.

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26

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.

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 provided by Aetna Life Insurance Company.