

# Active Health Option with HRA

## Summary of Benefits

### Aetna Medical Plan Coverage

Cost Sharing	In-Network	Out-of-Network
<b>Annual Deductible</b>		
• individual	\$1,600	\$3,200
• family	\$3,200	\$6,400
<b>Out-of-Pocket Maximum</b> (includes deductibles)		
• individual	\$4,600	\$9,200
• family	\$9,200*	\$18,400
<b>Lifetime Coverage Limit</b>	Does Not Apply	

Covered Service (maximums are combined in- and out-of-network)	In-Network	Out-of-Network (subject to Reasonable and Customary limits)
<b>Primary Care</b>		
Primary Doctor Office Visit	90% after in-network deductible is met	50% after out-of-network deductible is met
Specialist Office Visit	90% after in-network deductible is met	50% after out-of-network deductible is met
<b>Preventive Care</b>		
Routine Physical Exam • 1 exam per calendar year	100% covered; no deductible	50% covered; no deductible
Colorectal Cancer Screenings (age 50 and above) • 1 fecal occult blood test per calendar year • 1 sigmoidoscopy every 5 years • 1 double contrast barium enema every 5 years • 1 colonoscopy every 10 years	100% covered; no deductible	50% covered; no deductible
Well-woman Exam (includes Pap smear) • 1 exam per calendar year	100% covered; no deductible	50% covered; no deductible
Routine Mammogram	100% covered; no deductible	50% covered; no deductible

\* In 2020, if you are enrolled in family coverage, the maximum out-of-pocket you will pay for any one family member will not be more than \$8,150.

<b>Covered Service</b> (maximums are combined in- and out-of-network)	<b>In-Network</b>	<b>Out-of-Network</b> (subject to Reasonable and Customary limits)
<b>Pediatric Exams</b> <ul style="list-style-type: none"> <li>• 1<sup>st</sup> 12 months: 7 exams</li> <li>• 2<sup>nd</sup> 12 months: 3 exams</li> <li>• 3<sup>rd</sup> 12 months: 3 exams</li> <li>• age 3-18 years: 1 exam per calendar year</li> </ul>	100% covered; no deductible	50% covered; no deductible
Immunizations (child)	100% covered; no deductible	50% covered; no deductible
<b>Outpatient Care</b>		
Outpatient X-ray and Laboratory Services	90% after in-network deductible is met	50% after out-of-network deductible is met
Outpatient Surgery	90% after in-network deductible is met	50% after out-of-network deductible is met
<b>Physical Therapy</b> <ul style="list-style-type: none"> <li>• 60 visits per calendar year provided significant improvement is expected</li> </ul> <b>Occupational and Speech Therapy</b> <ul style="list-style-type: none"> <li>• 60 visits per calendar year provided significant improvement is expected</li> </ul>	90% after in-network deductible is met	50% after out-of-network deductible is met
<b>Maternity Care</b>		
Routine Prenatal Office Visit	100% covered; no deductible	50% after out-of-network deductible
Postnatal Office Visit	90% after in-network deductible	50% after out-of-network deductible
In-hospital Delivery	90% after in-network deductible is met	50% after out-of-network deductible is met
Newborn Nursery Services	90% after in-network deductible is met	50% after out-of-network deductible is met
<b>Inpatient Services</b>		
Hospital (room and board are covered up to the semi-private room rate)	90% after in-network deductible is met	50% after out-of-network deductible is met
Inpatient X-Ray and Laboratory	90% after in-network deductible is met	50% after out-of-network deductible is met
Inpatient Physician and Surgeon	90% after in-network deductible is met	50% after out-of-network deductible is met

<b>Covered Service</b> (maximums are combined in- and out-of-network)	<b>In-Network</b>	<b>Out-of-Network</b> (subject to Reasonable and Customary limits)
<b>Other Care</b>		
Skilled Nursing Facility ( <i>non-custodial care</i> ) <ul style="list-style-type: none"> <li>up to a maximum of 100 days per calendar year</li> </ul>	90% after in-network deductible is met	50% after out-of-network deductible is met
Home Health Care ( <i>non-custodial care</i> ) <ul style="list-style-type: none"> <li>up to 120 visits per calendar year</li> </ul>	90% after in-network deductible is met	50% after out-of-network deductible is met
Hospice Care	90% after in-network deductible is met	50% after out-of-network deductible is met
<b>Emergency Care</b>		
Emergency Room <ul style="list-style-type: none"> <li>emergency care</li> <li>non-emergency care</li> </ul>	90% after in-network deductible is met Not covered	90% after in-network deductible is met Not covered
Urgent Care Facility	90% after in-network deductible is met	50% after in-network deductible is met
Ambulance <ul style="list-style-type: none"> <li>emergency use</li> <li>non-emergency use</li> </ul>	90% after in-network deductible is met Not covered	90% after in-network deductible is met Not covered
<b>Mental Health Care</b>		
Mental Health Treatment		
<ul style="list-style-type: none"> <li>inpatient</li> </ul>	90% after in-network deductible is met	50% after out-of-network deductible is met
<ul style="list-style-type: none"> <li>outpatient</li> </ul>	90% after in-network deductible is met	50% after out-of-network deductible is met
Substance Abuse Treatment		
<ul style="list-style-type: none"> <li>inpatient</li> </ul>	90% after in-network deductible is met	50% after out-of-network deductible is met
<ul style="list-style-type: none"> <li>outpatient</li> </ul>	90% after in-network deductible is met	50% after out-of-network deductible is met

## Express Scripts Prescription Drug Coverage

	In-Network Pharmacy
<b>Retail</b> <i>(up to a 30-day supply)</i>	
Generic Drug	You pay 20% (no less than \$10 / no more than \$20)
Formulary Drug	You pay 30% (no less than \$30 / no more than \$80)
Non-Formulary Drug*	You pay 50% (no less than \$50 / no more than \$120)
<b>Mail-Order and CVS Smart90</b> <b>(up to a 90-day supply)</b>	
Generic Drug	You pay 20% (no less than \$25 / no more than \$50)
Formulary Drug	You pay 30% (no less than \$75 / no more than \$200)
Non-Formulary Drug*	You pay 50% (no less than \$125 / no more than \$300)

\*If a prescriber prescribes a non-formulary brand-name drug where a generic is available, you will pay the generic drug coinsurance plus the difference in cost between the generic and brand-name drug.

Please note:

-Coinsurance amounts do not apply to drugs that are part of the SavonSP program.

-There are 2 options to receive your 90-day maintenance medication: Express Scripts mail order or CVS Smart90 programs.