Standard Medical Option

Summary of Benefits

Aetna Medical Plan Coverage

Cost Sharing	In-Network	Out-of-Network
Annual Deductible		
• individual	$1,250	$2,500
• family	$2,500	$5,000
Out-of-Pocket Maximum (includes deductibles)		
• individual	$3,750	$7,500
• family	$7,500	$15,000
Lifetime Coverage Limit	Does Not Apply	

Covered Service (maximums are combined in- and out-of-network)	**In-Network**	**Out-of-Network** (subject to Reasonable and Customary limits)
Primary Care		
Primary Doctor Office Visit	80% after in-network deductible is met	50% after out-of-network deductible is met
Specialist Office Visit	80% after in-network deductible is met	50% after out-of-network deductible is met
Preventive Care		
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

Covered Service (maximums are combined in- and out-of-network)	**In-Network**	**Out-of-Network** (subject to Reasonable and Customary limits)
Pediatric Exams • 1st 12 months: 7 exams • 2nd 12 months: 3 exams • 3rd 12 months: 3 exams • age 3-18 years: 1 exam per calendar year	100% covered; no deductible	50% covered; no deductible
Immunizations (child)	100% covered; no deductible	50% covered; no deductible
Outpatient Care		
Outpatient X-ray and Laboratory Services	80% after in-network deductible is met	50% after out-of-network deductible is met
Outpatient Surgery	80% after in-network deductible is met	50% after out-of-network deductible is met
Physical Therapy • 60 visits per calendar provided significant improvement is expected Occupational and Speech Therapy • 60 visits per calendar year provided significant improvement is expected	80% after in-network deductible is met	50% after out-of-network deductible is met
Maternity Care		
Routine Prenatal Office Visit	100% covered; no deductible	50% after out-of-network deductible
Postnatal Office Visit	80% after in-network deductible is met	50% after out-of-network deductible
In-hospital Delivery	80% after in-network deductible is met	50% after out-of-network deductible is met
Newborn Nursery Services	80% after in-network deductible is met	50% after out-of-network deductible is met
Inpatient Services		
Hospital *(room and board are covered up to the semi-private room rate)*	80% after in-network deductible is met	50% after out-of-network deductible is met
Inpatient X-Ray and Laboratory	80% after in-network deductible is met	50% after out-of-network deductible is met
Inpatient Physician and Surgeon	80% after in-network deductible is met	50% after out-of-network deductible is met

Covered Service (maximums are combined in- and out-of-network)	**In-Network**	**Out-of-Network** (subject to Reasonable and Customary limits)
Other Care		
Skilled Nursing Facility *(non-custodial care)* • up to a maximum of 100 days per calendar year	80% after in-network deductible is met	50% after out-of-network deductible is met
Home Health Care *(non-custodial care)* • up to 120 visits per calendar year	80% after in-network deductible is met	50% after out-of-network deductible is met
Hospice Care	80% after in-network deductible is met	50% after out-of-network deductible is met
Emergency Care		
Emergency Room		
• emergency care	80% after in-network deductible is met	80% after in-network deductible is met
• non-emergency care	Not covered	Not covered
Urgent Care Facility	80% after in-network deductible is met	50% after in-network deductible is met
Ambulance		
• emergency use	80% after in-network deductible is met	80% after in-network deductible is met
• non-emergency use	Not covered	Not covered
Mental Health Care		
Mental Health Treatment		
• inpatient	80% after in-network deductible is met	50% after out-of-network deductible is met
• outpatient	80% after in-network deductible is met	50% after out-of-network deductible is met
Substance Abuse Treatment		
• inpatient	80% after in-network deductible is met	50% after out-of-network deductible is met
• outpatient	80% after in-network deductible is met	50% after out-of-network deductible is met

Express Scripts Prescription Drug Coverage

	In-Network Pharmacy
Retail *(up to a 30-day supply)*	
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)
Mail-Order and CVS Smart90 *(up to a 90-day supply)*	
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.