

Active Health Option with HRA

Summary of Benefits

Aetna Medical Plan Coverage

Cost Sharing	In-Network	Out-of-Network
Annual Deductible		
• individual	\$1,600	\$3,200
• family	\$3,200	\$6,400
Out-of-Pocket Maximum (includes deductibles)		
• individual	\$4,600	\$9,200
• family	\$9,200*	\$18,400
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	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
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

* In 2019, 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 \$7,900.

Covered Service (maximums are combined in- and out-of-network)	In-Network	Out-of-Network (subject to Reasonable and Customary limits)
Pediatric Exams <ul style="list-style-type: none"> • 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	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
Physical Therapy <ul style="list-style-type: none"> • 60 visits per calendar year provided significant improvement is expected Occupational and Speech Therapy <ul style="list-style-type: none"> • 60 visits per calendar year provided significant improvement is expected 	90% 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	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
Inpatient Services		
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

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 (<i>non-custodial care</i>) <ul style="list-style-type: none"> up to a maximum of 100 days per calendar year 	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"> up to 120 visits per calendar year 	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
Emergency Care		
Emergency Room <ul style="list-style-type: none"> emergency care non-emergency care 	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"> emergency use non-emergency use 	90% after in-network deductible is met Not covered	90% after in-network deductible is met Not covered
Mental Health Care		
Mental Health Treatment		
<ul style="list-style-type: none"> inpatient 	90% after in-network deductible is met	50% after out-of-network deductible is met
<ul style="list-style-type: none"> outpatient 	90% after in-network deductible is met	50% after out-of-network deductible is met
Substance Abuse Treatment		
<ul style="list-style-type: none"> inpatient 	90% after in-network deductible is met	50% after out-of-network deductible is met
<ul style="list-style-type: none"> outpatient 	90% after in-network deductible is met	50% after out-of-network deductible is met

Express Scripts Prescription Drug Coverage

	In-Network Pharmacy
Retail <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)
Mail-Order <i>(up to a 90-day supply)</i>	
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.