



** In-network deductibles increasing for 2020 policy year to:

\$500 - Individual

\$1,000 - Family

PSATS

Effective Date: 01-01-2018

Open Choice® (PPO) - Pennsylvania Plan C

**PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY**

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	\$300 Individual ** \$600 Family	\$1,000 Individual \$2,000 Family
All covered expenses, accumulate separately toward the preferred or non-preferred Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. 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	10%	20%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	\$ 6,600 Individual \$13,200 Family	\$10,000 Individual \$20,000 Family
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, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. Pharmacy expenses do apply towards 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 Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Not Applicable	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 \$400 per occurrence.	
Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	20%; after deductible
1 exam every 12 months for members age 22 and older.		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived for immunizations only	20%; deductible waived
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 year thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	20%; deductible waived
Includes routine tests and related lab fees. 1 routine exam per calendar year.		
Routine Mammograms	Covered 100%; deductible waived	20%; after deductible
Women's Health	Covered 100%; deductible waived	20%; 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.		



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Routine Digital Rectal Exam	Covered 100%; deductible waived	20%; after deductible
Prostate-specific Antigen Test	Covered 100%; deductible waived	20%; after deductible
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%; deductible waived	20%; after deductible
Routine Eye Exams 1 routine exam per 24 months.	Covered 100%; deductible waived	20%; after deductible
Routine Hearing Exams	Not Covered	Not Covered
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to non-Specialist	\$35 office visit copay; deductible waived	20%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	\$35 office visit copay; deductible waived	20%; after deductible
Pre-Natal Maternity	\$35 office visit copay; deductible waived	20%; after deductible
E-visit to Non-Specialist	\$35 office visit copay; deductible waived	Not Applicable
An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through our authorized internet E-visit service vendor.		
E-visit to Specialist	\$35 office visit copay; deductible waived	Not Applicable
An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through our authorized internet E-visit service vendor.		
Walk-in Clinics	\$35 office visit copay; deductible waived	20%; after deductible
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.		
Allergy Testing	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	20%; after deductible
Allergy Injections	10%; after deductible	20%; after deductible
DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray	10%; after deductible	20%; after deductible
All covered expenses, accumulate separately toward the preferred or non-preferred Deductible. 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.		
Diagnostic Laboratory	10%; after deductible	20%; after deductible
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.		
Diagnostic Outpatient Complex Imaging	10%; after deductible	20%; after deductible
EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Provider	\$25 copay; deductible waived	20%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered



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Emergency Room	\$100 copay; deductible waived	Same as preferred care.
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	10%; after deductible	10%; after deductible
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	10%; after deductible	20%; 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)	10%; after deductible	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Hospital Expenses	10%; after deductible	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Surgery	10%; after deductible	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	10%; after deductible	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient	\$35 office visit copay; deductible waived	20%; after deductible
Additional outpatient visits may be provided. Each day of inpatient benefits may be converted into two additional outpatient visits.		
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
ALCOHOL/DRUG ABUSE SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	10%; after deductible	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Residential Treatment Facility	10%; after deductible	20%; after deductible
Outpatient	\$35 office visit copay; deductible waived	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Convalescent Facility	10%; after deductible	20%; after deductible
Limited to 90 days per calendar year.		
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Home Health Care	10%; after deductible	20%; after deductible
Limited to 60 visits 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	10%; after deductible	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	10%; after deductible	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Private Duty Nursing - Outpatient	10%; after deductible	20%; after deductible
Outpatient Speech Therapy	\$35 office visit copay; deductible waived	20%; after deductible
Limited to 30 visits per calendar year.		



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Outpatient Physical and Occupational Therapy Limited to 30 visits per calendar year.	\$35 office visit copay; deductible waived	20%; after deductible
Spinal Manipulation Therapy Limited to 20 visits per calendar year.	\$35 office visit copay; deductible waived	20%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit.	\$35 office visit copay; deductible waived	20%; after deductible
Autism Applied Behavior Analysis Covered same as any other expense with no age or visit limitations.	Covered the same as any other expense based on the type of service performed and place of service where rendered	Covered the same as any other expense based on the type of service performed and place of service where rendered
Autism Physical, Occupational and Speech Therapy To age 21, covered same as any other Physical Occupational Combined Therapy expense.	\$35 office visit copay; deductible waived	20%; after deductible
Durable Medical Equipment	10%; after deductible	20%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Generic FDA-approved Women's Contraceptives	Covered 100%; deductible waived	Not Covered
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	20%; after deductible
Transplants	10%; after deductible Preferred coverage is provided at an IOE contracted facility only.	20%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Not Covered	Not Covered
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
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; after deductible

Diagnosis and treatment of the underlying medical condition.



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Comprehensive Infertility Services	Not Covered	Not Covered
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
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.
Tubal Ligation	Covered 100%; deductible waived	Covered 100%; deductible waived

PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Retail	20% copay, after deductible for generic drugs, formulary brand-name drugs, and non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	20% copay, after deductible for generic drugs, formulary brand-name drugs, and non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.
Mail Order	\$15 copay for generic drugs, formulary brand-name drugs, and non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not Applicable
Pharmacy Deductible	Individual \$50; Family \$100	

Aetna Specialty CareRx

First prescription fill at any retail drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®.

Choose Generics with Dispense as Written (DAW) override - The member pays the applicable copay only, if the physician requires brand. If the member requests brand when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.

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

Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).

Precert for growth hormones included.

GENERAL PROVISIONS

Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Waived

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

- For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

- For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.



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Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc., Aetna Health Insurance Company, Aetna Life Insurance Company and/or Aetna HealthAssurance Pennsylvania, Inc. Each insurer has sole financial responsibility for its own plans and products.

This managed care plan may not cover all of your health care expenses. Read your contract carefully to determine which health care services are covered. To contact the plan if you are a member, call the number on your ID card; all others, call 1-888-982-3862.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

The following is a 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.



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- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Home births
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services, including 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.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862**.

Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862**.

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **www.aetna.com**.

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