aetna®

**High Desert & Inland Employee-Employer Trust – PPO HSA 6**
Effective Date: 07-01-2017
**Open Access® Managed Choice® - California**
**Qualified High Deductible Health Plan**

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

| PLAN FEATURES | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Deductible** (per calendar year) | $2,250 Individual (for Ind. plan only)<br>$2,600 Individual plus 1 (family plan)<br>$4,500 Family (family plan) | $2,250 Individual (for Ind. plan only)<br>$2,600 Individual plus 1 (family plan)<br>$4,500 Family (family plan) |
| All covered expenses accumulate simultaneously toward both the preferred and non-preferred Deductible.<br>Unless otherwise indicated, the deductible must be met prior to benefits being payable.<br>Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible.<br>Pharmacy expenses apply towards the Deductible.<br>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**<br>Applies to all expenses unless otherwise stated. | 20% | 50% |
| **Payment Limit** (per calendar year) | $3,000 Individual (for Ind. plan only)<br>$3,000 Individual plus 1 (family plan)<br>$6,000 Family (family plan) | $6,000 Individual (for Ind. plan only)<br>$6,000 Individual plus 1 (family plan)<br>$12,000 Family (family plan) |
| All covered expenses accumulate simultaneously toward both the preferred and non-preferred Payment Limit.<br>Certain member cost sharing elements may not apply toward the Payment Limit.<br>Pharmacy expenses apply towards the Payment Limit.<br>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.<br>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**<br>Unlimited except where otherwise indicated. | | |
| **Payment for Non-Preferred Care**** | Not Applicable | Professional: 105% of Medicare<br>Facility: 140% of Medicare |
| **Primary Care Physician Selection** | Optional | Not Applicable |
| **Certification Requirements -**<br>Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care.<br>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**<br>1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older. | Covered 100%; deductible waived | Not Covered |
| **Routine Well Child Exams/Immunizations**<br>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. | Covered 100%; deductible waived | Not Covered |
| **Routine Gynecological Care Exams**<br>Recommended: One exam per calendar year. Includes routine tests and related lab fees.<br>Members may choose ob/gyns as PCP's | Covered 100%; deductible waived | Not Covered |

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| **Routine Mammograms** | Covered 100%; deductible waived | Not Covered |
| Recommended: One baseline mammogram for covered females age 35-39, one mammogram per calendar year for covered females age 40 and over. | | |
| **Women's Health** | Covered 100%; deductible waived | Not Covered |
| 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.<br>Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply. | | |
| **Routine Digital Rectal Exam** | Covered 100%; deductible waived | Not Covered |
| Recommended: For covered males age 40 and over. | | |
| **Prostate-specific Antigen Test** | Covered 100%; deductible waived | Not Covered |
| Recommended: For covered males age 40 and over. | | |
| **Colorectal Cancer Screening** | Covered 100%; deductible waived | Not Covered |
| Recommended: For all members age 50 and over. | | |
| **Routine Eye Exams** | Covered 100%; deductible waived | Not Covered |
| 1 routine exam per 24 months. | | |
| **Routine Hearing Screening** | Covered 100%; deductible waived | Not Covered |
| **PHYSICIAN SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Office Visits to PCP** | 20%; after deductible | 50%; after deductible |
| Includes services of an internist, general physician, family practitioner or pediatrician. | | |
| **Specialist Office Visits** | 20%; after deductible | 50%; after deductible |
| **Audiometric Hearing Exam** | 20%; after deductible | 50%; after deductible |
| **Pre-Natal Maternity** | Covered 100%; deductible waived | 50%; after deductible |
| **Walk-in Clinics** | 20%; after deductible | 50%; 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** | 20%; after deductible | 50%; after deductible |
| **Allergy Injections** | 20%; after deductible | 50%; after deductible |
| **DIAGNOSTIC PROCEDURES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Diagnostic X-ray** | 20% after $25 copay; after deductible | 50%; 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 Laboratory** | 20% after $25 copay; after deductible | 50%; 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** | 20% after $100 copay; after deductible | 50%; after deductible |
| **EMERGENCY MEDICAL CARE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Urgent Care Provider** | 20%; after deductible | 50%; after deductible |
| **Non-Urgent Use of Urgent Care Provider** | Not Covered | Not Covered |
| **Emergency Room** | 20% after $100 copay; after deductible | Same as in-network care |
| **Non-Emergency Care in an Emergency Room** | Not Covered | Not Covered |

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| **Emergency Use of Ambulance** | 20%; after deductible | Same as in-network care |
| **Non-Emergency Use of Ambulance** | Not Covered | Not Covered |
| **HOSPITAL CARE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient Coverage** | 20% after $100 copay; after deductible | 50%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Inpatient Maternity Coverage** (includes delivery and postpartum care) | 20% after $100 copay; after deductible | 50%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Outpatient Hospital Expenses** | 20%; after deductible | 50%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **Outpatient Surgery - Hospital** | 20%; after deductible | 50%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **Outpatient Surgery - Freestanding Facility** | 20%; after deductible | 50%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **MENTAL HEALTH SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Mental Health Inpatient** | 20% after $100 copay; after deductible | 50%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Mental Health Office Visits** | 20%; after deductible | 50%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **Other Mental Health Services** | 20%; after deductible | 50%; after deductible |
| **SUBSTANCE ABUSE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Substance Abuse Inpatient** | 20% after $100 copay; after deductible | 50%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Residential Treatment Facility** | 20% after $100 copay; after deductible | 50%; after deductible |
| **Substance Abuse Rehabilitation Visits** | 20%; after deductible | 50%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **Other Substance Abuse Services** | 20%; after deductible | 50%; after deductible |
| **OTHER SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Skilled Nursing Facility** | 20%; after deductible | 20%; after deductible |
| Limited to 100 days per calendar year. | | |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Home Health Care** | 20%; after deductible | 50%; after deductible |
| Limited to 120 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** | Covered 100%, deductible waived | 50%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Hospice Care - Outpatient** | Covered 100%, deductible waived | 50%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **Spinal Manipulation Therapy** | 20%; after deductible | 50%; after deductible |
| Limited to 20 visits per calendar year. | | |

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| **Outpatient Speech Therapy** | 20%; after deductible | 50%; after deductible |
| **Outpatient Physical and Occupational Therapy** | 20%; after deductible | 50%; after deductible |
| **Autism Behavioral Therapy**<br>Covered same as any other Outpatient Mental Health benefit | Refer to MBH Outpatient Mental Health | Refer to MBH Outpatient Mental Health |
| **Autism Applied Behavior Analysis**<br>Covered same as any other Outpatient Mental Health Other Services benefit | Refer to MBH Outpatient Mental Health Other Services | Refer to MBH Outpatient Mental Health Other Services |
| **Autism Physical Therapy** | 20%; after deductible | 50%; after deductible |
| **Autism Occupational Therapy** | 20%; after deductible | 50%; after deductible |
| **Autism Speech Therapy** | 20%; after deductible | 50%; after deductible |
| **Durable Medical Equipment** | 20%; after deductible | 50%; after deductible |
| **Diabetic Supplies** -- (if not covered under Pharmacy benefit) | Covered same as any other medical expense. | Covered same as any other medical expense. |
| **Orthotics**<br>Orthotics and special footwear covered for persons with foot disfigurement. | 20%; after deductible | 50%; after deductible |
| **Contraceptive drugs and devices not obtainable at a pharmacy** | Covered 100%; deductible waived | Covered same as any other expense. |
| **Generic FDA-approved Women's Contraceptives** | Covered 100%; deductible waived | Covered same as any other expense. |
| **Hearing Aids**<br>Limited to every 24 mo's | Covered 100%; deductible waived | Covered 100%; deductible waived |
| **Transplants** | 20% after $100 copay; after deductible<br>Preferred coverage is provided at an IOE contracted facility only. | 50%; after deductible<br>Non-Preferred coverage is provided at a Non-IOE facility. |
| **Bariatric Surgery** | 20% after $100 copay; after deductible | 50%; after deductible |
| **Acupuncture**<br>Limited to 20 visits per calendar year. | 20%; after deductible | 50%; after deductible |
| **Out of Area Dependents** | Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available. | |
| **FAMILY PLANNING** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Infertility Treatment**<br>Diagnosis and treatment of the underlying medical condition only. | Your cost sharing is based on the type of service and where it is performed | Your cost sharing is based on the type of service and where it is performed |
| **GIFT** | Not Covered | Not Covered |
| **Comprehensive Infertility Services**<br>Artificial insemination and ovulation induction | Not Covered | Not Covered |
| **Advanced Reproductive Technology (ART)**<br>In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery | Not Covered | Not Covered |
| **Vasectomy** | 20%; after deductible | 50%; after deductible |
| **Tubal Ligation** | Covered 100%; deductible waived | 50%; after deductible |

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| PHARMACY | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan. | | |
| **Pharmacy Plan Type** | Aetna Premier Plus Open Formulary | |
| **Generic Drugs** | | |
| **Retail** | $10 copay | 25% of submitted cost; after applicable copay |
| **Mail Order** | $20 copay | Not Applicable |
| **Preferred Brand-Name Drugs** | | |
| **Retail** | $25 copay | 25% of submitted cost; after applicable copay |
| **Mail Order** | $50 copay | Not Applicable |
| **Non-Preferred Brand-Name Drugs** | | |
| **Retail** | $40 copay | 25% of submitted cost; after applicable copay |
| **Mail Order** | $80 copay | Not Applicable |
| **Premier Plus Specialty Drugs** | | |
| **Preferred Specialty** | 30% up to a $200 copay maximum | Not Applicable |
| **Non-Preferred Specialty** | 30% up to a $200 copay maximum | Not Applicable |
| **Pharmacy Day Supply and Requirements** | | |
| **Retail** | Up to a 30 day supply | |
| **Mail Order** | Up to a 31-90 day supply from Aetna Rx Home Delivery®. | |
| **Premier Plus Specialty** | Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred Aetna Specialty Pharmacy network. | |
| **Choose Generics with Dispense as Written (DAW) override** - member pays applicable copay of the physician required 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.<br>Performance Enhancing Drugs limited to 4 tablets per month.<br>Oral fertility drugs included.<br>Oral chemotherapy drugs covered 100%<br>Premier Plus Pre-certification for Specialty Drugs<br>Premier Plus Step Therapy included<br>One transition fill allowed within 90 days of member's effective date<br>Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network. | | |
| **GENERAL PROVISIONS** | | |
| **Dependents Eligibility** | Spouse, children from birth to age 26 regardless of student status. | |

**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.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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.

- 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.

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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 traduccion 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.**