



**PLAN DESIGN & BENEFITS  
 PROVIDED BY AETNA HEALTH OF CALIFORNIA INC.**

<b>PLAN FEATURES</b>	<b>IN-NETWORK</b>
<b>Deductible</b> (per contract year)	None Individual  None Family
<b>Out-of-Pocket Maximum</b> (per contract year)	\$5,000 Individual  \$10,000 Family
In-Network expenses include coinsurance/copays and deductibles. Pharmacy expenses apply towards the Out-of-Pocket-Maximum. The family Out-of-Pocket Maximum is a cumulative Out-of-Pocket Maximum for all family members. The family Out-of-Pocket Maximum can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Out-of-Pocket Maximum amount.	
<b>Lifetime Maximum</b>	Unlimited except where otherwise indicated.
<b>Primary Care Physician Selection</b>	Required
<b>Referral Requirement</b>	Required
<b>PREVENTIVE CARE</b>	<b>IN-NETWORK</b>
<b>Routine Adult Physical Exams/ Immunizations</b> 1 exam every 12 months for members age 22 and older.	Covered 100%
<b>Routine Well Child Exams/Immunizations</b> (Age and frequency schedules apply)	Covered 100%
<b>Routine Gynecological Care Exams</b> 1 exam per 12 months Includes Pap smear, HPV screening, and related lab fees.	Covered 100%
<b>Routine Mammograms</b> Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	Covered 100%
<b>Women's Health</b> 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.	Covered 100%
<b>Routine Digital Rectal Exams / Prostate Specific Antigen Test</b> Recommended for males age 40 and over.	Covered 100%
<b>Colorectal Cancer Screening</b> Recommended: For all members age 50 and over. Frequency schedule applies.	Covered 100%
<b>Routine Eye Exams</b> 1 routine exam per 24 months. Direct access to participating providers without a referral.	Covered 100%
<b>Routine Hearing Screening</b>	Covered 100%
<b>PHYSICIAN SERVICES</b>	<b>IN-NETWORK</b>
<b>Primary Care Physician Visits</b> Includes services of an internist, general physician, family practitioner or pediatrician.	\$45 office visit copay



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<b>Specialist Office Visits</b>	\$45 copay
<b>Pre-Natal Maternity</b>	Covered 100%
<b>Allergy Testing</b>	\$45 office visit copay
<b>Allergy Injections</b>	\$45 office visit copay
<b>DIAGNOSTIC PROCEDURES</b>	<b>IN-NETWORK</b>
<b>Diagnostic Laboratory</b>	Covered 100%
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.	
<b>Diagnostic X-ray</b>	Covered 100%
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.	
<b>Diagnostic X-ray for Complex Imaging Services</b>	Covered 100%
<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>
<b>Urgent Care Provider</b>	\$45 copay
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered
<b>Emergency Room</b>	\$100 copay
Copay waived if admitted	
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered
<b>Emergency Use of Ambulance</b>	\$100 copay
<b>Non-Emergency Use of Ambulance</b>	Not Covered
<b>HOSPITAL CARE</b>	<b>IN-NETWORK</b>
<b>Inpatient Coverage</b>	Covered 50%
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
<b>Inpatient Maternity Coverage</b> (includes delivery and postpartum care)	Covered 50% for Physician maternity services; Covered 50% for Facility services
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
<b>Outpatient Surgery - Freestanding Facility</b>	Covered 50%
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
<b>Outpatient Hospital</b>	Covered 50%
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK</b>
<b>Mental Health Inpatient</b>	Covered 50%
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
<b>Mental Health Office Visits</b>	Covered 100%
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
<b>SUBSTANCE ABUSE</b>	<b>IN-NETWORK</b>
<b>Inpatient Detoxification</b>	Covered 50%
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
<b>Outpatient Detoxification</b>	Covered 100%
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	



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<b>Inpatient Rehabilitation</b>	Covered 50%
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
<b>Residential Treatment Facility</b>	Covered 50%
<b>Outpatient Rehabilitation</b>	Covered 100%
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	

OTHER SERVICES	IN-NETWORK
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<b>Skilled Nursing Facility</b>	Covered 50%
Limited to 100 days; per contract year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
<b>Home Health Care</b>	\$45 per visit
Limited to 120 visits; per contract year Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	
<b>Hospice Care - Inpatient</b>	Covered 100%
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
<b>Hospice Care - Outpatient</b>	Covered 100%
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
<b>Outpatient Rehabilitation Therapy</b>	\$45 per visit
Includes speech, physical, occupational therapy	
<b>Autism Behavioral Therapy</b>	Refer to MBH Outpatient Mental Health
Covered same as any other Outpatient Mental Health benefit	
<b>Autism Applied Behavior Analysis</b>	Refer to MBH Outpatient Mental Health Other Services
Covered same as any other Outpatient Mental Health Other Services benefit	
<b>Autism Physical Therapy</b>	\$45 copay
<b>Autism Occupational Therapy</b>	\$45 copay
<b>Autism Speech Therapy</b>	\$45 copay
<b>Spinal Manipulation Therapy</b>	\$10 copay
Limited to 30 visits per plan year.	
<b>Durable Medical Equipment</b>	Covered 100%
<b>Hearing Aids - every 24 mo's.</b>	Covered 100%
<b>Diabetic Supplies</b>	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.
<b>Women's Contraceptive drugs and devices not obtainable at a pharmacy</b>	Covered 100%
<b>Affordable Care Act mandated Women's Contraceptives</b>	Covered 100%
<b>Transplants</b>	Covered 50%
Preferred coverage is provided at an IOE contracted facility only.	
<b>Bariatric Surgery</b>	Covered 50%
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	

FAMILY PLANNING	IN-NETWORK
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<b>Infertility Treatment</b>	Your cost sharing is based on the type of service and where it is performed Diagnosis and treatment of the underlying medical condition only.
<b>GIFT</b>	Not Covered
Limited to 1 attempt per lifetime	



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<b>Comprehensive Infertility Services</b>	Not Covered
Artificial insemination and ovulation induction	
<b>Advanced Reproductive Technology (ART)</b>	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	
<b>Vasectomy</b>	Your cost sharing is based on the type of service and where it is performed
<b>Tubal Ligation</b>	Covered 100%
<b>PRESCRIPTION DRUG BENEFITS IN-NETWORK</b>	
<b>Pharmacy Plan Type</b>	Aetna Premier Plus Open Formulary
<b>Generic Drugs</b>	
	<b>Retail</b> \$10 copay
	<b>Mail Order</b> \$20 copay
<b>Preferred Brand-Name Drugs</b>	
	<b>Retail</b> \$30 copay
	<b>Mail Order</b> \$60 copay
<b>Non-Preferred Brand-Name Drugs</b>	
	<b>Retail</b> 50% up to Maximum \$100
	<b>Mail Order</b> 50% up to Maximum \$200
<b>Premier Plus Specialty Drugs</b>	
	<b>Preferred Specialty</b> 20% up to Maximum \$100
	<b>Non-Preferred Specialty</b> 20% up to Maximum \$100
<b>Pharmacy Day Supply and Requirements</b>	
	<b>Retail</b> Up to a 30 day supply
	<b>Mail Order</b> Up to a 31-90 day supply from Aetna Rx Home Delivery®.
	<b>Premier Plus Specialty</b> 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 specialty pharmacy network.
<b>Choose Generics with Dispense as Written (DAW) override</b> - 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.	
<b>Plan Includes:</b> Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. Performance Enhancing Drugs limited to 4 tablets per month. Oral fertility drugs included. Oral chemotherapy drugs covered 100% Premier Plus Pre-certification for Specialty Drugs Premier Plus Step Therapy included One transition fill allowed within 90 days of member's effective date Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.	
<b>GENERAL PROVISIONS</b>	
<b>Dependents Eligibility</b>	Spouse, children from birth to age 26 regardless of student status.



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**Exclusions and Limitations**

**Health benefits and health insurance plans are offered and/or underwritten by Aetna Health of California Inc. Each insurer has sole financial responsibility for its own products.**

This material is for information only. Health benefits 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.

- 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.
- Orthotics except diabetic orthotics.
- 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 or inadequacies including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.

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 and Aetna Specialty Pharmacy refer to Aetna Rx Home Delivery, LLC and Aetna Specialty Pharmacy, LLC, respectively. Aetna Rx Home Delivery and Aetna Specialty Pharmacy are licensed pharmacy subsidiaries of Aetna Inc. that operate through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery and Aetna Specialty Pharmacy 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 pharmacies' cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.



High Desert & Inland Employee-Employer Trust – HMO 6  
Effective Date: 07-01-2018  
HMO - California

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

**If you require language assistance, please call the Member Services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).**

**Si requiere la asistencia de un representante que hable su idioma, por favor llame al número de Servicios al Miembro que aparece en su tarjeta de identificación y se le comunicará con la línea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intérprete). TDD-1-800-628-3323 (sólo para las personas con impedimentos auditivos).**

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

For more information about Aetna plans, refer to [www.aetna.com](http://www.aetna.com). While this material is believed to be accurate as of the production date, it is subject to change.

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