aetna

Sedgwick County Area Educational Services
Effective Date: 10-01-2017
Managed Choice ® POS - Kansas

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$6,000 Individual $12,000 Family	$12,000 Individual $24,000 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 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 Applies to all expenses unless otherwise stated.	Covered 100%	30%
Payment Limit (per calendar year)	$6,450 Individual $12,900 Family	$13,000 Individual $26,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses apply towards the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage and deductibles (except any penalty amounts) may be used to satisfy 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: 100% of Medicare Facility: 100% of Medicare
Primary Care Physician Selection	Required	Not Applicable
Referral Requirement	Required	None
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.		
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	30%; after deductible
1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.		
Routine Well Child Exams	Covered 100%; deductible waived	30%; after deductible
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.		
Childhood Immunizations	Covered 100%; deductible waived	30%; after deductible. Covered 100% from birth to age 6; deductible waived
Routine Gynecological Care Exams	Covered 100%; deductible waived	30%; after deductible
Recommended: One exam per calendar year. Includes routine tests and related lab fees. Direct access to participating providers without a referral.		

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Routine Mammograms	Covered 100%; deductible waived	30%; after deductible
Women's Health	Covered 100%; deductible waived	30%; 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.		
Routine Digital Rectal Exam	Covered 100%; deductible waived	30%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	30%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered under Routine Adult Exams
Recommended: For all members age 50 and over.		
Routine Eye Exams	Covered 100%; deductible waived	30%; after deductible
1 routine exam per 12 months, no referral required.		
Routine Hearing Screening	Covered 100%; deductible waived	30%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP	$40 copay; deductible waived	30%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$65 office visit copay; after deductible	30%; after deductible
Audiometric Hearing Exam	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; after deductible	Covered according to standard claim practice.
Walk-in Clinics	$40 office visit copay; deductible waived	30%; 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	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
Allergy Injections	Your cost sharing is based on the type of service and where it is performed. Covered 100% when an office visit charge is not applicable.	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	Covered 100%; after deductible	30%; 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	Covered 100%; after deductible	30%; 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	Covered 100%; after deductible	30%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$50 copay; after deductible	30%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	$200 copay; after deductible	Same as in-network care
Copay waived if admitted		

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Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%; 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	$250 copay; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	$250 copay; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	$250 per confinement copay; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient	$65 copay; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	$250 per confinement copay; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	$250 copay; after deductible	30%; after deductible
Outpatient	$65 copay; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	$250 per confinement copay; after deductible	30%; after deductible
Limited to 60 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	Covered 100%; after deductible	30%; after deductible
Hospice Care - Inpatient	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Outpatient Speech Therapy	$40 copay; after deductible	30%; after deductible
Limited to 60 visits per calendar year.		
Outpatient Physical and Occupational Therapy	$40 copay; after deductible	30%; after deductible
Limited to 60 visits per calendar year combined		

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Autism Behavioral Therapy 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 Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Physical Therapy To age 12, unlimited visits	$40 copay; after deductible	30%; after deductible
Autism Occupational Therapy To age 12, unlimited visits	$40 copay; after deductible	30%; after deductible
Autism Speech Therapy To age 12, unlimited visits	$40 copay; after deductible	30%; after deductible
Spinal Manipulation Therapy	$40 copay; after deductible	30%; after deductible
Durable Medical Equipment	Covered 100%; after deductible	30%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Vision Eyewear	Not Covered	Not Covered
Transplants	$250 copay; after deductible; Preferred coverage is provided at an IOE contracted facility only.	30%; after deductible; Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
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 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
Comprehensive Infertility Services	Not Covered	Not Covered
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
Vasectomy	Covered 100%; after deductible	30%; after deductible
Tubal Ligation	Covered 100%; deductible waived	30%; after deductible
Voluntary Abortion	Not Covered	Not Covered
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Value Open Formulary	
Value Drugs Tier 1A		
Retail	$3 copay	Not Covered
Mail Order	$7.50 copay	Not Applicable
Preferred Generic Drugs		
Retail	$15 copay	Not Covered
Mail Order	$37.50 copay	Not Applicable

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Preferred Brand-Name Drugs		
Retail	$30 copay	Not Covered
Mail Order	$75 copay	Not Applicable
Non-Preferred Generic and Brand-Name Drugs		
Retail	$50 copay	Not Covered
Mail Order	$125 copay	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply. For a 31-90 day supply you will be responsible for the Mail Order Drug copay.	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Value 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 specialty pharmacy network.	

Deductible waived for generics
Deductible waived for value drugs/tier 1A

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
A limited list of over-the-counter medications are covered when filled with a prescription.
Performance Enhancing Drugs limited to 6 tablets per month.
Oral chemotherapy drugs covered 100%.
Value Pre-certification included.
Value 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.

GENERAL PROVISIONS

Dependents Eligibility Spouse, children from birth to age 26 regardless of student status.

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.

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.
• Hearing aids
• 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 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.**

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