CITY OF OWASSO
Effective Date: 07-01-2023
Aetna Choice® POS II – ASC
Standard Plan

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit limitations - For any service or supply that is subject to a maximum visit, day, or dollar limitation on a per year basis, the benefit year begins on January 1st unless otherwise mandated. Refer to your plan documents for more information.		
Deductible (per calendar year)	None Individual None Family	$1,000 Individual $3,000 Family
Unless otherwise indicated, the deductible must be met before benefits are payable.		
Member coinsurance	Covered 100%	You pay 50%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$4,000 Individual $8,000 Family	$4,500 Individual $9,000 Family
All covered expenses accumulate separately toward the in-network or out-of-network 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, copays, 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 Out-of-Network Care**	Not Applicable	Provider: 105% of Medicare Facility: 140% of Medicare
Primary care physician selection	Optional	Not Applicable
Precertification requirements - Some out-of-network services need approval by us in advance (precertification). Without this approval, we reduce benefits by $400. Refer to your plan documents for a full list of services that need this approval.		
Referral requirement	Not required	None
Telehealth consultations - Covered services for telemedicine consultations are available from a number of different kinds of providers under your plan. Log onto your secure Aetna website at https://www.aetna.com/ to review our telemedicine provider listings and get more information about your options, including specific cost sharing amounts.		
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine adult physical exams/ immunizations	Covered 100%	50%; after deductible
1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older		
Routine well child exams/immunizations	Covered 100%	50%; after deductible
7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.		
Routine gynecological care exams	Covered 100%	50%; after deductible
1 exam and pap smear per year, includes related fees.		
Routine mammogram	Covered 100%	50%; after deductible
1 per year for covered females age 40 and over.		
Women's health	Covered 100%	50%; 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%	50%; after deductible
Recommended: For covered males age 40 and over.		

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Prostate-specific antigen Test Recommended: For covered males age 40 and over.	Covered 100%	50%; after deductible
Colorectal cancer screening Recommended: For all members age 45 and over.	Covered 100%	50%; after deductible
Routine eye exams 1 routine exam per 12 months.	Covered 100%	50%; after deductible
Routine hearing screening	Covered 100%	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office visits to primary care physician (PCP) Includes services of an internist, general physician, family practitioner or pediatrician.	$30 office visit copay	50%; after deductible
Telehealth consultation with non-specialist	$30 office visit copay	50%; after deductible
Specialist office visits	$40 office visit copay	50%; after deductible
Telehealth consultation with specialist	$40 office visit copay	50%; after deductible
Hearing exams 1 routine exam per 24 months.	Covered 100%	50%; after deductible
Pre-Natal Maternity	Covered 100%	50%; after deductible
Walk-in clinics Walk-in Clinics are free-standing health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be Walk-in Clinics.	$30 copay **Designated Walk-in clinics** Covered 100%	50%; after deductible
Telehealth consultations for non-emergency services through a walk-in clinic We pay telehealth screenings and counseling services from a walk-in-clinic as a preventive care benefit.	Your cost sharing depends on the type of service and where you receive it. **Designated Walk-in clinics** Covered 100%	50%; after deductible
Allergy testing	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
Allergy injections	Your cost sharing amount depends on the type of service and where you receive it. Covered 100% when an office visit charge is not applicable.	Your cost sharing amount depends on the type of service and where you receive it.
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray 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.	Covered 100%	50%; after deductible
Diagnostic laboratory 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.	Covered 100%	50%; after deductible
Diagnostic complex imaging 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.	$50 copay	50%; after deductible

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EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent care provider	$50 office visit copay	50%; after deductible
Non-urgent use of urgent care provider	Not Covered	Not Covered
Emergency room Copay waived if admitted	$150 copay	Same as in-network care
Non-emergency care in an emergency room	Not Covered	Not Covered
Emergency use of ambulance	Covered 100%	Covered 100%; no deductible
Non-emergency use of ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient coverage	$150 per day for the first 5 days per confinement, thereafter Covered 100%	50% after $500 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient maternity coverage (includes delivery and postpartum care)	$150 per day for the first 5 days per confinement, thereafter Covered 100%	50% after $500 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient hospital	Covered 100%	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.		
Outpatient surgery - hospital	$100 copay	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.		
Outpatient surgery - freestanding facility	$100 copay	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%	50% after $500 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental health office visits	Covered 100%	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Crisis intervention services	Covered 100%	50%; after deductible
Mental health telehealth consultations	Covered 100%	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other mental health services	Covered 100%	50%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%	50% after $500 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential treatment facility	Covered 100%	50% after $500 copay; after deductible
Substance abuse office visits	Covered 100%	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Substance abuse telehealth consultations	Covered 100%	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other substance abuse services	Covered 100%	50%; after deductible

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OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Spinal Manipulation Therapy Limited to 15 visits per year	$40 copay	50%; after deductible
Outpatient Physical and Occupational Therapy Limited to 60 visits per year	$40 copay	50%; after deductible
Outpatient Rehabilitative Speech Therapy Limited to 60 visits per year	$40 copay	50%; after deductible
Habilitative Physical Therapy	Covered 100%	50%; after deductible
Habilitative Occupational Therapy	Covered 100%	50%; after deductible
Habilitative Speech Therapy	Covered 100%	50%; after deductible
Autism Physical Therapy	Covered 100%	50%; after deductible
Autism Occupational Therapy	Covered 100%	50%; after deductible
Autism Speech Therapy	Covered 100%	50%; after deductible
Autism Behavioral Therapy Combined with outpatient mental health visits	Covered 100%	50%; after deductible
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health All Other benefit	Covered 100%	50%; after deductible
Skilled nursing facility Limited to 90 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$150 per day for the first 5 days per confinement, thereafter Covered 100%	50% after $500 copay; after deductible
Home health care Limited to 120 visits per year Private duty nursing not included. Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	$40 copay	50%; after deductible
Hospice care - inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%	Covered 100%; no deductible
Hospice care - outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%	Covered 100%; no deductible
Private duty nursing Limited to 70 eight hour shifts per year. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.	Covered 100%	50%; after deductible
Durable medical equipment	Covered 100%	50%; after deductible
Diabetic supplies -- (if not covered under the prescription drug benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Affordable Care Act mandated women's contraceptives	Covered 100%	Covered same as any other expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%	Covered same as any other medical expense.
Infusion therapy Administered in the home or physician's office	$40 copay	50%; after deductible

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Infusion therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
Gene-based, Cellular, and other Innovative Therapies (GCIT™)	Your cost sharing amount depends on the type of service and where you receive it. $40 copay In-network coverage is provided at GCIT™ designated facilities only.	Not Covered
Transplants	$150 per day for the first 5 days per confinement, thereafter Covered 100% Preferred coverage is provided at an IOE contracted facility only.	50% after $500 copay; after deductible
Bariatric surgery Limited to $10,00 per lifetime	$150 per day for the first 5 days per confinement, thereafter Covered 100%	50% after $500 copay; after deductible
Acupuncture Limited to 15 visits per year	$30 copay	50%; after deductible
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
Comprehensive infertility services Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART) 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	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
Tubal ligation	Covered 100%	50%; after deductible

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PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy plan type	Aetna Standard Open Formulary	
Generic drugs		
Retail	$10 copay	50% of submitted cost; after applicable in-network cost share
Mail order	$20 copay	Not Applicable
Preferred brand-name drugs		
Retail	$25 copay	50% of submitted cost; after applicable in-network cost share
Mail order	$50 copay	Not Applicable
Non-preferred brand-name drugs		
Retail	$40 copay	50% of submitted cost; after applicable in-network cost share
Mail order	$80 copay	Not Applicable
Specialty drugs		
Preferred specialty	50% Maximum $75	Not Covered
Non-preferred specialty	50% Maximum $75	Not Covered
Pharmacy day supply and requirements		
Retail	Up to a 30 day supply from Aetna National Network, 31 to 90 day supply covered at retail pharmacies in the Extended Day Supply Network.	
Mail order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	Up to a 30 day supply All prescription fills must be through our preferred specialty pharmacy network. Aetna Specialty Performance Network Drug List	

Plan Includes: Diabetic supplies, blood glucose monitors, prescription weight loss drugs 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).
$30 copay maximum per fill per 30-day supply of insulin drugs
Seasonal Vaccinations covered 100% in-network
Preventive Vaccinations covered 100% in-network
Travel Vaccinations covered 100% in-network
Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.
Precertification for specialty drugs included

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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.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.
• 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.

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.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Navigator member site.

This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in-network. You pay your plan's copayments and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments and deductibles.

Plans are provided by: Aetna Health Inc. 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. 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.

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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.
• 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.

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

Translation of this material into another language may be available. Please call Member Services at the number on the back of your ID card.

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.**
Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.

Oklahoma

All contract state benefits shown above will match for this ancillary state.