Aetna Preventive Medical Benefits Highlights Effective August 1, 2014 - I.B.E.W. Local 77

The purpose of this document is to help you make decisions; it is not a contract.

Aetna Preventive -- Local 77		Aetna Preventive -- Most/L77 Plan	
In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
GENERAL DESIGN			
Deductible (per calendar year)			
No deductible	$250 per person $750 per family	$100 per person $300 per family	$450 per person $1,350 per family
		Deductible applies to most services, except as noted. Deductible does not apply for prescriptions or when the Inpatient co-pay or emergency room co-pay applies	
Annual Out of Pocket Maximum (OOP Max) includes copayments and coinsurance after any applicable deductible. Excludes prescription drug copays.			
$ 500 per person $1,000 per family	$3,000 per person $6,000 per family	$2,000 per person $4,000 per family	$3,000 per person $6,000 per family
Total Annual Out of Pocket Maximum: includes medical copayments, coinsurance, and the deductible, if applicable. Excludes prescription drug copays.			
$ 500 per person $1,000 per family	$3,250 per person $6,750 per family	$2,100 per person $4,300 per family	$3,450 per person $7,350 per family
Hospital Copay			
None	None	$200 copay per admission	$200 copay per admission
Hospital Pre-admission Authorization			
Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission	Member responsible for obtaining precertification of out-of-network care	Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission	Member responsible for obtaining precertification of out-of-network care
Choice of Providers			
Any Aetna contracted provider member. No primary care physician selection required. No referrals required.	Any licensed, qualified provider of your choice. Expenses paid based on reasonable* charges. You pay the difference between R&C and billed charges.	Aetna contracted providers. No primary care physician selection or referrals required. Aexcel specialists must be used in designated specialty areas to receive the maximum benefit.	Any licensed, qualified provider of your choice. Expenses paid based on recognized charges*. You pay the difference between recognized and billed charges.
COVERED EXPENSES			
Acupuncture			
Paid at 100% after $10 copay	Paid at 70%	Paid at 100% after $15 copay	Paid at 60%
All acupuncture services subject to ongoing review and approval by Aetna for medical necessity		All acupuncture services subject to ongoing review and approval by Aetna for medical necessity.	
Alcohol/Drug Abuse Treatment			
Inpatient: Paid at 100% Outpatient: Paid at 100% after $10 copay	Inpatient: Paid at 70% Outpatient: Paid at 70%	Inpatient: Paid at 90% after $200 copay Outpatient: Paid at 100% after $15 copay	Inpatient: Paid at 60% after $200 copay. Outpatient: Paid at 60%
Contraceptives			
Contraceptive devices and other products covered as medical benefit. (See Prescription Drugs.)	Contraceptive devices and other products covered as medical benefit. (See prescription drugs.)	Contraceptive devices and other products covered as medical benefit. (See prescription drugs.)	Contraceptive devices and other products covered as medical benefit. (See prescription drugs.)

Aetna Preventive -- Local 77		Aetna Preventive -- Most/L77 Plan	
In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Durable Medical Equipment			
Paid at 100% Breast pump covered at 100% through DME provider	Paid at 70%	Paid at 90% Breast pump covered at 100% through DME provider	Paid at 60%
Emergency Medical Care			
➢ **Urgent Care Clinic**			
Paid at 100% after $35 copay	Paid at 70%	Paid at 100% after $15 copay (no fee for preventive care)	Paid at 60%
➢ **Emergency Room (copays waived if admitted)**			
Paid at 100% after $50 copay	Paid the same as in-network except if it's non-emergency, then it's 70% after $50 copay	Paid at 90% after $150 copay	Paid at 90% after $150 copay If non-emergency, paid at 60% after copay
➢ **Ambulance**			
Paid at 100% when medically necessary. Non-emergency transport must be approved in advance.		Paid at 90% when medically necessary. Non-emergency transportation must be approved in advance.	
Allergy Shots			
Paid at 100%	Paid at 70%	Paid at 90%	Paid at 60% after deductible
Gender Reassignment Services			
Not covered	Not covered	Covered as any other service; copays/coinsurance depend on type and location of service provided.	Covered as any other service; copays/coinsurance depend on type and location of service provided.
Hearing Aids (per ear, every 36 months)			
Up to $1,000	Up to $1,000	Up to $1,000	Up to $1,000
		In-network coinsurance applies whether purchased in- or out-of-network. Deductible does not apply.	
Home Health Care			
Paid at 100%	Paid at 70%	Paid at 90%	Paid at 60%
Maximum benefit of 130 visits per calendar year for in- and out-of-network combined.		Maximum benefit of 130 visits per calendar year for in- and out-of-network combined.	
Hospital Inpatient			
Paid at 100%	Paid at 70%	Paid at 90% after $200 copay. Physician services paid at 80% if Aexcel specialist not used in specialty areas.	Paid at 60% after $200 copay
Hospital Outpatient			
Paid at 100%	Paid at 70%	Paid at 90% after deductible. Physician services paid at 80% if Aexcel specialist is not used in specialty areas.	Paid at 60% after satisfaction of deductible
Hospice			
Paid at 100%	Not covered	Paid at 90%	Not covered
Maternity Care (delivery and related hospital)			
Paid at 100%	Paid at 70%	Paid at 90% after $200 copay	Paid at 60% after $200 copay

Aetna Preventive -- Local 77		Aetna Preventive -- Most/L77 Plan	
In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Maternity Care (prenatal and postpartum)			
Paid at 100% after $10 copay	Paid at 70%	Paid 100% after one $15 copay	Paid at 60%
Mental Health Care (inpatient)			
Paid at 100%	Paid at 70%	Paid at 90% after $200 copay	Paid at 60% after $200 copay
Mental Health Care (outpatient)			
Paid at 100% after $10 copay	Paid at 70%	Paid at 100% after $15 copay	Paid at 60% after deductible
Physician Office Visit (routine and specialist)			
Paid at 100% after $10 copay	Paid at 70%	Paid at 100% after $15 copay	Paid at 60%
Prescription Drugs (retail)			
For a 31-day supply: **Generic**: $10 copay **Preferred brand**: $20 copay **Non-preferred drugs**: $40 copay Generic oral contraceptives are covered at 100%. Contraceptive devices and other prescription contraceptive products are covered under the medical plan benefit. Selected preventive over-the-counter drugs covered at 100% in certain situations.	Not covered	For a 31-day supply: **Generic**: 30% coinsurance **Brand**: 40% coinsurance The minimum coinsurance is $10, or actual cost of the drug if less. Maximum coinsurance is $100 per drug. Coinsurance applies to the annual $1,200 out-of-pocket prescription maximum per person, $3,600 per family. Prescription Allowance on all non-sedating antihistamines (for allergy symptoms) and Proton Pump Inhibitors (for heartburn relief and ulcer treatment): City pays $20 per month, participant pays remainder; some over the counter medications are also included. $5 copay for generic diabetic drugs and supplies, $15 copay for brand. Many contraceptive products are covered. Medical devices covered under medical benefit. Generic Oral contraceptives covered at 100%. Coinsurance for asthma, anti-high cholesterol, and tobacco cessation drugs 10% for generic and 20% for brand. Selected preventive over-the-counter drugs covered at 100% in certain situations. Generic oral contraceptives are covered at 100%. Contraceptive devices and other prescription contraceptive products are covered under the medical plan benefit.	Not covered
Prescription Drugs (mail order)			
For a 90-day supply: Generic: $20 copay Preferred brand: $40 copay Non-preferred drugs: $80 copay Generic oral contraceptives are covered at 100%.	Not covered	For a 90-day supply: **Generic**: 30% coinsurance **Brand**: 40% coinsurance Minimum is $20 or double the cost of the drug if less. Maximum is $200 per drug. Generic oral contraceptives are covered at 100%.	Not Covered
Prescription Drugs Annual Out of Pocket Maximum			
$1,200 per person $2,400 per family (Effective January 1, 2015)	Not covered	$1,200 per person $3,600 per family	Not covered
Preventive Care			
Paid at 100% Covers adult physical and well child exams, immunizations, digital rectal exams/PSA, colorectal cancer screening.	Paid at 70% for well woman care and mammograms. No other preventive services covered.	Paid at 100% Covers adult physical and well child exams, immunizations, digital rectal exams/PSA, colorectal cancer screening.	Paid at 60% for well woman care and mammograms. No other preventive services covered.

Aetna Preventive -- Local 77		Aetna Preventive -- Most/L77 Plan	
In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Rehabilitation Services (inpatient)			
Paid at 100%	Paid at 70%	Paid at 90% after $200 copay	Paid at 60% after $200 copay
120 days per calendar year for skilled nursing and rehab services in- and out-of-network combined.		120 days per calendar year for skilled nursing and rehab services in- and out-of-network combined.	
Rehabilitation Services (outpatient)			
Paid at 100% after $10 copay	Paid at 70%	Paid at 100% after $15 copay	Paid at 60%
Benefit includes physical/massage, speech, occupational and cardiac/pulmonary therapy. Coinsurance does apply to the annual out-of-pocket maximum. Maximum of 20 visits per calendar year for each of the above listed benefits for in-network and out-of-network combined.		Includes medically necessary physical/massage, speech, occupational and cardiac/pulmonary therapy for non-chronic conditions. Coverage of services subject to Aetna's review for medical necessity at any time.	
Skilled Nursing Facility			
Paid at 100%	Paid at 70%	Paid at 90% after $200 copay	Paid at 60% after $200 copay
Maximum of 120 days per calendar year for in-network and out-of-network combined		Maximum of 120 days per calendar year for in- and out-of-network combined.	
Smoking Cessation			
Only covers counseling	Only covers counseling	Smoking cessation prescription drugs covered subject to 10% generic, 20% brand drug coinsurance.	Not covered
Spinal Manipulations			
Paid at 100% after $10 copay	Paid at 70%	Paid at 100% after $15 copay	Paid at 60%
Maximum of 20 visits per year for in-network and out-of-network combined		Maximum of 20 visits per year for in-network and out-of-network combined	
Sterilization Procedures			
Inpatient: Paid at 100% Outpatient: Paid at 100% after $10 copay.	Paid at 70%	Inpatient: Paid at 90% after $200 copay Outpatient: Paid at 90%	Inpatient: Paid at 60% after $200 copay. Outpatient: Paid at 60%
Temporomandibular Joint Services			
Not covered		Covered as any other service; copays/coinsurance depend on type and location of service provided.	Covered as any other service; copays/coinsurance depend on type and location of service provided.
		$5,000 lifetime maximum for non-surgical services in- and out-of-network combined.	
Tooth Injury (due to accident)			
Inpatient: Paid at 100% Outpatient: Paid at 100% after $10 copay.	Paid at 70%	Inpatient: Paid at 90% after $200 copay. Outpatient: Paid at 100% after $15 copay for office visit; other charges paid at 90%	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%
Vision Exam/Hardware			
Covered under VSP		Covered under VSP	
X-ray and Lab Tests			
Paid at 100%	Paid at 70%	Paid at 90% Provider responsible for precertification of high tech radiology	Paid at 60%

* Recognized charges are the lower of the provider's usual charge for performing a service, and the charge Aetna determines to be the recognized charge percentage in the geographic area where the service is provided.