

Aetna Traditional 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 Traditional -- Local 77		Aetna Traditional -- Most/L77 Plan	
In-Network	Out-of-Network	In-Network	Out-of-Network
GENERAL DESIGN			
Deductible (per calendar year)			
\$100 per person \$300 per family	\$150 per person \$450 per family	\$ 400 per person \$1,200 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	\$1,000 per person \$3,000 per family
Annual Out of Pocket Maximum (OOP Max) includes copayments and coinsurance after any applicable deductible. Excludes prescription drug copays.			
\$200 per person \$600 per family	\$1,200 per person \$3,600 per family	\$1,000 per person \$3,000 per family	\$2,000 per person \$6,000 per family
Total Annual Out of Pocket Maximum: includes medical copayments, coinsurance, and the deductible. Excludes prescription drug copays.			
\$300 per person \$900 per family	\$1,350 per person \$4,050 per family	\$1,400 per person \$4,200 per family	\$3,000 per person \$9,000 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 80% Maximum of 12 visits per calendar year.	Paid at 60%	Paid at 80% Maximum of 12 visits per calendar year in-and out-of-network combined.	Paid at 60%
Alcohol/Drug Abuse Treatment			
Inpatient: Paid at 80% for inpatient and outpatient	Pain at 80% for inpatient and outpatient	Inpatient: Paid at 80% after \$200 copay Outpatient: Paid at 80% 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 benefits. (See Prescription Drugs). No deductible.	

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Durable Medical Equipment			
Paid at 80% Breast pump covered at 100% through DME provider	Paid at 80%	Paid at 80% Breast pump covered at 100% through DME provider	Paid at 60%
Emergency Medical Care			
➤ Urgent Care Clinic			
Paid at 80%	Paid at 80%	Paid at 80%	Paid at 60%
➤ Emergency Room (copays waived if admitted)			
Paid at 80%	Paid the same as in-network except if it's non-emergency, then it's 60%	Paid at 80% after \$150 copay	Paid at 80% after \$150 copay. If not emergency, paid at 60%.
➤ Ambulance			
Paid at 80% when medically necessary. Non-emergency transport must be approved in advance.		Paid at 80% when medically necessary. Non-emergency transportation must be approved in advance by Aetna.	
Allergy Shots			
Paid at 80%	Paid at 60%	Paid at 80%	Paid at 60%
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 In-network coinsurance applies whether purchased in- or out-of-network. Deductible does not apply.	Up to \$1,000
Home Health Care			
Paid at 90% Maximum benefit of 130 visits per calendar year for in- and out-of-network combined.	Paid at 90%	Paid at 80% Maximum benefit of 130 visits per calendar year for in- and out-of-network combined.	Paid at 60%
Hospital Inpatient			
Paid at 80%	Paid at 60%	Paid at 80% after \$200 copay. Physician services paid at 70% if Aexcel specialist not used in specialty areas.	Paid at 60% after \$200 copay
Hospital Outpatient			
Paid at 80%	Paid at 60%	Paid at 80% after deductible. Physician services paid at 70% if Aexcel specialist is not used in specialty areas.	Paid at 60% after satisfaction of deductible
Hospice			
Paid at 90%		Paid at 80%	Paid at 60%
Maternity Care (delivery and related hospital)			
Paid at 80%	Paid at 60%	Paid at 80% after \$200 copay	Paid at 60% after \$200 copay

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Maternity Care (prenatal and postpartum)			
Paid at 80%	Paid at 60%	Paid 80%	Paid at 60%
Mental Health Care (inpatient)			
Paid at 80%	Paid at 60%	Paid at 80% after \$200 copay	Paid at 60% after \$200 copay
Mental Health Care (outpatient)			
Paid at 80%	Paid at 60%	Paid at 80% after \$200 copay	Paid at 60% after \$200 copay
Physician Office Visit (routine and specialist)			
Paid at 80%	Paid at 60%	Paid at 80%	Paid at 60%
Prescription Drugs (retail)			
<p>For a 34-day supply or 100 unit supply (whichever is greater): Generic and brand prescriptions: \$15 copay</p> <p>Generic oral contraceptives are covered at 100%. Contraceptive devices and other prescription contraceptive products are covered under the medical plan benefits. Selected preventive over-the-counter drugs covered at 100% in certain situations Non-formulary drugs not covered.</p>	Not covered	<p>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.</p> <p>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. 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 benefits.</p>	Not covered
Prescription Drugs (mail order)			
<p>For a 90-day supply: Generic and brand prescriptions: \$30 copay Non-formulary drugs are not covered. Generic oral contraceptives covered at 100%.</p>	Not covered	<p>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 covered at 100%.</p>	Not covered
Prescription Drugs Annual Out of Pocket Max			
\$1,200 per person \$3,600 per family	(Effective January 1, 2015)	Not covered	\$1,200 per person \$3,600 per family
Preventive Care			
<p>Paid at 100% Covers adult physical and well child exams, immunizations, digital rectal exams/PSA, colorectal cancer screening.</p>	<p>Paid at 60% for mammograms, deductible waived. No other preventive services covered.</p>	<p>Paid at 100% Covers adult physical and well child exams, immunizations, digital rectal exams/PSA, colorectal cancer screening.</p>	<p>Paid at 60% for mammograms. No other preventive services covered.</p>

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Rehabilitation Services (inpatient)			
Paid at 80%	Paid at 60%	Paid at 80% after \$200 copay	Paid at 60% after \$200 copay
Rehabilitation Services (outpatient)			
Paid at 80%	Paid at 80%	Paid at 80%	Paid at 60%
Coinsurance does not apply to out-of-pocket maximum. Maximum calendar year benefit of 30 visits for all services combined (physical/massage, speech, occupational and cardiac/pulmonary therapy).		Includes medically necessary physical/massage, speech, occupational and cardiac/pulmonary therapy for non-chronic conditions. Coinsurance does not apply to OOP Max. Coverage of services subject to Aetna's review for medical necessity at any time.	
Skilled Nursing Facility			
Paid at 80%	Paid at 80%	Paid at 80% after \$200 copay	Paid at 60% after \$200 copay
Maximum of 90 days per calendar year		Maximum of 90 days per calendar year for in- and out-of-network combined.	
Smoking Cessation			
Lifetime maximum of one 90-day supply of smoking cessation aids or drugs. See Prescription Drugs, retail.	Not covered	Lifetime maximum of one 90-day supply of aids or drugs. Coinsurance 10% generic, 20% brand. See Prescription Drugs.	Not covered
Spinal Manipulations			
Paid at 80%	Paid at 80%	Paid at 80%	Paid at 60%
Maximum of 10 visits per year for in-network and out-of-network combined		Maximum of 10 visits per year for in-network and out-of-network combined	
Sterilization Procedures			
Paid at 80%	Paid at 60%	Inpatient: Paid at 80% after \$200 copay Outpatient: Paid at 80%	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. \$5,000 lifetime maximum for non-surgical services in- and out-of-network combined.	Covered as any other service; copays/coinsurance depend on type and location of service provided.
Tooth Injury (due to accident)			
Paid at 80%	Paid at 80%	Inpatient: Paid at 80% after \$200 copay. Outpatient: Paid at 80%	Inpatient: Paid at 60% after \$200 copay Outpatient: Paid at 60%
Maximum \$600 per occurrence.			
Vision Exam/Hardware			
Covered under VSP		Covered under VSP	
X-ray and Lab Tests			
Paid at 80%	Paid at 60%	Paid at 80% 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.