aetna™

ActOne Government Solutions
Effective Date: 01-01-2025
Open Choice® PPO - Nevada

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit limitations - Some service or supplies have limits on them per year. There might be a maximum number of visits or days, or a dollar limit per year. In such cases, the benefit year begins on January 1 (unless otherwise noted). Refer to your plan documents to learn more.		
Deductible (per calendar year)	$1,000 per Individual $2,000 per Family	$2,000 per Individual $4,000 per Family
Covered expenses in-network add up towards your in-network deductible. Covered expenses out-of-network add up towards your out-of-network deductible. You must first meet the deductible before the plan begins paying benefits, unless otherwise noted. The amount you pay (cost sharing) for some medical services does not count toward your deductible. Prescription drug costs do not count toward the deductible. Refer to your plan documents for details. Your family will have one deductible. You will meet it when the expenses of several family members add up to the family deductible. No one person will have to pay more than the individual deductible.		
Member coinsurance Applies to all expenses except as noted.	Covered 100%	You pay 40%
Out-of-pocket limit (per calendar year)	$2,500 per Individual $5,000 per Family	$5,000 per Individual $10,000 per Family
Covered expenses in-network add up towards your in-network out-of-pocket limit. Covered expenses out-of-network add up towards your out-of-network out-of-pocket limit. Some of your cost sharing may not count toward the out-of-pocket limit. Your pharmacy expenses count toward your out-of-pocket limit. In-network expenses include coinsurance/copays and deductibles. Out-of-network expenses include coinsurance and deductibles. Penalty amounts do not apply. Your family will have one out-of-pocket limit. You will meet it when the expenses of several family members add up to the family out-of-pocket limit. No one person will have to pay more than the individual out-of-pocket limit amount.		
Lifetime maximum Unlimited except where otherwise indicated.		
Payment for out-of-network care**	Does not apply	Professional: Prevailing Charges Facility: Prevailing Charges
Primary care physician selection	Does not apply	Does not apply
Precertification requirements - Some out-of-network services need approval by us in advance (precertification). Without this approval, we reduce benefits by $500. Refer to your plan documents for a full list of services that need this approval.		
Referral requirement	Not required	None
Telehealth consultations - You can access covered services for telehealth visits from different kinds of providers in your network. Log on to **Aetna.com** to see a list of telehealth providers. You'll also find more about your options, including cost share amounts.		
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine adult physical exams/ immunizations 1 exam every 12 months until age 65, then 1 exam every 12 months age 65 and older	Covered 100%; no deductible	40%; after deductible
Routine well child exams/immunizations • 7 exams in the first 12 months • 3 exams from age 13 months to 24 months • 3 exams from age 25 months to 36 months • 1 exam every 12 months thereafter until age 22	Covered 100%; no deductible	40%; after deductible
Routine gynecological care exams 1 exam and pap smear per year, includes related fees.	Covered 100%; no deductible	40%; after deductible

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Routine mammogram Recommended: One per year for members age 40 and over	Covered 100%; no deductible	40%; after deductible
Women's health 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. Also includes: contraceptive methods (ACA mandated contraceptives, including contraceptives and devices you can't get at a pharmacy), sterilization procedures (including tubal ligation), patient education and counseling. Limits may apply.	Covered 100%; no deductible	40%; after deductible
Pre-natal maternity	Covered 100%; no deductible	40%; after deductible
Routine digital rectal exam Recommended: For members age 40 and over	Covered 100%; no deductible	40%; after deductible
Prostate-specific antigen test Recommended: For members age 40 and over	Covered 100%; no deductible	40%; after deductible
Colorectal cancer screening Recommended: For members age 45 and over	Covered 100%; no deductible	40%; after deductible
Routine eye exams 1 routine exam per 12 months.	$50 copay; no deductible	40%; after deductible
Routine hearing screening	Covered 100%; no deductible	40%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office visits to non-specialist Includes services of an internist, general physician, family practitioner or pediatrician.	$30 office visit copay; no deductible	40%; after deductible
Telehealth consultation with non-specialist	$30 office visit copay; no deductible	40%; after deductible
Specialist office visits	$50 office visit copay; no deductible	40%; after deductible
Telehealth consultation with specialist	$50 office visit copay; no deductible	40%; after deductible
Hearing exams	Not Covered	Not Covered
Walk-in clinics Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services. Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices.	$30 copay; no deductible **Designated Walk-in clinics** Covered 100%; no deductible	40%; 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 (Other than complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	Covered 100%; after deductible	40%; after deductible
Diagnostic laboratory When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	Covered 100%; after deductible	40%; after deductible
Diagnostic complex imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	Covered 100%; after deductible	40%; after deductible

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EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent care provider	$75 office visit copay; no deductible	40%; after deductible
Non-urgent use of urgent care provider	50%; after deductible	50%; after deductible
Emergency room Copay waived if admitted	$300 copay; no deductible	Same as in-network care
Non-emergency care in an emergency room	50%; after deductible	50%; after deductible
Emergency use of ambulance	Covered 100%; no 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	40%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Inpatient maternity coverage (includes delivery and postpartum care)	$250 copay; after deductible	40%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Outpatient hospital	Covered 100%; after deductible	40%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
Outpatient surgery - hospital	Covered 100%; after deductible	40%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
Outpatient surgery - freestanding facility	Covered 100%; after deductible	40%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	$250 copay; after deductible	40%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Mental health office visits	$50 copay; no deductible	40%; after deductible
Mental health telehealth consultations	$50 office visit copay; no deductible	40%; after deductible
Other mental health services	Covered 100%; after deductible	40%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		

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SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	$250 copay; after deductible	40%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Residential treatment facility	$250 copay; after deductible	40%; after deductible
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Substance abuse office visits	$50 copay; no deductible	40%; after deductible
Substance abuse telehealth consultations	$50 office visit copay; no deductible	40%; after deductible
Other substance abuse services	Covered 100%; after deductible	40%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
THERAPY SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Spinal manipulation therapy	$50 copay; no deductible	40%; after deductible
Limited to 12 visits per year		
Outpatient short-term rehabilitation	$50 copay; no deductible	40%; after deductible
Limited to 30 visits per year Includes physical, occupational, and speech therapies.		
Habilitative physical therapy	Covered 100%; after deductible	40%; after deductible
Habilitative occupational therapy	Covered 100%; after deductible	40%; after deductible
Habilitative speech therapy	Covered 100%; after deductible	40%; after deductible
Autism related physical therapy	Covered 100%; after deductible	40%; after deductible
Autism related occupational therapy	Covered 100%; after deductible	40%; after deductible
Autism related speech therapy	Covered 100%; after deductible	40%; after deductible
Autism related behavioral therapy	$50 copay; no deductible	40%; after deductible
These benefits are combined with outpatient mental health visits		
Autism related applied behavior analysis	Covered 100%; after deductible	40%; after deductible
Your benefits for these services are the same as any other outpatient mental health other services benefit		
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled nursing facility	Covered 100%; after deductible	40%; after deductible
Limited to 30 days per year When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Home health care	Covered 100%; after deductible	40%; after deductible
Limited to 60 visits per year Private duty nursing not included. Limited to three visits per day by staff from a home health care agency. One visit equals a period of four hours or less.		
Hospice care - inpatient	Covered 100%; after deductible	40%; after deductible
30 days/lifetime When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Hospice care - outpatient	Covered 100%; after deductible	40%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		

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Private duty nursing	Not Covered	Not Covered
Durable medical equipment	Covered 100%; after deductible	40%; after deductible
Diabetic supplies -- (if not covered under the prescription drug benefit)	Covered same as any other medical expense. You pay your prescription drug cost sharing amount if you have prescription drug coverage. If not, you pay your PCP visit cost sharing amount.	Covered same as any other medical expense. You pay your prescription drug cost sharing amount if you have prescription drug coverage. If not, you pay your PCP visit cost sharing amount.
Infusion therapy - home/office	$50 copay; no deductible	40%; after deductible
Infusion therapy - outpatient hospital/freestanding facility	Covered 100%; after deductible	40%; after deductible
Gene-based, Cellular, and other Innovative Therapies (GCIT™)	Your cost sharing amount depends on the type of service and where you receive it. Covered 100%: after deductible for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.	Not Covered
Transplants	$250 copay; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.	40%; after deductible Out-of-network coverage applies when you use a non-IOE facility. You will pay more out of pocket when using a non-IOE facility.
Bariatric surgery	Not Covered	Not Covered
Acupuncture Limited to 10 visits per year	$30 copay; no deductible	40%; after deductible
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility treatment	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.
You have coverage for artificial insemination and the diagnosis and treatment of the underlying cause of infertility.		
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), ovulation induction (OI), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery		
Fertility preservation	Not Covered	Not Covered
Vasectomy	Covered 100%; after deductible	40%; after deductible
Tubal ligation	Covered 100%; no deductible	40%; after deductible

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PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy plan type	Advanced Control Plan	
Prescription drug out-of-pocket limit	Prescription drug expenses apply to your medical out-of-pocket limit.	
Preferred generic drugs		
Retail	$20 copay	40% of submitted cost; after applicable in-network cost share
Mail order	$40 copay	40% of submitted cost; after applicable in-network cost share
Preferred brand-name drugs		
Retail	$60 copay	40% of submitted cost; after applicable in-network cost share
Mail order	$120 copay	40% of submitted cost; after applicable in-network cost share
Non-preferred generic and brand-name drugs		
Retail	$100 copay	40% of submitted cost; after applicable in-network cost share
Mail order	$200 copay	40% of submitted cost; after applicable in-network cost share
Specialty drugs		
Preferred specialty	40%	Not Covered
Non-preferred specialty	50%	Not Covered
Pharmacy day supply and requirements		
Retail	You can get up to a 30-day supply from CVS Caremark® National Network	
Mail order	You can get a 31-90-day supply from CVS Caremark® Mail Service Pharmacy.	
Specialty	You can get up to a 30-day supply of specialty drugs You may fill your first prescription at any retail or specialty pharmacy. After that, all other fills must be through our preferred specialty pharmacy network. Advanced Control Formulary Aetna Insured List	

Your prescription drug plan also includes:
• Diabetic supplies
• $25 copay maximum per fill per 30 day supply for formulary insulin drugs
• A limited list of over-the-counter medications when filled with a prescription

Family planning
• Oral fertility drugs included.
• Contraceptives covered up to a 12-month supply. Contraceptive copay strategy applies.

The following are covered 100% in-network:
• Oral chemotherapy drugs
• Seasonal vaccinations
• Preventive vaccinations
• Affordable Care Act (ACA) eligible preventive medications and contraceptives, also includes male condoms
Refer to **Aetna.com** for a complete list of eligible prescription drugs.

Precertification requirements
Some covered prescription drugs need approval from us before we will cover the drug.
Some covered prescription drugs require step therapy before we cover them. With step therapy, you must first try one or more drugs before we will pay for drugs that require step therapy.
To get the most up-to-date precertification requirements and a list of drugs that require step therapy, see your plan documents or go online to your member website.

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Choose generics - Sometimes you or your provider may ask for a brand-name prescription drug when a generic is available. If so, you will pay the brand-name copay plus the difference between the generic price and the brand-name price.

GENERAL PROVISIONS	
Dependents who are eligible to be on your plan	Spouse, children from birth to age 26. Student status of children does not matter.

**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.
This amount is based on the out-of-network plan you or your employer picks.
• For doctors and other professionals the amount is based on the "prevailing" charges. We get this data from an external database.

• 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 **1-866-337-8417.**

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

Coverage Period: 01/01/2025 - 12/31/2025

aetna : ACTONE GOVERNMENT SOLUTIONS
Open Choice® - MedPremier 100/60 $1K

Coverage for: Individual + Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.boongroup.com/OnlineRequests/Default.aspx or by calling 1-866-337-8417. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-866-337-8417 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: Individual $1,000 / Family $2,000. Out-of-Network: Individual $2,000 / Family $4,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency care & prescription drugs; plus in-network office visits & preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual $2,500 / Family $5,000. Out-of-Network: Individual $5,000 / Family $10,000.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See http://www.aetna.com/dse/custom/bn or call 1-866-337-8417 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit, deductible doesn't apply	40% coinsurance	None
	Specialist visit	$50 copay/visit, deductible doesn't apply	40% coinsurance	None
	Preventive care /screening /immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition **Prescription drug coverage** is administered by Caremark More information about **prescription drug coverage** is available at www.Caremark.com	Preferred generic drugs	Copay/prescription, deductible doesn't apply: $20 (retail), $40 (mail order)	40% coinsurance after copay/prescription, deductible doesn't apply: $20 (retail), $40 (mail order)	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics.
	Preferred brand drugs	Copay/prescription, deductible doesn't apply: $60 (retail), $120 (mail order)	40% coinsurance after copay/prescription, deductible doesn't apply: $60 (retail), $120 (mail order)	
	Non-preferred generic/brand drugs	Copay/prescription, deductible doesn't apply: $100 (retail), $200 (mail order)	40% coinsurance after copay/prescription, deductible doesn't apply: $100 (retail), $200 (mail order)	
	Specialty drugs	Copay/prescription, deductible doesn't apply: 40% (preferred), 50% (non-preferred)	Not covered	First prescription fill at a retail pharmacy or specialty Pharmacy. Subsequent fills must be through CVS Caremark Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	40% coinsurance	None
	Physician/surgeon fees	0% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$300 copay/visit, deductible doesn't apply	$300 copay/visit, deductible doesn't apply	Out-of-network emergency use paid the same as in-network. 50% coinsurance for non-emergency use.
	Emergency medical transportation	No charge	No charge	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	$75 copay/visit, deductible doesn't apply	40% coinsurance	50% coinsurance for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/stay	40% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	0% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $50 copay/visit, deductible doesn't apply; other outpatient services: 0% coinsurance	Office & other outpatient services: 40% coinsurance	None
	Inpatient services	$250 copay/stay	40% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge	40% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of $500 for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	0% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	$250 copay/stay	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	40% coinsurance	60 visits/calendar year. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	$50 copay/visit, deductible doesn't apply	40% coinsurance	30 visits/calendar year for Physical, Occupational and Speech Therapy combined.
	Habilitation services	0% coinsurance	40% coinsurance	None
	Skilled nursing care	0% coinsurance	40% coinsurance	30 days/calendar year. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	0% coinsurance	40% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	0% coinsurance	40% coinsurance	30 days/lifetime for inpatient. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
If your child needs dental or eye care	Children's eye exam	$50 copay/visit, deductible doesn't apply	40% coinsurance	1 routine eye exam/12 months.
	Children's glasses	Not covered	Not covered	Benefits may be available under separate plan.
	Children's dental check-up	Not covered	Not covered	Benefits may be available under separate plan.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture - 10 visits/calendar year for disease, injury & chronic pain.
- Chiropractic care - 12 visits/calendar year.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, including artificial insemination.
- Routine eye care (Adult) - 1 routine eye exam/12 months.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

Nevada Division of Insurance, (702) 486-4009, http://doi.nv.gov/Consumers.

- For more information on your rights to continue coverage, contact the plan at 1-866-337-8417.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general toll free number at 1-866-337-8417. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Nevada Division of Insurance, (702) 486-4009, http://doi.nv.gov/Consumers.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact Office of Consumer Health Assistance, 150 Pollock Drive, Las Vegas, NV 89119, (702) 486-3587, (888) 333-1597, https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/, cha@govcha.nv.gov

Does this plan provide Minimum Essential Coverage? **Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,000
Specialist copayment	$50
Hospital (facility) copayment	$250
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,360**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist copayment	$50
Hospital (facility) copayment	$250
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Diabetic supplies *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$1,700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,820**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,000
Specialist copayment	$50
Hospital (facility) copayment	$250
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

The plan would be responsible for the other costs of these EXAMPLE covered services.

BENEFITS SUMMARY

Plan design and benefits insured and administered by Aetna Life Insurance Company (Aetna).
Unless otherwise indicated, all benefits and limitations are per covered person.

Inside this Benefits Summary:

Vision Care

Vision Exams (every 12 months)	$85
Single Lenses (every 24 months)	$95
Contact Lenses (every 24 months)	$95
Bi-focal Lenses (every 24 months)	$120
Frames (every 24 months)	$120

Fees for other services must be paid by you. Benefit period is 12 consecutive months beginning on the later of your effective date or your most recent eye exam covered under this plan.

Vision Care Exclusions:

This plan does not cover all health care expenses and has exclusions and limitations. Members should refer to their booklet certificate to determine which health care services are covered and to what extent. The following is a **partial list** of services and supplies that are generally *not covered*. **However, your plan may contain exceptions to this list based on state mandates or the plan design purchased.**

- Orthoptic vision training, subnormal vision aids, any associated supplemental testing.
- Medical and/or surgical treatment of the eyes or supporting structure.
- Any eye or vision examination, or any corrective eyewear, required by an employer as a condition of employment.

Dental	
Maximum benefit per coverage year	$2,000
Deductible per coverage year	$25
Preventive services (includes checkups and cleanings)	You are responsible for paying up to 0%† of the Recognized Charges. These services have no waiting period.
Basic services (includes fillings, oral surgery, and denture, crown and bridge repair)	You are responsible for paying up to 20%† of the Recognized Charges. These services have no waiting period.
Major services (includes Perio and Endodontics, crowns, bridges, and dentures)	You are responsible for paying up to 50%† of the Recognized Charges. You must be covered under the dental plan without interruption for 12 months before the plan begins to pay for these services.

†The percentage of the cost that you are responsible for paying a preferred provider is based on a **Negotiated Charge**. A **Negotiated Charge** is the maximum amount that a preferred provider has agreed to charge for a covered visit, service, or supply. After your plan limits have been reached, the provider may require that you pay the full charge rather than the **Negotiated Charge**.

The percentage of the cost that you are responsible for paying a non-preferred provider is based on a **Recognized Charge**. A **Recognized Charge** is the amount that Aetna recognizes as payable by the plan for a visit, service, or supply. For non-preferred providers (except inpatient and outpatient facilities and pharmacies), the **Recognized Charge** generally equals the 80th percentile of what providers in that geographic area charge for that service, based on the FAIR Health RV Benchmarks database from FAIR Health, Inc. This means that 80% of the charges in the database for geographic area are that amount or less – and 20% are more – for that service or supply. For preferred providers, the *Recognized Charge* equals the **Negotiated Charge**. A non-preferred provider may require that you pay more than the **Recognized Charge**, and this additional amount would be your responsibility.

To locate a preferred provider, call toll-free **1-866-292-3374** or visit **www.aetna.com/docfind/custom/aahc/bn**.

In Texas, the Preferred Provider Organization (PPO) network is known as the Participating Dental Network (PDN).

Dental Exclusions:

This plan does not cover all health care expenses and has exclusions and limitations. Members should refer to their booklet certificate to determine which health care services are covered and to what extent. The following is a **partial list** of services and supplies that are generally *not covered*. **However, your plan may contain exceptions to this list based on state mandates or the plan design purchased.**

The following charges are not covered under the dental plan, and they will not be recognized toward satisfaction of any deductible amount.

- Cosmetic procedures unless needed as a result of injury.
- Any procedure, service or supplies that are included as covered medical expenses under another group medical expense benefit plan.
- Prescribed drugs, pre-medication, analgesia or general anesthesia.
- Services provided for any type of temporomandibular (TMJ) or related structures, or myofascial pain.
- Charges in excess of the Recognized Charge, based on the 80th percentile of the FAIR Health RV Benchmarks.

Questions and answers

What should I do in case of an emergency?
In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

What if I don't understand something I've read here, or have more questions?
Please call us. We want you to understand these benefits before you decide to enroll. You may reach one of our Customer Service representatives Monday through Friday, 8 a.m. to 6 p.m., by calling toll free **1-866-292-3374**. We're here to answer questions before and after you enroll.

Important information about your benefits

Search our network for doctors, hospitals and other health care providers
Here's how you can find out if your health care provider is in our network. Log in to **www.aetna.com/voluntary** and follow the path to find a doctor, or call us at the toll-free number on your Aetna ID card. If you would like a printed list of doctors, contact Member Services at the toll-free number on your Aetna ID card. Our online directory is more than just a list of doctors' names and addresses. It also includes information about where the physician attended medical school, board certification status, language spoken and gender. You can even get driving directions to the office. If you don't have Internet access, call Member Services to ask about this information.

Complaints and appeals
Please tell us if you are not satisfied with a response you received from us or with how we do business. Call Member Services to file a verbal complaint or to ask for the address to mail a written complaint. You can also e-mail Member Services through the secure member website. If you're not satisfied after talking to a Member Services representative, you can ask us to send your issue to the appropriate department.
If you don't agree with a denied claim, you can file an appeal. To file an appeal, follow the directions in the letter or explanation of benefits statement that explains that your claim was denied. The letter also tells you what we need from you and how soon we will respond.

We protect your privacy
We consider personal information to be private. Our policies protect your personal information from unlawful use. By "personal information," we mean information that can identify you as a person, as well as your financial and health information. Personal information does not include what is available to the public. For example, anyone can access information about what the plan covers. It also does not include reports that do not identify you.
When necessary for your care or treatment, the operation of our health plans or other related activities, we use personal information within our company, share it with our affiliates and may disclose it to: your doctors, dentists, pharmacies, hospitals and other caregivers, other insurers, vendors, government departments and third-party administrators (TPAs).
We obtain information from many different sources —particularly you, your employer or benefits plan sponsor if applicable, other insurers, health maintenance organizations or TPAs, and health care providers.
These parties are required to keep your information private as required by law. Some of the ways in which we may use your information include: Paying claims, making decisions about what the plan covers, coordination of payments with other insurers, quality assessment, activities to improve our plans and audits.
We consider these activities key for the operation of our plans. When allowed by law, we use and disclose your personal information in the ways explained above without your permission. Our privacy notice includes a complete explanation of the ways we use and disclose your information. It also explains when we need your permission to use or disclose your information.
We are required to give you access to your information. If you think there is something wrong or missing in your personal information, you can ask that it be changed. We must complete your request within a reasonable amount of time. If we don't agree with the change, you can file an appeal.
If you'd like a copy of our privacy notice, call **1-866-292-3374** or visit us at **www.aetna.com.**

Ancillary Benefits Exclusions & Limitations

The following expenses are not covered under the Aetna Dental Care Benefit:

(a) Class B expenses incurred during the first 12 months of coverage, unless the Insured provides proof of the coverage under a prior dental plan. However, credit is available only if the Insured notifies the Employer of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this Plan, exclusive of any waiting period. Credit will be given for each day of coverage under all prior creditable coverage, provided fewer than 63 days elapsed between coverage under any two plans;

(b) replacement of existing dentures or bridgework less than five years old, or for replacement because of loss or theft;

(c) charges for orthodontics, unless shown in the Schedule of Benefits;

(d) charges for services with respect to congenital malformations (other than for a newborn child of the Insured);

(e) charges for dental care which are covered under any other part of this Plan;

(f) charges by anyone other than a Dentist, except for charges for dental prophylaxis performed by a Dental Hygienist, under the supervision and direction of a Dentist;

(g) charges for more than one fluoride treatment, one dental prophylaxis, or one bite-wing x-ray in a six-month period; and

(h) charges for more than one complete mouth x-ray in a two-year period.

(i) Charges for which the Covered Person is not legally required to pay or for charges which would not have been made if no charge had existed.

The following expenses are not covered under the Aetna Vision Care Benefit:

(a) charges for more than one routine eye exam in 12 consecutive months;

(b) charges for more than one pair of eye glasses including lenses and frames, or one pair of contact lenses within 24 consecutive months;

(c) charges for eye glasses or contact lenses not prescribed by an eye doctor;

(d) charges for sunglasses, plain or prescription, safety lenses, or goggles;

(e) charges for radial keratotomy or similar surgery done in treating myopia; and

(f) charges for eye surgery, or vision charges which are covered under any other part of this Plan.

(g) Charges for which the Covered Person is not legally required to pay or for charges which would not have been made if no charge had existed.