aetna®

J. Paul Getty Trust
Effective Date: 01-01-2019
Aetna Choice® POS II -- ASC

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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductibles (per calendar year)	$1,350 Individual $2,700 Family	$1,500 Individual $3,000 Family
All covered medical and pharmacy expenses are applied separately toward meeting the in-network and out-of-network Deductibles. Unless otherwise indicated, the deductible must be met prior to any benefits being paid by the plan. Member cost sharing for certain services, as indicated in the plan, are excluded from charges that may meet the Deductible. Once Family Deductible is met, all family members will be considered as having met their Deductible. There is no Individual Deductible to satisfy within the Family Deductible.		
Member Coinsurance Applies to all expenses unless otherwise stated.	10%	30%
Payment Limit/per calendar year *(Includes deductibles noted above)*	$3,300 Individual $6,750 Family	$4,300 Individual $11,600 Family
All covered medical and pharmacy expenses accumulate separately toward the in-network or out-of-network 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. Pharmacy expenses apply toward the Payment Limit. There is no Individual Payment Limit to satisfy within the Family Payment Limit. Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit.		
Lifetime Maximum Unlimited, except where otherwise indicated.		
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of out-of-network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months	Covered 100%; deductible waived	30%; after deductible

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Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	30%; after deductible
7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter		
Routine Gynecological Care Exams	Covered 100%; deductible waived	30%; after deductible
Recommended: One exam per calendar year. Includes routine tests and related lab fees.		
Routine Mammograms	Covered 100%; deductible waived	30%; after deductible
Recommended: One per calendar year for covered females age 40 and over.		
Women's Health	Covered 100%; deductible waived	30%; after deductible
Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		
Routine Digital Rectal Exam	Covered 100%; deductible waived	30%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	30%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	30%; after deductible
Recommended: For all members age 50 and over.		
Routine Eye Exams	Covered 100%; deductible waived	Not Covered
1 routine exam per 24 months.		
Routine Hearing Exams	Covered 100%; deductible waived	30%; after deductible
1 routine exam per 24 months.		
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist	10%; after deductible	30%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	10%; after deductible	30%; after deductible
Pre-Natal Maternity	Covered 100%; deductible waived	Covered according to standard claim practice.
Walk-in Clinics	10%; after deductible	Not Covered
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.		
Allergy Testing	10%; after deductible	30%; after deductible
Allergy Injections	10%; after deductible	30%; after deductible

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DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray (other than Complex Imaging Services)	10%; after deductible	30%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic Laboratory	10%; after deductible	30%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic Complex Imaging	10%; after deductible	30%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	10%; after deductible	30%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	10%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	10%; after deductible	10%; after deductible
Non-Emergency Use of Ambulance	10%; after deductible	10%; after deductible
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Hospital Expenses	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Surgery	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
ALCOHOL/DRUG ABUSE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	10%; after deductible	30%; after deductible

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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Residential Treatment Facility	10%; after deductible	30%; after deductible
Outpatient	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Convalescent Facility	10%; after deductible	30%; after deductible
Limited to 120 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Home Health Care	10%; after deductible	30%; after deductible
Limited to 120 visits per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.		
Hospice Care - Inpatient	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Private Duty Nursing	10%; after deductible	30%; after deductible
Limited to 70 eight hour shifts per calendar year. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.		
Outpatient Short-Term Rehabilitation	10%; after deductible	30%; after deductible
Includes Spinal Manipulation, Physical, and Occupational Therapy, limited to 90 visits per calendar year.		
Speech Therapy	10%; after deductible	30%; after deductible
Unlimited		
Acupuncture	10%; after deductible	30%; after deductible
Autism Behavioral Therapy	10%; after deductible	30%; after deductible
Combined with outpatient mental health visits		
Autism Applied Behavior Analysis	10%; after deductible	30%; after deductible
Autism Physical Therapy	10%; after deductible	30%; after deductible
Autism Occupational Therapy	10%; after deductible	30%; after deductible
Autism Speech Therapy	10%; after deductible	30%; after deductible
Durable Medical Equipment	10%; after deductible	30%; after deductible
Diabetic Supplies	10%; after deductible	30%; after deductible
Generic FDA-approved Women's Contraceptives	Covered 100%; deductible waived	30%; after deductible
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	30%; after deductible
Vision Eyewear	Not Covered	Same as preferred care.

Transplants	10%; after deductible Preferred coverage is provided at an IOE contracted facility only.	30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery Limited to $10,000 per lifetime	10%; after deductible	Not Covered

The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.

FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition.	10%; after deductible	30%; after deductible
Comprehensive Infertility Services	Not Covered	Not Covered
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
Vasectomy	10%; after deductible	30%; after deductible
Tubal Ligation	Covered 100%; deductible waived	30%; after deductible

PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan (Note: The deductible is waived for generic preventive drugs.)		
Pharmacy Plan Type	Aetna Premier Plus Open Formulary	
Retail Preventive Drug List	$0 copay for generic; deductible waived $35 copay for formulary brand-name; deductible waived	
Retail (up to a 30 day supply) Subject to deductible	$15 copay for generic drugs $35 copay for formulary brand-name drugs $50 copay for non-formulary brand-name	30% of submitted cost; after applicable copay
Mail Order (31-90 day supply from Aetna Rx Home Delivery) Subject to deductible	$30 copay for generic drugs $70 copay for formulary brand-name drugs $100 copay for non-formulary brand-name	Not Covered
Aetna Premier Plus Specialty Drugs (up to a 30 day supply) Subject to deductible	$15 copay for generic drugs $35 copay for formulary brand-name drugs $50 copay for non-formulary brand-name	Not Covered

First prescription fill at any retail drug facility. Subsequent fills must be through our preferred Aetna Specialty Pharmacy network.
Premier Plus Specialty Drug List

Choose Generics with Dispense as Written (DAW) override - The member pays the applicable copay. If the physician requires brand-name, member would pay brand-name copay. If the member requests brand-name when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.

Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy.
Oral fertility drugs and performance enhanced drugs are included.
Premier Plus Pre-certification included; with 90 day Transition of Care
Premier Plus Step Therapy included; with 90 day Transition of Care
Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.

GENERAL PROVISIONS

Dependents Eligibility	Spouse; children from birth to age 26 regardless of student status; same sex or registered domestic partner.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.
Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.
The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

• 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.
• Durable medical Equipment
• 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.
• Orthotics except diabetic orthotics.
• 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 or inadequacies, including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Treatment of behavioral disorders.
• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.
In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.
Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**
Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

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Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com.**