



Omaha Track
Proposed Effective Date: 01-01-2018
Aetna Choice® POS II -- ASC

Qualified High Deductible Health Plan

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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	\$5,000 Individual \$10,000 Family	\$10,000 Individual \$20,000 Family
<p>All covered expenses accumulate separately toward the preferred or non-preferred Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount.</p>		
Member Coinsurance	Covered 100%	30%
<p>Applies to all expenses unless otherwise stated.</p>		
Payment Limit (per calendar year)	\$5,000 Individual \$10,000 Family	\$15,000 Individual \$30,000 Family
<p>All covered expenses accumulate separately toward the preferred or non-preferred 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 towards 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.</p>		
Lifetime Maximum	Unlimited except where otherwise indicated.	
Primary Care Physician Selection	Optional	Not Applicable
<p>Certification Requirements - Certification for certain types of Non-Preferred 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.</p>		
Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	30%; after deductible
<p>1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.</p>		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	30%; after deductible
<p>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 to age 22.</p>		
Routine Gynecological Care Exams	Covered 100%; deductible waived	30%; after deductible



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Recommended: One exam per calendar year. Includes routine tests and related lab fees.

Routine Mammograms	Covered 100%; deductible waived	30%; after deductible
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	Covered under Routine Adult Exams
Recommended: For all members age 50 and over.		
Routine Eye Exams	Covered 100%; deductible waived	30%; after deductible
1 routine exam per 24 months.		
Routine Hearing Screening	Covered 100%; deductible waived	30%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to Non-Specialist	Covered 100%; after deductible	30%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	Covered 100%; after deductible	30%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	Covered according to standard claim practice.
Walk-in Clinics	Covered 100%; after deductible	30%; after deductible
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	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed. Covered 100% when an office visit charge is not applicable.	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray (other than Complex Imaging Services)	Covered 100%; 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.		



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Diagnostic Laboratory	Covered 100%; 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	Covered 100%; after deductible	30%; after deductible
EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Provider	Covered 100%; after deductible	30%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	Covered 100%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%; after deductible	30%; after deductible
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	Covered 100%; after deductible	30%; after deductible
Substance Abuse Office Visits	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		



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OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Other Substance Abuse Services	Covered 100%; after deductible	30%; after deductible
Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	30%; after deductible
Home Health Care Limited to 60 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.	Covered 100%; after deductible	30%; after deductible
Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	30%; after deductible
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	30%; after deductible
Private Duty Nursing	Not Covered	Not Covered
Outpatient Short-Term Rehabilitation Includes speech, physical, occupational therapy; limited to 60 visits per calendar year	Covered 100%; after deductible	30%; after deductible
Spinal Manipulation Therapy Limited to 20 visits per calendar year.	Covered 100%; after deductible	30%; after deductible
Autism Behavioral Therapy Combined with outpatient mental health visits	Covered 100%; after deductible	30%; after deductible
Autism Applied Behavior Analysis	100%; after deductible	30%; after deductible
Autism Physical Therapy Visits combined with Short Term Rehabilitation.	100%; after deductible	30%; after deductible
Autism Occupational Therapy Visits combined with Short Term Rehabilitation.	Covered 100%; after deductible	30%; after deductible
Autism Speech Therapy Visits combined with Short Term Rehabilitation.	Covered 100%; after deductible	30%; after deductible
Durable Medical Equipment	Covered 100%; after deductible	30%; after deductible
Diabetic Supplies	Covered same as any other medical expense.	Covered same as any other medical expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.
Infusion Therapy Administered in the home or physician's office	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed



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Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Vision Eyewear	Not Covered	Not Covered
Transplants	Covered 100%; 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	Not Covered	Not Covered
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Diagnosis and treatment of the underlying medical condition only.		
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 is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Tubal Ligation	Covered 100%; deductible waived	Your cost sharing is based on the type of service and where it is performed
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.		
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Value Drugs Tier 1A		
	Retail Covered 100%	30% of submitted
	Mail Order Covered 100%	Not Applicable



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Preferred Generic Drugs			
	Retail	Covered 100%	30% of submitted cost
	Mail Order	Covered 100%	Not Applicable
Preferred Brand-Name Drugs			
	Retail	Covered 100%	30% of submitted cost
	Mail Order	Covered 100%	Not Applicable
Non-Preferred Generic and Brand-Name Drugs			
	Retail	Covered 100%	30% of submitted cost
	Mail Order	Covered 100%	Not Applicable
Value Plus Specialty Drugs			
	Preferred Specialty	Covered 100%	Not Applicable
	Non-Preferred Specialty	Covered 100%	Not Applicable
Pharmacy Day Supply and Requirements			
	Retail	Up to a 30 day supply from Aetna Standard National Network Percentage copays will not be doubled	
	Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
	Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. All prescription fills must be through our preferred specialty pharmacy network.	

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: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
 A limited list of over-the-counter medications are covered when filled with a prescription.
 Oral chemotherapy drugs covered 100%
 Value Plus Pre-certification included
 Value Plus Step Therapy included
 One transition fill allowed within 90 days of member's effective date
 Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

GENERAL PROVISIONS

Dependents Eligibility Spouse, children from birth to age 26 regardless of student status.
 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.



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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.

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-**

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Puede estar disponible la traducción 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**.

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ERROR REPORT
This is a report that will outline any benefits that did not transfer from AQC to e.Proposal to print on the plan design or to highlight any benefits that were in AQC, but not in e.Proposal.
If you receive any errors please log your error in the PE Product Data Report (PDR) , and manually update the plan design(s) with the value(s) you selected in AQC.
Plan Sponsor: Omaha Track
Quote: 157888
Option: 1
Location: CT
Product: HSA Open POS II

BENEFIT AVAILABLE IN AQC, BUT NOT IN E-PROPOSAL	
Benefit Display Name	Infusion therapy home or office
Plan Name	Open POS II Plan
Error at Position	Group Name = Other Services Group Record Id = 2118 Section Name = Infusion therapy home or office Section Record Id = 2212 Row Record Id = 17929 Column Record Id = 55436
Rule Error	Overall text could not be resolved
PFRI Details	
PFRI ID = 39175 Product Type = 1 Product Basis = 0 Package Type = 0 Product Category = 114 Product Category Type = 116 TPID = 201652 UC Code = COINS Nature Code = PREF Benefit Class = BSCS Ucv SeqNo = 100007 Ucv Description = Covered the same as any other expense based on the type of service performed and place of service where rendered Context Id = 10 Rule Id = 38 Rule Class Name = ConcatenationOfText BaseRule Class Name = BaseCheckRule Column Rec Id = 55436 Proposal Variable Id = 1 Error = true AQC Error = false Required Code = O	
PFRI ID = 39175 Product Type = 1 Product Basis = 0 Package Type = 0 Product Category = 114 Product Category Type = 116 TPID = 201652 UC Code = COINS Nature Code = PREF Benefit Class = BSCS Ucv SeqNo = 100007 Ucv Description = Covered the same as any other expense based on the type of service performed and place of service where rendered Context Id = 10 Rule Id = 28 Rule Class Name = DeterminePlanPays BaseRule Class Name = BaseCheckRule Column Rec Id = 55436 Proposal Variable Id = 1 Error = false AQC Error = true Required Code = O	
No numeric value found for the UCVDdescription	



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	PFRI ID = 39176 Product Type = 1 Product Basis = 0 Package Type = 0 Product Category = 114 Product Category Type = 116 TPID = 201652 UC Code = DEDAPP Nature Code = PREF Benefit Class = GRID Ucv SeqNo = 100000 Ucv Description = N/A Context Id = 10 Rule Id = 36 Column Rec Id = 55436 Proposal Variable Id = 1 Error = true AQC Error = false Required Code = 0
	No Replacement Text Fragments found for the PFRI