



URS | CH2M Oak Ridge LLC (UCOR)  
 Plan A: ETPP Aetna OAMC – Active Salaried, Paducah USW  
 Effective Date: 01-01-2018  
 Open Access<sup>®</sup> Managed Choice<sup>®</sup> POS – Ohio

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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
<b>Deductible</b> (per calendar year)	\$400 Individual \$800 Family	\$1,000 Individual \$2,000 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 do not 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>		
<b>Member Coinsurance</b>	20%	40%
<p>Applies to all expenses unless otherwise stated.</p>		
<b>Payment Limit</b> (per calendar year)	\$5,100 Individual \$10,200 Family	\$13,200 Individual \$26,400 Family
<p>All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses do not apply towards the 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. 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>		
<b>Lifetime Maximum</b>	Unlimited except where otherwise indicated.	
<b>Payment for Non-Preferred</b>	Not Applicable	Professional: 300% of Medicare Facility: 300% of Medicare
<b>Primary Care Physician Selection</b>	Optional	Not Applicable
<b>Certification Requirements -</b>	<p>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 \$300 per occurrence.</p>	
<b>Referral Requirement</b>	None	None
<b>PREVENTIVE CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Routine Adult Physical Exams/ Immunizations</b>	Covered 100%; deductible waived	40%; after deductible
<p>1 exam every 12 months for members age 22 and older.</p>		
<b>Routine Well Child Exams/Immunizations</b>	Covered 100%; deductible waived	40%; 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>		
<b>Routine Gynecological Care Exams</b>	Covered 100%; deductible waived	40%; after deductible
<p>Includes routine tests and related lab fees. One per calendar year.</p>		
<b>Routine Mammograms</b>	Covered 100%; deductible waived	40%; after deductible
<p>Recommended: One baseline mammogram for covered females age 35-39, one mammogram per calendar year for covered females age 40 and over.</p>		



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<b>Women's Health</b>	Covered 100%; deductible waived	40%; 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.		
<b>Routine Digital Rectal Exam</b>	Covered 100%; deductible waived	40%; after deductible
Recommended: For covered males age 40 and over.		
<b>Prostate-specific Antigen Test</b>	Covered 100%; deductible waived	40%; after deductible
Recommended: For covered males age 40 and over.		
<b>Colorectal Cancer Screening</b>	Covered 100%; deductible waived	40%; after deductible
Recommended: For all members age 50 and over.		
<b>Routine Eye Exams</b>	\$60 copay; deductible waived	40%; after deductible
1 routine exam per 24 months.		
<b>Routine Hearing Screening</b>	Covered 100%; deductible waived	40%; deductible waived
<b>PHYSICIAN SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Office Visits to PCP</b>	\$30 copay; deductible waived	40%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
<b>Specialist Office Visits</b>	\$60 copay; deductible waived	40%; after deductible
<b>Audiometric Hearing Exam</b>	Covered 100%; deductible waived	40%; after deductible
1 routine exam per 24 months.		
<b>Pre-Natal Maternity</b>	Covered 100%; deductible waived	40%; after deductible
<b>Walk-in Clinics</b>	\$30 copay; deductible waived	40%; 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.		
<b>Allergy Testing</b>	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.
<b>Allergy Injections</b>	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.
<b>DIAGNOSTIC PROCEDURES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Diagnostic X-ray</b>	20%; after deductible	40%; 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.		
<b>Diagnostic Laboratory</b>	20%; after deductible	40%; 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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<b>Diagnostic Outpatient Complex Imaging</b>	20%; after deductible	40%; after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Urgent Care Provider</b>	20% after \$75 copay; after deductible	40%; after deductible
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered	Not Covered
<b>Emergency Room</b>	20% after \$200 copay; after deductible	Same as in-network care
Copay waived if admitted		
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered	Not Covered
<b>Emergency Use of Ambulance</b>	20%; after deductible	Same as in-network care
<b>Non-Emergency Use of Ambulance</b>	Not Covered	Not Covered
<b>HOSPITAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient Coverage</b>	20% after \$300 per confinement copay; after deductible	40% after \$300 per confinement deductible; after plan deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
<b>Inpatient Maternity Coverage</b> (includes delivery and postpartum care)	20% after \$300 per confinement copay; after deductible	40% after \$300 per confinement deductible; after plan deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
<b>Outpatient Hospital Expenses</b>	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
<b>Outpatient Surgery</b>	20% after \$300 copay; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
<b>Outpatient Surgery - Freestanding Facility</b>	20% after \$300 copay; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient Biologically Based</b>	20% after \$300 per confinement copay; after deductible	40% after \$300 per confinement deductible; after plan deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
<b>Inpatient Non-Biologically Based</b>	20% after \$300 per confinement copay; after deductible	40% after \$300 per confinement deductible; after plan deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
<b>Outpatient Biologically Based</b>	\$60 copay; deductible waived	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
<b>Outpatient Non-Biologically Based</b>	\$60 copay; deductible waived	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
<b>Other Mental Health Services</b>	Covered 100%; deductible waived	40%; after deductible
<b>SUBSTANCE ABUSE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient</b>	20% after \$300 per confinement copay; after deductible	40% after \$300 per confinement deductible; after plan deductible



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Your cost sharing applies to all covered benefits incurred during your inpatient stay.

<b>Residential Treatment Facility</b>	20% after \$300 per confinement copay; after deductible	40% after \$300 per confinement deductible; after plan deductible
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<b>Substance Abuse Office Visits</b>	\$60 copay; deductible waived	40%; after deductible
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Your cost sharing applies to all covered benefits incurred during your outpatient visit.

<b>Other Substance Abuse Services</b>	Covered 100%; deductible waived	40%; after deductible
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<b>OTHER SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
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<b>Convalescent Facility</b>	20% after \$300 per confinement copay; after deductible	40% after \$300 per confinement deductible; after plan deductible
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Limited to 120 days per calendar year.

Your cost sharing applies to all covered benefits incurred during your inpatient stay.

<b>Home Health Care</b>	20%; after deductible	40%; after deductible
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Limited to 120 visits per plan year. Includes Private Duty Nursing limited to 70 eight hour shifts per plan year.

Each visit by a nurse or therapist is one visit.

<b>Hospice Care - Inpatient</b>	20% after \$300 per confinement copay; after deductible	40% after \$300 per confinement deductible; after plan deductible
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Your cost sharing applies to all covered benefits incurred during your inpatient stay.

<b>Hospice Care - Outpatient</b>	20%; after deductible	40%; after deductible
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Your cost sharing applies to all covered benefits incurred during your outpatient visit.

<b>Outpatient Short-Term Rehabilitation</b>	20%; after deductible	40%; after deductible
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Includes Speech, Physical, Occupational and Spinal Manipulation Therapy, limited to 60 combined visits per calendar year.

<b>Autism Behavioral Therapy</b>	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
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Covered same as any other Outpatient Mental Health benefit

<b>Autism Applied Behavior Analysis</b>	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
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Covered same as any other Outpatient Mental Health Other Services benefit

<b>Autism Physical Therapy</b>	20%; after deductible	40%; after deductible
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<b>Autism Occupational Therapy</b>	20%; after deductible	40%; after deductible
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<b>Autism Speech Therapy</b>	20%; after deductible	40%; after deductible
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<b>Durable Medical Equipment</b>	20%; after deductible	40%; after deductible
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<b>Hearing Hardware</b>	Covered 100%; deductible waived	Covered 100%; deductible waived
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Limited to \$500 per ear per 36-month period.

<b>Diabetic Supplies -- (if not covered under Pharmacy benefit)</b>	Covered same as any other medical expense.	Covered same as any other medical expense.
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<b>Women's Contraceptive drugs and devices not obtainable at a pharmacy</b>	Covered 100%; deductible waived	40% (payable as any other covered expense) after medical deductible
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<b>Women's Contraceptive drugs and devices not obtainable at a pharmacy</b>	Covered 100%; deductible waived	40% (payable as any other covered expense) after medical deductible
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**pharmacy**



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<b>Affordable Care Act mandated Women's Contraceptives</b>	Covered 100%; deductible waived	40%; after deductible
<b>Infusion Therapy</b> 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
<b>Infusion Therapy</b> 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
<b>Transplants</b>	20% after \$300 per confinement copay; after deductible Preferred coverage is provided at an IOE contracted facility only.	40% after \$300 per confinement deductible; after plan deductible Non-Preferred coverage is provided at a Non-IOE facility.
<b>Mouth, Jaws and Teeth</b> (oral surgery procedures, whether medical or dental in nature)	Your cost sharing is based on the type of service and where it is performed.	40%; after deductible
<b>Out of Area Dependents</b>	Coverage provided at the non-preferred benefit level of the plan.	
<b>FAMILY PLANNING</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Infertility Treatment</b> Diagnosis and treatment of the underlying medical condition.	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.
<b>Comprehensive Infertility Services</b> Coverage includes Artificial Insemination (limited to six courses of treatment per member's lifetime) and Ovulation Induction (limited to six courses of treatment per member's lifetime). Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law.	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.
<b>Vasectomy</b>	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.
<b>Tubal Ligation</b>	Covered 100%; deductible waived	Your cost sharing is based on the type of service and where it is performed.
<b>PHARMACY</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Pharmacy Plan Type</b>	Aetna Premier Plus Open Formulary	



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<b>Generic Drugs</b>			
	<b>Retail</b>	After Rx deductible, 30% Maximum \$150 per script	After Rx deductible, 40% after applicable copay
	<b>Mail Order</b>	After Rx deductible, 30% Maximum \$300 per script	Not Applicable
<b>Preferred Brand-Name Drugs</b>			
	<b>Retail</b>	After Rx deductible, 30% Maximum \$150 per script	After Rx deductible, 40% after applicable copay
	<b>Mail Order</b>	After Rx deductible, 30% Maximum \$300 per script	Not Applicable
<b>Non-Preferred Brand-Name Drugs</b>			
	<b>Retail</b>	After Rx deductible, 30% Maximum \$300 per script	After Rx deductible, 40% after applicable copay
	<b>Mail Order</b>	After Rx deductible, 30% Maximum \$600 per script	Not Applicable
<b>Premier Plus Specialty Drugs</b>			
	<b>Preferred Specialty</b>	After Rx deductible, 30% Maximum \$400 per script	Not Applicable
	<b>Non-Preferred Specialty</b>	After Rx deductible, 30% Maximum \$400 per script	Not Applicable
<b>Pharmacy Day Supply and Requirements</b>			
	<b>Retail</b>	Up to a 30 day supply from Aetna Standard National Network Percentage copays will not be doubled	
	<b>Mail Order</b>	Up to a 31-90 day supply from Aetna Rx Home Delivery <sup>®</sup> .	
	<b>Premier Plus Specialty</b>	Up to a 30 day supply from Aetna Specialty Pharmacy Network.	
<b>Plan Includes:</b> Diabetic supplies, contraceptive drugs and devices obtainable from a pharmacy. Oral and injectable fertility drugs included. Premier Plus Pre-Certification for Specialty Drugs. Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.			
<b>Prescription Drug Calendar Year Deductible</b> (must be satisfied before any drug benefits are paid)		\$100 Individual	\$100 Individual
		\$200 Family	\$200 Family
Unless otherwise indicated, the pharmacy deductible must be met prior to pharmacy benefits being payable. Once family pharmacy deductible is met, all family members will be considered as having met their pharmacy deductible for the remainder of the calendar year			
<b>Prescription Drug Calendar Year Payment Limit</b>		\$1,500 Individual	\$1,500 Individual
		\$3,000 Family	\$3,000 Family
<b>GENERAL PROVISIONS</b>			
<b>Dependents Eligibility</b>		Spouse, children from birth to age 26	

\*\*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.

• For doctors and other professionals 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.



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- 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.

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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.



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- 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 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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