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URS | CH2M Oak Ridge LLC - UCOR
Plan B: Oak Ridge Active USW & ATLC - ORNL
Effective Date: 01-01-2019
Open Access® Managed Choice® POS - Ohio

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$300 Individual $600 Family	$600 Individual $1,200 Family
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.		
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%	30%
Payment Limit (per calendar year)	$6,350 Individual $12,700 Family	$2,000 Individual $4,000 Family
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 apply towards the in-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. 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.		
Lifetime Maximum Unlimited except where otherwise indicated.		
Payment for Non-Preferred	Not Applicable	Professional: 300% of Medicare Facility: 300% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
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 $300 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members age 22 and older.	Covered 100%; deductible waived	30%; after deductible
Routine Well Child Exams/Immunizations 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.	Covered 100%; deductible waived	30%; after deductible
Routine Gynecological Care Exams Includes routine tests and related lab fees. One per calendar year.	Covered 100%; deductible waived	30%; after deductible
Routine Mammograms Recommended: One baseline mammogram for covered females age 35-39, one mammogram per calendar year for covered females age 40 and over.	Covered 100%; deductible waived	30%; after deductible

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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	$45 copay; deductible waived	30%; after deductible
1 routine exam per 24 months.		
Routine Hearing Screening	Covered 100%; deductible waived	30%; deductible waived
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP	$35 copay; deductible waived	30%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$45 copay; deductible waived	30%; after deductible
Audiometric Hearing Exam	Covered 100%; deductible waived	30%; after deductible
1 exam per 24 months.		
Pre-Natal Maternity	Covered 100%; deductible waived	30%; after deductible
Walk-in Clinics	$35 copay; deductible waived	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	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 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 Outpatient Complex Imaging	Covered 100%; after deductible	30%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$100 copay; after deductible	30%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	$200 copay; after deductible	Same as in-network care
Copay waived if admitted		

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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	$250 per confinement copay; after deductible	30% after $250 per confinement deductible; after plan deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	$250 per confinement copay; after deductible	30% after $250 per confinement deductible; after plan 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 inpatient stay.		
Outpatient Surgery	Covered 100% after $50 copay; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Surgery - Freestanding Facility	Covered 100% after $50 copay; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	$250 per confinement copay; after deductible	30% after $250 per confinement deductible; after plan deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	$45 copay; deductible waived	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%; deductible waived	30%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	$250 per confinement copay; after deductible	30% after $250 per confinement deductible; after plan deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	$250 per confinement copay; after deductible	30% after $250 per confinement deductible; after plan deductible
Outpatient	$45 copay; deductible waived	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%; deductible waived	30%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Convalescent Facility	$250 per confinement copay; after deductible	30% after $250 per confinement deductible; after plan deductible
Limited to 120 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	Covered 100%; after deductible	30%; after deductible
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.		
Hospice Care - Inpatient	$250 per confinement copay; after deductible	30% after $250 per confinement deductible; after plan deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		

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Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	30%; after deductible
Outpatient Short-Term Rehabilitation Includes Speech, Physical, Occupational and Spinal Manipulation Therapy, limited to 60 visits per calendar year.	Covered 100%; after deductible	30%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Physical Therapy	Covered 100%; after deductible	30%; after deductible
Autism Occupational Therapy	Covered 100%; after deductible	30%; after deductible
Autism Speech Therapy	Covered 100%; after deductible	30%; after deductible
Durable Medical Equipment	Covered 100%; after deductible	30%; after deductible
Hearing Hardware Limited to $500 per ear per 36-month period.	Covered 100%; deductible waived	Covered 100%; deductible waived
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	30% (payable as any other covered expense) after medical deductible
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	30%; after deductible
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
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
Transplants	$250 per confinement copay; after deductible Preferred coverage is provided at an IOE contracted facility only.	30% after $250 per confinement deductible; after plan deductible Non-Preferred coverage is provided at a Non-IOE facility.
Mouth, Jaws and Teeth (oral surgery procedures, whether medical or dental in nature)	Your cost sharing is based on the type of service and where it is performed.	30%; after deductible
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan.	
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment 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.

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Comprehensive Infertility Services	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.
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.		
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**
Pharmacy Plan Type	Aetna Premier Plus Open Formulary	
Generic Drugs		
Retail	After Rx deductible, 20% copay with $10 minimum	After Rx deductible, 30% of recognized charge; after applicable copay
Mail Order	After Rx deductible, $20 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	After Rx deductible, 30% copay with $10 minimum	After Rx deductible, 30% of recognized charge; after applicable copay
Mail Order	After Rx deductible, $40 copay	Not Applicable
Non-Preferred Brand-Name Drugs		
Retail	After Rx deductible, 30% copay with $10 minimum	After Rx deductible, 30% of recognized charge; after applicable copay
Mail Order	After Rx deductible, $60 copay	Not Applicable
Premier Plus Specialty Drugs		
Preferred Specialty	After Rx deductible, 30% with $25 minimum and $50 maximum copay	Not Applicable
Non-Preferred Specialty	After Rx deductible, 30% with $40 minimum and $80 maximum copay	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®.	
Premier Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network.	
Plan Includes: 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.		
Prescription Drug Calendar Year Deductible (must be satisfied before any drug benefits are paid)	$75 Individual	$75 Individual
All covered pharmacy expenses accumulate toward both the preferred and non-preferred pharmacy deductible. Unless otherwise indicated, the pharmacy deductible must be met prior to pharmacy benefits being payable.		
GENERAL PROVISIONS		
Dependents Eligibility	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.

• 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.
• 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.**

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

For more information about Aetna plans, refer to **www.aetna.com.**