City of Anaheim
Effective Date: 01-01-2017
Traditional Choice®TC – California
Comprehensive Medical Plan (CMED) with Rx

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

PLAN FEATURES	
Deductible	$0 Individual $0 Family
Unless otherwise indicated, the deductible must be met prior to benefits being payable. 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 cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible..	
Payment Limit	$2,000 Individual $4,000 Family
Certain member cost sharing elements may not apply toward 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.	
Lifetime Maximum	Unlimited except where otherwise indicated.
Primary Care Physician Selection	Not Applicable
Certification Requirements -	Certification for Hospital Admissions must be obtained to avoid a reduction in benefits paid. Excluded amount applied separately to each type of expense is $250 per occurrence.
Referral Requirement	None
PREVENTIVE CARE	
Routine Adult Physical Exams/ Immunizations	Covered 100%
1 exam every 12 months for members age 18 to age 22; 1 exam every 24 months for ages 22 and older. 1 exam every 12 months for members 65 and older.	
Routine Well Child Exams/Immunizations	Covered 100%
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 12 months thereafter to age 22.	
Routine Gynecological Care Exams	Covered 100%
Recommended: One exam per calendar year. Includes routine tests and related lab fees.	
Routine Mammograms	Covered 100%
Recommended: One per calendar year for covered females age 40 and over.	
Women's Health	Covered 100%
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%
Recommended: For covered males age 40 and over.	
Prostate-specific Antigen Test	Covered 100%
Recommended: For covered males age 40 and over.	
Colorectal Cancer Screening	Covered under Routine Adult Exams
Recommended: For all members age 50 and over.	

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Routine Eye Exams 1 routine exam per 12 months.	Covered 100%
Routine Hearing Screening 1 hearing exam every 12 months	Covered 100%
Vision Eyewear	$200 every 12 months
Hearing Aids Limited to $1,000 every 36 months	Covered 100%
PHYSICIAN SERVICES	
Office Visits to non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician.	Covered 100%
Specialist Office Visits	Covered 100%
Pre-Natal Maternity	Covered 100%
Walk-in Clinics	Covered 100%
Allergy Testing	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Allergy Injections	Member cost sharing is based on the type of service performed and the place of service where it is rendered
DIAGNOSTIC PROCEDURES	
Diagnostic X-ray (other than Complex Imaging Services) 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.	Covered 100%
Diagnostic Laboratory 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.	Covered 100%
Diagnostic Outpatient Complex Imaging	Covered 100%
EMERGENCY MEDICAL CARE	
Urgent Care Provider	Covered 100%
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	Covered 100%
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	Covered 100%
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered 100%
Inpatient Maternity Coverage (includes delivery and postpartum care) The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered 100%
Outpatient Hospital Expenses The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered 100%
MENTAL HEALTH SERVICES	
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered 100%

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Outpatient	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
ALCOHOL/DRUG ABUSE SERVICES	
Inpatient	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Residential Treatment Facility	Covered 100%
Outpatient	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
OTHER SERVICES	
Convalescent Facility	Covered 100%
Limited to 100 days per calendar year.	
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Home Health Care	Covered 100%
Limited to 70 visits per calendar year.	
Home health care services include private duty nursing	
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	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Hospice Care - Outpatient	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	
Autism Behavioral Therapy	Covered 100%
Covered same as any other Outpatient Mental Health benefit	
Autism Applied Behavior Analysis	Covered 100%
Covered same as any other Outpatient Mental Health benefit with no age or visit limitations.	
Autism Physical Therapy	Covered 100%
Autism Occupational Therapy	Covered 100%
Autism Speech Therapy	Covered 100%
Outpatient Speech Therapy	Covered 100%
Outpatient Physical and Occupational Therapy	Covered 100%
Spinal Manipulation Therapy	Covered 100%
Limited to 20 visits per calendar year.	
Durable Medical Equipment	Covered 100%
Acupuncture	Covered 100%
Limited to 12 visits per calendar year	
Diabetic Supplies	Covered same as any other expense.
Contraceptive drugs and devices not obtainable at a pharmacy	Covered same as any other expense.
Generic FDA-approved Women's Contraceptives	Covered same as any other expense.
Transplants	Covered 100%
Non-Preferred coverage is provided at a Non-IOE facility.	
Bariatric Surgery	Not Covered
FAMILY PLANNING	
Infertility Treatment	Applicable cost sharing based on the type of service performed and place of service where rendered
Diagnosis and treatment of the underlying medical condition only.	

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Comprehensive Infertility Services	Not Covered
Advanced Reproductive Technology (ART)	Not Covered
Tubal Ligation	Covered 100%
Vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered
PHARMARCY	**PREFERRED CARE**
Pharmacy Plan Type	Premier Formulary
Retail	$10 copay for generic drugs, $30 copay for formulary brand-name drugs, and $50 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.
Mail Order	$20 copay for generic drugs, $60 copay for formulary brand-name drugs, and $100 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.

Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.

Plan Includes: Performance Enhancing Medication, Contraceptive drugs and devices obtainable from a pharmacy, Diabetic supplies.

Precert for growth hormones included

Formulary Generic FDA-approved Women's Contraceptives covered 100% in network

GENERAL PROVISIONS

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

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc., Aetna Health Insurance Company, Aetna Life Insurance Company and/or Aetna HealthAssurance Pennsylvania, Inc. Each insurer has sole financial responsibility for its own plans and products.

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.

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• 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.**