CALIFORNIA JOCKEY WELFARE CORPORATION
Proposed Effective Date: 01-01-2015
HMO - California

PLAN DESIGN & BENEFITS

PROVIDED BY AETNA HEALTH OF CALIFORNIA INC. - FULL RISK

PLAN FEATURES	IN-NETWORK
Deductible (per calendar year)	None Individual None Family
Out-of-Pocket Maximum (per calendar year)	$2,500 Individual $5,000 Family
In-Network expenses include coinsurance/copays and deductibles. Pharmacy expenses apply towards the Out-of-Pocket-Maximum. The family Out-of-Pocket Maximum is a cumulative Out-of-Pocket Maximum for all family members. The family Out-of-Pocket Maximum can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Out-of-Pocket Maximum amount.	
Lifetime Maximum	Unlimited except where otherwise indicated.
Primary Care Physician Selection	Required
Referral Requirement	Required
PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%
1 exam every 12 months for members age 22 and older.	
Routine Well Child Exams/Immunizations (Age and frequency schedules apply)	Covered 100%
Routine Gynecological Care Exams	Covered 100%
1 exam per 12 months Includes Pap smear, HPV screening, and related lab fees.	
Routine Mammograms	Covered 100%
Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	
Women's Health	Covered 100%
Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply. 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.	
Routine Digital Rectal Exams / Prostate Specific Antigen Test	Covered 100%
Recommended for males age 40 and over.	
Colorectal Cancer Screening	Covered 100%
Recommended: For all members age 50 and over. Frequency schedule applies.	
Routine Eye Exams	Covered 100% 1 routine exam per 24 months.
Direct access to participating providers without a referral.	
Routine Hearing Screening	Covered 100%
PHYSICIAN SERVICES	**IN-NETWORK**
Primary Care Physician Visits	Office Hours: $15 copay; After Office Hours/Home: $20 copay
Includes services of an internist, general physician, family practitioner or pediatrician.	

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Specialist Office Visits	$30 copay
Pre-Natal Maternity	Covered 100%
E-visit to PCP	$15 copay
An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through our authorized internet E-visit service vendor.	
E-visit to Specialist	$30 copay
An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through our authorized internet E-visit service vendor.	
Walk-in Clinics	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 Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Allergy Testing	Member cost sharing is based on the type of service performed and the place of service where it is rendered
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic Laboratory	Covered 100%
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 X-ray	Covered 100%
Outpatient hospital or other Outpatient facility (other than Complex Imaging Services)	
Diagnostic X-ray for Complex Imaging Services	$100 copay
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care Provider	$35 copay
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	$150 copay
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	$150 copay
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK**
Inpatient Coverage	$250 per day for the first 3 days per admission, thereafter Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Inpatient Maternity Coverage (includes delivery and postpartum care)	$15 copay for Physician Maternity Services; $250 per day for the first 3 days per admission, thereafter Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Outpatient Hospital	$150 copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient Mental Illness	$250 per day for the first 3 days per admission, thereafter Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Outpatient Mental Illness	$30 copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	

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ALCOHOL/DRUG ABUSE SERVICES	IN-NETWORK
Inpatient Detoxification	$250 per day for the first 3 days per admission, thereafter Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Outpatient Detoxification	$30 copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
Inpatient Rehabilitation	$250 per day for the first 3 days per admission, thereafter Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Residential Treatment Facility	$250 per day for the first 3 days per admission, thereafter Covered 100%
Outpatient Rehabilitation	$30 copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
OTHER SERVICES	**IN-NETWORK**
Skilled Nursing Facility	$250 per day for the first 3 days per admission, thereafter 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 100 visits per calendar year.
Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	
Hospice Care - Inpatient	$250 per day for the first 3 days per admission, thereafter 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 visit.	
Outpatient Rehabilitation Therapy	$30 copay
Includes speech, physical, occupational therapy	
Spinal Manipulation Therapy	$15 copay
Limited to 20 visits per calendar year	
Autism Behavioral Therapy	$30 copay
Covered same as any other Outpatient Mental Health benefit	
Autism Applied Behavior Analysis	$30 copay
Covered same as any other Outpatient Mental Health benefit	
Autism Physical Therapy	$30 copay
Autism Occupational Therapy	$30 copay
Autism Speech Therapy	$30 copay
Acupuncture	$15 copay
Limited to 20 visits per calendar year	
Durable Medical Equipment	Covered 100%
Prosthetics	Covered 100%
Orthotics	Covered 100%
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%
Generic FDA-approved Women's Contraceptives	Covered 100%
Transplants	$250 per day for the first 3 days per admission, thereafter Covered 100% Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery	$250 per day for the first 3 days per admission, thereafter Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	

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FAMILY PLANNING	IN-NETWORK
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Diagnosis and treatment of the underlying medical condition.	
Comprehensive Infertility Services	Not Covered
Advanced Reproductive Technology (ART)	Not Covered
Vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Tubal Ligation	Covered 100%
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK**
Pharmacy Plan Type	Open Formulary; with mid-year changes
Retail	$10 copay for formulary generic drugs, $20 copay for formulary brand-name drugs, and $35 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.
Mail Order	$20 copay for formulary generic drugs, $40 copay for formulary brand-name drugs, and $70 copay for non-formulary brand-name and generic drugs up to a 31-90 day supply from Aetna Rx Home Delivery.
Plan Includes: Diabetic supplies. Performance Enhancement Medication (4 tablets per month).	
Oral fertility drugs included.	
Precert included.	
Step Therapy included	
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.

Exclusions and Limitations

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health of California Inc. Each insurer has sole financial responsibility for its own products.

This material is for information only. Health benefits 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.

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• 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 and Aetna Specialty Pharmacy refer to Aetna Rx Home Delivery, LLC and Aetna Specialty Pharmacy, LLC, respectively. Aetna Rx Home Delivery and Aetna Specialty Pharmacy are licensed pharmacy subsidiaries of Aetna Inc. that operate through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery and Aetna Specialty Pharmacy 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 pharmacies' 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.

If you require language assistance, please call the Member Services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).

Si requiere la asistencia de un representante que hable su idioma, por favor llame al número de Servicios al Miembro que aparece en su tarjeta de identificación y se le comunicará con la línea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intérprete). TDD-1-800-628-3323 (sólo para las personas con impedimentos auditivos).

Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com.** While this material is believed to be accurate as of the production date, it is subject to change.