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Justworks Employment Group LLC

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PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Q. PLAN FEATURES	IN-NETWORK
Deductible (per calendar year)	None Individual None Family
Member Coinsurance Applies to all expenses unless otherwise stated.	0%
Payment Limit (per calendar year) Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses 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.	$3,500 Individual $8,750 Family
Lifetime Maximum Unlimited except where otherwise indicated.	
Primary Care Physician Selection	Optional
Referral Requirement	None
PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam per calendar year up to age 65, 1 exam per calendar year age 65 and older	Covered 100%
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 calendar year thereafter to age 22.	Covered 100%
Routine Gynecological Care Exams 2 exams per calendar year. Includes routine tests and related lab fees.	Covered 100%
Routine Mammograms	Covered 100%
Women's Health 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.	Covered 100%
Routine Digital Rectal Exam	Covered 100%
Prostate-specific Antigen Test	Covered 100%
Colorectal Cancer Screening Recommended: For all members age 50 and over.	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Routine Eye Exams 1 routine exam per 12 months.	Covered 100%
Routine Hearing Screening	Not Covered
PHYSICIAN SERVICES	**IN-NETWORK**
Office Visits to Non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician.	$30 office visit copay
Specialist Office Visits Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.	$50 copay

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Audiometric Hearing Exam	Not Covered
Pre-Natal Maternity	Covered 100%
Walk-in Clinics	$30 office visit copay
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	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	**IN-NETWORK**
Diagnostic X-ray	Covered 100%
(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.	
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 Outpatient Complex Imaging	Covered 100%
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care Provider	$75 copay
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	$200 copay
Copay waived if admitted	
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	Covered 100%
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK**
Inpatient Coverage	$750 copay
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Inpatient Maternity Coverage	$750 copay
(includes delivery and postpartum care)	
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Outpatient Hospital Expenses	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
Outpatient Surgery	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
Outpatient Surgery - Freestanding Facility	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient	$750 copay
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Outpatient	$50 copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	

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Crisis Intervention Services	$50 copay
ALCOHOL/DRUG ABUSE SERVICES	**IN-NETWORK**
Inpatient	$750 copay
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Residential Treatment Facility	$750 copay
Outpatient	$50 copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
OTHER SERVICES	**IN-NETWORK**
Convalescent Facility	Covered 100%
Limited to 60 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 120 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.	
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 visit.	
Private Duty Nursing - Outpatient	Covered 100%
Limited to 70 eight hour shifts per calendar year.	
Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.	
Outpatient Short-Term Rehabilitation	$50 copay
Includes Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year, unlimited for early intervention services from birth to age 3.	
Spinal Manipulation Therapy	$50 copay
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health
Covered same as any other Outpatient Mental Health benefit	
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health
Covered same as any other Outpatient Mental Health benefit with no visit limits or age restrictions up to 680 hours per a calendar year.	
Autism Physical Therapy	$50 copay
Autism Occupational Therapy	$50 copay
Autism Speech Therapy	$50 copay
Durable Medical Equipment	50%
Diabetic Supplies	Covered same as PCP office visit cost sharing
Generic FDA-approved Women's Contraceptives	Covered 100%
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%
Hearing Aids	Not Covered
Fertility Drugs (oral and injectable)	Covered 100%
Physician charges included (oral and injectable fertility drugs obtained at a pharmacy are covered under the Rx plan).	
Vision Eyewear	Not Covered
Transplants	$750 copay Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery	$750 copay
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Out of Area Dependents	No coverage for non-emergency care received outside the service area.

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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	Applicable cost sharing based on the type of service performed and place of service where rendered
Coverage includes Artificial Insemination and Ovulation Induction.	
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%
PHARMACY	**IN-NETWORK**
Pharmacy Plan Type	Aetna Value Open Formulary
Retail	$10 copay for formulary generic drugs, $30 copay for formulary brand-name drugs, and $50 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, $60 copay for formulary brand-name drugs, and $100 copay for non-formulary brand-name and generic drugs. Up to a 31-90 day supply from Aetna Rx Home Delivery®.
Aetna Value Specialty Drugs	$10 copay for formulary generic drugs, $30 copay for formulary brand-name drugs, and $50 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.
First prescription fill at any retail drug facility. Subsequent fills must be through our preferred Aetna Specialty Pharmacy network.	
Value Specialty Drug List	
Plan Includes: Diabetic supplies and medication covered at PCP cost sharing and Contraceptive drugs and devices obtainable from a pharmacy.	
Performance Enhancing Drugs limited to 4 tablets per month.	
Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).	
Value Pre-certification included	
Value Step Therapy included	
One transition fill allowed within 90 days of member's effective date	
Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.	
Prescription Drug Calendar Year Deductible(must be satisfied before any drug benefits are paid)	$100 Individual $300 Family
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. 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	
GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.
Plans are provided by: Aetna Health Inc. 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.	

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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.
If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.
•All medical or 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 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 behavorial disorders;
• Weight control services including surgical procedure, 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.**

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Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com.**