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FOR

JUSTWORKS.

A2

aetna

Justworks Employment Group LLC

Open Access® Managed Choice® POS - New York
Justworks A2

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	None Individual None Family	$2,000 Individual $5,000 Family
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)	$4,000 Individual $10,000 Family	$5,000 Individual $12,500 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 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: 140% of Medicare Fees Facility: 140% of Medicare Fees
We cover the cost of care differently based on whether health care providers, such as doctors and hospitals, are "in network" or "out of network." We want to help you understand how much we will 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. As an example, you may choose a doctor in our network. You may choose to visit an out-of-network doctor. If you choose a doctor who is out of network, your health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital. When you choose out-of-network care, we will limit the amount it will pay. This limit is called the "recognized" or "allowed" amount. When you choose out-of-network care, we "recognize" an amount 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 out-of-network doctor sets the rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes" or "allows." 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 maximum out-of-pocket. To learn more about how we pay out-of-network benefits visit our website. You can avoid these extra costs by getting your care from our broad network of health care providers. This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.		
Primary Care Physician Selection	Optional	Not Applicable

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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 $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-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%	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 calendar year thereafter to age 22.	Covered 100%	Covered 100%; deductible waived
Routine Gynecological Care Exams 2 exams per calendar year. Includes routine tests and related lab fees.	Covered 100%	30%; after deductible
Routine Mammograms	Covered 100%	30%; after deductible
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%	30%; after deductible
Routine Digital Rectal Exam	Covered 100%	30%; after deductible
Prostate-specific Antigen Test	Covered 100%	30%; after deductible
Colorectal Cancer Screening Recommended: For all members age 50 and over.	Covered 100%	Covered under Routine Adult Exams
Routine Eye Exams 1 routine exam per 12 months.	Covered 100%	30%; after deductible
Routine Hearing Screening	Covered 100%	30%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	$30 copay	30%; after deductible
Specialist Office Visits	$50 copay	30%; after deductible
Audiometric Hearing Exam	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%	Covered according to standard claim practice.
Walk-in Clinics 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.	$30 copay	30%; after deductible
Allergy Testing	Member cost sharing is based on the type of service performed and the place of service where it is rendered	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	Member cost sharing is based on the type of service performed and the place of service where it is rendered

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DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray	Covered 100%	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%	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%	30%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$75 copay	30%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	$150 copay	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	$600 copay	30%; after deductible
Per confinement charge applied per admission, 3x limit per calendar year, waived if readmitted to a hospital, regardless of cause, within 90 days. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	$50 copay for Physician maternity services; 100% [after $600 per stay copay] for Facility services; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Hospital Expenses	Covered 100%	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Surgery	Covered 100%	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Surgery - Freestanding Facility	100% after $75 copay	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	$600 copay	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient	$50 copay	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Crisis Intervention Services	$50 copay	30%; after deductible
ALCOHOL/DRUG ABUSE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	$600 copay	30%; after deductible
Member cost sharing is based on the type of service performed and the place of service where it is rendered		

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Residential Treatment Facility	$600 copay	30%; after deductible
Outpatient	$50 copay	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Convalescent Facility	Covered 100%	30%; after deductible
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%	25%; deductible waived
Limited to 120 days 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%	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	Covered 100%	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Private Duty Nursing - Outpatient	Covered 100%	30%; after deductible
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	30%; after deductible
Includes Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year, unlimited for early intervention services from birth to age 3.		
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health	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	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	30%; after deductible
Autism Occupational Therapy	$50 copay	30%; after deductible
Autism Speech Therapy	$50 copay	30%; after deductible
Spinal Manipulation Therapy	$50 copay	30%; after deductible
Hearing Aids	Not Covered	Not Covered
Durable Medical Equipment	50%	50%; after deductible
Diabetic Supplies	Covered same as PCP office visit cost sharing	Covered same as any other medical expense.
Fertility Drugs (oral and injectable)	Covered 100%	30%; after deductible
Physician charges included (oral and injectable fertility drugs obtained at a pharmacy are covered under the Rx plan).		
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%	Covered same as any other expense.
Generic FDA-approved Women's Contraceptives	Covered 100%	30%; after deductible
Transplants	$600 copay Preferred coverage is provided at an IOE contracted facility only.	30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.

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Bariatric Surgery	$600 per confinement copay	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered	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	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Coverage includes Artificial Insemination and Ovulation Induction.		
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
ART coverage includes: In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery.		
Vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Tubal Ligation	Covered 100%	Member cost sharing is based on the type of service performed and the place of service where it is rendered
PHARMACY	**IN-NETWORK**	**OUT-OF-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.	30% of submitted cost; after applicable copay
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®.	Not Applicable
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.	Not Applicable
Value Specialty Drug List First prescription fill at any retail drug facility. Subsequent fills must be through our preferred Aetna Specialty Pharmacy network.		

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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.

GENERAL PROVISIONS

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

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.

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.
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.**

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