



# The Orthodox HealthPlan

The Orthodox HealthPlan  
Health Reimbursement (HRA) Plan  
Effective Date: 05-01-2020  
Aetna HealthFund™ Open Access® Managed Choice® POS

## FUND FEATURES

<b>HealthFund Amount</b>	\$750 Employee \$1,500 Family
Amount contributed to the Fund by the employer Fund amount reflected is on a per calendar year basis. The fund received may be prorated based on your effective date of coverage. The Family HealthFund amount applies to all family members combined. There is no Individual HealthFund limit within the Family HealthFund amount.	
<b>Fund Coinsurance</b>	100%
Percentage at which the Fund will reimburse	
<b>Fund Administration</b>	The Fund will be used to pay for your member responsibility, including your deductible and coinsurance. Once the deductible is met, the underlying medical plan provides coverage and if a Fund balance still exists, the Fund will pay your member responsibility (i.e. your share of coinsurance) until the Out of Pocket Maximum has been reached or the Fund has been exhausted, whichever comes first. Services covered at 100% with no deductible will be paid by the plan and not by the Fund.
<b>Employee Termination from Your HealthFund</b>	Any remaining HealthFund benefit amount is forfeited (or terminated) when the employee's HealthFund coverage terminates.
<b>Fund Rollover</b>	Any remaining HealthFund benefit amount at end of the year is rolled over into next year's HealthFund benefit amount.
<b>Eligible Fund Expenses</b>	Fund covers same expenses as the medical plan. Expenses above the Reasonable & Customary limit, any plan limits, and any non covered expenses are not eligible for reimbursement under the Fund.
<b>Fund Payment/Assignment</b>	Network Providers: Automatic Assignment to provider. Non-Network Providers: Member may assign payment to provider.
<b>Pro-ration for New Employees</b>	No pro-ration.
<b>Pro-ration for Family Status Change</b>	No pro-ration. Change to new tier based on new employee status.
<b>Prescription Drug Plan</b>	Prescription Drug expenses are integrated with the medical Out-of-Pocket Limit (i.e. expenses are applied towards the medical out-of-pocket maximum but not the medical deductible) and are not integrated with the Fund (i.e., not eligible for reimbursement from the Fund).



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PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
<b>Deductible</b> (per calendar year)	\$3,000 Individual \$6,000 Family	\$5,000 Individual \$10,000 Family
<p>All covered expenses accumulate simultaneously toward both the in-network and out-of-network 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.</p>		
<b>Member Coinsurance</b>	10%	30%
<p>Applies to all expenses unless otherwise stated.</p>		
<b>Payment Limit</b> (per calendar year)	\$5,000 Individual \$10,000 Family	\$7,000 Individual \$14,000 Family
<p>All covered expenses accumulate simultaneously toward both the in-network and out-of-network 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.</p>		
<b>Lifetime Maximum</b>	Unlimited except where otherwise indicated.	
<b>Payment for Out-of-Pocket Care**</b>	Not Applicable	Professional: 300% of Medicare Facility: 300% of Medicare
<b>Primary Care Physician Selection</b>	Optional	Not Applicable
<b>Certification Requirements -</b>	<p>Certification for certain types of out-of-network 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 \$200 or 50% of the scheduled benefit amount per occurrence, whichever is less.</p>	
<b>Referral Requirement</b>	None	None



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PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
<b>Routine Adult Physical Exams/ Immunizations</b> 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%; deductible waived	30%; after deductible
<b>Routine Well Child Exams/Immunizations</b> 7 exams first 12 months, 3 exams 13 <sup>th</sup> – 24 <sup>th</sup> months, 3 exams 25 <sup>th</sup> – 36 <sup>th</sup> months, 1 exam per 12 months thereafter to age 22	Covered 100%; deductible waived	Covered 100%; deductible waived
<b>Routine Gynecological Care Exams</b> 2 OBGYN exams and pap smears per year	Covered 100%; deductible waived	30%; after deductible
<b>Routine Mammograms</b>	Covered 100%; deductible waived	30%; after deductible
<b>Women's Health</b> 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%; deductible waived	30%; after deductible
<b>Routine Digital Rectal Exam</b> Recommended for covered males age 40 and over	Covered 100%; deductible waived	30%; after deductible
<b>Prostate-specific Antigen Test</b> Recommended for covered males age 40 and over	Covered 100%; deductible waived	30%; after deductible
<b>Colorectal Cancer Screening</b> Recommended: For all members age 45 and over.	Covered 100%; deductible waived	30%; deductible waived
<b>Routine Eye Exams</b> 1 routine exam per 12 months.	Covered 100%; deductible waived	30%; after deductible
<b>Routine Hearing Screening</b>	Covered 100%; deductible waived	30%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
<b>Office Visits to PCP</b> Includes services of an internist, general physician, family practitioner or pediatrician.	10%; after deductible	30%; after deductible
<b>Specialist Office Visits</b>	10%; after deductible	30%; after deductible
<b>Hearing Exams</b> 1 routine exam per 24 months.	10%; deductible waived	30%; after deductible
<b>Pre-Natal Maternity</b>	Covered 100%; deductible waived	30%; after deductible
<b>Walk-in Clinics</b> Walk-in Clinics are free-standing health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be Walk-in-Clinics	Covered 100%; deductible waived	30%; after deductible
<b>Allergy Testing</b>	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
<b>Allergy Injections</b>	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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	IN-NETWORK	OUT-OF-NETWORK
<b>DIAGNOSTIC PROCEDURES</b>		
<b>Diagnostic X-ray</b> 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%; deductible waived	30%; after deductible
<b>Diagnostic Laboratory</b> 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%; deductible waived	30%; after deductible
<b>Diagnostic Outpatient Complex Imaging</b>	Covered 100%; deductible waived	30%; after deductible
<b>EMERGENCY MEDICAL CARE</b>		
<b>Urgent Care Provider</b>	10%; after deductible	30%; after deductible
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered	Not Covered
<b>Emergency Room</b>	10%; after deductible	Same as in-network care
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered	Not Covered
<b>Emergency Use of Ambulance</b>	10%; after deductible	Same as in-network care
<b>Non-Emergency Use of Ambulance</b>	Not Covered	Not Covered
<b>HOSPITAL CARE</b>		
<b>Inpatient Coverage</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	30%; after deductible
<b>Inpatient Maternity Coverage</b> (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	30%; after deductible
<b>Outpatient Hospital Expenses</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	30%; after deductible
<b>Outpatient Surgery - Hospital</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	30%; after deductible
<b>Outpatient Surgery - Freestanding Facility</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	30%; after deductible
<b>MENTAL HEALTH SERVICES</b>		
<b>Inpatient</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	30%; after deductible
<b>Mental Health Office Visits</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	30%; after deductible
<b>Other Mental Health Services</b>	Covered 100%; deductible waived	30%; after deductible
<b>SUBSTANCE ABUSE</b>		
<b>Inpatient</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	30%; after deductible
<b>Residential Treatment Facility</b>	10%; after deductible	30%; after deductible
<b>Substance Abuse Office Visits</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	30%; after deductible



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<b>OTHER SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Other Substance Abuse Services</b>	Covered 100%; deductible waived	30%; after deductible
<b>Skilled Nursing Facility</b> Limited to 90 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	30%; after deductible
<b>Home Health Care</b> Limited to 120 visits per calendar year. Private duty nursing not included. Limited to 3 intermittent visits per day by a participating home health care agency. 1 visit equals a period of 4 hours or less	10%; deductible waived	25%; deductible waived
<b>Hospice Care - Inpatient</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	30%; after deductible
<b>Hospice Care - Outpatient</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	25%; after deductible
<b>Private Duty Nursing – Outpatient</b> Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.	Covered as part of Home Health Care	Covered as part of Home Health Care
<b>Spinal Manipulation Therapy</b>	10%; after deductible	30%; after deductible
<b>Outpatient Speech Therapy</b> Limited to 30 visits per year.	10%; after deductible	30%; after deductible
<b>Outpatient Physical and Occupational Therapy</b> Limited to 60 visits per year combined.	10%; after deductible	30%; after deductible
<b>Habilitative Services (Physical/Occupational/Speech Therapy)</b>	Covered 100%; deductible waived	30%; after deductible
<b>Autism Behavioral Therapy</b> Covered same as any other Outpatient Mental Health benefit	10%; after deductible	30%; after deductible
<b>Autism Applied Behavior Analysis</b> Covered same as any other Outpatient Mental Health benefit	Covered 100%; deductible waived	30%; after deductible
<b>Autism Physical Therapy</b>	Covered 100%; deductible waived	30%; after deductible
<b>Autism Occupational Therapy</b>	Covered 100%; deductible waived	30%; after deductible
<b>Autism Speech Therapy</b>	Covered 100%; deductible waived	30%; after deductible
<b>Early Intervention Services</b>	Child from birth to age 3, covered at 100% after deductible, no copay	Child from birth to age 3, covered at 100%, after deductible, no copay.
<b>Hearing Aids</b> Limited to: 1 hearing per ear every 24 months	10%; after deductible	30%; after deductible
<b>Durable Medical Equipment</b>	10%; after deductible	30%; after deductible
<b>Diabetic Supplies (if not covered under pharmacy benefit)</b>	Covered same as any other medical expense.	Covered same as any other medical expense.
<b>Prosthetics</b>	10%; after deductible	30%; after deductible
<b>Women's Contraceptive drugs and devices not obtainable at a pharmacy</b>	Covered 100%; deductible waived	Covered same as any other expense.
<b>Affordable Care Act mandated Women's Contraceptives</b>	Covered 100%; deductible waived	Covered same as any other expense.



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<b>Infusion Therapy</b> 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
<b>Infusion Therapy</b> 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
<b>Vision Eyewear</b>	Not Covered	Not Covered
<b>Transplants</b>	10%; after deductible Preferred coverage is provided at an IOE contracted facility only.	30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
<b>Bariatric Surgery</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	30%; after deductible
<b>Out of Area Dependents</b>	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	
<b>FAMILY PLANNING</b>		
	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Infertility Treatment</b>	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
Diagnosis and treatment of the underlying medical condition only.		
<b>Comprehensive Infertility Services</b> Coverage includes Artificial Insemination.	10%; after deductible	30%; after deductible
<b>Advanced Reproductive Technology (ART)</b> ART coverage includes: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Limited to 2 courses of treatment per member's lifetime. Maximum applies to all procedures covered by any of our plans except where prohibited by law.	10%; after deductible	30%; after deductible
<b>Vasectomy</b>	Your cost sharing is based on the type of service and where it is performed	30%; after deductible
<b>Tubal Ligation</b>	Covered 100%; deductible waived	30%; after deductible



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PHARMACY	IN-NETWORK	OUT-OF-NETWORK
<b>Pharmacy Plan Type</b>	Aetna Standard Plan opt out with ACSF	
<b>Generic Drugs</b>		
<b>Retail</b>	\$10 copay	30% of submitted cost; after applicable copay
<b>Mail Order</b>	\$20 copay	Not Applicable
<b>Preferred Brand-Name Drugs</b>		
<b>Retail</b>	\$25 copay	30% of submitted cost; after applicable copay
<b>Mail Order</b>	\$50 copay	Not Applicable
<b>Non-Preferred Brand-Name Drugs</b>		
<b>Retail</b>	\$50 copay	30% of submitted cost; after applicable copay
<b>Mail Order</b>	\$100 copay	Not Applicable

Pharmacy Day Supply and Requirements		
<b>Retail</b>	Up to a 30 day supply from Aetna National Network For a 31-60 day supply you will be responsible for the Mail Order Drug copay	
<b>Mail Order</b>	A 31-90 day supply from CVS Caremark Mail Service Pharmacy	
<b>Specialty</b>	Up to a 30 day supply Standard Opt Out Aetna Insured List	

**Choose Generics with Dispense as Written (DAW) override** - The member pays the applicable copay only, if the physician requires brand. If the member requests brand when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.

**Plan Includes:** Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.  
 Contraceptives covered up to a 12 month supply. Contraceptive copay strategy applies.  
 A limited list of over-the-counter medications are covered when filled with a prescription.  
 Includes sexual dysfunction drugs for females and males, including daily dose, additional 6 tablets a month for males for erectile dysfunction.  
 Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).  
 Oral chemotherapy drugs covered 100%  
 Precertification for specialty drugs included  
 Step Therapy included  
 Seasonal Vaccinations covered 100% in-network  
 Preventive Vaccinations covered 100% in-network  
 Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.



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**GENERAL PROVISIONS**

**Dependents Eligibility**

Spouse, children from birth regardless of student status. Dependent children terminate coverage at the end of the calendar year in which they turn 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 and 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-pocket 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.





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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
- 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.
- 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/enhancement, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- 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.

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