



The  
Orthodox HealthPlan

Orthodox HealthPlan  
Effective Date: 05-01-2015  
Aetna HealthFund™ Open Choice® (PPO)

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.		
<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 plan year is rolled over into next years 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 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 Payment Limit (i.e. expenses are applied towards the medical Payment Limit but not with the medical deductible) and are not integrated with the Fund (i.e., not eligible for reimbursement from the Fund).	
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
All covered expenses accumulate separately toward the preferred or non-preferred 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.		
<b>Member Coinsurance</b>	10%	30%
Applies to all expenses unless otherwise stated.		



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<b>Payment Limit</b> (per calendar year)	\$5,000 Individual	\$7,000 Individual
	\$10,000 Family	\$14,000 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 do 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.

<b>Payment for Non-Preferred Care**</b>	Not Applicable	Professional: 300% of Medicare Facility: 300% of Medicare
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\*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 you 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. This amount is based on "reasonable" or "prevailing" charges. We get this data from an external database.

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.

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.

<b>Primary Care Physician Selection</b>	Not Applicable	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.

<b>Referral Requirement</b>	None	None
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<b>PREVENTIVE CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
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<b>Routine Adult Physical Exams/ Immunizations</b>	Covered 100%; deductible waived	30%; after deductible
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1 exam per calendar year up to age 65, 1 exam per calendar year age 65 and older



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<b>Routine Well Child Exams/Immunizations</b> 7 exams in the first 12 months of life, 3 exams in the 13th-24th months of life, 3 exams 25-36 months, 1 exam per calendar year thereafter to age 22.	Covered 100%; deductible waived	Covered 100%; deductible waived
<b>Routine Gynecological Care Exams</b> 2 exams per calendar year. Includes routine tests and related lab fees.	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>	Covered 100%; deductible waived	30%; after deductible
<b>Prostate-specific Antigen Test</b>	Covered 100%; deductible waived	30%; after deductible
<b>Colorectal Cancer Screening</b> Recommended: For all members age 50 and over.	Covered 100%; deductible waived	30%; after deductible
<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
<b>PHYSICIAN SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Office Visits to non-Specialist</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>Pre-Natal Maternity</b>	Covered 100%; deductible waived	Covered according to standard claim practice.
<b>E-visit to Non-Specialist</b> 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.	10%; after deductible	30%; after deductible
<b>E-visit to Specialist</b> 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.	10%; after deductible	30%; after deductible
<b>Walk-in Clinics</b> 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.	10%; after deductible	30%; after deductible
<b>Allergy Testing</b>	10%; after deductible	30%; after deductible
<b>Allergy Injections</b>	10%; after deductible	30%; after deductible
<b>DIAGNOSTIC PROCEDURES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</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.	10%; after deductible	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.	10%; after deductible	30%; after deductible



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<b>Diagnostic Outpatient Complex Imaging</b>	10%; after deductible	30%; after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</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>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient Coverage</b>	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Inpatient Maternity Coverage</b> (includes delivery and postpartum care)	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Outpatient Hospital Expenses</b>	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
<b>Outpatient Surgery</b>	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
<b>Outpatient Surgery - Freestanding Facility</b>	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient</b>	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Outpatient</b>	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
<b>Crisis Intervention Services</b>	10%; after deductible	30%; after deductible
<b>ALCOHOL/DRUG ABUSE SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient</b>	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Residential Treatment Facility</b>	10%; after deductible	30%; after deductible
<b>Outpatient</b>	10%; after deductible	30%; after deductible
<b>OTHER SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Convalescent Facility</b>	10%; after deductible	30%; after deductible
Limited to 90 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Home Health Care</b>	10%; deductible waived	25%; deductible waived
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.		
<b>Hospice Care - Inpatient</b>	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		



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<b>Hospice Care - Outpatient</b>	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
<b>Private Duty Nursing - Outpatient</b>	Not Covered	Not Covered
<b>Outpatient Speech Therapy</b>	10%; after deductible	30%; after deductible
Limited to 30 visits per calendar year. Unlimited for early intervention services from birth to age 3.		
<b>Outpatient Physical and Occupational Therapy</b>	10%; after deductible	30%; after deductible
Limited to 60 visits per calendar year combined, unlimited for early intervention services from birth to age 3.		
<b>Spinal Manipulation Therapy</b>	10%; after deductible	30%; after deductible
<b>Autism Behavioral Therapy</b>	10%; after deductible	30%; after deductible
Covered same as any other Outpatient Mental Health benefit		
<b>Autism Applied Behavior Analysis</b>	10%; after deductible	30%; after deductible
Covered same as any other Outpatient Mental Health benefit with no visit limits or age restrictions up to 680 hours per a calendar year.		
<b>Autism Physical Therapy</b>	10%; after deductible	30%; after deductible
<b>Autism Occupational Therapy</b>	10%; after deductible	30%; after deductible
<b>Autism Speech Therapy</b>	10%; after deductible	30%; after deductible
<b>Durable Medical Equipment</b>	10%; after deductible	30%; after deductible
<b>Diabetic Supplies</b>	Covered same as PCP office visit cost sharing	Covered same as any other medical expense.
<b>Generic FDA-approved Women's Contraceptives</b>	Covered 100%; deductible waived	Not Covered
<b>Contraceptive drugs and devices not obtainable at a pharmacy</b>	Covered 100%; deductible waived	Covered same as any other medical expense.
<b>Fertility Drugs (oral and injectable)</b>	10%; after deductible	30%; after deductible
<b>Transplants</b>	10%; after deductible	30%; after deductible
	Preferred coverage is provided at an IOE contracted facility only.	Non-Preferred coverage is provided at a Non-IOE facility.
<b>Bariatric Surgery</b>	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>"Other" Health Care</b> -- 20% member coinsurance after the preferred (per calendar year) deductible for services that are neither "preferred" nor "non-preferred".		
<b>FAMILY PLANNING</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Infertility Treatment</b>	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.		
<b>Comprehensive Infertility Services</b>	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.		
<b>Advanced Reproductive Technology (ART)</b>	10%; after deductible	30%; after deductible
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.		



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Limited to \$10,000 lifetime maximum. Maximum applies to all procedures covered by any of our plans except where prohibited by law.

<b>Vasectomy</b>	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
<b>Tubal Ligation</b>	Covered 100%; deductible waived	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
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Pharmacy Plan Type	IN-NETWORK	OUT-OF-NETWORK
<b>Retail</b> (2 times retail copay for 31-60 day supply at participating pharmacies. Percentage copays will not be doubled)	Open Formulary \$15 copay for generic drugs, \$25 copay for formulary brand-name drugs, and \$40 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.	30% of submitted cost after the applicable preferred copay
<b>Mail Order</b>	\$30 copay for generic drugs, \$50 copay for formulary brand-name drugs, and \$80 copay for non-formulary brand-name and generic drugs up to a 31-90 day supply from Aetna Rx Home Delivery.	Not Applicable
<b>Aetna Specialty CareRx</b>	\$15 copay for formulary generic drugs, \$25 copay for formulary brand-name drugs, and \$40 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.	Not Covered

First prescription fill at any retail drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®.  
Expanded 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).  
Precert for growth hormones included. Expanded Precert included.  
Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.

<b>Prescription Drug Calendar Year</b>	\$50 Individual	\$50 Individual
<b>Deductible</b> (must be satisfied before any drug benefits are paid)	\$100 Family	\$100 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**



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**Dependents Eligibility**

Spouse, children from birth to the end of the calendar year in which they turn 26.

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 traducción 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](http://www.aetna.com).

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