HEALTH PLAN OF SAN MATEO
Effective Date: 08-01-2023
HMO

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA HEALTH OF CALIFORNIA INC. - FULL RISK

PLAN FEATURES	IN-NETWORK
Benefit limitations - Some service or supplies have limits on them per year. There might be a maximum number of visits or days, or a dollar limit per year. In such cases, the benefit year begins on January 1 (unless otherwise noted). Refer to your plan documents to learn more.	
Deductible (per calendar year)	None Individual None Family
The amount you pay (cost sharing) for some medical services does not count toward your deductible. Prescription drug costs do not count toward the deductible. Refer to your plan documents for details.	
Out-of-pocket limit (per calendar year)	$1,000 per Individual $2,000 per Family
Covered expenses in-network add up towards your in-network out-of-pocket limit. Covered expenses out-of-network add up towards your out-of-network out-of-pocket limit. Some of your cost sharing may not count toward the out-of-pocket limit. Your pharmacy expenses count toward your out-of-pocket limit. In-Network expenses include coinsurance/copays and deductibles. Your family will have one out-of-pocket limit. You will meet it when the expenses of several family members add up to the family out-of-pocket limit. No one person will have to pay more than the individual out-of-pocket limit amount.	
Lifetime maximum	Unlimited except where otherwise indicated.
Primary care physician selection	Required
Referral requirement	You'll need a PCP referral for most in-network services
Telehealth consultations - You can access covered services for telehealth visits from different kinds of providers in your plan. Log on to **Aetna.com** to see a list of telehealth providers. You'll also find more about your options, including cost share amounts.	
PREVENTIVE CARE	**IN-NETWORK**
Routine adult physical exams/ immunizations 1 exam every 12 months	Covered 100%
Routine well child exams • 7 exams in the first 12 months • 3 exams from age 13 through 24 months • 3 exams from age 25 through 36 months • 1 exam every 12 months from age 3 until age 22 years	Covered 100%
Childhood immunizations	Covered 100%
Routine gynecological care exams 1 exam and pap smear every 12 months, including HPV screening and related fees	Covered 100%
Routine mammogram Recommended: One per year for members age 40 and over	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. Also includes: contraceptive methods (ACA mandated contraceptives, including contraceptives and devices you can't get at a pharmacy), sterilization procedures (including tubal ligation), patient education and counseling. Limits may apply.	Covered 100%
Pre-natal maternity	Covered 100%
Routine digital rectal exams / Prostate specific antigen test Recommended: For members age 40 and over	Covered 100%

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Colorectal cancer screening Recommended: For all members age 45 and over. Frequency schedule applies.	Covered 100%
Routine eye exams 1 routine exam per 24 months. Direct access to participating providers without a referral.	Covered 100%
Routine hearing screening	Covered 100%
PHYSICIAN SERVICES	**IN-NETWORK**
Primary care physician visits Includes services of an internist, general physician, family practitioner or pediatrician.	$20 office visit copay
Telehealth consultation with non-specialist	$20 office visit copay
Specialist office visits	$20 office visit copay
Telehealth consultation with specialist	$20 office visit copay
Walk-in clinics Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services. Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices.	$20 copay
Allergy testing	Your cost sharing amount depends on the type of service and where you receive it.
Allergy injections	Your cost sharing amount depends on the type of service and where you receive it.
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic X-ray (Other than complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	Covered 100%
Diagnostic laboratory When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	Covered 100%
Diagnostic complex imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	$100 copay
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent care provider	$35 office visit copay
Non-urgent use of urgent care provider	Not Covered
Emergency room Copay waived if admitted	$100 copay
Non-emergency care in an emergency room	Not Covered
Emergency use of ambulance	$100 copay
Non-emergency use of ambulance	Not Covered

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HOSPITAL CARE	IN-NETWORK
Inpatient coverage	Covered 100%
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Inpatient maternity coverage (includes delivery and postpartum care)	$20 for Physician Maternity Services; Covered 100% for Facility services
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Outpatient hospital	Covered 100%
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	
MENTAL HEALTH SERVICES	**IN-NETWORK**
Mental health inpatient	Covered 100%
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Mental health office visits	Covered 100%
Mental health telehealth consultations	Covered 100%
Other mental health services	Covered 100%
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient	Covered 100%
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Residential treatment facility	Covered 100%
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Substance abuse office visits	Covered 100%
Substance abuse telehealth consultations	Covered 100%
Other substance abuse services	Covered 100%
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	
THERAPY SERVICES	**IN-NETWORK**
Spinal manipulation therapy	$20 copay
Limited to 20 visits per year Direct access to participating providers without a referral.	
Outpatient short-term rehabilitation	$20 copay
Includes speech, physical, occupational therapy	
Habilitative physical therapy	Refer to MBH Outpatient Mental Health All Other
Habilitative occupational therapy	Refer to MBH Outpatient Mental Health All Other
Habilitative speech therapy	Refer to MBH Outpatient Mental Health All Other
Autism related physical therapy	Refer to MBH Outpatient Mental Health All Other
Autism related occupational therapy	Refer to MBH Outpatient Mental Health All Other

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Autism related speech therapy	Refer to MBH Outpatient Mental Health All Other
Autism related behavioral therapy	Refer to MBH Outpatient Mental Health
These benefits are combined with outpatient mental health visits.	
Autism related applied behavior analysis	Refer to MBH Outpatient Mental Health Other Services
Your benefits for these services are the same as any other outpatient mental health other services benefit	
OTHER SERVICES	**IN-NETWORK**
Skilled nursing facility Limited to 100 days per year	Covered 100%
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Home health care Limited to 120 visits per year	$20 copay
Limited to three visits per day by staff from a home health care agency. One visit equals a period of four hours or less.	
Hospice care - inpatient	Covered 100%
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Hospice care - outpatient	Covered 100%
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	
Durable medical equipment	Covered 100%
Prosthetics	Covered 100%
Orthotics	Covered 100%
Orthotics and special footwear covered for persons with foot disfigurement.	
Diabetic supplies -- (if not covered under the prescription drug benefit)	Covered same as any other medical expense. You pay your prescription drug cost sharing amount if you have prescription drug coverage. If not, you pay your PCP visit cost sharing amount.
Infusion therapy Administered in the home or physician's office	$20 copay
Infusion therapy - outpatient hospital/freestanding facility	Your cost sharing amount depends on the type of service and where you receive it.
Transplants	Covered 100% In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.
Bariatric surgery	Covered 100%
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Acupuncture Limited to 20 visits per year	$15 copay

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FAMILY PLANNING	IN-NETWORK
Infertility treatment	Your cost sharing amount depends on the type of service and where you receive it.
You have coverage for the diagnosis and treatment of the underlying cause of infertility.	
Fertility preservation	Your cost sharing amount depends on the type of service and where you receive it.
Includes coverage for cryopreservation and storage for iatrogenic infertility Iatrogenic infertility is infertility that may occur as a result of certain types of medical treatment	
Comprehensive infertility services Artificial insemination and ovulation induction	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered
Vasectomy	Your cost sharing amount depends on the type of service and where you receive it.
Tubal ligation	Covered 100%
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK**
Pharmacy plan type	Advanced Control Plan - Aetna
Prescription drug out-of-pocket limit	Prescription drug expenses apply to your medical out-of-pocket limit.
Preferred generic drugs	
Retail	$10 copay
Mail order	$20 copay
Preferred brand-name drugs	
Retail	$25 copay
Mail order	$50 copay
Non-preferred generic and brand-name drugs	
Retail	$40 copay
Mail order	$80 copay
Pharmacy day supply and requirements	
Retail	1x retail copay for 30 day supply, 2x retail copay for 31-60 day supply, and 3x retail copay for 61-90 day supply from Aetna National Network.
Mail order	You can get a 31-90-day supply from CVS Caremark® Mail Service Pharmacy.
Specialty	You can get up to a 30-day supply of specialty drugs. You must fill all specialty drugs through our preferred specialty pharmacy network. Advanced Control Formulary Aetna Insured List

Your prescription drug plan also includes:
- Diabetic supplies
- Prescription weight loss drugs
- Sexual dysfunction drugs, including daily dose, additional 6 tablets a month for erectile dysfunction
- A limited list of over-the-counter medications when filled with a prescription
- Contraceptives covered up to a 12-month supply. Contraceptive copay strategy applies.

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The following are covered 100% in-network:
• Oral chemotherapy drugs
• Seasonal vaccinations
• Preventive vaccinations
• Affordable Care Act (ACA) eligible preventive medications
Refer to **Aetna.com** for a complete list of eligible prescription drugs.

Precertification requirements -
Some covered prescription drugs need approval from us before we will cover the drug.
Some covered prescription drugs require step therapy before we cover them. With step therapy, you must first try one or more drugs before we will pay for drugs that require step therapy.
To get the most up-to-date precertification requirements and a list of drugs that require step therapy, see your plan documents or go online to your member website.

Choose generics - Sometimes you or your provider may ask for a brand-name prescription drug when a generic is available. If so, you will pay the brand-name copay plus the difference between the generic price and the brand-name price.

GENERAL PROVISIONS

Dependents who are eligible to be on your plan	Spouse, children from birth to age 26. Student status of children does not matter.

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.
• 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.

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• 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.

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.
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