MEDICAL BENEFITS

Administered by Aetna Inc

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. Hanover County offers you a choice of three plans: CDHP, Standard, and Premium.

Within the Aetna Inc Network, you and your family members may visit any licensed provider and receive the greatest out-of-pocket savings if you see an OAP provider. If you choose to see an out-of-network provider, you will incur additional out-of-pocket expenses, and you may be billed for the difference in the cost of the services.

The Consumer Driven Health Plan (CDHP) option is a qualified plan for a Health Savings Account (HSA). With an HSA, you are able to set aside pre-tax funds into an account to be used for qualified medical expenses. For more information on how your HSA works, please see the HSA section of this booklet located on page 10.

Prescription coverage is offered through Aetna/CVS Caremark. Additional information on pharmacy benefits can be found at www.aetna.com and www.caremark.com.

	CDHP		Standard		Premium	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Individual/Family)	$3,000 / $6,000	$4,200 / $8,400	$1,000 / $2,000	$2,000 / $4,000	$500 / $1,000	$1,500 / $3,000
Annual Out-of-Pocket Maximum (Individual/ Family)	$4,000 / $8,000	$8,000 / $16,000	$4,000 / $8,000	$8,000 / $16,000	$3,000 / $6,000	$6,000 / $12,000
HSA Contribution (Individual/Family)	$1,300 / $2,500		None		None	
Member Coinsurance	10%	40%	20%	40%	20%	40%
DOCTOR'S OFFICE						
Preventive Care	No Charge	Ded, then 30%	No Charge	Ded, then 30%	No Charge	Ded, then 30%
Primary Care Office Visit	Ded, then 10%	Ded, then 40%	$35 Copay	Ded, then 40%	$25 Copay	Ded, then 40%
Telehealth	Ded, then 10%	N/A	$10 Copay	N/A	$10 Copay	N/A
Specialist Office Visit	Ded, then 10%	Ded, then 40%	$75 Copay	Ded, then 40%	$50 Copay	Ded, then 40%
Urgent Care	Ded, then 10%	Ded, then 40%	$75 Copay, then 20%	Ded, then 40%	$50 Copay, then 20%	Ded, then 40%
Diagnostic Lab/ Xray services / Advanced Imaging	Ded, then 10%	Ded, then 40%	*Lab/ Xray: 20% Imaging: Ded, then 20%	Ded, then 40%	*Lab/ Xray: 20% Imaging: Ded, then 20%	Ded, then 40%

*Coverage for the Diagnostic Laboratory is deductible then 20% if performed at an outpatient facility and 20%, waive deductible if performed at an independent Lab.

NOTE: Deductibles, copays, and coinsurance accumulate toward the out-of-pocket maximums. Usual, Customary, and Reasonable charges apply for all out-of-network benefits.

MEDICAL BENEFITS

Administered by Aetna Inc

	CDHP		Standard		Premium	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
HOSPITAL SERVICES						
Emergency Room	Ded, then 10%	Ded, then 10%	Ded, then 20%	Ded, then 20%	Ded, then 20%	Ded, then 20%
Inpatient Facility	Ded, then 10%	Ded, then 40%	Ded, then 20%	Ded, then 40%	Ded, then 20%	Ded, then 40%
Outpatient Surgery	Ded, then 10%	Ded, then 40%	Ded, then 20%	Ded, then 40%	Ded, then 20%	Ded, then 40%
Ambulance Service	Ded, then 10%	Ded, then 10%	Ded, then 20%	Ded, then 20%	Ded, then 20%	Ded, then 20%
MENTAL HEALTH SERVICES						
Inpatient Services	Ded, then 10%	Ded, then 40%	Ded, then 10%	Ded, then 40%	Ded, then 10%	Ded, then 40%
Outpatient Services	Ded, then 10%	Ded, then 40%	$25 Copay	Ded, then 40%	$25 Copay	Ded, then 40%
OTHER SERVICES						
Maternity Services	Ded, then 10%	Ded, then 40%	Ded, then 20%	Ded, then 40%	Ded, then 20%	Ded, then 40%
Chiropractic Care (30 visits)	Ded, then 10%	Ded, then 40%	$45 Copay	Ded, then 40%	$35 Copay	Ded, then 40%
Physical, Occupational and Speech Therapy Services	Ded, then 10%	Ded, then 40%	$45 Copay	Ded, then 40%	$35 Copay	Ded, then 40%
Routine Eye Exams	$10 Copay	$45 allowance	$10 Copay	$45 allowance	$10 Copay	$45 allowance
PRESCRIPTION DRUGS						
Deductible (Individual / Family)	$3,000 / $6,000*		$50 / $100	Not covered	$50 / $100	Not covered
Out of Pocket Max (Individual / Family)	$4,000 / $8,000*		$3,000 / $6,000		$3,000 / $6,000	
Retail (Administered by Aetna/CVS Caremark)						
Generic Drug	$5	Not covered	$5	Not covered	$5	Not covered
Preferred Brand Drug	$30	Not covered	$30	Not covered	$30	Not covered
Non-Preferred Brand Drug	$50	Not covered	$50	Not covered	$50	Not covered
Specialty	20%, to a $200 max	Not covered	20%, to a $100 max	Not covered	20%, to a $100 max	Not covered
Mail Order						
Generic Drug	$10	N/A	$10	N/A	$10	N/A
Preferred Brand Drug	$75	N/A	$75	N/A	$75	N/A
Non-Preferred Brand Drug	$100	N/A	$100	N/A	$100	N/A
Specialty	N/A	N/A	N/A	N/A	N/A	N/A

NOTE: Deductibles, copays, and coinsurance accumulate toward the out-of-pocket maximums. Usual, Customary, and Reasonable charges apply for all out-of-network benefits.

*Combined Medical and Pharmacy Drug Deductible and Out of Pocket Maximum.