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Effective Date: 01-01-2019
Aetna Select[SM]

PLAN DESIGN & BENEFITS-EPO
ADMINISTERED BY AETNA HEALTH INSURANCE COMPANY - SELF-FUNDED

PLAN FEATURES	IN-NETWORK
Deductible (per year)	$200 Individual $400 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	Covered 100%
Applies to all expenses unless otherwise stated.	
Payment Limit (per year)	$2,200 Individual $4,400 Family
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.	
Primary Care Physician Selection	Required
Referral Requirement	Required
PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived
1 exam every 12 months	
Routine Well Child Exams	Covered 100%; deductible waived
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 year thereafter.	
Routine Gynecological Care Exams	Covered 100%; deductible waived
1 exam and pap smear per calendar year, includes related fees.	
Routine Mammograms	Covered 100%; deductible waived
Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	
Women's Health	Covered 100%; deductible waived
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.	
Routine Digital Rectal Exam	Covered 100%; deductible waived
1 exam annually for males age 40 and over.	
Prostate-specific Antigen Test	Covered 100%; deductible waived
1 exam annually for males age 40 and over.	
Colorectal Cancer Screening	Covered 100%; deductible waived
Recommended: For all members age 50 and over.	

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Routine Hearing Screening Every 24 months	$15 copay; deductible waived
PHYSICIAN SERVICES	**IN-NETWORK**
Primary Care Physician Visits	$15 copay; deductible waived
Specialist Office Visits	$15 copay; deductible waived
Pre-Natal Maternity	Covered 100%; deductible waived
Walk-in Clinics	$15 copay; deductible waived
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.	
E-Visit (Teladoc)	$15 copay; deductible waived
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic X-ray	$15 copay; deductible waived
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%; deductible waived
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.	
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care Provider	$50 copay; deductible waived
Emergency Room Copay waived if admitted	$75 copay; deductible waived
Non-Emergency Care in an Emergency Room	Not Covered
Ambulance	Covered 100%; after deductible
HOSPITAL CARE	**IN-NETWORK**
Inpatient Coverage	Covered 100%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Inpatient Maternity Coverage (includes delivery and postpartum care)	Covered 100%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Outpatient Hospital	Covered 100%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	
Outpatient Surgery - Hospital	Covered 100%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient	Covered 100%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Outpatient	$15 copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Mental Health Services	Covered 100%; deductible waived
Behavioral Health Telemedicine (Televideo only)	$15 copay; deductible waived
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient	Covered 100%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	

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PHARMACY	IN-NETWORK
Substance Abuse Office Visits	$15 copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Substance Abuse Services	Covered 100%; deductible waived
OTHER SERVICES	**IN-NETWORK**
Skilled Nursing Facility	Covered 100%; after deductible
Limited to 60 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Home Health Care	Covered 100%; after deductible
Limited to 120 visits per calendar year.	
Hospice Care - Inpatient	Covered 100%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Hospice Care - Outpatient	Covered 100%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Private Duty Nursing	Covered 100%; after deductible
Limited to 180 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	$15 copay; deductible waived
Include Speech, Physical, and Occupational Therapy – limited to 60 visits each per calendar year. Medical necessity review not required. Unlimited visits for cerebral palsy and autism diagnosis. Diagnosis of Developmental Delay allowed for Speech Therapy subject to Speech Therapy maximum.	
Spinal Manipulation Therapy	$15 copay; deductible waived
Limited to 25 visits per calendar year. Medical necessity review not required.	
Acupuncture Therapy	$15 copay; deductible waived
Limited to 25 visits per calendar year. Medical necessity review not required.	
Autism Applied Behavior Analysis	Covered 100%; deductible waived
Autism Physical Therapy	$15 copay; deductible waived
Autism Occupational Therapy	$15 copay; deductible waived
Autism Speech Therapy	$15 copay; deductible waived
Durable Medical Equipment	Covered 100%; after deductible
Hearing Aids	Covered 100%; after deductible
Limited to $5,000 per calendar year	
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived
Transplants	Covered 100%; after deductible for treatment in an Institute of Excellence (IOE) facility only. Treatment in a non-IOE facility is not covered.
Bariatric Surgery	Covered 100%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
FAMILY PLANNING	**IN-NETWORK**
Infertility Treatment	Applicable cost sharing based on the type of service performed and place of service where rendered
Diagnosis and treatment of the underlying medical condition only. Refer to Progyny document for additional infertility covered treatment	
Vasectomy	Covered 100%; after deductible
Tubal Ligation	Covered 100%; deductible waived

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Pharmacy Plan Type	Pharmacy benefits are provided by CVS/Caremark. Please check separate pharmacy documents for benefit details.
GENERAL PROVISIONS	

Dependents Eligibility - Spouse/Partner, Children/Stepchildren/Legally adopted children from birth to age 26 regardless of student status. Incapacitated children age 26 or older.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your health plan may pay some of that doctor's bill with prior authorization. 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 limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.
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-network benefits visit our website.

Plans are provided by: Aetna Health Inc. 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. 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.
• Custodial care.
• Dental care and dental X-rays.
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Non-medically necessary services or 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.
• 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.

Translation of this material into another language may be available. Please call Member Services at the number on the back of your ID card.

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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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