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Effective Date: 01-01-2019
Aetna Choice® POS II

PLAN DESIGN & BENEFITS - PPO
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per year)	$500 Individual $1,500 Family	$1,000 Individual $3,000 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.		
Member Coinsurance Applies to all expenses unless otherwise stated.	10%	30%
Payment Limit (per year)	$2,500 Individual $4,500 Family	$5,000 Individual $9,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred 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. Pharmacy expenses do apply towards 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	Recommended	Not Applicable
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.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months	Covered 100%; deductible waived	30%; after deductible
Routine Well Child Exams/Immunizations 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.	Covered 100%; deductible waived	30%; after deductible
Routine Gynecological Care Exams 1 exam and pap smear per calendar year, includes related fees.	Covered 100%; deductible waived	30%; after deductible
Routine Mammograms One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	Covered 100%; deductible waived	30%; after deductible

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Women's Health	Covered 100%; deductible waived	30%; after deductible
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 No age or frequency limits	Covered 100%; deductible waived	30%; after deductible
Prostate-specific Antigen Test No age or frequency limits	Covered 100%; deductible waived	30%; after deductible
Colorectal Cancer Screening Recommended: For all members age 50 and over.	Covered 100%; deductible waived	Covered under Routine Adult Exams
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening Every 24 months	$15 copay; deductible waived	30%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician.	$15 copay; deductible waived	30%; after deductible
Specialist Office Visits	$15 copay; deductible waived	30%; after deductible
Pre-Natal Maternity	Covered 100%; deductible waived	30%; after deductible
Walk-in Clinics 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.	$15 copay; deductible waived	30%; after deductible
Allergy Testing	10%; after deductible	30%; after deductible
Allergy Injections	10%; after deductible	30%; after deductible
E-Visit (Teladoc)	$15 copay; deductible waived	
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray (including Complex Imaging Services) 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
Diagnostic Laboratory 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
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$15 copay; deductible waived	30%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	10% after $75 copay; deductible waived	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Ambulance Transfer	10%; after deductible	10%; after deductible

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Non-Emergency Ambulance Transfer	10%; after deductible. Limitations apply. Precertification required	30%; after deductible. Limitations apply. Precertification required.
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	$15 copay; deductible waived	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	10%; after deductible	30%; after deductible
Behavioral Health Telemedicine (Televideo only)	$15 copay; deductible waived	30%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	10%; after deductible	30%; after deductible
Substance Abuse Office Visits	$15 copay; deductible waived	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	10%; after deductible	30%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	10%; after deductible	30%; 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	10%; after deductible	30%; after deductible
Limited to 120 visits per 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.		
Hospice Care - Inpatient	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing	10%; after deductible	30%; after deductible
Limited to 180 visits per year. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing visit.		
Outpatient Short-Term Rehabilitation	10%; after deductible	30%; after deductible
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	30%; after deductible
Limited to 25 visits per calendar year. Medical necessity review not required.		

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Acupuncture Therapy Limited to 25 visits per calendar year. Medical necessity review not required.	$15 copay; deductible waived	30%; after deductible
Autism Behavioral Therapy	$15 copay; deductible waived	30%; after deductible
Autism Applied Behavior Analysis	10%; after deductible	30%; after deductible
Autism Physical Therapy Unlimited	10%; after deductible	30%; after deductible
Autism Occupational Therapy Unlimited	10%; after deductible	30%; after deductible
Autism Speech Therapy Unlimited	10%; after deductible	30%; after deductible
Durable Medical Equipment	10%; after deductible	30%; after deductible
Hearing Aids Limited to $5000 per calendar year	10%; after deductible	30%; after deductible
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	30%; after deductible
Transplants	10%; after deductible for treatment in an Institute of Excellence (IOE) transplant facility.	30%; after deductible for treatment in a non-IOE facility.
Bariatric Surgery	10%; after deductible	Not covered
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	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. Refer to Progyny document for additional infertility covered treatment		
Vasectomy	10%; after deductible	30%; after deductible
Tubal Ligation	Covered 100%; deductible waived	30%; after deductible
PHARMACY	**IN-NETWORK**	
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.	

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. 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.

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• 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 the material into another language may be available. Please call Member Services at **1-888-982-3862.**
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.**