aetna

Hanover County
Effective Date: 01-01-2024
Aetna Choice® POS II -- ASC
Standard Plan

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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit Limitations - For any service or supply that is subject to a maximum visit, day, or dollar limitation on a per year basis, the benefit year begins on January 1st unless otherwise mandated. Refer to your plan documents for more information.		
Deductible (per calendar year)	$1,000 Individual $2,000 Family	$2,000 Individual $4,000 Family
All covered expenses accumulate separately toward the in-network and out-of-network 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.	20%	40%
Payment Limit (per calendar year)	$4,000 Individual $8,000 Family	$8,000 Individual $16,000 Family
All covered expenses accumulate separately toward the in-network or out-of-network 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 not 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	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network 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 $750 per occurrence.		
Referral Requirement	None	None
Telemedicine Consultations - Covered services for telemedicine consultations are available from a number of different kinds of providers under your plan. Log onto your secure Aetna website at https://www.aetna.com/ to review our telemedicine provider listings and get more information about your options, including specific cost sharing amounts.		
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%; deductible waived	30%; after deductible
Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	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	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	Covered 100%; deductible waived	30%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	30%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	30%; after deductible
Recommended: For all members age 45 and over.		
Routine Eye Exams	$10 office visit copay; deductible waived	$45 allowance per plan year
Routine Hearing Screening	Covered 100%; deductible waived	30%; after deductible
1 exam every 24 months		
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist	$30 office visit copay; deductible waived	40%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Telemedicine Consultation with Non-Specialist	$30 office visit copay; deductible waived	40%; after deductible
Specialist Office Visits	$70 office visit copay; deductible waived	40%; after deductible
Telemedicine Consultation with Specialist	$70 office visit copay; deductible waived	40%; after deductible
Telemedicine Consultation via Teladoc – General Medicine	$10 copay; deductible waived	N/A
Telemedicine Consultation via Teladoc – Behavioral Health	$25 copay; deductible waived	N/A
Telemedicine Consultation via Teladoc – Dermatology	$70 copay; deductible waived	N/A
Hearing Exams	$70 office visit copay; deductible waived	40%; after deductible
Pre-Natal Maternity	Covered 100%; deductible waived	40%; after deductible
Walk-in Clinics	$35 copay; deductible waived **Designated Walk-in Clinics** Covered 100%; deductible waived	40%; after deductible
Walk-in Clinics are free-standing health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be Walk-in Clinics.		
Allergy Testing	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
Allergy Injections	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
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray (other than Complex Imaging Services)	20%; deductible waived	40%; after deductible

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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	20%; deductible waived; performed at an independent lab 20%; after deductible; performed at an outpatient facility	40%; after deductible
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 Complex Imaging	20%; after deductible	40%; after deductible
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**	**OUT-OF-NETWORK**
Urgent Care Provider	$75 copay; deductible waived	40%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	20%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	20%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	$25 copay; deductible waived	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Mental Health Telemedicine Consultations	$25 copay; deductible waived	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	20%; after deductible	40%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	20%; after deductible	40%; after deductible
Substance Abuse Office Visits	$25 copay; deductible waived	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		

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Substance Abuse Telemedicine Consultations Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$25 copay; deductible waived	40%; after deductible
Other Substance Abuse Services	20%; after deductible	40%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility Limited to 120 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible	40%; after deductible
Home Health Care Private Duty Nursing not covered Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	20%; after deductible	40%; after deductible
Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible	40%; after deductible
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	40%; after deductible
Private Duty Nursing	Not Covered	Not Covered
Spinal Manipulation Therapy Limited to 30 visits per year	$45 copay; deductible waived	40%; after deductible
Outpatient Short-Term Rehabilitation Includes speech, physical, occupational therapy	$45 copay; deductible waived	40%; after deductible
Habilitative Physical Therapy	Refer to MBH Outpatient Mental Health	40%; after deductible
Habilitative Occupational Therapy	Refer to MBH Outpatient Mental Health	40%; after deductible
Habilitative Speech Therapy	Refer to MBH Outpatient Mental Health	40%; after deductible
Autism Behavioral Therapy Combined with outpatient mental health visits	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health All Other benefit	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Autism Physical Therapy	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Autism Occupational Therapy	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Autism Speech Therapy	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Durable Medical Equipment	20%; after deductible	40%; after deductible
Hearing Aids Limited to 2 hearing aids per lifetime	20%; after deductible	40%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.

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Infusion Therapy Administered in the home or physician's office	$70 copay; deductible waived	40%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	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
Acupuncture	Not Covered	Not Covered
Gene-based, Cellular, and other Innovative Therapies™ (GCIT)	Your cost sharing is based on the type of service and where it is performed $70 copay; deductible waived for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.	Not Covered
Vision Eyewear	Not Covered	Not Covered
Transplants	20%; after deductible Preferred coverage is provided at an IOE contracted facility only.	40%; after deductible
Bariatric Surgery	Your cost sharing is based on the type of service and where it is performed	Not Covered
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	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
Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	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	Not Covered
Vasectomy	Your cost sharing is based on the type of service and where it is performed	40%; after deductible
Tubal Ligation	Covered 100%; deductible waived	30%; after deductible

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PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	Aetna Standard Open Formulary	
Prescription Drug Per Year Deductible (must be satisfied before any drug benefits are paid)	$50 Individual	Not Covered
	$100 Family	Not Covered
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 year		
Prescription Drug Annual Out of Pocket Maximum	$3,000 Individual	Not Applicable
	$6,000 Family	Not Applicable
Generic Drugs		
Retail	$5 copay	Not Covered
Mail Order	$12.50 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$30 copay	Not Covered
Mail Order	$75 copay	Not Applicable
Non-Preferred Brand-Name Drugs		
Retail	$50 copay	Not Covered
Mail Order	$100 copay	Not Applicable
Specialty Drugs		
Preferred Specialty	20% Maximum $100	Not Covered
Non-Preferred Specialty	20% Maximum $100	Not Covered
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna National Network	
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	Up to a 90 day supply All prescription fills must be through our preferred specialty pharmacy network. Aetna Specialty Performance Network Drug List	
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Diabetic supplies, blood glucose monitors and contraceptive drugs and devices obtainable from a pharmacy. Precertification for specialty drugs included Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

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.

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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, unless medical in nature.
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- 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.
- 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/enhancement, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- 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.**

Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.