Outten & Golden, LLP
Proposed Effective Date: 01-01-2024
Open Access® Managed Choice® POS - NEW YORK
Qualified High Deductible Health Plan

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN DESIGN

PLAN FEATURES	IN-NETWORK	OUT-OF-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)	$2,500 per Individual $5,000 per Family	$5,000 per Individual $10,000 per Family
Covered expenses in-network add up towards your in-network deductible. Covered expenses out-of-network add up towards your out-of-network deductible. You must first meet the deductible before the plan begins paying benefits, unless otherwise noted. The amount you pay (cost sharing) for some medical services does not count toward your deductible. Prescription drug costs count toward the deductible. Refer to your plan documents for details. Once you meet the family deductible, then all family members have met it for the rest of the year. There is no individual deductible for members of a family.		
Member coinsurance Applies to all expenses except as noted.	You pay 10%	You pay 30%
Out-of-pocket limit (per calendar year)	$6,350 per Individual $6,350 per Family	$9,000 per Individual $18,000 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. Out-of-network expenses include coinsurance and deductibles. Penalty amounts do not apply. Once you meet the family out-of-pocket limit, then all family members have met it for the rest of the year. There is no individual out-of-pocket limit for members of a family.		
Lifetime maximum Unlimited except where otherwise indicated.		

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Payment for out-of-network care**	Does not apply	Professional: 125% of Medicare Facility: 125% of Medicare

*We cover the cost of care differently based on whether health care providers, such as doctors and hospitals, are "in network" or "out of network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this out-of-network care. As an example, you may choose a doctor in our network. You may choose to visit an out-of-network doctor. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. 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, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount. This amount is based on "reasonable" or "prevailing" charges. We get this data from an external database. Exactly how much Aetna "recognizes" depends on the plan you or your employer picks. Your out-of-network doctor sets the rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna plan "recognizes" or "allows." Your doctor may bill you for the dollar amount that Aetna doesn'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 maximum out-of-pocket. To learn more about how we pay out-of-network benefits visit Aetna.com. Type "how Aetna pays" in the search box. You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site. This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.

Primary care physician selection	Encouraged	Does not apply

Precertification requirements -
Some out-of-network services need approval by us in advance (precertification). Without this approval, we reduce benefits by $400 or 50%, whichever is less. Refer to your plan documents for a full list of services that need this approval.

Referral requirement	Not required	None

PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine adult physical exams/ immunizations 1 exam every year	Covered 100%; no deductible	30%; after deductible
Routine well child exams/immunizations • 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%; no deductible	Covered 100%; no deductible
Routine gynecological care exams 2 exams and pap smears per year, including related fees	Covered 100%; no deductible	30%; after deductible
Routine mammogram Recommended: One per year for members age 40 and over	Covered 100%; no deductible	30%; after deductible

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Women's health	Covered 100%; no deductible	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. 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.		
Pre-natal maternity	Covered 100%; no deductible	30%; after deductible
Routine digital rectal exam Recommended: For members age 40 and over	Covered 100%; no deductible	30%; after deductible
Prostate-specific antigen test Recommended: For members age 40 and over	Covered 100%; no deductible	30%; after deductible
Colorectal cancer screening Recommended: For members age 45 and over	Covered 100%; no deductible	30%; after deductible
Routine eye exams 1 routine exam per 24 months.	Covered 100%; no deductible	30%; after deductible
Routine hearing screening	Covered 100%; no deductible	30%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office visits to primary care physician (PCP) Includes services of an internist, general physician, family practitioner or pediatrician.	10%; after deductible	30%; after deductible
Specialist office visits	10%; after deductible	30%; after deductible
Hearing exams	Not Covered	Not Covered
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.	10%; after deductible	30%; after deductible
Allergy testing	Your cost sharing amount depends on the type of service and where you receive it.	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.	Your cost sharing amount depends on the type of service and where you receive it.
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-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.	10%; after deductible	30%; after deductible
Diagnostic laboratory When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	10%; after deductible	30%; after deductible
Diagnostic complex imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	10%; after deductible	30%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent care provider	10%; after deductible	30%; after deductible
Non-urgent use of urgent care provider	Not Covered	Not Covered
Emergency room	10%; after deductible	Same as in-network care
Non-emergency care in an emergency room	Not Covered	Not Covered
Emergency use of ambulance	10%; after deductible	Same as in-network care

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Non-emergency use of ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient coverage	10%; after deductible	30%; after deductible
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)	10%; after deductible	30%; after deductible
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	10%; after deductible	30%; after deductible
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.		
Outpatient surgery - hospital	10%; after deductible	30%; after deductible
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.		
Outpatient surgery - freestanding facility	10%; after deductible	30%; after deductible
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**	**OUT-OF-NETWORK**
Inpatient	10%; after deductible	30%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Inpatient non-biologically based	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental health office visits	10%; after deductible	30%; after deductible
Crisis intervention services	10%; after deductible	30%; after deductible
Other mental health services	10%; after deductible	30%; after deductible
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**	**OUT-OF-NETWORK**
Inpatient	10%; after deductible	30%; after deductible
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	10%; after deductible	30%; after deductible
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	10%; after deductible	30%; after deductible
Other substance abuse services	10%; after deductible	30%; after deductible
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.		

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THERAPY SERVICES	IN-NETWORK	OUT-OF-NETWORK
Spinal manipulation therapy	10%; after deductible	30%; after deductible
Outpatient short-term rehabilitation Limited to 60 visits per year Includes physical, occupational, and speech therapies.	10%; after deductible	30%; after deductible
Habilitative physical therapy	10%; after deductible	30%; after deductible
Habilitative occupational therapy	10%; after deductible	30%; after deductible
Habilitative speech therapy	10%; after deductible	30%; after deductible
Autism related physical therapy	10%; after deductible	30%; after deductible
Autism related occupational therapy	10%; after deductible	30%; after deductible
Autism related speech therapy	10%; after deductible	30%; after deductible
Autism related behavioral therapy These benefits are combined with outpatient mental health visits	10%; after deductible	30%; after deductible
Autism related applied behavior analysis Covered same as any other Outpatient Mental Health benefit	10%; after deductible	30%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled nursing facility Limited to 60 days per year When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	10%; after deductible	30%; after deductible
Home health care Limited to 60 visits per year Home health care services include private duty nursing Limited to three visits per day by staff from a home health care agency. One visit equals a period of four hours or less.	10%; after deductible	25%; after deductible
Hospice care - inpatient When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	10%; after deductible	30%; after deductible
Hospice care - outpatient 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.	10%; after deductible	30%; after deductible
Private duty nursing We count each period of up to 8 hours as one private duty nursing shift.	Covered as part of home health care	Covered as part of home health care
Durable medical equipment	10%; after deductible	30%; after deductible
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.	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 - home/office	10%; after deductible	30%; after deductible
Infusion therapy - outpatient hospital/freestanding facility	10%; after deductible	30%; after deductible

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Gene-based, Cellular, and other Innovative Therapies (GCIT™)	Your cost sharing amount depends on the type of service and where you receive it. 10%: after deductible for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.	Not Covered
Hearing aids 1 hearing aid per ear every 3 years	10%; after deductible	30%; after deductible
Transplants	10%; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.	30%; after deductible Out-of-network coverage applies when you use a non-IOE facility. You will pay more out of pocket when using a non-IOE facility.
Bariatric surgery	10%; after deductible	30%; after deductible
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 10 visits per year	10%; after deductible	30%; after deductible
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility treatment	Your cost sharing amount depends on the type of service and where you receive it.	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.		
Comprehensive infertility services Artificial insemination and ovulation induction	10%; after deductible	30%; after deductible
Advanced Reproductive Technology (ART)	10%; after deductible	30%; after deductible
Limited to 3 courses of treatment per member's lifetime. Maximum applies to all procedures covered by any of our plans except where prohibited by law. Coverage includes cryopreservation, storage and for iatrogenic only unlimited storage and cryopreservation. ART coverage includes: In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery.		
Vasectomy	Your cost sharing amount depends on the type of service and where you receive it.	30%; after deductible
Tubal ligation	Covered 100%; no deductible	30%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Pharmacy plan type	Advanced Control Plan - Aetna	
Prescription drug deductible	Prescription drug expenses apply to your medical deductible.	
Prescription drug out-of-pocket limit	Prescription drug expenses apply to your medical out-of-pocket limit.	

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Preferred generic drugs		
Retail	$10 copay	30% of submitted cost; after applicable in-network cost share
Mail order	$20 copay	Not Applicable
Preferred brand-name drugs		
Retail	$30 copay	30% of submitted cost; after applicable in-network cost share
Mail order	$60 copay	Not Applicable
Non-preferred generic and brand-name drugs		
Retail	$50 copay	30% of submitted cost; after applicable in-network cost share
Mail order	$100 copay	Not Applicable
Pharmacy day supply and requirements		
Retail	You can get up to a 30-day supply from Aetna National Network	
Mail order	You can get a 31-90-day supply from CVS Caremark® Mail Service Pharmacy.1	
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
• Insulin up to a $100 member payment maximum per fill per 30-day supply; no deductible for insulin 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

Family planning
• Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).
• Contraceptives covered up to a 12-month supply. Contraceptive copay strategy applies.

The following are covered 100% in-network:
• Oral chemotherapy drugs
• Seasonal vaccinations
• Preventive vaccinations
• Affordable Care Act (ACA) eligible preventive medications and contraceptives
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.

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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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.
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
• 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.
• 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 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.**
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.