IMMANUEL
Effective Date: 01-01-2023
Aetna Choice® POS II -- ASC
Qualified High Deductible Health 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)	$2,500 Individual $5,000 Family	$5,000 Individual $10,000 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 apply towards the Deductible. Once Family Deductible is met, all family members will be considered as having met their Deductible. There is no Individual Deductible to satisfy within the Family Deductible.		
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%	30%
Payment Limit (per calendar year)	$4,000 Individual $8,000 Family	$10,000 Individual $20,000 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 apply towards the Payment Limit. There is no Individual Payment Limit to satisfy within the Family Payment Limit. Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit.		
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 $400 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 per year up to age 65, 1 exam per year 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 year thereafter to age 22.	Covered 100%; deductible waived	30%; after deductible
Routine Gynecological Care Exams 1 exam and pap smear per year, includes related fees.	Covered 100%; deductible waived	30%; after deductible
Routine Mammograms 1 service maximum per year.	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. 1 exam per year.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	30%; after deductible
Recommended: For covered males age 40 and over. 1 exam per year		
Colorectal Cancer Screening	Covered 100%; deductible waived	30%; after deductible
Recommended: For all members age 45 and over.		
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	30%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Primary Care Physician (PCP)	$25 office visit copay; after deductible	30%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Telemedicine Consultation with Non-Specialist	$25 office visit copay; after deductible	30%; after deductible
Specialist Office Visits	$50 office visit copay; after deductible	30%; after deductible
Telemedicine Consultation with Specialist	$50 office visit copay; after deductible	30%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	30%; after deductible
Walk-in Clinics	$25 copay; after deductible **Designated Walk-in Clinics** Covered 100%; after deductible	30%; 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.		
Telemedicine Consultations for Non-Emergency Services through a Walk-in Clinic	Your cost sharing is based on the type of service and where it is performed **Designated Walk-in Clinics** Covered 100%; after deductible	30%; after deductible
If telemedicine preventive screening and counseling services are provided through a walk-in clinic, these services are paid under the preventive care benefit.		
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. Covered 100% when an office visit charge is not applicable.	Your cost sharing is based on the type of service and where it is performed

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DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray (other than Complex Imaging Services)	Covered 100%; after deductible	30%; 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 Laboratory	Covered 100%; after deductible	30%; 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	Covered 100%; after deductible	30%; 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 office visit copay; after deductible	30%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	$150 copay; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%; 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	Covered 100%; after deductible	30%; 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	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	Covered 100%; 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	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	$25 copay; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Mental Health Telemedicine Consultations	$25 office visit copay; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%; after deductible	30%; after deductible

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SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	Covered 100%; after deductible	30%; after deductible
Substance Abuse Office Visits	$25 copay; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Substance Abuse Telemedicine Consultations	$25 office visit copay; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%; after deductible	30%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	Covered 100%; after deductible	30%; after deductible
Limited to 60 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	Covered 100%; after deductible	30%; after deductible
Limited to 60 visits per year. Private Duty Nursing not included. Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.		
Hospice Care - Inpatient	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing	Covered 100%; after deductible	30%; after deductible
Limited to 60 eight hour shifts per year. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.		
Spinal Manipulation Therapy	$25 copay; after deductible	30%; after deductible
Limited to 20 visits per year		
Outpatient Short-Term Rehabilitation	$25 copay; after deductible	30%; after deductible
Includes speech, physical, occupational therapy; limited to 60 visits per year		
Habilitative Physical Therapy	Not Covered	Not Covered
Habilitative Occupational Therapy	Not Covered	Not Covered
Habilitative Speech Therapy	Not Covered	Not Covered
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	Not Covered	Not Covered
Autism Physical Therapy	Not Covered	Not Covered
Autism Occupational Therapy	Not Covered	Not Covered
Autism Speech Therapy	Not Covered	Not Covered
Durable Medical Equipment	Covered 100%; after deductible	30%; 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	Covered 100%; after deductible	30%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Covered 100%; after deductible	30%; after deductible
Acupuncture Limited to 10 visits per year	$25 copay; after deductible	30%; after deductible
Gene-based, Cellular, and other Innovative Therapies™ (GCIT)	Your cost sharing is based on the type of service and where it is performed Covered 100%: after deductible 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	Covered 100%; after deductible Preferred coverage is provided at an IOE contracted facility only.	30%; after deductible Non-Preferred coverage is provided at a Non-IOE contracted facility only.
Bariatric Surgery	Not Covered	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	Covered 100%; after deductible	30%; after deductible
Tubal Ligation	Covered 100%; deductible waived	30%; after deductible

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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	Aetna Standard Open Formulary	
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	$35 copay	30% of submitted cost; after applicable in-network cost share
Mail Order	$70 copay	Not Applicable
Non-Preferred Brand-Name Drugs		
Retail	$65 copay	30% of submitted cost; after applicable in-network cost share
Mail Order	$130 copay	Not Applicable
Specialty Drugs		
Preferred Specialty	$100 copay	Not Covered
Non-Preferred Specialty	$100 copay	Not Covered
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna National Network	
Voluntary Maintenance Choice	No refill restrictions or penalties apply. Members save when they fill a 90-day	
Mail Order	supply of maintenance drugs at CVS Caremark® Mail Service Pharmacy or at a CVS Pharmacy.	
Specialty	Up to a 30 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, prescription weight loss drugs and contraceptive drugs and devices obtainable from a pharmacy.
Includes sexual dysfunction drugs for females and males, including daily dose, additional 6 tablets a month for males for erectile dysfunction.
Precertification for specialty drugs included
Seasonal Vaccinations covered 100% in-network
Preventive Vaccinations covered 100% in-network
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.
• 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 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.