aetna®

Dickinson College
Effective Date: 07-01-2018
Aetna Choice® POS II -- ASC

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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per plan year)	$350 Individual $1,050 Family	$800 Individual $2,400 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 plan year)	$1,300 Individual $3,900 Family	$1,950 Individual $5,850 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 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 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 for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.	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 to age 22.	Covered 100%; deductible waived	30%; after deductible
Routine Gynecological Care Exams 1 exam and pap smear per plan year, includes related fees.	Covered 100%; deductible waived	30%; after deductible
Routine Mammograms	Covered 100%; deductible waived	30%; after deductible
Women's Health 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.	Covered 100%; deductible waived	30%; after deductible

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Routine Digital Rectal Exam For covered males age 40 and over.	Covered 100%; deductible waived	30%; after deductible
Prostate-specific Antigen Test For covered males age 40 and over.	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	Covered 100%; deductible waived	30%; after deductible
Medications	Certain over-the-counter preventive medications covered 100% in network.	
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician.	$20 copay; then covered 100%; deductible waived	30%; after deductible
Specialist Office Visits	$25 copay; then covered 100%; deductible waived	30%; after deductible
Hearing Exams 1 routine exam per 24 months.	$25 copay; then covered 100%; deductible waived	30%; after deductible
Pre-Natal Maternity	Covered 100%; deductible waived	Covered according to standard claim practice.
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.	$20 copay; then covered 100%; deductible waived	30%; after deductible
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) 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.	$25 copay then 10% coinsurance; 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
Diagnostic Complex Imaging	$25 copay then 10% coinsurance; after deductible	30%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$40 copay then covered 100%; deductible waived	30%; after deductible

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Emergency Room Copay waived if admitted	$125 copay then covered 100%; deductible waived	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
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$200 copay then 10% coinsurance; after deductible	30%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$200 copay then 10% coinsurance; after deductible	30%; after deductible
Outpatient Hospital Expenses Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	30%; after deductible
Outpatient Surgery - Hospital Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	30%; after deductible
Outpatient Surgery - Freestanding Facility Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	30%; after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$200 copay then 10% coinsurance; after deductible	30%; after deductible
Mental Health Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$25 copay; then covered 100%; deductible waived	30%; after deductible
Other Mental Health Services	Covered 100%; deductible waived	30%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$200 copay then 10% coinsurance; after deductible	30%; after deductible
Residential Treatment Facility	$200 copay then 10% coinsurance; after deductible	30%; after deductible
Substance Abuse Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$25 copay; then covered 100%; deductible waived	30%; after deductible
Other Substance Abuse Services	Covered 100%; deductible waived	30%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility Limited to 240 days per plan year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$200 copay then 10% coinsurance; after deductible	30%; after deductible
Home Health Care Limited to 120 visits per plan 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.	10%; after deductible	30%; after deductible

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Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	30%; after deductible
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	30%; after deductible
Private Duty Nursing	Not Covered	Not Covered
Outpatient Short-Term Rehabilitation Includes speech, physical, occupational therapy; limited to 25 visits per plan year	10%; after deductible	30%; after deductible
Spinal Manipulation Therapy Limited to 25 visits per plan year.	10%; after deductible	30%; 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 100%; deductible waived	30%; after deductible
Autism Physical Therapy Visits combined with Short Term Rehabilitation.	10%; after deductible	30%; after deductible
Autism Occupational Therapy Visits combined with Short Term Rehabilitation.	10%; after deductible	30%; after deductible
Autism Speech Therapy Visits combined with Short Term Rehabilitation.	10%; after deductible	30%; after deductible
Durable Medical Equipment	10%; after deductible	30%; after deductible
Diabetic Supplies	Covered same as any other medical expense.	Covered same as any other medical expense.
Hearing Hardware One hearing aid per ear every 24 months up to a $1,600 benefit maximum.	10%; after deductible	30%; after deductible
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.
Infusion Therapy Administered in the home or physician's office	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
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
Vision Eyewear	Not Covered	Not Covered
Transplants	$200 copay then 10% coinsurance; after deductible Preferred coverage is provided at an IOE contracted facility only.	30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$200 copay then 10% coinsurance; after deductible	30%; after deductible

FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**

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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.		
Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation induction		
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
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 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
Tubal Ligation	Covered 100%; deductible waived	Your cost sharing is based on the type of service and where it is performed
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.

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.
• 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.**