aetna®

Juniata College
Effective Date: 01-01-2017
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 calendar year)	$100 Individual $200 Family	$500 Individual $1,000 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.	Covered 100%	20%
Payment Limit (per calendar year)	$3,500 Individual $7,000 Family	$4,000 Individual $8,000 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 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	Not Applicable	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	Covered 100%; deductible waived	20%; after deductible
1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	20%; after deductible
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.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	20%; after deductible
Recommended: One exam per calendar year. Includes routine tests and related lab fees.		
Routine Mammograms	Covered 100%; deductible waived	20%; after deductible
Recommended: One per calendar year for covered females age 40 and over. 3D Mammograms included.		
Women's Health	Covered 100%; deductible waived	20%; 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	20%; after deductible
Recommended: For covered males age 40 and over.		

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

Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	20%; 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	20%; 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	20%; after deductible
Specialist Office Visits	$30 copay; deductible waived	20%; after deductible
Audiometric Hearing Exam	Not Covered	Not Covered
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.	$15 copay; deductible waived	20%; after deductible
Allergy Testing	Covered 100%; deductible waived	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Covered 100%; deductible waived	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.	Covered 100%; after deductible	20%; 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.	Covered 100%; after deductible	20%; after deductible
Diagnostic Complex Imaging	Covered 100%; after deductible	20%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$30 copay; deductible waived	Same as in-network care
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	$75 copay; deductible waived	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%; deductible waived	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.	$75 copay; deductible waived	20%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care)	$75 copay; deductible waived	20%; after deductible

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

Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	Covered 100%; deductible waived	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	$30 copay; deductible waived	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	$30 copay; deductible waived	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	$75 copay; deductible waived	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient	$15 copay; deductible waived	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	$75 copay; deductible waived	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	$75 copay; deductible waived	20%; after deductible
Outpatient	$15 copay; deductible waived	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	$75 copay; deductible waived	20%; after deductible
Limited to 90 days per calendar year.		
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	Covered 100%; after deductible	20%; after deductible
Limited to 120 visits per calendar 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	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing	Covered 100%; after deductible	20%; after deductible
Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.		
Outpatient Speech Therapy	$15 copay; deductible waived	20%; after deductible
Limited to 60 visits per calendar year.		
Outpatient Physical Therapy	$15 copay; deductible waived	20%; after deductible
Limited to 60 visits per calendar year.		
Outpatient Occupational Therapy	$15 copay; deductible waived	20%; after deductible
Limited to 60 visits per calendar year.		
Spinal Manipulation Therapy	$30 copay; deductible waived	20%; after deductible
Limited to 25 visits per calendar year.		
Autism Behavioral Therapy	Refer to Mental Health Services Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Combined with outpatient mental health visits		
Autism Applied Behavior Analysis	Not Covered	Not Covered
Autism Physical Therapy	$15 copay; deductible waived	20%; after deductible
Visits combined with Physical Therapy		
Autism Occupational Therapy	$15 copay; deductible waived	20%; after deductible
Visits combined with Occupational Therapy		

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

Autism Speech Therapy Visits combined with Speech Therapy.	$15 copay; deductible waived	20%; after deductible
Durable Medical Equipment	Covered 100%; deductible waived	20%; after deductible
Hearing Aids Limited to a $1,000 lifetime maximum	Covered 100%; deductible waived	20%; after deductible
Diabetic Supplies	Covered same as any other medical expense.	Covered same as any other medical expense.
Generic FDA-approved Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.
Vision Eyewear	Not Covered	Not Covered
Transplants	$75 copay; deductible waived Preferred coverage is provided at an Institute Of Excellence contracted facility only.	20%; after deductible Non-Preferred coverage is provided at a Non- Institute Of Excellence facility.
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	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
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Premier Plus Open Formulary	
Value Drugs Tier 1A		
Retail (31 days)	$3 copay	Not Covered
Retail (32-60 days)	$6 copay	Not Covered
Retail (61-90 days)	$9 copay	Not Covered
Mail Order	$6 copay	Not Applicable
Generic Drugs		
Retail (31 days)	$10 copay	Not Covered
Retail (32-60 days)	$20 copay	Not Covered
Retail (61-90 days)	$30 copay	Not Covered

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

Mail Order	$20 copay	Not Applicable
Retail (31 days)	$10 copay	Not Covered
Preferred Brand-Name Drugs		
Retail (31 days)	10% $20 Minimum, $100 Maximum	Not Covered
Retail (32-60 days)	10% $40 Minimum, $200 Maximum	Not Covered
Retail (61-90 days)	10% $60 Minimum, $300 Maximum	Not Covered
Mail Order	$40 copay	Not Applicable
Non-Preferred Brand-Name Drugs		
Retail (31 days)	10% $40 Minimum, $100 Maximum	Not Covered
Retail (32-60 days)	10% $80 Minimum, $400 Maximum	Not Covered
Retail (61-90 days)	10% $120 Minimum, $300 Maximum	Not Covered
Mail Order	$80 copay	Not Applicable
Premier Plus Specialty Drugs		
Preferred Specialty	10% $20 Minimum, $100 Maximum	Not Applicable
Non-Preferred Specialty	10% $40 Minimum, $100 Maximum	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 31 day supply; Up to a 32-60 day supply; Up to a 61-90 day supply. Percentage copays will not be doubled	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Premier Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred Aetna Specialty Pharmacy network.	

Deductible waived for generics
Deductible waived for value drugs/tier 1A
Deductible waived for mail order drugs

Choose Generics with Dispense as Written (DAW) override - The member pays the applicable copay. If the physician requires brand-name, member would pay brand-name copay. If the member requests brand-name when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
A limited list of over-the-counter medications are covered when filled with a prescription.
Smoking Cessation included.
Premier Plus Pre-certification for Specialty Drugs.
Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.

Prescription Drug Calendar Year Deductible(must be satisfied before any drug benefits are paid. For Retail Drugs only.)	$50 Individual	$50 Individual
	$150 Family	$150 Family

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

All covered pharmacy expenses accumulate toward both the preferred and non-preferred pharmacy deductible. 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 calendar year

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.

- 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.
- 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.
- 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.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

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.**

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

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.**