ASPEN HR PEO, LLC
Effective Date: 12-01-2022
Open Access® Managed Choice® POS - New York

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

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)	None Individual None Family	$300 Individual $750 Family
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)	$2,000 Individual $4,000 Family	$2,000 Individual $4,000 Family
All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses apply towards the 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. 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.		
Payment for Out-of-Network Care**	Not Applicable	Professional: Prevailing Charges Facility: Prevailing Charges
*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	Optional	Not Applicable

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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 or 50% of the scheduled benefit amount per occurrence, whichever is less.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam per calendar year up to age 65, 1 exam per calendar year age 65 and older	Covered 100%	20%; after deductible
Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13-24 months, 3 exams 25-36 months, 1 exam per calendar year thereafter to age 22.	Covered 100%	Covered 100%; deductible waived
Routine Gynecological Care Exams 2 obgyn exams and pap smears per calendar year	Covered 100%	20%; after deductible
Routine Mammograms	Covered 100%	20%; 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%	20%; after deductible
Routine Digital Rectal Exam	Covered 100%	20%; after deductible
Prostate-specific Antigen Test	Covered 100%	20%; after deductible
Colorectal Cancer Screening Recommended: For all members age 45 and over.	Covered 100%	20%; after deductible
Routine Eye Exams 1 routine exam per 12 months.	Covered 100%	20%; after deductible
Routine Hearing Screening	Covered 100%	20%; 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.	$15 office visit copay	20%; after deductible
Specialist Office Visits	$20 office visit copay	20%; after deductible
Hearing Exams 1 routine exam per 24 months.	$20 copay	20%; after deductible
Pre-Natal Maternity	Covered 100%	20%; after deductible
Walk-in Clinics 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.	$15 copay	20%; 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; 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	Covered 100%	20%; 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%	20%; 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 Outpatient Complex Imaging	Covered 100%	20%; 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	20%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	$250 copay	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	$250 per day for the first 3 days per confinement, thereafter Covered 100%	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	$250 per day for the first 3 days per confinement, thereafter Covered 100%	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	Covered 100%	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	Covered 100%	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	$75 copay	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	$250 per day for the first 3 days per confinement, thereafter Covered 100%	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	$15 copay	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Crisis Intervention Services	$15 copay	20%; after deductible
Other Mental Health Services	Covered 100%	20%; after deductible

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SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	$250 per day for the first 3 days per confinement, thereafter Covered 100%	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	$250 per day for the first 3 days per confinement, thereafter Covered 100%	20%; after deductible
Substance Abuse Office Visits	$15 copay	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%	20%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	$250 per day for the first 3 days per confinement, thereafter Covered 100%	20%; 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%	25%; deductible waived
Limited to 120 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	$250 copay per day with a 3 day maximum	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	Covered 100%	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing - Outpatient	Covered 100%	20%; after deductible
Limited to 70 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	$20 copay	20%; after deductible
Outpatient Short-Term Rehabilitation	Covered 100%	20%; after deductible
Limited to 60 visits per year. Unlimited for Early Intervention Services from birth to age 3. Includes speech, physical, occupational therapy		
Habilitative Physical Therapy	Covered 100%	20%; after deductible
Habilitative Occupational Therapy	Covered 100%	20%; after deductible
Habilitative Speech Therapy	Covered 100%	20%; after deductible
Autism Behavioral Therapy	$15 copay	20%; after deductible
Covered same as any other Outpatient Mental Health benefit		
Autism Applied Behavior Analysis	$15 copay	20%; after deductible
Covered same as any other Outpatient Mental Health benefit		
Autism Physical Therapy	Covered 100%	20%; after deductible
Autism Occupational Therapy	Covered 100%	20%; after deductible
Autism Speech Therapy	Covered 100%	20%; after deductible
Hearing Aids	Covered 100%	20%; after deductible
Limited to:1 hearing aid per ear every 3 years		

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Durable Medical Equipment	50%	50%; after deductible
Diabetic Supplies	Covered same as any other expense.	Covered same as any other expense.
Fertility Drugs (oral and injectable)	Covered 100%	20%; after deductible
Physician charges included (oral and injectable fertility drugs obtained at a pharmacy are covered under the Rx plan).		
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%	Covered same as any other expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	$20 copay	20%; 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
Vision Eyewear	Not Covered	Not Covered
Transplants	$250 per day for the first 3 days per confinement, thereafter Covered 100% Preferred coverage is provided at an IOE contracted facility only.	20%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	$250 per day for the first 3 days per confinement, thereafter Covered 100%	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Acupuncture Limited to 10 visits per year	$15 copay	20%; after deductible
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
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	Covered 100%	20%; after deductible
Coverage includes artificial insemination and ovulation. Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law.		
Advanced Reproductive Technology (ART)	Covered 100%	20%; after deductible
ART coverage includes Invitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery, and cryopreservation, unlimited storage. 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.		
Vasectomy	Covered 100%	20%; after deductible
Tubal Ligation	Covered 100%	20%; after deductible

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Voluntary Abortion	Covered 100%	20%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Advanced Control Plan - Aetna	
Preferred Generic Drugs		
Retail	$10 copay	20% of submitted cost; after applicable in-network cost share
Mail Order	$20 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$55 copay	20% of submitted cost; after applicable in-network cost share
Mail Order	$110 copay	Not Applicable
Non-Preferred Generic and Brand-Name Drugs		
Retail	$100 copay	20% of submitted cost; after applicable in-network cost share
Mail Order	$200 copay	Not Applicable
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 All prescription fills must be through our preferred specialty pharmacy network. Advanced Control Formulary Aetna Insured List	

Choose Generics with Dispense as Written (DAW) override - The member pays the applicable copay only, if the physician requires brand-name. 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 medication covered at PCP cost sharing and Contraceptive drugs and devices obtainable from a pharmacy.
$100 copay maximum per fill per 30-day supply of insulin drugs
Contraceptives covered up to a 12 month supply. Contraceptive copay strategy applies.
A limited list of over-the-counter medications are covered when filled with a prescription.
Includes sexual dysfunction drugs for females and males, including daily dose, additional 6 tablets a month for males for erectile dysfunction.
Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).
Oral chemotherapy drugs covered 100%
Precertification and quantity limits included
Advanced Control Formulary Aetna Insured Step Therapy
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.

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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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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 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.

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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.