J.M. Huber Corporation
Effective Date: 01-01-2020
Aetna Choice® POS II -- ASC
Qualified High Deductible Health Plan
Choice I 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)	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 Family
All covered expenses accumulate simultaneously toward the in-network or 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.	20%	40%
Payment Limit (per calendar year)	$3,400 Individual $6,800 Family	$6,800 Individual $13,600 Family
All covered expenses accumulate simultaneously 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 20% per occurrence.		
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%; deductible waived	40%; 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%; deductible waived	40%; after deductible
Routine Gynecological Care Exams 1 exam and pap smear per year, includes related fees.	Covered 100%; deductible waived	40%; after deductible
Routine Mammograms	Covered 100%; deductible waived	40%; 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	40%; after deductible

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Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	40%; after deductible
Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	40%; after deductible
Colorectal Cancer Screening Recommended: For all members age 45 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	40%; 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%; after deductible	40%; after deductible
Specialist Office Visits	20%; after deductible	40%; after deductible
Hearing Exams 1 routine exam per 24 months.	20%; after deductible	40%; after deductible
Pre-Natal Maternity	Covered 100%; deductible waived	40%; 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.	**Designated Walk-in Clinics** Covered 100%; after deductible **All Other Network Providers** 20%; after deductible	40%; after deductible
Allergy Testing	20%; after deductible	40%; after deductible
Allergy Injections	20%; after deductible	40%; after deductible
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.	20%; after deductible	40%; 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.	20%; after deductible	40%; after deductible
Diagnostic Complex Imaging 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.	20%; after deductible	40%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	20%; after deductible	Same as in-network care
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	20%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	20%; 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	20%; after deductible	40%; after deductible

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Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	20%; after deductible	40%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	20%; after deductible	40%; after deductible
Substance Abuse Office Visits	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	20%; after deductible	40%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	20%; after deductible	40%; after deductible
Limited to 120 days per year		
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	20%; after deductible	40%; after deductible
Limited to 120 visits per year		
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	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing	Not Covered	Not Covered
Spinal Manipulation Therapy	20%; after deductible	40%; after deductible
Limited to 30 visits per year		
Acupuncture	20%; after deductible	40%; after deductible
Limited to 30 visits per year		
Outpatient Short-Term Rehabilitation	20%; after deductible	40%; after deductible
Includes speech, physical, occupational therapy; limited to 60 visits per year		

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Habilitative Physical Therapy	20%; after deductible	40%; after deductible
Habilitative Occupational Therapy	20%; after deductible	40%; after deductible
Habilitative Speech Therapy	20%; after deductible	40%; 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 same as any other Outpatient Mental Health All Other benefit	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Autism Physical Therapy	20%; after deductible	40%; after deductible
Autism Occupational Therapy	20%; after deductible	40%; after deductible
Autism Speech Therapy	20%; after deductible	40%; after deductible
Durable Medical Equipment	20%; after deductible	40%; after deductible
Hearing Aids Limited to $3,500 every two years.	20%; after deductible	40%; after deductible
Diabetic Supplies	Not Covered	Not Covered
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	40%; after deductible
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	40%; after deductible
Infusion Therapy Administered in the home or physician's office	20%; after deductible	40%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	20%; after deductible	40%; after deductible
Vision Eyewear	Not Covered	Not Covered
Transplants	Covered 100%; after deductible Preferred coverage is provided at an IOE contracted facility only.	40%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery Limited to $10,000 per lifetime	20%; after deductible	Not Covered

Your cost sharing applies to all covered benefits incurred during your inpatient stay.

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FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	20%; after deductible	40%; after deductible
Diagnosis and treatment of the underlying medical condition only.		
Comprehensive Infertility Services	Not Covered	Not Covered
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	20%; after deductible	40%; after deductible
Tubal Ligation	Covered 100%; deductible waived	40%; after deductible
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 **1-866-276-1820.** Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-866-276-1820.**

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.