aetna®

Bucks & Montgomery County Schools
Effective Date: 07-01-2020
BMCS Open Choice 1

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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	None Individual None Family	$600 Individual $1,200 Family
All out of network covered expenses accumulate towards the 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, is 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	Covered 100%	30%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$3,500 Individual $7,000 Family	$7,500 Individual $15,000 Family
All covered expenses accumulate toward both the preferred or non-preferred Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays(except any penalty amounts) may be used to satisfy the preferred or non-preferred 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 Non-Preferred Care**	Not Applicable	Professional: 100% of Medicare Facility: 100% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Precertification Requirements -		
Certain non-participating providers/participating provider self referred services require precertification or benefits will be reduced - penalty amount applied separately to each type of expense is $1,000 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%	30%; deductible waived
1 exam per year for members age 22 and older.		
Routine Well Child Exams/Immunizations	Covered 100%	30%; deductible waived
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%	30%; deductible waived
One exam per calendar year. Includes routine tests and related lab fees.		
Routine Mammograms	Covered 100%	30%; deductible waived
Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.		
Women's Health	Covered 100%	30%; deductible waived
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%	30%; deductible waived
Recommended: For covered males age 40 and over.		

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Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%	30%; deductible waived
Colorectal Cancer Screening Recommended: For all members age 50 and over.	Covered 100%	30%; deductible waived
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Not Covered	Not Covered
Calibrated and Non-Calibrated instrument exams are covered as part of well visit.		
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist Includes services of an internist, general physician, family practitioner, pediatrician or OB/GYN.	$10 copay	30%; after deductible
Specialist Office Visits	$20 copay	30%; after deductible
Pre-Natal Maternity	Covered 100%	30%; after deductible
Walk-in Clinics	$10 copay	30%; after deductible
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.		
Allergy Testing	Member cost sharing is based on the type of service performed and the place of service where it is rendered. Covered 100% when an office visit charge is not applicable.	30%; after deductible
Allergy Injections	Member cost sharing is based on the type of service performed and the place of service where it is rendered. Covered 100% when an office visit charge is not applicable.	30%; 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 copay	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.	Covered 100%	30%; after deductible
Diagnostic Complex Imaging	$20 copay	30%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$28 copay	30%; after deductible
Non-Urgent Use of Urgent Care Provider	$28 copay	30%; after deductible
Emergency Room Copay waived if admitted	$100 copay	Same as in-network care
Non-Emergency Care in an Emergency Room	$100 copay	Same as in-network care
Emergency Use of Ambulance	Covered 100%	Same as in-network care
Non-Emergency Use of Ambulance	Covered 100%	30% after deductible
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	$75 copay per day (maximum of 5 copays per admission)	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		

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Inpatient Maternity Coverage (includes delivery and postpartum care)	$10 for initial Physician Maternity visit; $75 copay per day (maximum of 5 copays per admission)	30% for initial Physician Maternity visit; after deductible; 30% for Facility Services; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Hospital Expenses	Covered 100%	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Surgery - Hospital	$75 copay	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Surgery - Freestanding Facility	$75 copay	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	$75 copay per day (maximum of 5 copays per admission)	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient	$20 copay	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
ALCOHOL/DRUG ABUSE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	$75 copay per day (maximum of 5 copays per admission)	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Residential Treatment Facility	$75 copay per day (maximum of 5 copays per admission)	30%; after deductible
Outpatient	$20 copay	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Convalescent Facility	Covered 100%	30%; after deductible
Limited to 120 days per calendar year.		
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Home Health Care	Covered 100%	30%; after deductible
Hospice Care - Inpatient	Covered 100%	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	Covered 100%	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Private Duty Nursing	Covered 100%	30%; after deductible
45-8 hour shifts per calendar year		
Outpatient Short-Term Rehabilitation	$15 copay (visits 1-30) $25 copay (visits 31-60)	30%; after deductible
Includes Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year.		
Spinal Manipulation Therapy	$20 copay	30%; after deductible
Limited to 30 visits per calendar year.		
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis	$20 copay	30%; after deductible
Autism Physical Therapy	100% after copay $15 copay (visits 1-30) $25 copay (visits 31+)	30%; after deductible
Annual benefit maximum for non-essential Autism benefits: $38,276 for members to age 21		

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Autism Occupational Therapy	100% after copay $15 copay (visits 1-30) $25 copay (visits 31+)	30%; after deductible
Annual benefit maximum for non-essential Autism benefits: $38,276 for members to age 21		
Autism Speech Therapy	100% after copay $15 copay (visits 1-30) $25 copay (visits 31+)	30%; after deductible
Annual benefit maximum for non-essential Autism benefits: $38,276 for members to age 21		
Durable Medical Equipment	$20 copay	30%; 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%	Covered same as any other expense.
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%	Covered same as any other medical expense.
Vision Eyewear	Not Covered	Not Covered
Transplants	$75 copay per day (maximum of 5 copays per admission) Preferred coverage is provided at an Institute of Excellence (IOE) contracted facility only.	30%; after deductible Non-Preferred coverage is provided at a Non-Institute of Excellence facility.
Bariatric Surgery	Covered same as any other medical expense.	Covered same as any other medical expense.
Limited to one bariatric surgery per lifetime.		
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Diagnosis and treatment of the underlying medical condition.		
Comprehensive Infertility Services	Not Covered	Not Covered
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
Vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Tubal Ligation	Covered 100%	Member cost sharing is based on the type of service performed and the place of service where it is rendered

Formulary generic FDA - approved Women's Contraceptives 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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**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay 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
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 or another life threatening disease or condition.
• 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.
• Orthotics except diabetic orthotics.
• 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 or inadequacies, 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.**