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Bucks & Montgomery Community Schools
Effective Date: 07-01-2020
BMCS POS

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA HEALTH INC. AND AETNA HEALTH INSURANCE COMPANY - SELF-FUNDED

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	None Individual	$1,000 Individual
	None Family	$3,000 Family
Applicable covered expenses accumulate separately toward the in-network and out-of-network providers Deductible. 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.		
Out-of-Pocket Maximum (per calendar year)	$3,500 Individual	$10,000 Individual
	$7,000 Family	$30,000 Family
All applicable covered expenses accumulate separately toward the in-network and out-of-network Out-of-Pocket-Maximum. In-network expenses include coinsurance/copays and deductibles. Out-of-network expenses include coinsurance. Penalty amounts do not apply. Pharmacy expenses do not apply towards the Out-of-Pocket-Maximum. The family Out-of-Pocket Maximum is a cumulative Out-of-Pocket Maximum for all family members. The family Out-of-Pocket Maximum can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Out-of-Pocket Maximum amount.		
Lifetime Maximum	Unlimited except where otherwise indicated.	Unlimited except where otherwise indicated.
Benefit Limitations -- For any service or supply that is subject to a maximum visit, day, or dollar limitation, such services or supplies accumulate toward both the participating provider and non-participating provider benefit limits under this plan.		
Payment for Non-Preferred Care**	Not Applicable	Professional: 110% of Medicare Facility: 110% of Medicare
Primary Care Physician Selection	Required	Not Applicable
Precertification Requirement Certain non-participating providers/participating provider self referred services require precertification or benefits will be reduced. Refer to your plan documents for a complete list of services that require precertification.		
Referral Requirement	Required	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam per year for members age 22 and older.	Covered 100%	50%; deductible waived
Routine Well Child Exams/Immunizations (Age and frequency schedules apply)	Covered 100%	50%; deductible waived
Routine Gynecological Care Exams 1 exam per year. Includes routine tests and related lab fees.	Covered 100%	50%; deductible waived
Routine Mammograms	Covered 100%	50%; deductible waived
Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.		

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Women's Health	Covered 100%	50%; 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 Exams / Prostate Specific Antigen Test	Covered 100%	50%; deductible waived
Recommended for males age 40 and over.		
Colorectal Cancer Screening	Covered 100%	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Recommended for all members age 50 and over. Frequency schedule applies.		
Routine Eye Exams	$25 copay	Not Covered
1 routine exam per 24 months.		
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 member's selected Primary Care Physician	$15 copay	50%; after deductible
Specialist Office Visits	$25 copay	50%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.		
Pre-Natal Maternity	Covered 100%	Covered according to standard claim practice.
Walk-in Clinics	$15 copay	50%; 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.	50%; 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.	50%; after deductible
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic Laboratory	Covered 100%	50%; 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 X-ray	Covered 100%	50%; 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.		

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Diagnostic X-ray for Complex Imaging Services	Covered 100%	50%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$24 copay	50%; after deductible
Non-Urgent Use of Urgent Care Provider	$24 copay	50%; 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%	50% after deductible
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	$250 copay	50% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	$25 for Physician Maternity Services; $250 copay for Facility Services	50% for Physician Maternity Services; after deductible; 50% for Facility Services; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Surgery	$100 copay	50% per visit; 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 Mental Illness	$250 copay	50% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Mental Illness	$25 copay	50% per visit; 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 Detoxification	$250 copay	50% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Detoxification	$25 copay	50% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Inpatient Rehabilitation	$250 copay	50% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Residential Treatment Facility	$250 copay	50% per admission; after deductible
Outpatient Rehabilitation	$25 copay	50% per visit; 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**
Skilled Nursing Facility	Covered 100%	50% per admission; after deductible
Limited to 180 days in network and 240 days out of network; per calendar year The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Home Health Care	Covered 100%	50%; after deductible
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	Covered 100%	50% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	Covered 100%	50% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		

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Outpatient Rehabilitation Therapy Limited to 60 consecutive day period per condition Includes speech, physical, occupational therapy	Covered 100%	50%; after deductible
Spinal Manipulation Therapy Limited to 100 visits; per calendar year	Covered 100%	50%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health benefit	$25 copay	50%; after deductible
Autism Physical Therapy	Covered 100%	50%; after deductible
Annual benefit maximum for non-essential Autism benefits: $38,276 for members to age 21		
Autism Occupational Therapy	Covered 100%	50%; after deductible
Annual benefit maximum for non-essential Autism benefits: $38,276 for members to age 21		
Autism Speech Therapy	Covered 100%	50%; after deductible
Annual benefit maximum for non-essential Autism benefits: $38,276 for members to age 21		
Durable Medical Equipment	Covered 100%	50%; after deductible (must pre-certify if over $1,500)
Diabetic Supplies	Covered same as any other medical expense.	Covered same as any other medical expense.
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%	Covered same as any other medical expense.
Generic FDA-approved Women's Contraceptives	Covered 100%	Covered same as any other expense.
Hearing Aids	Not Covered	Not Covered
Transplants	$250 copay Preferred coverage is provided at an Institute of Excellence (IOE) contracted facility only.	50% per admission; 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.
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition.	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
Comprehensive Infertility Services Coverage includes artificial insemination	$25 copay	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
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

**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.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your 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, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.
• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.
• For hospitals and other facilities, the amount is based on "prevailing" charges. We get this data from an external database.
Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don'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 out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.
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 Navigator member site.
This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us 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 cost sharing and deductibles.
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 us 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.

Exclusions and Limitations

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. and Aetna Life Insurance Company. Each insurer has sole financial responsibility for its own products.

This material is for information only. 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.

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.

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.
- 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.

If you require language assistance, please call the Member Services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).

Si requiere la asistencia de un representante que hable su idioma, por favor llame al número de Servicios al Miembro que aparece en su tarjeta de identificación y se le comunicará con la línea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intérprete). TDD-1-800-628-3323 (sólo para las personas con impedimentos auditivos).

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **www.aetna.com.** While this material is believed to be accurate as of the production date, it is subject to change.