aetna™

**PLAN DESIGN AND BENEFITS - NY Silver OAEPO 5000 50% HSA (2022)**

**NY Group Business 1-100 Employees**

This plan only provides access to covered benefits when provided by a network provider. The plan does not provide access to covered benefits when provided by an out-of-network provider, except for emergency care provided for an emergency medical condition. This plan will pay for the emergency care subject to in-network benefits.

| PLAN FEATURES | NETWORK CARE | OUT-OF-NETWORK CARE |
|---|---|---|
| **Primary Care Physician Selection** | Optional | Not applicable |
| **Deductible** (per calendar year) | $5,000 Individual<br>$10,000 Family | Not applicable |
| Unless otherwise indicated, the deductible must be met before benefits can be paid. | | |
| As indicated in the plan, member cost sharing for certain services are excluded from the charges to meet the deductible. | | |
| Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and copays (except any penalty amounts) may be used to satisfy the Payment Limit. | | |
| No one family member may contribute more than the individual deductible amount to the family deductible. | | |
| **Member Coinsurance**<br>(applies to all expenses unless otherwise stated) | 50% | Not applicable |
| **Payment Limit**<br>(per calendar year, includes deductible) | $6,200 Individual<br>$12,400 Family | Not applicable |
| No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum. | | |
| **Referral Requirement** | Not Required | Not applicable |
| **PHYSICIAN SERVICES** | **NETWORK CARE** | **OUT-OF-NETWORK CARE** |
| **Office Visits to Non-Specialist** | 50% after deductible | Not covered |
| Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illness or injury. | | |
| **Specialist Office Visits** | 50% after deductible | Not covered |
| **Walk-in Clinics** | Covered in full after deductible | Not covered |
| Walk-in clinics are freestanding 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. | | |
| **Maternity - Delivery and Post-Partum Care** | 50% after deductible | Not covered |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Allergy Testing** | 50% after deductible | Not covered |
| **Allergy Injections** | 50% after deductible | Not covered |
| **PREVENTIVE CARE** | **NETWORK CARE** | **OUT-OF-NETWORK CARE** |
| Preventive care services are covered in accordance with Health Care Reform. | | |
| **Routine Adult Physical Exams and Immunizations**<br>Coverage is limited to 1 exam per calendar year. | Covered in full | Not covered |
| **Routine Well Child Exams and Immunizations**<br>Coverage is limited 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 calendar year thereafter to age 22. | Covered in full | Not covered |
| **Routine Gynecological Exams**<br>Includes Pap smear, HPV screening and related lab fees. Coverage is limited to 2 exams per calendar year. | Covered in full | Not covered |
| **Routine Mammograms**<br>For covered females age 40 and over. Frequency schedule applies. | Covered in full | Not covered |

| | | |
|---|---|---|
| **Women's Health**<br>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; Limitations may apply. | Covered in full | Not covered |
| **Prenatal Maternity** | Covered in full | Not covered |
| **Routine Digital Rectal Exam / Prostate-Specific Antigen Test**<br>Recommended: For covered males age 40 and over. Frequency schedule applies. | Covered in full | Not covered |
| **Colorectal Cancer Screening**<br>Recommended: For all members age 45 and over. Frequency schedule applies. | Covered in full | Not covered |
| **Routine Eye and Hearing Screenings** | Paid as part of routine physical exam. | Not covered |
| HEARING SERVICES | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Hearing Exam** (by Specialist)<br>Coverage is limited to 1 exam every 24 months. | 50% after deductible | Not covered |
| **Hearing Aid**<br>Coverage is limited to one every 3 years (one or both ears). Includes repair and replacement. | 50% after deductible | Not covered |
| VISION SERVICES | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Adult Routine Eye Exams (Refraction)** | Not covered | Not covered |
| **Pediatric Routine Eye Exams (Refraction)**<br>Coverage is limited to 1 exam every 12 months age 0-19. | 50% after deductible | Not covered |
| **Adult Vision Hardware** | Not covered | Not covered |
| **Pediatric Vision Hardware**<br>Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses every 12 months age 0-19 unless required more frequently with appropriate documentation. | 50% after deductible | Not covered |
| DIAGNOSTIC PROCEDURES | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Outpatient Diagnostic Laboratory** | 50% after deductible | Not covered |
| **Outpatient Diagnostic X-ray (except for Complex Imaging Services)** | 50% after deductible | Not covered |
| **Outpatient Diagnostic X-ray for Complex Imaging Services**<br>Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required. | 50% after deductible | Not covered |
| **Outpatient Diagnostic Laboratory Performed in a PCP Office Visit** | 50% after deductible | Not covered |
| **Outpatient Diagnostic X-ray Performed in a PCP Office Visit (except for Complex Imaging Services)** | 50% after deductible | Not covered |
| **Outpatient Diagnostic X-ray for Complex Imaging Services Performed in a PCP Office Visit**<br>Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required. | 50% after deductible | Not covered |

| | | |
|---|---|---|
| **Outpatient Diagnostic Laboratory Performed in a Specialist Offic Visit** | 50% after deductible | Not covered |
| **Outpatient Diagnostic X-ray Performed in a Specialist Offic Visit (except for Complex Imaging Services)** | 50% after deductible | Not covered |
| **Outpatient Diagnostic X-ray for Complex Imaging Services Performed in a Specialist Offic Visit** Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required. | 50% after deductible | Not covered |
| EMERGENCY MEDICAL CARE | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Urgent Care Provider** | 50% after deductible | Not covered |
| **Non-Urgent Use of Urgent Care Provider** | Not covered | Not covered |
| **Emergency Room** | 50% after deductible | Paid as In-Network |
| **Non-Emergency Care in an Emergency Room** | Not covered | Not covered |
| **Emergency Use of Ambulance** | 50% after deductible | Paid as In-Network |
| **Non-Emergency Use of Ambulance** | 50% after deductible | Not covered |
| HOSPITAL CARE | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Inpatient Coverage** Including maternity (prenatal, delivery and postpartum) and transplants. | 50% after deductible | Not covered |
| **Outpatient Surgery** Provided in an outpatient hospital department or freestanding surgical facility. | 50% after deductible | Not covered |
| **Colonoscopy** (non-preventive) | Member cost sharing is based on the type of service performed and the place rendered. | Not covered |
| **Transplants** Coverage is limited to IOE facilities only. Excludes travel and lodging expenses for donors and companions. | 50% after deductible | Not covered |
| MENTAL HEALTH and SUBSTANCE USE SERVICES | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Inpatient Mental Health & Substance Use Services** | 50% after deductible | Not covered |
| **Outpatient Office Visit Mental Health & Substance Use Services** | 50% after deductible | Not covered |
| **Outpatient Other Mental Health & Substance Use Services** (e.g,:partial hospitalization programs, intensive outpatient programs) | 50% after deductible | Not covered |
| OTHER SERVICES AND PLAN DETAILS | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Skilled Nursing Facility** | 50% after deductible | Not covered |
| **Home Health Care** Coverage is limited to 40 visits per calendar year. 1 visit equals a period of 4 hours or less. | 25% after deductible | Not covered |
| **Infusion Therapy** Provided in the home or physician's office. | 50% after deductible | Not covered |
| **Infusion Therapy** Provided in the outpatient hospital department or freestanding facility. | 50% after deductible | Not covered |
| **Gene-Based, Cellular and Other Innovative Therapies (GCIT)** Coverage is limited to GCIT designated facilities only. | Member cost sharing is based on the type of service performed and the place rendered. | Not covered |
| **Hospice Care - Inpatient** | 50% after deductible | Not covered |
| **Hospice Care Outpatient** | 50% after deductible | Not covered |

| | | |
|---|---|---|
| **Private Duty Nursing -** Outpatient | Not covered | Not covered |
| **Outpatient Short-Term Rehabilitation - Physical Therapy**<br><br>Coverage is limited to 60 visits per calendar year, per condition, PT/OT/ST combined, rehabilitation & habilitation separate. | 50% after deductible | Not covered |
| **Outpatient Short-Term Rehabilitation - Occupational Therapy**<br><br>Coverage is limited to 60 visits per calendar year, per condition, PT/OT/ST combined, rehabilitation & habilitation separate. | 50% after deductible | Not covered |
| **Outpatient Short-Term Rehabilitation - Speech Therapy**<br><br>Coverage is limited to 60 visits per calendar year, per condition, PT/OT/ST combined, rehabilitation & habilitation separate. | 50% after deductible | Not covered |
| **Outpatient Chiropractic** | 50% after deductible | Not covered |
| **Habilitative Physical, Occupational and Speech Therapy** | 50% after deductible | Not covered |
| **Autism Behavioral Therapy** | 50% after deductible | Not covered |
| **Autism Applied Behavior Analysis** | 50% after deductible | Not covered |
| **Autism Physical, Occupational and Speech Therapy** | 50% after deductible | Not covered |
| **Acupuncture**<br>Coverage is limited to 10 visits per calendar year. | 50% after deductible | Not covered |
| **Durable Medical Equipment** | 50% after deductible | Not covered |
| **Diabetic Supplies not obtainable at a pharmacy** | Covered same as any other medical expense. | Not covered |
| **Bariatric Surgery** | 50% after deductible | Not covered |
| FAMILY PLANNING | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Infertility Treatment - Diagnostic only**<br>Covered only for the diagnosis and treatment of the underlying medical condition. | Member cost sharing is based on the type of service performed and the place rendered. | Not covered |
| **Infertility Treatment - Artificial Insemination or Ovulation Induction** | 50% after deductible | Not covered |
| **Advanced Reproductive Technology.** Including, but not limited to, GIFT, ZIFT, IVF, ICSI, ovum microsurgery and cryopreserved embryo transfers. | Not covered | Not covered |
| **Vasectomy** | 50% after deductible | Not covered |
| **Tubal Ligation** | Covered in full | Not covered |
| PEDIATRIC DENTAL SERVICES | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Preventive & Diagnostic** (includes exams, cleanings, x-rays, fluoride, sealants)<br>Coverage is limited to 1 dental exam and cleaning per 6-month period age 0-19. | Covered in full after deductible | Not covered |
| **Basic** (includes space maintainers, fillings, anesthesia, denture adjustments)<br>Coverage is limited to age 0-19. | 30% after deductible | Not covered |
| **Major** (includes crowns, endodontics, periodontics, oral surgery, dentures, bridges)<br>Coverage is limited to age 0-19. | 50% after deductible | Not covered |

| | | |
|---|---|---|
| **Orthodontia** (limited to medically necessary orthodontia)<br>Coverage is limited to age 0-19. | 50% after deductible | Not covered |
| PHARMACY DEDUCTIBLE | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Prescription drug calendar year deductible** | Prescription drugs purchased at a network pharmacy are subject to the in-network medical deductible which must be satisfied before any prescription drug benefits are paid. | Prescription drugs purchased at a network pharmacy are subject to the in-network medical deductible which must be satisfied before any prescription drug benefits are paid. |
| PHARMACY - PRESCRIPTION DRUG BENEFITS | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Generic Drugs** | | |
| **Retail** | $15 copayment after deductible | Not covered |
| **MailOrder** | $37.50 copayment after deductible | Not covered |
| **Preferred Brand Drugs** | | |
| **Retail** | $65 copayment after deductible | Not covered |
| **MailOrder** | $162.50 copayment after deductible | Not covered |
| **Non-Preferred Drugs** | | |
| **Retail** | 50% after deductible | Not covered |
| **MailOrder** | 50% after deductible | Not covered |
| **Speciality Drugs** | | |
| **Preferred Speciality** | Same as applicable cost share.<br>Same as applicable cost share. | Not covered |
| **Non-Preferred Speciality** | Same as applicable cost share.<br>Same as applicable cost share. | Not covered<br>Not covered |
| **Pharmacy Day Supply and Requirements** | | |
| **Retail :**<br>Up to a 30 day supply. | | |
| **Mail Order :**<br>A 31-90 day supply from CVS Caremark Mail Service PharmacyTM at the Mail Order Drug copay. | | |
| **Specialty :**<br>Up to a 30 day supply | | |

**Specialty Drugs -** All prescription fills must be through our preferred specialty pharmacy network.

**True Accumulation -** Some specialty prescription drugs may qualify for third-party copay assistance programs, like a manufacturer coupon or a rebate. These could lower out-of-pocket costs. Any amount received through one of these programs will not apply towards the Deductible or Out-of-Pocket Maximum.

**Full Choose Generics -** If the member or the physician requests brand when generic is available, the member pays the applicable cost-sharing plus the cost difference between the generic and brand. Penalty does not apply to medical deductible and integrated MOOP.

**Precertification -** Included. See formulary for details.

**Step Therapy -** Included. See formulary for details.

**Pharmacy Plan includes:**

Diabetic supplies obtainable from a pharmacy (Including: needles, syringes, test strips, lancets and alcohol swabs - available at retail or mail order).

**Performance Enhancing Drugs -** Coverage is included for up to 4 pills per month for lifestyle/performance drugs. See Aetna Formulary for details on precertification.

Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

Preventive and seasonal vaccinations covered 100% in-network.

**Network and Non-network Providers**

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 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.

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 provider who is out-of-network, your Aetna health plan will not pay any of that provider 's bill. You will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

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 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 the network. You pay cost sharing 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 cost sharing and deductibles.

**What's Not Covered**

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial 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 purchased.

- All medical or hospital services not specifically covered in or which are limited or excluded in the plan documents
- Charges related to any eye surgery mainly to correct refractive errors
- Cosmetic surgery, including breast reduction
- Custodial care
- Adult dental care and x-rays
- Donor egg retrieval
- Experimental and investigational procedures
- Immunizations for travel or work
- Infertility services, including, but not limited to, 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
- Non-medically necessary services or supplies
- Orthotics except as specified in the plan
- Over-the-counter medications and supplies
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs
- Special duty nursing
- Weight reduction programs, or dietary supplements

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. CVS Caremark® Mail Service Pharmacy and Aetna are part of the CVS Health family of companies. Preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates.The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

If your plan covers outpatient prescription drugs, your plan includes a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step therapy, please refer to our website at **www.aetna.com**, or the Aetna Medication Formulary Guide. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage.

While this information is believed to be accurate as of the print date, it is subject to change.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Plans are provided by Aetna Health Inc.

For more information about Aetna plans, refer to **www.aetna.com**.

FORM #: 14.35.301.1 E (09/21) © 2021 Print Date:09-29-2021 TPID: 14047696