NATIONAL HEALTH CARE, INC. AND AFFILIATES VOLUNTARY
Effective Date: 01-01-2019
Aetna Open Access® Aetna Select℠

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

PLAN FEATURES	IN-NETWORK
Deductible (per calendar year)	$1,750 Individual $5,000 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. 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	20%
Applies to all expenses unless otherwise stated.	
Payment Limit (per calendar year)	$7,900 Individual $15,800 Family
Certain member cost sharing elements may not apply toward 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.	
Primary Care Physician Selection	Optional
Referral Requirement	None
PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived
1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	
Routine Well Child Exams	Covered 100%; 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%; deductible waived
1 exam and pap smear per calendar year, includes related fees.	
Routine Mammograms	Covered 100%; deductible waived
Recommended:1 per calendar year age 40 and over	
Women's Health	Covered 100%; 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%; deductible waived
Recommended: For covered males age 40 and over.	

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Prostate-specific Antigen Test	Covered 100%; deductible waived
Recommended: For covered males age 40 and over.	
Colorectal Cancer Screening	Covered 100%; deductible waived
Recommended: For all members age 50 and over.	
Routine Eye Exams	Covered 100%; deductible waived
1 routine exam per 24 months.	
Routine Hearing Screening	Covered 100%; deductible waived
PHYSICIAN SERVICES	**IN-NETWORK**
Office Visits to PCP	$30 copay; deductible waived
Includes services of an internist, general physician, family practitioner or pediatrician	
Specialist Office Visits	$50 copay; deductible waived
Hearing Exams	$50 copay; deductible waived
1 routine exam per 24 months.	
Pre-Natal Maternity	Covered 100%; deductible waived
Walk-in Clinics	$30 copay; deductible waived
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	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
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic X-ray	Preventative X-Ray covered in Full Diagnostic X-Ray- 20%; after deductible- Free Standing Facility 30%; after deductible- Hospital Based
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	Preventative Lab covered in Full Diagnostic Lab - 20%; after deductible- Free Standing Facility 30%; after deductible- Hospital Based
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 Complex Imaging	15%; after deductible- Free Standing Facility 25%; after deductible- Hospital Based
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care Provider	$150 copay; deductible waived
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	$300 copay; deductible waived
Copay waived if admitted	

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Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	20%; after deductible
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK**
Inpatient Coverage Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible
Outpatient Hospital The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	20%; after deductible
Outpatient Surgery - Hospital The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	20%; after deductible
Outpatient Surgery - Freestanding Facility The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	20%; after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible
Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$50 copay; deductible waived
Other Mental Health Services	Covered 100%; deductible waived
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible
Residential Treatment Facility	20%; after deductible
Substance Abuse Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$50 copay; deductible waived
Other Substance Abuse Services	Covered 100%; deductible waived
OTHER SERVICES	**IN-NETWORK**
Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible
Home Health Care Limited to 80 visits per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.	20%; after deductible
Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible

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Private Duty Nursing	20%; after deductible
Limited to 70 eight hour shifts per calendar year. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.	
Outpatient Speech Therapy Limited to 30 visits per calendar year.	$50 copay; deductible waived Includes Outpatient Hospital Facility services.
Spinal Manipulation Therapy Limited to 20 visits per calendar year.	$50 copay; deductible waived
Outpatient Physical Therapy Limited to 30 visits per calendar year.	$50 copay; deductible waived Includes Outpatient Hospital Facility services.
Outpatient Occupational Therapy Limited to 30 visits per calendar year.	$50 copay; deductible waived Includes Outpatient Hospital Facility services.
Autism Behavioral Therapy Combined with outpatient mental health visits	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered the same as any other Mental Health Other services benefit.	Refer to MBH Mental Health Other Services
Autism Physical Therapy	$50 copay; deductible waived
Autism Occupational Therapy	$50 copay; deductible waived
Autism Speech Therapy	$50 copay; deductible waived
Durable Medical Equipment	20%; after deductible
Hearing Aids Limited to $1,000 maximum per 24 months for child to age 13 years.	Covered 100%; deductible waived
Nutritional Support Limited to 3 visits per calendar year.	Your cost sharing is based on the type of service and where it is performed
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived
Infusion Therapy Administered in the home or physician's office	Your cost sharing is based on the type of service and where it is performed
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

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Transplants	20%; after deductible Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery	Not Covered
FAMILY PLANNING	**IN-NETWORK**
Infertility Treatment	Applicable cost sharing based on the type of service performed and place of service where rendered
Diagnosis and treatment of the underlying medical condition only.	
Comprehensive Infertility Services	Not Covered
Artificial insemination and ovulation induction	
Advanced Reproductive Technology (ART)	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
Tubal Ligation	Covered 100%; deductible waived
PHARMACY	**IN-NETWORK**
Pharmacy Plan Type	None
GENERAL PROVISIONS	
Dependents Eligibility - Spouse, children from birth to age 26 regardless of student status.	

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.
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.

Plans are provided by: Aetna Health Inc. 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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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.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery and Aetna Specialty Pharmacy refer to Aetna Rx Home Delivery, LLC and Aetna Specialty Pharmacy, LLC, respectively. Aetna Rx Home Delivery and Aetna Specialty Pharmacy are licensed pharmacy subsidiaries of Aetna Inc. that operate through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery and Aetna Specialty Pharmacy may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacies' cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

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

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Translation of this material into another language may be available. Please call Member Services at the number on the back of your ID card.

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.**

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