



NATIONAL HEALTH CARE, INC. AND AFFILIATES  
 Effective Date: 01-01-2020  
 Aetna Choice® POS II -- ASC  
 Qualified High Deductible Health Plan

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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
<b>Benefit Limitations</b> - 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.		
<b>Deductible</b> (per calendar year)	\$6,600 Individual \$13,200 Family	\$20,000 Individual \$40,000 Family
All covered expenses accumulate simultaneously toward both the in-network and 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. 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.		
<b>Member Coinsurance</b>	Covered 100%	30%
Applies to all expenses unless otherwise stated.		
<b>Payment Limit</b> (per calendar year)	\$6,600 Individual \$13,200 Family	Unlimited Individual Unlimited Family
All covered expenses accumulate simultaneously toward both 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. 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.		
<b>Lifetime Maximum</b>	Unlimited except where otherwise indicated.	
<b>Primary Care Physician Selection</b>	Optional	Not Applicable
<b>Certification Requirements</b> - 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 \$400 per occurrence.		
<b>Referral Requirement</b>	None	None
<b>PREVENTIVE CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Routine Adult Physical Exams/ Immunizations</b>	Covered 100%; deductible waived	30%; after deductible
1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older		
<b>Routine Well Child Exams/Immunizations</b>	Covered 100%; deductible waived	30%; after deductible
7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per year thereafter to age 22.		
<b>Routine Gynecological Care Exams</b>	Covered 100%; deductible waived	30%; after deductible
1 exam and pap smear per calendar year, includes related fees.		
<b>Routine Mammograms</b>	Covered 100%; deductible waived	30%; after deductible
<b>Women's Health</b>	Covered 100%; deductible waived	30%; after deductible
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.		
<b>Routine Digital Rectal Exam</b>	Covered 100%; deductible waived	30%; after deductible
Recommended: For covered males age 40 and over.		



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<b>Prostate-specific Antigen Test</b> Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	30%; after deductible
<b>Colorectal Cancer Screening</b> Recommended: For all members age 45 and over.	Covered 100%; deductible waived	Covered under Routine Adult Exams
<b>Routine Eye Exams</b> 1 routine exam per 24 months.	Covered 100%; deductible waived	30%; after deductible
<b>Routine Hearing Screening</b>	Covered 100%; deductible waived	30%; after deductible
<b>Medications</b>	Certain over-the-counter preventive medications covered 100% in network.	
<b>PHYSICIAN SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Office Visits to Non-Specialist</b> Includes services of an internist, general physician, family practitioner or pediatrician.	Covered 100%; after deductible	30%; after deductible
<b>Specialist Office Visits</b>	Covered 100%; after deductible	30%; after deductible
<b>Hearing Exams</b> 1 routine exam per 24 months.	Covered 100%; deductible waived	30%; after deductible
<b>Pre-Natal Maternity</b>	Covered 100%; deductible waived	30%; after deductible
<b>Walk-in Clinics</b> 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.	Covered 100%; after deductible	30%; after deductible
<b>Allergy Testing</b>	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
<b>Allergy Injections</b>	Your cost sharing is based on the type of service and where it is performed. Covered 100% when an office visit charge is not applicable.	Your cost sharing is based on the type of service and where it is performed
<b>DIAGNOSTIC PROCEDURES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Diagnostic X-ray</b> (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.	Covered 100%; after deductible	30%; after deductible
<b>Diagnostic Laboratory</b> 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%; after deductible	30%; after deductible
<b>Diagnostic Complex Imaging</b> 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%; after deductible	30%; after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Urgent Care Provider</b>	Covered 100%; after deductible	30%; after deductible
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered	Not Covered
<b>Emergency Room</b>	Covered 100%; after deductible	Same as in-network care
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered	Not Covered
<b>Emergency Use of Ambulance</b>	Covered 100%; after deductible	Same as in-network care
<b>Non-Emergency Use of Ambulance</b>	Not Covered	Not Covered



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<b>HOSPITAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient Coverage</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	30%; after deductible
<b>Inpatient Maternity Coverage</b> (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	30%; after deductible
<b>Outpatient Hospital Expenses</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	30%; after deductible
<b>Outpatient Surgery - Hospital</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	30%; after deductible
<b>Outpatient Surgery - Freestanding Facility</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	30%; after deductible
<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	30%; after deductible
<b>Mental Health Office Visits</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	30%; after deductible
<b>Other Mental Health Services</b>	Covered 100%; after deductible	30%; after deductible
<b>SUBSTANCE ABUSE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	30%; after deductible
<b>Residential Treatment Facility</b>	Covered 100%; after deductible	30%; after deductible
<b>Substance Abuse Office Visits</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	30%; after deductible
<b>Other Substance Abuse Services</b>	Covered 100%; after deductible	30%; after deductible
<b>OTHER SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Skilled Nursing Facility</b> Limited to 60 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	30%; after deductible
<b>Home Health Care</b> Limited to 80 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.	Covered 100%; after deductible	30%; after deductible
<b>Hospice Care - Inpatient</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	30%; after deductible
<b>Hospice Care - Outpatient</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	30%; after deductible
<b>Private Duty Nursing</b> Limited to 70 eight-hour shifts per year. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.	Covered 100%; after deductible	30%; after deductible
<b>Spinal Manipulation Therapy</b> Limited to 20 visits per year	Covered 100%; after deductible	30%; after deductible
<b>Outpatient Rehabilitative Speech Therapy</b> Limited to 30 visits per year.	Covered 100%; after deductible	30%; after deductible



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<b>Outpatient Rehabilitative Physical Therapy</b> Limited to 30 visits per year.	Covered 100%; after deductible	30%; after deductible
<b>Outpatient Rehabilitative Occupational Therapy</b> Limited to 30 visits per year.	Covered 100%; after deductible	30%; after deductible
<b>Habilitative Physical Therapy</b>	Not Covered	Not Covered
<b>Habilitative Occupational Therapy</b>	Not Covered	Not Covered
<b>Habilitative Speech Therapy</b>	Not Covered	Not Covered
<b>Autism Behavioral Therapy</b> Combined with outpatient mental health visits	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
<b>Autism Applied Behavior Analysis</b> 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
<b>Autism Physical Therapy</b>	Covered 100%; after deductible	30%; after deductible
<b>Autism Occupational Therapy</b>	Covered 100%; after deductible	30%; after deductible
<b>Autism Speech Therapy</b>	Covered 100%; after deductible	30%; after deductible
<b>Durable Medical Equipment</b>	Covered 100%; after deductible	30%; after deductible
<b>Hearing Aids</b> Limited to \$1,000 maximum per 24 months for child to age 13 years.	Covered 100%; after deductible	30%; after deductible
<b>Nutritional Counseling</b> Limited to 3 visits per calendar year.	Covered 100%; after deductible	30%; after deductible
<b>Diabetic Supplies</b> -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
<b>Affordable Care Act Mandated Women's Contraceptives</b>	Covered 100%; deductible waived	Covered same as any other expense.
<b>Women's Contraceptive drugs and devices not obtainable at a pharmacy</b>	Covered 100%; deductible waived	Covered same as any other medical expense.
<b>Infusion Therapy</b> Administered in the home or physician's office	Covered 100%; after deductible	30%; after deductible
<b>Infusion Therapy</b> Administered in an outpatient hospital department or freestanding facility	Covered 100%; after deductible	30%; after deductible
<b>Vision Eyewear</b>	Not Covered	Not Covered
<b>Transplants</b>	Covered 100%; after deductible Preferred coverage is provided at an IOE contracted facility only.	30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
<b>Bariatric Surgery</b>	Not Covered	Not Covered
<b>FAMILY PLANNING</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Infertility Treatment</b> Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
<b>Comprehensive Infertility Services</b> Artificial insemination and ovulation induction	Not Covered	Not Covered



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<b>Advanced Reproductive Technology (ART)</b>	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		
<b>Vasectomy</b>	Covered 100%; after deductible	30%; after deductible
<b>Tubal Ligation</b>	Covered 100%; deductible waived	30%; after deductible
<b>GENERAL PROVISIONS</b>		
<b>Dependents Eligibility</b>	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.

- 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.



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Aetna, or its affiliate(s), receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates may reduce the amount a member pays the pharmacy for covered prescriptions. CVS Caremark® Mail Service Pharmacy refers to CVS Caremark® Mail Service Pharmacy, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with CVS Caremark® Mail Service 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 pharmacy's 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.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862**. Puede estar disponible la traducción 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](http://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.

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