



The New School  
Effective Date: 01-01-2021  
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)	\$1,500 Individual \$3,000 Family	\$3,000 Individual \$6,000 Family
All covered expenses accumulate separately toward 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. Pharmacy expenses apply towards the Deductible. Once Family Deductible is met, all family members will be considered as having met their Deductible. There is no Individual Deductible to satisfy within the Family Deductible.		
<b>Member Coinsurance</b>	20%	40%
Applies to all expenses unless otherwise stated.		
<b>Payment Limit</b> (per calendar year)	\$3,000 Individual \$6,000 Family	\$6,000 Individual \$13,000 Family
All covered expenses accumulate separately toward the in-network and 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. Pharmacy expenses apply towards the Payment Limit. There is no Individual Payment Limit to satisfy within the Family Payment Limit. Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit.		
<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
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
<b>Routine Adult Physical Exams/ Immunizations</b> 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%; deductible waived	40%; after deductible
<b>Routine Well Child Exams/Immunizations</b> 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%; deductible waived	40%; after deductible
<b>Routine Gynecological Care Exams</b> 1 exam and pap smear per calendar year, includes related fees.	Covered 100%; deductible waived	40%; after deductible
<b>Routine Mammograms</b>	Covered 100%; deductible waived	40%; after deductible
<b>Women's Health</b> 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.	Covered 100%; deductible waived	40%; after deductible
<b>Routine Digital Rectal Exam</b> Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	40%; after deductible



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<b>Prostate-specific Antigen Test</b>	Covered 100%; deductible waived	40%; after deductible
Recommended: For covered males age 40 and over.		
<b>Colorectal Cancer Screening</b>	Covered 100%; deductible waived	Covered under Routine Adult Exams
Recommended: For all members age 45 and over.		
<b>Routine Hearing Screening</b>	Covered 100%; deductible waived	40%; 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 member's selected Primary Care Physician</b>	20%; after deductible	40%; after deductible
<b>Specialist Office Visits</b>	20%; after deductible	40%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.		
<b>Hearing Exams</b>	Not Covered	Not Covered
<b>Pre-Natal Maternity</b>	Covered 100%; deductible waived	40%; after deductible
<b>Walk-in Clinics</b>	20%; after deductible	40%; after deductible
	<b>Designated Walk-in Clinics</b>	
	Covered 100%; after deductible	
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.		
<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	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>	20%; after deductible	40%; after deductible
(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.		
<b>Diagnostic Laboratory</b>	20%; after deductible	40%; 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.		
<b>Diagnostic Complex Imaging</b>	20%; after deductible	40%; 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.		
<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Urgent Care Provider</b>	20%; after deductible	40%; after deductible
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered	Not Covered
<b>Emergency Room</b>	20%; 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>	20%; after deductible	Same as in-network care
<b>Non-Emergency Use of Ambulance</b>	20%; after deductible	20%; after deductible
<b>HOSPITAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient Coverage</b>	20%; after deductible	40%; after deductible



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Your cost sharing applies to all covered benefits incurred during your inpatient stay.

<b>Inpatient Maternity Coverage</b> (includes delivery and postpartum care)	20%; after deductible	40%; after deductible
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Your cost sharing applies to all covered benefits incurred during your inpatient stay.

<b>Outpatient Hospital Expenses</b>	20%; after deductible	40%; after deductible
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Your cost sharing applies to all covered benefits incurred during your outpatient visit.

<b>Outpatient Surgery - Hospital</b>	20%; after deductible	40%; after deductible
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Your cost sharing applies to all covered benefits incurred during your outpatient visit.

<b>Outpatient Surgery - Freestanding Facility</b>	20%; after deductible	40%; after deductible
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Your cost sharing applies to all covered benefits incurred during your outpatient visit.

<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
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<b>Inpatient</b>	20%; after deductible	40%; after deductible
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Your cost sharing applies to all covered benefits incurred during your inpatient stay.

<b>Mental Health Office Visits</b>	20%; after deductible	40%; after deductible
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Your cost sharing applies to all covered benefits incurred during your outpatient visit.

<b>Other Mental Health Services</b>	20%; after deductible	40%; after deductible
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<b>SUBSTANCE ABUSE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
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<b>Inpatient</b>	20%; after deductible	40%; after deductible
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Your cost sharing applies to all covered benefits incurred during your inpatient stay.

<b>Residential Treatment Facility</b>	20%; after deductible	40%; after deductible
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<b>Substance Abuse Office Visits</b>	20%; after deductible	40%; after deductible
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Your cost sharing applies to all covered benefits incurred during your outpatient visit.

<b>Other Substance Abuse Services</b>	20%; after deductible	40%; after deductible
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<b>OTHER SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
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<b>Skilled Nursing Facility</b>	20%; after deductible	40%; after deductible
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Limited to 30 days per year

Your cost sharing applies to all covered benefits incurred during your inpatient stay.

<b>Home Health Care</b>	20%; after deductible	40%; after deductible
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Limited to 90 visits per year.

Private Duty Nursing not covered

Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.

<b>Hospice Care - Inpatient</b>	20%; after deductible	40%; after deductible
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Your cost sharing applies to all covered benefits incurred during your inpatient stay.

<b>Hospice Care - Outpatient</b>	20%; after deductible	40%; after deductible
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Your cost sharing applies to all covered benefits incurred during your outpatient visit.

<b>Private Duty Nursing</b>	Not Covered	Not Covered
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<b>Spinal Manipulation Therapy</b>	20%; after deductible	40%; after deductible
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Limited to 20 visits per year

<b>Outpatient Short-Term Rehabilitation</b>	20%; after deductible	40%; after deductible
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Includes speech, physical, occupational therapy; limited to 90 visits per year



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<b>Habilitative Physical Therapy</b>	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
<b>Habilitative Occupational Therapy</b>	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
<b>Habilitative Speech Therapy</b>	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
<b>Autism Behavioral Therapy</b>	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Combined with outpatient mental health visits		
<b>Autism Applied Behavior Analysis</b>	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Covered same as any other Outpatient Mental Health All Other benefit		
<b>Autism Physical Therapy</b>	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
<b>Autism Occupational Therapy</b>	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
<b>Autism Speech Therapy</b>	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
<b>Durable Medical Equipment</b>	20%; after deductible	40%; 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	20%; after deductible	40%; after deductible
<b>Infusion Therapy</b> Administered in an outpatient hospital department or freestanding facility	20%; after deductible	40%; after deductible
<b>Vision Eyewear</b>	Not Covered	Not Covered
<b>Transplants</b>	20%; after deductible Preferred coverage is provided at an IOE contracted facility only.	40%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
<b>Bariatric Surgery</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible	Not Covered
<b>FAMILY PLANNING</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Infertility Treatment</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
Diagnosis and treatment of the underlying medical condition only.		
<b>Comprehensive Infertility Services</b> Artificial insemination and ovulation induction	20%; after deductible	40%; after deductible
<b>Advanced Reproductive Technology (ART)</b> ART coverage includes: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Limited to \$10,000 per lifetime. Maximum applies to all procedures covered by any of our plans except where prohibited by law.	20%; after deductible	40%; after deductible



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<b>Vasectomy</b>	Your cost sharing is based on the type of service and where it is performed	40%; after deductible
<b>Tubal Ligation</b>	Covered 100%; deductible waived	40%; after deductible
<b>GENERAL PROVISIONS</b>		
<b>Dependents Eligibility</b>	Spouse, Domestic Partner and 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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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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