PRESIDENT AND TRUSTEES OF BATES COLLEGE
Effective Date: 01-01-2027
Aetna Choice® POS II -- ASC

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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit limitations - Some service or supplies have limits on them per year. There might be a maximum number of visits or days, or a dollar limit per year. In such cases, the benefit year begins on January 1 (unless otherwise noted). Refer to your plan documents to learn more.		
Deductible (per calendar year)	$2,500 per Individual $5,000 per Family	$3,500 per Individual $7,000 per Family
Covered expenses add up toward both the in-network and out-of-network deductible at the same time. You must first meet the deductible before the plan begins paying benefits, unless otherwise noted. The amount you pay (cost sharing) for some medical services does not count toward your deductible. Prescription drug costs do not count toward the deductible. Refer to your plan documents for details. Your family will have one deductible. You will meet it when the expenses of several family members add up to the family deductible. No one person will have to pay more than the individual deductible.		
Member coinsurance Applies to all expenses except as noted.	You pay 20%	You pay 40%
Out-of-pocket limit (per calendar year)	$6,000 per Individual $12,000 per Family	$8,000 per Individual $16,000 per Family
Covered expenses add up toward both the in-network and out-of-network out-of-pocket limit at the same time. Pharmacy expenses count toward the out-of-pocket limit. In-network expenses include coinsurance/copays and deductibles. Your family will have one out-of-pocket limit. You will meet it when the expenses of several family members add up to the family out-of-pocket limit. No one person will have to pay more than the individual out-of-pocket limit amount. Out-of-network expenses include coinsurance and deductibles. Penalty amounts do not apply.		
Lifetime maximum Unlimited except where otherwise indicated.		
Payment for out-of-network care**	Does not apply	Professional: Prevailing Charges Facility: Facility Charge Review
Primary care physician selection	Encouraged	Does not apply
Precertification requirements - Some out-of-network services need approval by us in advance (precertification). Without this approval, we reduce benefits by $400. Refer to your plan documents for a full list of services that need this approval.		
Referral requirement	Not required	None
Telehealth consultations - You can access covered services for telehealth visits from different kinds of providers in your network. Log on to **Aetna.com** to see a list of telehealth providers. You'll also find more about your options, including cost share amounts.		
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine adult physical exams/ immunizations 1 exam every year	Covered 100%; no deductible	20%; after deductible
Routine well child exams/immunizations • 7 exams in the first 12 months • 3 exams from age 13 months to 24 months • 3 exams from age 25 months to 36 months • 1 exam every year thereafter until age 22	Covered 100%; no deductible	20%; after deductible
Routine gynecological care exams 1 exam and pap smear per year, includes related fees.	Covered 100%; no deductible	20%; after deductible
Breast cancer screening Recommended: One per year for members age 40 and over	Covered 100%; no deductible	20%; after deductible

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Women's health	Covered 100%; no deductible	20%; 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. Also includes: contraceptive methods (ACA mandated contraceptives, including contraceptives and devices you can't get at a pharmacy), sterilization procedures (including tubal ligation), patient education and counseling. Limits may apply.		
Pre-natal maternity	Covered 100%; no deductible	20%; after deductible
Routine digital rectal exam	Covered 100%; no deductible	20%; after deductible
Recommended: For members age 40 and over		
Prostate-specific antigen test	Covered 100%; no deductible	20%; after deductible
Recommended: For members age 40 and over		
Colorectal cancer screening	Covered 100%; no deductible	20%; after deductible
Recommended: For members age 45 and over		
Routine eye exams	Covered 100%; no deductible	20%; after deductible
1 routine exam per calendar year.		
Routine hearing screening	Covered 100%; no deductible	20%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office visits to primary care physician (PCP)	$35 office visit copay; no deductible	20%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Telehealth consultation with non-specialist	$35 office visit copay; no deductible	20%; after deductible
Specialist office visits	$45 office visit copay; no deductible	20%; after deductible
Telehealth consultation with specialist	$45 office visit copay; no deductible	20%; after deductible
Hearing exams	Covered 100%; no deductible	20%; after deductible
1 routine exam per 24 months.		
Walk-in clinics	$35 copay; no deductible	20%; after deductible
Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services. Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices.		
Allergy testing	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
Allergy injections	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic x-ray (Other than complex imaging services)	Covered 100%; no deductible	20%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.		
Diagnostic laboratory	Covered 100%; no deductible	20%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.		
Diagnostic complex imaging	20%; after deductible	40%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.		

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EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent care provider	$50 office visit copay; no deductible	20%; after deductible
Non-urgent use of urgent care provider	Not Covered	Not Covered
Emergency room Copay waived if admitted	$200 copay; no deductible	Same as in-network care
Non-emergency care in an emergency room	Not Covered	Not Covered
Emergency use of ambulance	Covered 100%; no deductible	Same as in-network care
Non-emergency use of ambulance	Covered 100%; no deductible	Covered 100%; no deductible
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient coverage	20%; after deductible	40%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Inpatient maternity coverage (includes delivery and postpartum care)	20%; after deductible	40%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Outpatient hospital	20%; after deductible	40%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
Outpatient surgery - hospital	20%; after deductible	40%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
Outpatient surgery - freestanding facility	20%; after deductible	40%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	20%; after deductible	40%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Mental health office visits	$45 copay; no deductible	20%; after deductible
Mental health telehealth consultations	$45 office visit copay; no deductible	20%; after deductible
Other mental health services	Covered 100%; no deductible	20%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	20%; after deductible	40%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Residential treatment facility	20%; after deductible	40%; after deductible
When admitted into a facility, cost sharing amount counts toward all covered benefits received.		
Substance abuse office visits	$45 copay; no deductible	20%; after deductible
Substance abuse telehealth consultations	$45 office visit copay; no deductible	20%; after deductible

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Other substance abuse services	Covered 100%; no deductible	20%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
THERAPY SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Spinal manipulation therapy	$45 copay; no deductible	20%; after deductible
Outpatient rehabilitative physical and occupational therapy	$45 copay; no deductible	20%; after deductible
Outpatient rehabilitative speech therapy	$45 copay; no deductible	20%; after deductible
Early Intervention Services	Covered same as any other medical expense.	Covered same as any other medical expense.
Children from birth to age 3; maximum of $3,200 per child per year. Lifetime maximum of $9,600.		
Habilitative physical therapy	Covered 100%; no deductible	20%; after deductible
Habilitative occupational therapy	Covered 100%; no deductible	20%; after deductible
Habilitative speech therapy	Covered 100%; no deductible	20%; after deductible
Autism related physical therapy	Covered 100%; no deductible	20%; after deductible
Autism related occupational therapy	Covered 100%; no deductible	20%; after deductible
Autism related speech therapy	Covered 100%; no deductible	20%; after deductible
Autism related behavioral therapy	$45 copay; no deductible	20%; after deductible
These benefits are combined with outpatient mental health visits		
Autism related applied behavior analysis	Covered 100%; no deductible	20%; after deductible
Your benefits for these services are the same as any other outpatient mental health other services benefit		
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled nursing facility	20%; after deductible	40%; after deductible
Limited to 100 days per year When admitted into a facility, cost sharing amount counts toward all covered benefits received.		
Home health care	20%; after deductible	40%; after deductible
Limited to 120 visits per year Private duty nursing not included. Limited to three visits per day by staff from a home health care agency.		
Hospice care - inpatient	20%; after deductible	40%; after deductible
When admitted into a facility, cost sharing amount counts toward all covered benefits received.		
Hospice care - outpatient	20%; after deductible	40%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
Private duty nursing	Not Covered	Not Covered
Durable medical equipment	Covered 100%; no deductible	20%; after deductible
Prosthetics	Covered 100%; no deductible	20%; after deductible
Hearing aids	Covered 100%; after deductible	Covered 100%; after deductible
1 hearing aid to a maximum of $3,000 per ear every 36 months		
Diabetic supplies		
• If not covered under the prescription drug benefit	You pay your PCP visit cost sharing amount	You pay your PCP visit cost sharing amount
• If covered under the prescription drug benefit	Applicable prescription drug cost sharing amount applies	Applicable prescription drug cost sharing amount applies
Infusion therapy - home/office	$45 copay; no deductible	20%; after deductible

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Infusion therapy - outpatient hospital/freestanding facility	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
Gene-based, Cellular, and other Innovative Therapies (GCIT™)	Your cost sharing amount depends on the type of service and where you receive it. $50 copay: after deductible for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.	Not Covered
Transplants	20%; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.	40%; after deductible Out-of-network coverage applies when you use a non-IOE facility. You will pay more out of pocket when using a non-IOE facility.
Bariatric surgery	20%; after deductible	40%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Acupuncture	$35 copay; no deductible	20%; after deductible
Limited to 20 visits per year		
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Basic infertility	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
You have coverage for artificial insemination and the diagnosis and treatment of the underlying cause of infertility.		
Advanced Reproductive Technology (ART)	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing depends on the type of service and where you receive it.
ART coverage includes in vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery and ovulation induction (OI). Maximum applies to all procedures covered by any of our plans except where prohibited by law.		
Fertility preservation	Your cost sharing depends on the type of service and where you receive it.	Your cost sharing depends on the type of service and where you receive it.
Includes coverage for cryopreservation for iatrogenic infertility Iatrogenic infertility is infertility that may occur as a result of certain types of medical treatment		
Vasectomy	Your cost sharing amount depends on the type of service and where you receive it.	40%; after deductible
Tubal ligation	Covered 100%; no deductible	40%; after deductible

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PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy plan type	Advanced Control Plan	
Prescription drug out-of-pocket limit	Prescription drug expenses apply to your medical out-of-pocket limit.	
Generic drugs		
Retail	$10 copay	20% of submitted cost; after applicable in-network cost share
Mail order	$20 copay	Not applicable
Preferred brand-name drugs		
Retail	$35 copay	20% of submitted cost; after applicable in-network cost share
Mail order	$70 copay	Not applicable
Non-preferred brand-name drugs		
Retail	$50 copay	20% of submitted cost; after applicable in-network cost share
Mail order	$100 copay	Not applicable
Specialty drugs		
Preferred specialty	$75 copay	Not Covered
Non-preferred specialty	$75 copay	Not Covered
Pharmacy day supply and requirements		
Retail	You can get up to a 30-day supply from Aetna National Network For a 31-90 day supply you will be responsible for the Mail Order Drug copay.	
Mail order	You can get a 31-90-day supply from CVS Caremark® Mail Service Pharmacy. You must fill all specialty drugs through our preferred specialty pharmacy network. Aetna Specialty Performance Network Drug List	

Prescription drug plan also includes:
• Diabetic supplies and blood glucose monitors
• Sexual dysfunction drugs, including daily dose, additional 30 tablets a month for erectile dysfunction

Family planning
• Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).

The following are covered 100% in-network:
• Oral chemotherapy drugs
• Seasonal vaccinations
• Affordable Care Act (ACA) eligible preventive medications and contraceptives
Refer to **Aetna.com** for a complete list of eligible prescription drugs.

Precertification requirements
Some covered prescription drugs need approval from us before we will cover the drug.
Some covered prescription drugs require step therapy before we cover them. With step therapy, you must first try one or more drugs before we will pay for drugs that require step therapy.
To get the most up-to-date precertification requirements and a list of drugs that require step therapy, see your plan documents or go online to your member website.

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GENERAL PROVISIONS

Dependents who are eligible to be on your plan	Spouse, children from birth to age 26. Student status of children does not matter.

**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.
This amount is based on the out-of-network plan you or your employer picks.
• For doctors and other professionals the amount is based on the "prevailing" charges. We get this data from an external database.

• For hospitals and other facilities, the amount is based on the Facility Fee Schedule.

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 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 and deductibles.

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.

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

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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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.

*****This plan document provides you with an overview of some of your benefits and your cost share obligations. This information is for illustrative purposes ONLY. This document is not an official document and may differ from your Certificate of Coverage (COC), which is your official document. Refer to your COC for your coverage and services and any obligations on your part.**

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