Westchester County Health Care Corporation - Non-Represented
Effective Date: 01-01-2011
Aetna Choice™ POS II - ASC

PLAN DESIGN & BENEFITS

PLAN FEATURES	Primary In-Network		Regional In-Network		Out of Network	
Deductible (per calendar year)	None	Individual	None	Individual	$400	Individual
	None	Family	None	Family	$800	Family

Unless otherwise indicated, the Deductible must be met prior to benefits being payable.
The Family Deductible may be met by any combination of family claims; however, a member may apply no more than $200 towards the Family Deductible. Once the Family Deductible is met, all family members will be considered as having met their deductible for the remainder of the calendar year.

	Primary In-Network		Regional In-Network		Out of Network	
Plan Coinsurance	100%		90%		80% after deductible	

Applies to all expenses unless otherwise stated.

	Primary In-Network		Regional In-Network		Out of Network	
Payment Limit (per calendar year)	None	Individual	$1,250	Individual	$2,000	Individual
	None	Family	$2,500	Family	$4,000	Family

Certain member cost sharing elements may not apply toward the Payment Limit.
Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year. There is no Individual Payment Limit to satisfy within the Family Payment Limit.

	Primary In-Network	Regional In-Network	Out of Network
Lifetime Maximum	Unlimited	Unlimited	**Unlimited**

Certification Requirements -
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 $200 per occurrence.

	Primary In-Network	Regional In-Network	Out of Network
Referral Requirement	None	None	None

PREVENTIVE CARE	Primary In-Network	Regional In-Network	Out of Network
Routine Adult Physical Exams	Covered 100%	Covered 100%	80% after deductible (up to $100 per calendar year

1 exam every 2 years for adults ages 19 to 50. Adults age 50 and older, 1 exam per calendar year.

	Primary In-Network	Regional In-Network	Out of Network
Routine Well Child Exams/Immunizations	Covered 100%	Covered 100%	Not Covered

7 exams in the first 12 months of life, 4 exams in the 13th-24th months of life; 1 exam per calendar year thereafter to age 19.

	Primary In-Network	Regional In-Network	Out of Network
Routine Gynecological Care Exams	Covered 100% (2 exams per year)	Covered 100% (1 exam per year)	Not Covered

Includes Pap smear and related lab fees;
Limited to 2 exams per calendar year in totality

	Primary In-Network	Regional In-Network	Out of Network
Routine Mammograms	Covered 100%	Covered 100%	80% after deductible

1 Baseline 35-39 and 1 exam per 12 months for covered females age 40 and over.
Covered at any age based on medical history.

Routine Digital Rectal Exam / Prostate-specific Antigen Test 1 exam per calendar year for adults age 50 and older. Covered at any age based on medical history.	Covered 100%	Covered 100%	Not Covered
Colorectal Cancer Screening For all members age 50 and over. Covered at any age based on medical history.	Covered 100%	Covered 100%	Not Covered
PHYSICIAN SERVICES	**Primary In-Network**	**Regional In-Network**	**Out of Network**
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	$10 copay	$15 copay	80% after deductible
Specialist Office Visits	$10 copay	$20 copay	80% after deductible
Allergy Testing	$10 copay	$15 copay	80% after deductible
Allergy Injections	$10 copay	$15 copay	80% after deductible
DIAGNOSTIC PROCEDURES	**Primary In-Network**	**Regional In-Network**	**Out of Network**
Diagnostic Laboratory and X-ray 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%	$15 copay	80% after deductible
EMERGENCY MEDICAL CARE	**Primary In-Network**	**Regional In-Network**	**Out of Network**
Urgent Care Provider (benefit availability may vary by location)	$10 copay	$15 copay	80% after deductible
Emergency Room Copay waived if admitted	$25 copay	$50 copay	$50 copay
Non-Emergency care in an Emergency Room	Benefits are paid Out of Network	Benefits are paid Out of Network	80% after deductible
Ambulance	Covered 100%	Covered 100%	Covered 100%
HOSPITAL CARE	**Primary In-Network**	**Regional In-Network**	**Out of Network**
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	100%	90%	80% after deductible
Inpatient Maternity Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	100%	90%	80% after deductible
Outpatient Hospital Expenses (including surgery) The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered 100%	$15 copay	80% after deductible

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MENTAL HEALTH SERVICES	Primary In-Network	Regional In-Network	Out of Network
Inpatient	100%	90%	80% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.			
Outpatient	Covered 100%	$15 copay	80% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.			

ALCOHOL/DRUG ABUSE SERVICES	Primary In-Network	Regional In-Network	Out of Network
Inpatient	100%	90%	80% after deductible
Outpatient	100%	90%	80% after deductible
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit.			

OTHER SERVICES	Primary In-Network	Regional In-Network	Out of Network
Convalescent Facility	100%	90%	80% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.			
Home Health Care	100%	90%	80% after deductible
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.			
Hospice Care - Inpatient	100%	90%	80% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay			
Hospice Care - Outpatient	100%	90%	80% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit			
Private Duty Nursing - Outpatient	100%	90%	80% after deductible
Outpatient Short-Term Rehabilitation	Covered 100%	$20 copay	80% after deductible
Includes Speech, Physical, Occupational, and Spinal Manipulation Therapy, limited to 60 visits per calendar year.			
Durable Medical Equipment	100%	90%	80% after deductible
Hearing Aid Allowance	100% (up to $150 every 36 months)	90% (up to $150 every 36 months)	80% after deductible (up to $150 every 36 months)
Diabetic Supplies	100%	$15 copay	80% after deductible
Contraceptive drugs and devices not obtainable at a pharmacy	Not Covered	Not Covered	Not Covered

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Transplants	100% In-Network coverage is provided at an IOE contracted facility only	90% In-Network coverage is provided at an IOE contracted facility only	80% after deductible Out of Network coverage is provided at a Non-IOE facility.
Mouth, Jaws and Teeth (oral surgery procedures, medical in nature only)	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
FAMILY PLANNING	**Primary In-Network**	**Regional In-Network**	**Out of Network**
Infertility Treatment - Diagnosis and treatment of the underlying medical condition	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Comprehensive Infertility Services	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Not Covered

Comprehensive Infertility Services include Artificial Insemination (limited to 6 ovulatory cycles within a 2 year period per member's lifetime) and Ovulation Induction (limited to 6 ovulatory cycles within a 2 year period per member's lifetime). Lifetime maximum applies to all procedures covered by any Aetna plan except where prohibited by law. A second course of treatment is available if a confirmed pregnancy results. To obtain coverage approval for a course of treatment, call the Infertility Unit at 1-800-575-5999.

Advanced Reproductive Technology (ART)	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Not Covered

ART services include: 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 3 courses of treatment within a 1.5 year period per members lifetime. Maximum applies to all procedures covered by any Aetna plan except where prohibited by law.
A second course of treatment is available if a confirmed pregnancy results. To obtain coverage approval for a course of treatment, call the Infertility Unit at 1-800-575-5999.

Voluntary Sterilization Including tubal ligation and vasectomy.	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
GENERAL PROVISIONS			
Dependents Eligibility	Spouse, Domestic Partner, children from birth to age 26		
Pre-existing Conditions Rule	On effective date: *Waived* After effective date: *Waived*		

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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 or rider(s) purchased by your employer.

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; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Immunizations for travel or work; Nonmedically necessary services or supplies; Orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing.

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. All 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.

Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary.

Plans are provided by Aetna Life Insurance Company.