aetna®

Carnegie Mellon University L95
Effective Date: 07-01-2024
Aetna Open Access® Aetna Select℠

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

PLAN FEATURES	IN-NETWORK
Deductible (per plan year)	None Individual None Family
Member Coinsurance	Covered 100%
Applies to all expenses unless otherwise stated.	
Out-of-pocket limit (per plan year)	$6,350 Individual $12,700 Family
Certain member cost sharing elements may not apply toward the Maximum out-of-pocket limit. Pharmacy expenses apply towards the Maximum out-of-pocket 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 Maximum out-of-pocket limit. The family Maximum out-of-pocket limit is a cumulative Maximum out-of-pocket limit for all family members. The family Maximum out-of-pocket 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 Maximum out-of-pocket limit.	
Lifetime Maximum	
Unlimited except where otherwise indicated.	
Primary Care Physician Selection	Not Required
Referral Requirement	None
PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%
1 exam every 12 months	
Routine Well Child Exams	Covered 100%
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%
Recommended: One exam per plan year. Includes routine tests and related lab fees.	
Routine Mammograms	Covered 100%
Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	
Women's Health	Covered 100%
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%
Recommended: For covered males age 40 and over. Frequency schedules may apply.	
Prostate-specific Antigen Test	Covered 100%
Recommended: For covered males age 40 and over. Frequency schedules may apply.	
Colorectal Cancer Screening	Covered 100%
Recommended: For all members age 50 and over. Frequency schedules may apply.	
Routine Eye Exams	$15 copay
1 routine exam per 12 months.	
Routine Hearing Screening	Covered 100%
PHYSICIAN SERVICES	**IN-NETWORK**
Primary Care Physician Visits	Covered 100%
Includes services of an internist, general physician, family practitioner or pediatrician.	

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Specialist Office Visits	Covered 100%
Audiometric Hearing Exam	Covered 100%
1 routine exam per 12 months to age 18	
Pre-Natal Maternity	Covered 100%
Walk-in Clinics	Covered 100%
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	Covered 100%
Allergy Injections	Covered 100%
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic X-ray	Covered 100%
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	Covered 100%
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	Covered 100%
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care Provider	Covered 100%
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	$25 copay
Copay waived if admitted	
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	Covered 100%
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK**
Inpatient Coverage	Covered 100%
Applies to all covered benefits incurred during your inpatient stay.	
Inpatient Maternity Coverage (includes delivery and postpartum care)	Covered 100%
Applies to all covered benefits incurred during your inpatient stay.	
Outpatient Hospital	Covered 100%
Applies to all covered benefits incurred during your outpatient visit.	
Outpatient Surgery - Hospital	Covered 100%
Applies to all covered benefits incurred during your outpatient visit.	
Outpatient Surgery - Freestanding Facility	Covered 100%
Applies to all covered benefits incurred during your outpatient visit.	
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient	Covered 100%
Applies to all covered benefits incurred during your inpatient stay.	
Outpatient	Covered 100%
Applies to all covered benefits incurred during your outpatient visit.	

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Partial Hospitalization	Covered 100%
Applies to all covered benefits incurred during your outpatient visit.	
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient	Covered 100%
Applies to all covered benefits incurred during your inpatient stay.	
Residential Treatment Facility	Covered 100%
Outpatient	Covered 100%
Applies to all covered benefits incurred during your outpatient visit.	
Partial Hospitalization	Covered 100%
Applies to all covered benefits incurred during your outpatient visit.	
OTHER SERVICES	**IN-NETWORK**
Skilled Nursing Facility	Covered 100%
Limited to 100 days per plan year. Applies to all covered benefits incurred during your inpatient stay.	
Home Health Care	Covered 100%
Hospice Care - Inpatient	Covered 100%
Applies to all covered benefits incurred during your inpatient stay.	
Hospice Care - Outpatient	Covered 100%
Applies to all covered benefits incurred during your outpatient visit.	
Private Duty Nursing	Covered 100%
Habilitative Services	Covered 100%
Outpatient Short-Term Rehabilitation	Covered 100%
Limited to 45 visits per plan year. Includes speech, physical, occupational therapy	
Spinal Manipulation Therapy	Covered 100%
Limited to 20 visits per plan year.	
Autism Behavioral Therapy	Covered 100%
Autism Applied Behavior Analysis	Covered 100%
Autism Physical Therapy	Covered 100%
Visits combined with Short Term Rehabilitation.	
Autism Occupational Therapy	Covered 100%
Visits combined with Short Term Rehabilitation.	
Autism Speech Therapy	Covered 100%
Visits combined with Short Term Rehabilitation.	
Durable Medical Equipment	Covered 100%
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.
Generic FDA-approved Women's Contraceptives	Covered 100%
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%
Transplants	Covered 100% Coverage is provided at an Institute of Excellence contracted facility only.
Bariatric Surgery	Not Covered
Applies to all covered benefits incurred during your inpatient stay.	
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.	

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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	$100 copay
Tubal Ligation	Covered 100%
PHARMACY	**IN-NETWORK**
Pharmacy Plan Type	Advanced Control Formulary
Preferred Generic Drugs	
Retail	$5 copay
Mail Order	$5 copay
Preferred Brand-Name Drugs	
Retail	$5 copay
Mail Order	$5 copay
Non - Preferred Brand & Generic Drugs	
Retail	Member pays 100%
Mail Order	Member pays 100%
Retail Out-of-Network Coverage	Not Covered
Value Specialty Drugs	
Preferred Specialty	$5 copay
Non-Preferred Specialty	Not Covered
Pharmacy Day Supply and Requirements	
Retail	Up to a 30 day supply
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.
Value Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. All prescription fills must be through our preferred Aetna Specialty Pharmacy network.

Choose Generics - If the member or the physician requests brand-name when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
A limited list of over-the-counter medications are covered when filled with a prescription.
Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).
Advanced Control
-Precertification included
Advanced Control
-Step Therapy included
One transition fill allowed within 90 days of member's effective date
Formulary generic FDA - approved Women's Contraceptives covered 100% in network.

GENERAL PROVISIONS

Dependents Eligibility - Spouse, children from birth to age 26 regardless of student status.

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.

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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.

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.

Translation of the material into another language may be available. Please call Member Services at **1-800-835-8742**

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-800-835-8742**

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Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **www.aetna.com.**