



President and Trustees of Bates College
 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 |
|---|--------------------------------------|--------------------------------------|
| Benefit Limitations - 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. | | |
| Deductible (per calendar year) | \$2,800 Individual \$5,600 Family | \$2,800 Individual \$5,600 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. Pharmacy expenses apply towards 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. | | |
| Member Coinsurance | 20% | 40% |
| Applies to all expenses unless otherwise stated. | | |
| Payment Limit (per calendar year) | \$3,500 Individual \$7,000 Family | \$3,500 Individual \$7,000 Family |
| All covered expenses accumulate simultaneously toward both 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. 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. | | |
| Lifetime Maximum Unlimited except where otherwise indicated. | | |
| Primary Care Physician Selection | Optional | Not Applicable |
| 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 \$400 per occurrence. | | |
| Referral Requirement | None | None |
| PREVENTIVE CARE | IN-NETWORK | OUT-OF-NETWORK |
| Routine Adult Physical Exams/Immunizations 1 exam per year up to age 65, 1 exam per year age 65 and older | Covered 100%; deductible waived | 20%; after deductible |
| Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13-24 months, 3 exams 25-36 months, 1 exam per year thereafter to age 22. | Covered 100%; deductible waived | 20%; after deductible |
| Routine Gynecological Care Exams 1 exam and pap smear per year, includes related fees. | Covered 100%; deductible waived | 20%; after deductible |
| Routine Mammograms | Covered 100%; deductible waived | 20%; after deductible |
| Women's Health 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 | 20%; after deductible |



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| Routine Digital Rectal Exam Recommended: For covered males age 40 and over. | Covered 100%; deductible waived | 20%; after deductible |
| Prostate-specific Antigen Test Recommended: For covered males age 40 and over. | Covered 100%; deductible waived | 20%; after deductible |
| Colorectal Cancer Screening Recommended: For all members age 45 and over. | Covered 100%; deductible waived | Covered under Routine Adult Exams |
| Routine Eye Exams 1 routine exam per year. | Covered 100%; deductible waived | 20%; after deductible |
| Routine Hearing Screening | Covered 100%; deductible waived | 20%; after deductible |
| PHYSICIAN SERVICES | IN-NETWORK | OUT-OF-NETWORK |
| Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician. | 20%; after deductible | 40%; after deductible |
| Specialist Office Visits | 20%; after deductible | 40%; after deductible |
| Hearing Exams 1 routine exam per 24 months. | Covered 100%; deductible waived | 40%; after deductible |
| Pre-Natal Maternity | Covered 100%; deductible waived | 40%; after deductible |
| Walk-in Clinics 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. | 20%; after deductible | 40%; after deductible |
| Allergy Testing | 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 |
| Allergy Injections | 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 |
| DIAGNOSTIC PROCEDURES | IN-NETWORK | OUT-OF-NETWORK |
| Diagnostic X-ray (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. | 20%; after deductible | 40%; after deductible |
| Diagnostic Laboratory 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. | 20%; after deductible | 40%; after deductible |
| Diagnostic Complex Imaging 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. | 20%; after deductible | 40%; after deductible |
| EMERGENCY MEDICAL CARE | IN-NETWORK | OUT-OF-NETWORK |
| Urgent Care Provider | 20%; after deductible | 40%; after deductible |
| Non-Urgent Use of Urgent Care Provider | Not Covered | Not Covered |
| Emergency Room | 20%; after deductible | Same as in-network care |
| Non-Emergency Care in an Emergency Room | Not Covered | Not Covered |
| Emergency Use of Ambulance | 20%; after deductible | Same as in-network care |
| Non-Emergency Use of Ambulance | 20%; after deductible | 20%; after deductible |



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| HOSPITAL CARE | IN-NETWORK | OUT-OF-NETWORK |
|--|--------------------------------|-----------------------|
| Inpatient Coverage Your cost sharing applies to all covered benefits incurred during your inpatient stay. | 20%; after deductible | 40%; after deductible |
| Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay. | 20%; after deductible | 40%; after deductible |
| Outpatient Hospital Expenses Your cost sharing applies to all covered benefits incurred during your outpatient visit. | 20%; after deductible | 40%; after deductible |
| Outpatient Surgery - Hospital Your cost sharing applies to all covered benefits incurred during your outpatient visit. | 20%; after deductible | 40%; after deductible |
| Outpatient Surgery - Freestanding Facility Your cost sharing applies to all covered benefits incurred during your outpatient visit. | 20%; after deductible | 40%; after deductible |
| MENTAL HEALTH SERVICES | IN-NETWORK | OUT-OF-NETWORK |
| Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay. | 20%; after deductible | 40%; after deductible |
| Mental Health Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit. | 20%; after deductible | 40%; after deductible |
| Other Mental Health Services | Covered 100%; after deductible | 40%; after deductible |
| SUBSTANCE ABUSE | IN-NETWORK | OUT-OF-NETWORK |
| Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay. | 20%; after deductible | 40%; after deductible |
| Residential Treatment Facility | 20%; after deductible | 40%; after deductible |
| Substance Abuse Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit. | 20%; after deductible | 40%; after deductible |
| Other Substance Abuse Services | Covered 100%; after deductible | 40%; after deductible |
| OTHER SERVICES | IN-NETWORK | OUT-OF-NETWORK |
| Skilled Nursing Facility Limited to 100 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay. | 20%; after deductible | 40%; after deductible |
| Home Health Care Limited to 120 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. | 20%; after deductible | 40%; after deductible |
| Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay. | 20%; after deductible | 40%; after deductible |
| Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit. | 20%; after deductible | 40%; after deductible |
| Private Duty Nursing | Not Covered | Not Covered |
| Spinal Manipulation Therapy | 20%; after deductible | 40%; after deductible |
| Outpatient Rehabilitative Speech Therapy | 20%; after deductible | 40%; after deductible |
| Outpatient Physical and Occupational Therapy | 20%; after deductible | 40%; after deductible |
| Acupuncture Limited to 20 visits per year. | 20%; after deductible | 40%; after deductible |



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| 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 | Refer to MBH Outpatient Mental Health All Other | Refer to MBH Outpatient Mental Health All Other |
| Habilitative Occupational Therapy | Refer to MBH Outpatient Mental Health All Other | Refer to MBH Outpatient Mental Health All Other |
| Habilitative Speech Therapy | Refer to MBH Outpatient Mental Health All Other | Refer to MBH Outpatient Mental Health All Other |
| Autism Behavioral Therapy | Refer to MBH Outpatient Mental Health | Refer to MBH Outpatient Mental Health |
| Combined with outpatient mental health visits | | |
| Autism Applied Behavior Analysis | 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 | | |
| Autism Physical Therapy | Refer to MBH Outpatient Mental Health All Other | Refer to MBH Outpatient Mental Health All Other |
| Autism Occupational Therapy | Refer to MBH Outpatient Mental Health All Other | Refer to MBH Outpatient Mental Health All Other |
| Autism Speech Therapy | Refer to MBH Outpatient Mental Health All Other | Refer to MBH Outpatient Mental Health All Other |
| Hearing Aids | Covered 100%; after deductible | Covered 100%; after deductible |
| 1 hearing aid to a maximum of \$3,000 per ear every 36 months | | |
| Durable Medical Equipment | 20%; after deductible | 40%; after deductible |
| Prosthetics | Covered 100%; deductible waived | 40%; after deductible |
| Diabetic Supplies -- (if not covered under Pharmacy benefit) | Covered same as any other medical expense. | Covered same as any other medical expense. |
| Affordable Care Act mandated Women's Contraceptives | Covered 100%; deductible waived | Covered same as any other expense. |
| Women's Contraceptive drugs and devices not obtainable at a pharmacy | Covered 100%; deductible waived | Covered same as any other medical expense. |
| Infusion Therapy | 20%; after deductible | 40%; after deductible |
| Administered in the home or physician's office | | |
| Infusion Therapy | 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 |
| Administered in an outpatient hospital department or freestanding facility | | |
| Vision Eyewear | Not Covered | Not Covered |
| Transplants | 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. |
| Bariatric Surgery | 20%; after deductible | 40%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |



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| FAMILY PLANNING | | IN-NETWORK | OUT-OF-NETWORK |
|---|-------------------|--|---|
| Infertility Treatment | | 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. | | | |
| Comprehensive Infertility Services | | 20%; after deductible | 40%; after deductible |
| Artificial insemination and ovulation induction | | | |
| Advanced Reproductive Technology (ART) | | 20%; after deductible | 40%; after deductible |
| 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. | | | |
| Vasectomy | | Your cost sharing is based on the type of service and where it is performed | 40%; after deductible |
| Tubal Ligation | | Covered 100%; deductible waived | 40%; after deductible |
| PHARMACY | | IN-NETWORK | OUT-OF-NETWORK |
| The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan. | | | |
| Pharmacy Plan Type | | Aetna Standard Open Formulary | |
| Generic Drugs | | | |
| | Retail | Covered 100% | 20% of submitted cost; after applicable copay |
| | Mail Order | Covered 100% | Not Applicable |
| Preferred Brand-Name Drugs | | | |
| | Retail | Covered 100% | 20% of submitted cost; after applicable copay |
| | Mail Order | Covered 100% | Not Applicable |
| Non-Preferred Brand-Name Drugs | | | |
| | Retail | Covered 100% | 20% of submitted cost; after applicable copay |
| | Mail Order | Covered 100% | Not Applicable |
| Pharmacy Day Supply and Requirements | | | |
| | Retail | Up to a 90 day supply from Aetna National Network Percentage copays will not be doubled | |
| Mandatory Maintenance Choice | | After two retail fills, members are required to fill a 90-day supply of maintenance drugs at CVS Caremark® Mail Service Pharmacy or at a CVS Pharmacy. Otherwise, the member will be responsible for 100 percent of the cost-share. | |
| | Opt Out | The member must notify us of whether they want to continue to fill at a network retail pharmacy by calling the number on the member ID card. All prescription fills must be through our preferred specialty pharmacy network. Aetna Specialty Performance Network Drug List | |
| Preventive Medications - Deductible is waived for certain preventive medications. A full list of these drugs is available on your secure member site or from your employer. | | | |



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Plan Includes: Diabetic supplies, blood glucose monitors, prescription weight loss drugs and contraceptive drugs and devices obtainable from a pharmacy.

Includes sexual dysfunction drugs for females and males, including daily dose, additional 30 tablets a month for males for erectile dysfunction.

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

Preferred and Generic Oral chemotherapy drugs covered 100%

Standard Pre-certification for Specialty Drugs included

Step Therapy included

Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

GENERAL PROVISIONS

Dependents Eligibility 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.



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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.

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**.

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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