



The Juilliard School
 Effective Date: 01-01-2023
 Open Access® Managed Choice® POS - New York
 Qualified High Deductible Health Plan

**PLAN DESIGN & BENEFITS
 PROVIDED BY AETNA LIFE INSURANCE COMPANY**

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)	\$1,750 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 for the remainder of the contract year. There is no Individual Deductible to satisfy within the Family Deductible.		
Member Coinsurance	20%	30%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	\$3,000 Individual \$6,000 Family	\$6,000 Individual \$12,000 Family
All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses apply towards the 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. 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.		
Lifetime Maximum Unlimited except where otherwise indicated.		
Payment for Out-of-Network Care**	Not Applicable	Professional: 140% of Medicare Facility: 140% of Medicare
*We cover the cost of care differently based on whether health care providers, such as doctors and hospitals, are "in network" or "out of network." We want to help you understand how much Aetna pays 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. As an example, you may choose a doctor in our network. You may choose to visit an out-of-network doctor. If you choose a doctor who is out of network, your Aetna 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, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount. This amount is based on "reasonable" or "prevailing" charges. We get this data from an external database. Exactly how much Aetna "recognizes" depends on the plan you or your employer picks. Your out-of-network doctor sets the rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna plan "recognizes" or "allows." Your doctor may bill you for the dollar amount that Aetna doesn'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 maximum out-of-pocket. To learn more about how we pay out-of-network benefits visit Aetna.com. Type "how Aetna pays" in the search box. 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 Aetna Navigator member site. 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, coinsurance and deductibles for your in-network level of benefits. Contact Aetna 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, coinsurance and deductibles.		
Primary Care Physician Selection	Optional	Not Applicable



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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 or 50% of the scheduled benefit amount per occurrence, whichever is less.		
Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	30%; after deductible
1 exam per year up to age 65, 1 exam per year age 65 and older		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	Covered 100%; deductible waived
7 exams first 12 months, 3 exams 13-24 months, 3 exams 25-36 months, 1 exam per year thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	30%; after deductible
2 obgyn exams and pap smears per year		
Routine Mammograms	Covered 100%; deductible waived	30%; after deductible
Women's Health	Covered 100%; deductible waived	30%; 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. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		
Routine Digital Rectal Exam	Covered 100%; deductible waived	30%; after deductible
Prostate-specific Antigen Test	Covered 100%; deductible waived	30%; after deductible
Colorectal Cancer Screening	Covered 100%; deductible waived	30%; after deductible
Recommended: For all members age 45 and over.		
Routine Eye Exams	Covered 100%; deductible waived	30%; after deductible
1 routine exam per 24 months.		
Routine Hearing Screening	Covered 100%; deductible waived	30%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to Primary Care Physician (PCP)	20%; after deductible	30%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	20%; after deductible	30%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	15%; after deductible
Walk-in Clinics	20%; after deductible	30%; 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.		
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



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DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic 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.	20%; after deductible	30%; 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	30%; after deductible
Diagnostic Outpatient 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	30%; after deductible
EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Provider	20%; after deductible	30%; 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	Not Covered	Not Covered
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	30%; 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	30%; after deductible
Outpatient Hospital Expenses Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	30%; after deductible
Outpatient Surgery - Hospital Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	30%; after deductible
Outpatient Surgery - Freestanding Facility Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	30%; 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	30%; after deductible
Mental Health Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	30%; after deductible
Crisis Intervention Services	20%; after deductible	30%; after deductible
Other Mental Health Services	20%; after deductible	30%; 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	30%; after deductible
Residential Treatment Facility	20%; after deductible	30%; after deductible
Substance Abuse Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	30%; after deductible
Other Substance Abuse Services	20%; after deductible	30%; after deductible



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OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility Limited to 60 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible	30%; after deductible
Home Health Care Limited to 40 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	25%; after deductible
Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible	30%; after deductible
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	30%; after deductible
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	20%; after deductible	30%; after deductible
Outpatient Short-Term Rehabilitation Limited to 60 visits per year. Unlimited for Early Intervention Services from birth to age 3. Includes speech, physical, occupational therapy	20%; after deductible	30%; after deductible
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 Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
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 Limited to:1 hearing aid per ear every 3 years	Covered 100%; after deductible	30%; after deductible
Durable Medical Equipment	20%; after deductible	30%; after deductible
Diabetic Supplies	Covered same as any other expense.	Covered same as any other expense.
Fertility Drugs (oral and injectable) Physician charges included (oral and injectable fertility drugs obtained at a pharmacy are covered under the Rx plan).	20%; after deductible	30%; after deductible
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.



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Infusion Therapy Administered in the home or physician's office	20%; after deductible	30%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	20%; after deductible	30%; after deductible
Vision Eyewear	Not Covered	Not Covered
Transplants	20%; after deductible Preferred coverage is provided at an IOE contracted facility only.	30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible	30%; after deductible
Acupuncture Limited to 10 visits per year	20%; after deductible	30%; after deductible
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	
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	30%; after deductible
Coverage includes artificial insemination and ovulation. Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law.		
Advanced Reproductive Technology (ART)	20%; after deductible	30%; after deductible
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 cryopreservation, unlimited storage. Limited to 3 courses of treatment per member's lifetime. Maximum applies to all procedures covered by any of our plans except where prohibited by law. Coverage includes cryopreservation, storage and for iatrogenic only unlimited storage and cryopreservation.		
Vasectomy	Your cost sharing is based on the type of service and where it is performed	30%; after deductible
Tubal Ligation	Covered 100%; deductible waived	30%; after deductible
Voluntary Abortion	Covered 100%; after deductible	30%; after deductible



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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	Advanced Control Plan - Aetna	
Preferred Generic Drugs		
	Retail \$10 copay	30% of submitted cost; after applicable in-network cost share
	Mail Order \$25 copay	Not Applicable
Preferred Brand-Name Drugs		
	Retail \$25 copay	30% of submitted cost; after applicable in-network cost share
	Mail Order \$62.50 copay	Not Applicable
Non-Preferred Generic and Brand-Name Drugs		
	Retail \$50 copay	30% of submitted cost; after applicable in-network cost share
	Mail Order \$125 copay	Not Applicable
Pharmacy Day Supply and Requirements		
	Retail Up to a 30 day supply from Aetna National Network	
	Mail Order A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
	First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.	
	Advanced Control Formulary Aetna Insured List	

Choose Generics with Dispense as Written (DAW) override - The member pays the applicable copay only, if the physician requires brand-name. If the member requests brand-name when a 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 medication covered at PCP cost sharing and Contraceptive drugs and devices obtainable from a pharmacy.

\$100 copay maximum per fill per 30-day supply of insulin drugs; deductible waived for insulin drugs

Contraceptives covered up to a 12 month supply. Contraceptive copay strategy applies.

A limited list of over-the-counter medications are covered when filled with a prescription.

Includes sexual dysfunction drugs for females and males, including daily dose, additional 6 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).

Oral chemotherapy drugs covered 100%

Precertification and quantity limits included

Advanced Control Formulary Aetna Insured Step Therapy

Seasonal Vaccinations covered 100% in-network

Preventive Vaccinations covered 100% in-network

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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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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If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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 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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