



THE J. PAUL GETTY TRUST  
 Effective Date: 01-01-2023  
 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
<b>Benefit Limitations</b> - 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.		
<b>Deductible</b> (per calendar year)	\$1,500 Individual \$3,000 Family	\$1,700 Individual \$3,400 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. There is no Individual Deductible to satisfy within the Family Deductible.		
<b>Member Coinsurance</b>	10%	30%
Applies to all expenses unless otherwise stated.		
<b>Payment Limit</b> (per calendar year)	\$3,300 Individual \$6,850 Family	\$4,300 Individual \$11,800 Family
All covered expenses accumulate separately toward the in-network or 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. 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.		
<b>Lifetime Maximum</b> Unlimited except where otherwise indicated.		
<b>Primary Care Physician Selection</b>	Optional	Not Applicable
<b>Certification Requirements</b> - 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.		
<b>Referral Requirement</b>	None	None
<b>Telemedicine Consultations</b> - Covered services for telemedicine consultations are available from a number of different kinds of providers under your plan. Log onto your secure Aetna website at <a href="https://www.aetna.com/">https://www.aetna.com/</a> to review our telemedicine provider listings and get more information about your options, including specific cost sharing amounts.		
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
<b>Routine Adult Physical Exams/ Immunizations</b> 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%; deductible waived	30%; after deductible
<b>Routine Well Child Exams/Immunizations</b> 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%; deductible waived	30%; after deductible
<b>Routine Gynecological Care Exams</b> 1 exam and pap smear per year, includes related fees.	Covered 100%; deductible waived	30%; after deductible
<b>Routine Mammograms</b>	Covered 100%; deductible waived	30%; after deductible



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<b>Women's Health</b>	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.		
<b>Routine Digital Rectal Exam</b>	Covered 100%; deductible waived	30%; after deductible
Recommended: For covered males age 40 and over.		
<b>Prostate-specific Antigen Test</b>	Covered 100%; deductible waived	30%; after deductible
Recommended: For covered males age 40 and over.		
<b>Colorectal Cancer Screening</b>	Covered 100%; deductible waived	30%; after deductible
Recommended: For all members age 45 and over.		
<b>Routine Eye Exams</b>	Covered 100%; deductible waived	Not Covered
1 routine exam per 24 months.		
<b>Routine Hearing Screening</b>	Covered 100%; deductible waived	30%; after deductible
<b>PHYSICIAN SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Office Visits to Primary Care Physician (PCP)</b>	10%; after deductible	30%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
<b>Telemedicine Consultation with Non-Specialist</b>	10%; after deductible	30%; after deductible
<b>Specialist Office Visits</b>	10%; after deductible	30%; after deductible
<b>Telemedicine Consultation with Specialist</b>	10%; after deductible	30%; after deductible
<b>Hearing Exams</b>	Covered 100%; deductible waived	30%; after deductible
1 routine exam per 24 months.		
<b>Pre-Natal Maternity</b>	Covered 100%; deductible waived	30%; after deductible
<b>Walk-in Clinics</b>	10%; after deductible	30%; after deductible
	<b>Designated Walk-in Clinics</b>	Covered 100%; 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.		
<b>Telemedicine Consultations for Non-Emergency Services through a Walk-in Clinic</b>	Your cost sharing is based on the type of service and where it is performed	30%; after deductible
	<b>Designated Walk-in Clinics</b>	Covered 100%; after deductible
If telemedicine preventive screening and counseling services are provided through a walk-in clinic, these services are paid under the preventive care benefit.		
<b>Allergy Testing</b>	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
<b>Allergy Injections</b>	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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<b>DIAGNOSTIC PROCEDURES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Diagnostic X-ray</b> (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.	10%; after deductible	30%; after deductible
<b>Diagnostic Laboratory</b> 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.	10%; after deductible	30%; after deductible
<b>Diagnostic Complex Imaging</b> 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.	10%; after deductible	30%; after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Urgent Care Provider</b>	10%; after deductible	30%; after deductible
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered	Not Covered
<b>Emergency Room</b>	10%; after deductible	Same as in-network care
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered	Not Covered
<b>Emergency Use of Ambulance</b>	10%; after deductible	Same as in-network care
<b>Non-Emergency Use of Ambulance</b>	10%; after deductible	10%; after deductible
<b>HOSPITAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient Coverage</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	30%; after deductible
<b>Inpatient Maternity Coverage</b> (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	30%; after deductible
<b>Outpatient Hospital Expenses</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	30%; after deductible
<b>Outpatient Surgery - Hospital</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	30%; after deductible
<b>Outpatient Surgery - Freestanding Facility</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	30%; after deductible
<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	30%; after deductible
<b>Mental Health Office Visits</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	30%; after deductible
<b>Mental Health Telemedicine Consultations</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	30%; after deductible
<b>Other Mental Health Services</b>	10%; after deductible	30%; after deductible



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<b>SUBSTANCE ABUSE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	30%; after deductible
<b>Residential Treatment Facility</b>	10%; after deductible	30%; after deductible
<b>Substance Abuse Office Visits</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	30%; after deductible
<b>Substance Abuse Telemedicine Consultations</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	30%; after deductible
<b>Other Substance Abuse Services</b>	10%; after deductible	30%; after deductible
<b>OTHER SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Skilled Nursing Facility</b> Limited to 120 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	30%; after deductible
<b>Home Health Care</b> Limited to 120 visits per year. Private Duty Nursing not included. Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	10%; after deductible	30%; after deductible
<b>Hospice Care - Inpatient</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	30%; after deductible
<b>Hospice Care - Outpatient</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	30%; after deductible
<b>Private Duty Nursing</b> Limited to 70 eight hour shifts per year. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.	10%; after deductible	30%; after deductible
<b>Outpatient Rehabilitative Speech Therapy</b>	10%; after deductible	30%; after deductible
<b>Outpatient Physical and Occupational Therapy</b> Includes Physical, Occupational and Spinal Manipulation Therapy; limited to 90 visits per year combined.	10%; after deductible	30%; after deductible
<b>Habilitative Physical Therapy</b>	10%; after deductible	30%; after deductible
<b>Habilitative Occupational Therapy</b>	10%; after deductible	30%; after deductible
<b>Habilitative Speech Therapy</b>	10%; after deductible	30%; after deductible
<b>Autism Behavioral Therapy</b> Combined with outpatient mental health visits	10%; after deductible	30%; after deductible
<b>Autism Applied Behavior Analysis</b> Covered same as any other Outpatient Mental Health All Other benefit	10%; after deductible	30%; after deductible
<b>Autism Physical Therapy</b>	10%; after deductible	30%; after deductible
<b>Autism Occupational Therapy</b>	10%; after deductible	30%; after deductible
<b>Autism Speech Therapy</b>	10%; after deductible	30%; after deductible
<b>Durable Medical Equipment</b>	10%; after deductible	30%; after deductible
<b>Diabetic Supplies -- (if not covered under Pharmacy benefit)</b>	Covered same as any other medical expense.	Covered same as any other medical expense.
<b>Affordable Care Act mandated Women's Contraceptives</b>	Covered 100%; deductible waived	Covered same as any other expense.
<b>Women's Contraceptive drugs and devices not obtainable at a pharmacy</b>	Covered 100%; deductible waived	Covered same as any other medical expense.



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<b>Infusion Therapy</b> Administered in the home or physician's office	10%; after deductible	30%; after deductible
<b>Infusion Therapy</b> Administered in an outpatient hospital department or freestanding facility	10%; after deductible	30%; after deductible
<b>Acupuncture</b>	10%; after deductible	30%; after deductible
<b>Gene-based, Cellular, and other Innovative Therapies™ (GCIT)</b>	Your cost sharing is based on the type of service and where it is performed 10%: after deductible for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.	Not Covered
<b>Vision Eyewear</b>	Not Covered	Not Covered
<b>Transplants</b>	10%; after deductible Preferred coverage is provided at an IOE contracted facility only.	30%; after deductible Non-Preferred coverage is provided at an Non-IOE contracted facility only.
<b>Bariatric Surgery</b> Limited to \$10,000 per lifetime Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	Not Covered
<b>FAMILY PLANNING</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Infertility Treatment</b>	Your cost sharing is based on the type of service and where it is performed Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed
<b>Comprehensive Infertility Services</b> Artificial insemination and ovulation induction	Not Covered	Not Covered
<b>Advanced Reproductive Technology (ART)</b> In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered	Not Covered
<b>Vasectomy</b>	Your cost sharing is based on the type of service and where it is performed	30%; after deductible
<b>Tubal Ligation</b>	Covered 100%; deductible waived	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.		
<b>Pharmacy Plan Type</b>	Aetna Standard Plan opt out	
<b>Generic Drugs</b>		
	<b>Retail</b> \$15 copay	30% of submitted cost; after applicable in-network cost share
	<b>Mail Order</b> \$30 copay	Not Applicable
<b>Preferred Brand-Name Drugs</b>		
	<b>Retail</b> \$35 copay	30% of submitted cost; after applicable in-network cost share
	<b>Mail Order</b> \$70 copay	Not Applicable
<b>Non-Preferred Brand-Name Drugs</b>		
	<b>Retail</b> \$50 copay	30% of submitted cost; after applicable in-network cost share
	<b>Mail Order</b> \$100 copay	Not Applicable
<b>Pharmacy Day Supply and Requirements</b>		
	<b>Retail</b>	Up to a 30 day supply from Aetna National Network
<b>Voluntary Maintenance Choice</b>	<b>Mail Order</b>	No refill restrictions or penalties apply. Members save when they fill a 90-day supply of maintenance drugs at CVS Caremark® Mail Service Pharmacy or at a CVS Pharmacy.
	<b>Specialty</b>	Up to a 30 day supply All prescription fills must be through our preferred specialty pharmacy network. Aetna Specialty Performance Network Drug List
<b>Preventive Medications</b> - Deductible is waived for certain preventive medications. A full list of these drugs is available on your secure member site or from your employer.		
<b>Choose Generics with Dispense as Written (DAW) override</b> - The member pays the applicable copay. If the physician requires brand-name, member would pay brand-name copay. 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.		
<b>Plan Includes:</b> Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. Includes sexual dysfunction drugs for females and males, including daily dose, additional 6 tablets a month for males for erectile dysfunction. Oral fertility drugs included. Precertification for specialty drugs included 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		
<b>Dependents Eligibility</b>	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.



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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.

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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