The Orthodox HealthPlan

The Orthodox Healthplan
Health Reimbursement (HRA) Plan
Effective Date: 05/01/2022
Aetna HealthFund™ Open Access® Managed Choice® POS

FUND FEATURES		
HealthFund Amount Amount contributed to the Fund by the employer Fund amount reflected is on a per year basis. The fund received may be prorated based on your effective date of coverage. The Family HealthFund amount applies to all family members combined. There is no Individual HealthFund limit within the Family HealthFund amount.	$850 Employee $1,600 Family	
Fund Coinsurance Percentage at which the Fund will reimburse	100%	
Fund Administration	The Fund will be used to pay for your member responsibility, including your deductible and coinsurance. Once the deductible is met, the underlying medical plan provides coverage and if a Fund balance still exists, the Fund will pay your member responsibility (i.e. your share of coinsurance) until the Out of Pocket Maximum has been reached or the Fund has been exhausted, whichever comes first. Services covered at 100% with no deductible will be paid by the plan and not by the Fund.	
Employee Termination from Your HealthFund	Any remaining HealthFund benefit amount is forfeited (or terminated) when the employee's HealthFund coverage terminates.	
Fund Rollover	Any remaining HealthFund benefit amount at end of the year is rolled over into next year's HealthFund benefit amount.	
Eligible Fund Expenses	Fund covers same expenses as the medical plan. Expenses above the Reasonable & Customary limit, any plan limits, and any non covered expenses are not eligible for reimbursement under the Fund.	
Fund Payment/Assignment	Network Providers: Automatic Assignment to provider. Non-Network Providers: Member may assign payment to provider.	
Pro-ration for New Employees	Monthly	
Pro-ration for Family Status Change	No pro-ration. Change to new tier based on new employee status.	
Prescription Drug Plan	Prescription Drug expenses are integrated with the medical Out-of-Pocket Limit (i.e. expenses are applied towards the medical out-of-pocket maximum but not the medical deductible) and are not integrated with the Fund (i.e., not eligible for reimbursement from the Fund).	
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) 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 do not 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.	$3,000 Individual $6,000 Family	$10,000 Individual $20,000 Family
Member Coinsurance Applies to all expenses unless otherwise stated.	10%	40%
Payment Limit (per calendar year) All covered expenses accumulate simultaneously toward both the in-network and out-of-network Payment Limit.	$5,000 Individual $10,000 Family	$15,000 Individual $30,000 Family

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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.
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.		
Payment for Out-of-Network Care**	Not Applicable	Professional: 300% of Medicare Facility: 300% of Medicare
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 $200 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	40%; after deductible
1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	40%; after deductible
7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	40%; after deductible
1 obgyn exam and pap smear per year		
Routine Mammograms	Covered 100%; deductible waived	40%; after deductible
Women's Health	Covered 100%; deductible waived	40%; 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	40%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	40%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	40%; after deductible
Recommended: For all members age 45 and over.		
Routine Eye Exams	Covered 100%; deductible waived	40%; after deductible
1 routine exam per 12 months.		
Routine Hearing Screening	Covered 100%; deductible waived	40%; after deductible

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PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to Primary Care Physician (PCP)	10%; after deductible	40%; after deductible
Specialist Office Visits Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.	10%; after deductible	40%; after deductible
Hearing Exams 1 routine exam per 24 months.	10%; deductible waived	40%; after deductible
Pre-Natal Maternity	Covered 100%; deductible waived	40%; after deductible
Walk-in Clinics	Covered 100%; after deductible **Designated Walk-in Clinics** Covered 100%; deductible waived	40%; 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
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	Covered 100%; after deductible	40%; after deductible
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%; after deductible	40%; after deductible
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 Outpatient Complex Imaging	Covered 100%; after deductible	40%; after deductible

EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Provider	10%; after deductible	40%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	10%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	10%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered

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HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	10%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	10%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	10%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	10%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	10%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	10%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	10%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%; deductible waived	40%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	10%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	10%; after deductible	40%; after deductible
Substance Abuse Office Visits	10%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%; deductible waived	40%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	10%; after deductible	40%; after deductible
Limited to 90 days per year		
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	10%; deductible waived	25%; deductible waived
Limited to 120 visits per year		
Home health care services include private duty nursing		
Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.		
Hospice Care - Inpatient	10%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	10%; after deductible	25%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing - Outpatient	Covered as part of Home Health Care	Covered as part of Home Health Care
Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.		
Spinal Manipulation Therapy	10%; after deductible	40%; after deductible
Outpatient Speech Therapy	10%; after deductible	40%; after deductible
Limited to 30 visits per year		
Outpatient Physical and Occupational Therapy	10%; after deductible	40%; after deductible
Limited to 60 visits per year combined.		
Habilitative Physical Therapy	10%; after deductible	40%; after deductible

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Habilitative Occupational Therapy	10%; after deductible	40%; after deductible
Habilitative Speech Therapy	10%; after deductible	40%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	10%; after deductible	40%; after deductible
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Covered 100%; deductible waived	40%; after deductible
Autism Physical Therapy	100%; after deductible	40%; after deductible
Autism Occupational Therapy	100%; after deductible	40%; after deductible
Autism Speech Therapy	100%; after deductible	40%; after deductible
Early Intervention Services	Child from birth to age 6, covered at 100%, after deductible, no copay	Child from birth to age 6, covered at 100%, after deductible, no copay
Hearing Aids Limited to:1 hearing aid per ear every 24 months	10%; after deductible	40%; after deductible
Durable Medical Equipment	10%; after deductible	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.
Prosthetics	10%; after deductible	40%; 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.
Infusion Therapy Administered in the home or physician's office	10%; after deductible	40%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	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
Vision Eyewear	Not Covered	Not Covered
Transplants	10%; 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 Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	40%; after deductible
Acupuncture Limited to 10 visits per year	10%; after deductible	40%; 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 Diagnosis and treatment of the underlying medical condition only.	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
Comprehensive Infertility Services	10%; after deductible	40%; after deductible

Coverage includes Artificial Insemination, limited to 3 courses per lifetime, and Ovulation Induction, limited to 4 courses per lifetime. Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law.

Advanced Reproductive Technology (ART)	10%; after deductible	40%; 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. Limited to 2 courses of treatment per member's lifetime. Maximum applies to all procedures covered by any of our plans except where prohibited by law.		
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**
Pharmacy Plan Type	Standard Opt Out Plan with ACSF Plan - Aetna	
Generic Drugs		
Retail	$10 copay	40% of submitted cost; after applicable in-network cost share
Mail Order	$20 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$40 copay	40% of submitted cost; after applicable in-network cost share
Mail Order	$80 copay	Not Applicable
Non-Preferred Brand-Name Drugs		
Retail	$70 copay	40% of submitted cost; after applicable in-network cost share
Mail Order	$140 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	
Specialty	Up to a 30 day supply Standard Opt Out 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 Contraceptive drugs and devices obtainable from a pharmacy. 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 for specialty drugs included Step Therapy 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		
Dependents Eligibility	Spouse, children from birth, regardless of student status. Dependent children terminate coverage effective on the plan sponsor renewal date following the date they reach the limiting age. Limiting age can be any qualifying age up to age 26.	

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay 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.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don'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 out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

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.

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 traduccion 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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