aetna®

Wabtec Corporation
Effective Date: 01-01-2018
Aetna Open Access® Aetna Select℠

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

PLAN FEATURES	IN-NETWORK
Deductible (per calendar year)	$750 Individual
Member Coinsurance	30% after deductible
Payment Limit (per calendar year)	$2,500 Individual $6,600 Family Per calendar year, each family member. Once met, plan pays 100% coinsurance (excluding applicable copays) for the rest of the calendar year benefit period.
Total Max Out of Pocket	$4,600 Individual $9,200 Family Includes medical deductible, coinsurance and copays. Once met, the plan pays 100% of covered services for the rest of the calendar year benefit period.
PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived
1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	
Routine Well Child Exams	Covered 100%; deductible waived
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 18.	
Routine Gynecological Care Exams	Covered 100%; deductible waived
Recommended: One exam per calendar year. Includes routine tests and related lab fees.	
Routine Mammograms	Covered 100%; deductible waived
Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	
Women's Health	Covered 100%; deductible waived
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
Recommended: For covered males age 40 and over.	
Prostate-specific Antigen Test	Not Covered
Colorectal Cancer Screening	Covered 100%; deductible waived
Recommended: For all members age 50 and over.	
PHYSICIAN SERVICES	**IN-NETWORK**
Primary Care Physician Visits	$25 copay; deductible waived
Specialist Office Visits	$35 copay; deductible waived
Pre-Natal Maternity	Covered 100%; deductible waived
Walk-in/Retail Clinics	$35 copay; deductible waived
Allergy Extracts and Injections	30% after deductible
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic X-ray	30% 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.	
	Additional $100 Copay
If performed at a facility/hospital based imaging Center for non-emergent/non-inpatient	

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Diagnostic Laboratory	30% 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.	
	Additional $40 Copay
If performed at a facility/hospital based labs for non-emergent/non-inpatient	
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care Provider	$35 copay; deductible waived
Emergency Room Copay waived if admitted	30% after $200 copay; deductible waived
Emergency Use of Ambulance	30% after deductible
HOSPITAL CARE	**IN-NETWORK**
Inpatient Coverage	30%; after deductible
Inpatient Maternity Coverage	30%; after deductible
Outpatient Hospital	30%; after deductible
Outpatient Surgery - Hospital	30%; after deductible
Outpatient Surgery - Freestanding Facility	30%; after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient	30%; after deductible
Outpatient	$35 copay; deductible waived
Other Mental Health Services	30%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient	30%; after deductible
Residential Treatment Facility	30%; after deductible
Outpatient	$35 copay; deductible waived
OTHER SERVICES	**IN-NETWORK**
Skilled Nursing Facility	30%; after deductible
Home Health Care	30%; after deductible
Hospice Care	30%; after deductible
Private Duty Nursing (Outpatient)	30%; after deductible
Spinal Manipulation Therapy	$20 copay after deductible
Autism Behavioral Therapy	$35 copay; deductible waived
Durable Medical Equipment, Orthotics, and Prosthetics	30%; after deductible
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived
Transplants	30%; after deductible at Institutes of Excellence only (not covered anywhere else)
FAMILY PLANNING	**IN-NETWORK**
Infertility Treatment	30%; after deductible
Diagnosis and treatment of the underlying medical condition only.	
Vasectomy	30%; after deductible
Tubal Ligation	Covered 100%; deductible waived
GENERAL PROVISIONS	
Dependents Eligibility - Spouse, children from birth to age 26 regardless of student status.	

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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 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.

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-(866) 317-6989.**
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Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-(866) 317-6989.**
For more information about Aetna plans, refer to **www.aetna.com.**

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