



DEALER TIRE, LLC  
 Effective Date: 01-01-2022  
 Aetna Choice® POS II -- ASC  
 Qualified High Deductible Health Plan  
 Choice POSII- H.S.A.

**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)	\$2,800 Individual \$5,000 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.		
<b>Member Coinsurance</b>	20%	40%
Applies to all expenses unless otherwise stated.		
<b>Payment Limit</b> (per calendar year)	\$4,000 Individual \$8,000 Family	\$4,500 Individual \$9,000 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.		
<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 per calendar year up to age 65, 1 exam per calendar year age 65 and older	Covered 100%; deductible waived	40%; after deductible
<b>Routine Well Child Exams/Immunizations</b> 7 exams first 12 months, 3 exams 13-24 months, 3 exams 25-36 months, 1 exam per calendar year thereafter to age 22.	Covered 100%; deductible waived	40%; after deductible
<b>Routine Gynecological Care Exams</b> 1 exam and pap smear per year, includes related fees.	Covered 100%; deductible waived	40%; after deductible
<b>Routine Mammograms</b>	Covered 100%; deductible waived	40%; after deductible



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<b>Women's Health</b>	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.		
<b>Routine Digital Rectal Exam</b>	Covered 100%; deductible waived	40%; after deductible
Recommended: For covered males age 40 and over.		
<b>Prostate-specific Antigen Test</b>	Covered 100%; deductible waived	40%; after deductible
Recommended: For covered males age 40 and over.		
<b>Colorectal Cancer Screening</b>	Covered 100%; deductible waived	40%; after deductible
Recommended: For all members age 45 and over.		
<b>Routine Eye Exams</b>	Covered 100%; deductible waived	40%; after deductible
1 routine exam per year.		
<b>Routine Hearing Screening</b>	Covered 100%; deductible waived	40%; after deductible
<b>PHYSICIAN SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Office Visits to Primary Care Physician (PCP)</b>	20%; after deductible	40%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
<b>Telemedicine Consultation with Non-Specialist</b>	20%; after deductible	40%; after deductible
<b>Specialist Office Visits</b>	20%; after deductible	40%; after deductible
<b>Telemedicine Consultation with Specialist</b>	20%; after deductible	40%; after deductible
<b>Hearing Exams</b>	20%; after deductible	40%; after deductible
1 routine exam per 24 months.		
<b>Pre-Natal Maternity</b>	Covered 100%; deductible waived	40%; after deductible
<b>Walk-in Clinics</b>	20%; after deductible	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.		
<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	40%; 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.	20%; after deductible	40%; 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.	20%; after deductible	40%; 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.	20%; after deductible	40%; after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Urgent Care Provider</b>	20%; after deductible	40%; after deductible
<b>Non-Urgent Use of Urgent Care Provider</b>	20%; after deductible	40%; after deductible
<b>Emergency Room</b>	20%; after deductible	Same as in-network care
<b>Non-Emergency Care in an Emergency Room</b>	20%; after deductible	40%; after deductible
<b>Emergency Use of Ambulance</b>	20%; after deductible	Same as in-network care
<b>Non-Emergency Use of Ambulance</b>	Not Covered	Not Covered
<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.	20%; after deductible	40%; 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.	20%; after deductible	40%; after deductible
<b>Outpatient Hospital Expenses</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	40%; after deductible
<b>Outpatient Surgery - Hospital</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	40%; after deductible
<b>Outpatient Surgery - Freestanding Facility</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	40%; 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.	20%; after deductible	40%; after deductible
<b>Mental Health Office Visits</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	40%; after deductible
<b>Mental Health Telemedicine Consultations</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	40%; after deductible
<b>Other Mental Health Services</b>	20%; after deductible	40%; after deductible



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<b>SUBSTANCE ABUSE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient</b>	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
<b>Residential Treatment Facility</b>	20%; after deductible	40%; after deductible
<b>Substance Abuse Office Visits</b>	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
<b>Substance Abuse Telemedicine Consultations</b>	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
<b>Other Substance Abuse Services</b>	20%; after deductible	40%; after deductible
<b>OTHER SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Skilled Nursing Facility</b>	20%; after deductible	40%; after deductible
Limited to 60 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
<b>Home Health Care</b>	20%; after deductible	40%; after deductible
Limited to 60 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.		
<b>Hospice Care - Inpatient</b>	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
<b>Hospice Care - Outpatient</b>	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
<b>Private Duty Nursing</b>	20%; after deductible	40%; after deductible
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.		
<b>Spinal Manipulation Therapy</b>	20%; after deductible	40%; after deductible
Limited to 20 visits per year		
<b>Outpatient Short-Term Rehabilitation</b>	20%; after deductible	40%; after deductible
Includes speech, physical, occupational therapy; limited to 60 visits per year		
<b>Habilitative Physical Therapy</b>	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
<b>Habilitative Occupational Therapy</b>	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
<b>Habilitative Speech Therapy</b>	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
<b>Autism Behavioral Therapy</b>	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Combined with outpatient mental health visits		
<b>Autism Applied Behavior Analysis</b>	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		
<b>Autism Physical Therapy</b>	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other



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<b>Autism Occupational Therapy</b>	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
<b>Autism Speech Therapy</b>	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
<b>Durable Medical Equipment</b>	20%; after deductible	40%; after deductible
<b>Diabetic Supplies --</b> (if not covered under Pharmacy benefit)	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.
<b>Infusion Therapy</b> Administered in the home or physician's office	20%; after deductible	40%; after deductible
<b>Infusion Therapy</b> Administered in an outpatient hospital department or freestanding facility	20%; after deductible	40%; after deductible
<b>Acupuncture</b> Limited to 10 visits per year	20%; after deductible	40%; 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 20%: 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>	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.
<b>Bariatric Surgery</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible	40%; after deductible
<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	40%; after deductible
<b>Tubal Ligation</b>	Covered 100%; deductible waived	40%; 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 Open Formulary	
<b>Generic Drugs</b>		
	<b>Retail</b> 20%	Not Covered
	<b>Mail Order</b> 20%	Not Applicable
<b>Preferred Brand-Name Drugs</b>		
	<b>Retail</b> 20%	Not Covered
	<b>Mail Order</b> 20%	Not Applicable
<b>Non-Preferred Brand-Name Drugs</b>		
	<b>Retail</b> 20%	Not Covered
	<b>Mail Order</b> 20%	Not Applicable
<b>Pharmacy Day Supply and Requirements</b>		
	<b>Retail</b>	Up to a 30 day supply from Aetna National Network Percentage copays will not be doubled
<b>Mandatory Maintenance Choice</b>		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.
	<b>Opt Out</b>	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.
	<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>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, blood glucose monitors, prescription weight loss drugs and contraceptive drugs and devices obtainable from a pharmacy. 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. 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.



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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](http://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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**Ohio**

All contract state benefits shown above will match for this ancillary state.