Jesuit Health Trust
Effective Date: 01-01-2024
Traditional Choice®TC - Connecticut
MEDICARE Plan is Primary – JHT Plan is Secondary

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

PLAN FEATURES	
Benefit limitations - Some service or supplies have limits on them per year. There might be a maximum number of visits or days, or a dollar limit per year. In such cases, the benefit year begins on January 1 (unless otherwise noted). Refer to your plan documents to learn more.	
Deductible	None Individual None Family
Lifetime maximum	Unlimited except where otherwise indicated.
Primary care physician selection	Encouraged
Precertification requirements -	Certification for hospital admission, treatment facility admissions, convalescent facility admissions, home healthcare, hospice care and private duty nursing must be obtained by the facility.
Referral requirement	Not required
PREVENTIVE CARE	
Routine adult physical exams/ immunizations	Covered 100%
Routine digital rectal exam For members age 40 and over	Covered 100%
Prostate-specific antigen test For members age 40 and over	Covered 100%
Colorectal cancer screening For all members age 45 and over	Covered 100%
Routine eye exams 1 routine exam per 12 months.	Covered 100%
Routine hearing screening	Covered 100%
PHYSICIAN SERVICES	
Office visits to non-specialist Includes services of an internist, general physician, family practitioner or pediatrician.	Covered 100%
Specialist office visits	Covered 100%
Hearing exams 1 routine exam per 12 months.	Covered 100%
Walk-in clinics	Not Covered
Allergy testing	Covered 100%
Allergy injections	Covered 100%
DIAGNOSTIC PROCEDURES	
Diagnostic X-ray (Other than complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	Covered 100%
Diagnostic laboratory When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	Covered 100%
Diagnostic complex imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	Covered 100%
EMERGENCY MEDICAL CARE	
Urgent care provider	Covered 100%
Non-urgent use of urgent care provider	Covered 100%
Emergency room	Covered 100%
Non-emergency care in an emergency room	Covered 100%
Emergency use of ambulance	Covered 100%

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Non-emergency use of ambulance	Covered 100%
HOSPITAL CARE	
Inpatient coverage	Covered 100%
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Outpatient hospital expenses	Covered 100%
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	
MENTAL HEALTH SERVICES	
Inpatient	Covered 100%
Combined Lifetime Maximum of $100,000 for all services (including inpatient and outpatient mental health and alcohol/drug abuse services combined).	
Mental health office visits	Covered 100%
Combined Lifetime Maximum of $100,000 for all services (including inpatient and outpatient mental health and alcohol/drug abuse services combined).	
Other mental health services	Covered 100%
SUBSTANCE ABUSE	
Inpatient	Covered 100%
Combined Lifetime Maximum of $100,000 for all services (including inpatient and outpatient mental health and alcohol/drug abuse services combined).	
Residential treatment facility	10%
Substance abuse office visits	Covered 100%
Combined Lifetime Maximum of $100,000 for all services (including inpatient and outpatient mental health and alcohol/drug abuse services combined).	
Other substance abuse services	Covered 100%
THERAPY SERVICES	
Spinal manipulation therapy	Covered 100%
Limited to 45 visits per year.	
Outpatient short-term rehabilitation	Covered 100%
Includes physical, occupational, and speech therapies.	
Habilitative physical therapy	Covered 100%
Habilitative occupational therapy	Covered 100%
Habilitative speech therapy	Covered 100%
Autism related physical therapy	Covered 100%
Autism related occupational therapy	Covered 100%
Autism related speech therapy	Covered 100%
Autism related behavioral therapy	Covered 100%
These benefits are combined with outpatient mental health visits	
Autism related applied behavior analysis	Covered 100%
Your benefits for these services are the same as any other outpatient mental health other services benefits.	
OTHER SERVICES	
Skilled nursing facility	Covered 100%
Limited to 120 days per year When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	

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Home health care Limited to 100 visits per year Private duty nursing not included. Limited to three visits per day by staff from a home health care agency. One visit equals a period of four hours or less.	Covered 100%
Hospice care - inpatient When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	Covered 100%
Hospice care - outpatient When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	0%
Private duty nursing - outpatient Limited to 70 eight hour shifts per year. We count each period of up to 8 hours as one private duty nursing shift.	Covered 100%
Durable medical equipment	Covered 100%
Orthotics	Covered 100%
Hearing aids 1 benefit maximum per ear hearing aid every 5 years; including repair	Covered 50%
Diabetic supplies -- (if not covered under the prescription drug benefit)	Covered same as any other medical expense. You pay your prescription drug cost sharing amount if you have prescription drug coverage. If not, you pay your PCP visit cost sharing amount.
Infusion therapy Administered in the home or physician's office	Covered 100%
Infusion therapy Administered in an outpatient hospital department or freestanding facility	Covered 100%
Transplants (Lifetime Maximum of $750,000)	Covered 100%
Bariatric surgery	Covered 100%
Acupuncture	Covered 100%
PHARMACY	
Pharmacy plan type	None
GENERAL PROVISIONS	
Dependents who are eligible to be on your plan	Spouse, children from birth to age 26. Student status of children does not matter.

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.

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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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.**
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