



Wabtec Corporation  
 Effective Date: 01-01-2018  
 Aetna Open Access® Aetna Select<sup>SM</sup>

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

<b>PLAN FEATURES</b>	<b>IN-NETWORK</b>
<b>Deductible</b> (per calendar year)	\$700 Individual
<b>Member Coinsurance</b>	20% after deductible
<b>Payment Limit</b> (per calendar year)	\$2,300 Individual                      \$6,000 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.
<b>Total Max Out of Pocket</b>	\$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.
<b>PREVENTIVE CARE</b>	<b>IN-NETWORK</b>
<b>Routine Adult Physical Exams/ Immunizations</b>	Covered 100%; deductible waived 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older
<b>Routine Well Child Exams</b>	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.
<b>Routine Gynecological Care Exams</b>	Covered 100%; deductible waived Recommended: One exam per calendar year. Includes routine tests and related lab fees.
<b>Routine Mammograms</b>	Covered 100%; deductible waived Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.
<b>Women's Health</b>	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.
<b>Routine Digital Rectal Exam</b>	Covered 100%; deductible waived Recommended: For covered males age 40 and over.
<b>Prostate-specific Antigen Test</b>	Not Covered
<b>Colorectal Cancer Screening</b>	Covered 100%; deductible waived
<b>PHYSICIAN SERVICES</b>	<b>IN-NETWORK</b>
<b>Primary Care Physician Visits</b>	\$25 copay; deductible waived
<b>Specialist Office Visits</b>	\$35 copay; deductible waived
<b>Pre-Natal Maternity</b>	Covered 100%; deductible waived
<b>Walk-in/Retail Clinics</b>	\$35 copay; deductible waived
<b>Allergy Extracts and Injections</b>	20% after deductible
<b>DIAGNOSTIC PROCEDURES</b>	<b>IN-NETWORK</b>
<b>Diagnostic X-ray</b>	20% 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
<b>Diagnostic Laboratory</b>	20% after deductible



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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

<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>
<b>Urgent Care Provider</b>	\$35 copay; deductible waived
<b>Emergency Room</b>	20% after \$200 copay; deductible waived
Copay waived if admitted	
<b>Emergency Use of Ambulance</b>	20% after deductible
<b>HOSPITAL CARE</b>	<b>IN-NETWORK</b>
<b>Inpatient Coverage</b>	20%; after deductible
<b>Inpatient Maternity Coverage</b>	20%; after deductible
<b>Outpatient Hospital</b>	20%; after deductible
<b>Outpatient Surgery - Hospital</b>	20%; after deductible
<b>Outpatient Surgery - Freestanding Facility</b>	20%; after deductible
<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK</b>
<b>Inpatient</b>	20%; after deductible
<b>Outpatient</b>	\$35 copay; deductible waived
<b>Other Mental Health Services</b>	20%; after deductible
<b>SUBSTANCE ABUSE</b>	<b>IN-NETWORK</b>
<b>Inpatient</b>	20%; after deductible
<b>Residential Treatment Facility</b>	20%; after deductible
<b>Outpatient</b>	\$35 copay; deductible waived
<b>OTHER SERVICES</b>	<b>IN-NETWORK</b>
<b>Skilled Nursing Facility</b>	20%; after deductible
<b>Home Health Care</b>	20%; after deductible
<b>Hospice Care</b>	20%; after deductible
<b>Private Duty Nursing (Outpatient)</b>	20%; after deductible
<b>Spinal Manipulation Therapy</b>	\$20 copay; deductible waived
<b>Autism Behavioral Therapy</b>	\$35 Copay; deductible waived
<b>Durable Medical Equipment, Orthotics, and Prosthetics</b>	20%; after deductible
<b>Affordable Care Act mandated Women's Contraceptives</b>	Covered 100%; deductible waived
<b>Transplants</b>	20%; after deductible at Institutes of Excellence only (not covered anywhere else)
<b>FAMILY PLANNING</b>	<b>IN-NETWORK</b>
<b>Infertility Treatment</b>	20%; after deductible
Diagnosis and treatment of the underlying medical condition only.	
<b>Vasectomy</b>	20%; after deductible
<b>Tubal Ligation</b>	Covered 100%; deductible waived
<b>GENERAL PROVISIONS</b>	
<b>Dependents Eligibility</b> - 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**.

Prepared: October 2017



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Puede estar disponible la traducción 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](http://www.aetna.com)**.

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