PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA HEALTH INC. - FULL RISK

PLAN FEATURES	IN-NETWORK
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 (per calendar year)	$500 per Individual $1,000 per Family
You must first meet the deductible before the plan begins paying benefits, unless otherwise noted. The amount you pay (cost sharing) for some medical services does not count toward your deductible. Prescription drug costs do not count toward the deductible. Refer to your plan documents for details. Your family will have one deductible. You will meet it when the expenses of several family members add up to the family deductible. No one person will have to pay more than the individual deductible.	
Out-of-pocket limit (per calendar year)	$1,000 per Individual $2,000 per Family
Covered expenses in-network add up towards your in-network out-of-pocket limit. Covered expenses out-of-network add up towards your out-of-network out-of-pocket limit. All basic health care services apply toward the out-of-pocket limit. However, member cost sharing for certain supplemental services may not apply toward the out-of-pocket limit. Your pharmacy expenses count toward your out-of-pocket limit. In-network expenses include coinsurance/copays and deductibles. Your family will have one out-of-pocket limit. You will meet it when the expenses of several family members add up to the family out-of-pocket limit. No one person will have to pay more than the individual out-of-pocket limit amount. The combined copayment for all basic health services will not exceed 200% of the average annual premium cost for subscribers or enrollees. This provision does not apply to supplemental benefits (mental health benefits, substance abuse benefits, or skilled nursing facility benefits, hospice care benefits, or optional/additional benefits).	
Lifetime maximum	Unlimited except where otherwise indicated.
Primary care physician selection	Encouraged
Referral requirement	Not required
Telehealth consultations - You can access covered services for telehealth visits from different kinds of providers in your plan. Log on to **Aetna.com** to see a list of telehealth providers. You'll also find more about your options, including cost share amounts.	
PREVENTIVE CARE	**IN-NETWORK**
Routine adult physical exams/ immunizations 1 exam every 12 months	Covered 100%; no deductible
Routine well child exams • 7 exams in the first 12 months • 3 exams from age 13 through 24 months • 3 exams from age 25 through 36 months • 1 exam every 12 months from age 3 until age 22 years	Covered 100%; no deductible
Childhood immunizations	Covered 100%; no deductible
Routine gynecological care exams 1 exam and pap smear per year, including related fees	Covered 100%; no deductible
Diagnostic mammogram	Covered 100%; no deductible
Routine screening mammogram Recommended: One per year for members age 40 and over	Covered 100%; no deductible

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Women's health	Covered 100%; no 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. Also includes: contraceptive methods (ACA mandated contraceptives, including contraceptives and devices you can't get at a pharmacy), sterilization procedures (including tubal ligation), patient education and counseling. Limits may apply.	
Pre-natal maternity	Covered 100%; no deductible
Routine digital rectal exams / Prostate specific antigen test	Covered 100%; no deductible
Recommended: For members age 40 and over	
Colorectal cancer screening	Covered 100%; no deductible
Recommended: For all members age 45 and over. Frequency schedule applies.	
Routine eye exams	Covered 100%; no deductible
1 routine exam per 24 months.	
Routine hearing screening	Covered 100%; no deductible
Children covered from birth to age 9	
PHYSICIAN SERVICES	**IN-NETWORK**
Primary care physician visits	$15 office visit copay; no deductible
Includes services of an internist, general physician, family practitioner or pediatrician.	
Telehealth consultation with non-specialist	$15 office visit copay; no deductible
Specialist office visits	$15 office visit copay; no deductible
Telehealth consultation with specialist	$15 office visit copay; no deductible
This is how much you pay for the services of an internist, general physician, family practitioner, or pediatrician if the physician is not your PCP.	
Walk-in clinics	$15 copay; no deductible
Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services. Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices.	
Allergy testing	Your cost sharing amount depends on the type of service and where you receive it.
Allergy injections	Your cost sharing amount depends on the type of service and where you receive it. Covered 100% when an office visit charge is not applicable.
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic X-ray (Other than complex imaging services)	$15 copay; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	
Diagnostic laboratory	Covered 100%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	
Diagnostic complex imaging	Covered 100%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	

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EMERGENCY MEDICAL CARE	IN-NETWORK
Urgent care provider	$35 office visit copay; no deductible
Non-urgent use of urgent care provider	Not Covered
Emergency room Copay waived if admitted	$100 copay; no deductible
Non-emergency care in an emergency room	Not Covered
Emergency use of ambulance	Covered 100%; no deductible
Non-emergency use of ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK**
Inpatient coverage When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	Covered 100%; after deductible
Inpatient maternity coverage (includes delivery and postpartum care) When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	$15 for Physician Maternity Services; no deductible; Covered 100% for Facility services; after deductible
Outpatient hospital 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.	Covered 100%; after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	Covered 100%; after deductible
Mental health office visits	$15 copay; no deductible
Mental health telehealth consultations	$15 office visit copay; no deductible
Other mental health services 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.	Covered 100%; no deductible
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	Covered 100%; after deductible
Residential treatment facility 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%; after deductible
Substance abuse office visits	$15 copay; no deductible
Substance abuse telehealth consultations	$15 office visit copay; no deductible
Other substance abuse services 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.	Covered 100%; no deductible

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THERAPY SERVICES	IN-NETWORK
Spinal manipulation therapy Limited to 20 visits per year	$25 copay; after deductible
Outpatient rehabilitative physical and occupational therapy	$15 copay; after deductible
Outpatient rehabilitative speech therapy	$15 copay; after deductible
Habilitative physical therapy	Refer to MBH Outpatient Mental Health All Other
Habilitative occupational therapy	Refer to MBH Outpatient Mental Health All Other
Habilitative speech therapy	Refer to MBH Outpatient Mental Health All Other
Autism related physical therapy	Refer to MBH Outpatient Mental Health All Other
Autism related occupational therapy	Refer to MBH Outpatient Mental Health All Other
Autism related speech therapy	Refer to MBH Outpatient Mental Health All Other
Autism related behavioral therapy These benefits are combined with outpatient mental health visits.	Refer to MBH Outpatient Mental Health
Autism related applied behavior analysis Your benefits for these services are the same as any other outpatient mental health other services benefit	Refer to MBH Outpatient Mental Health Other Services
OTHER SERVICES	**IN-NETWORK**
Skilled nursing facility Limited to 60 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.	Covered 100%; after deductible
Home health care Limited to 60 visits per year Limited to three visits per day by staff from a home health care agency. One visit equals a period of four hours or less.	$15 copay; after deductible
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%; after deductible
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.	$15 copay; after deductible
Durable medical equipment	50%; after deductible
Prosthetics	Covered 100%; no deductible
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.
Gene-based, Cellular, and other Innovative Therapies (GCIT™)	Your cost sharing amount depends on the type of service and where you receive it. $50 copay: no deductible for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.
Transplants	Covered 100%; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.
Bariatric surgery	Covered 100%; after deductible Limited to $10,000 per lifetime

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When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.

Acupuncture Limited to 10 visits per year	$15 copay; no deductible
FAMILY PLANNING	**IN-NETWORK**
Infertility treatment You have coverage for the diagnosis and treatment of the underlying cause of infertility.	Your cost sharing amount depends on the type of service and where you receive it.
Comprehensive infertility services Artificial insemination and ovulation induction	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered
Vasectomy	Your cost sharing amount depends on the type of service and where you receive it.
Tubal ligation	Covered 100%; no deductible

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PRESCRIPTION DRUG BENEFITS	IN-NETWORK
Pharmacy plan type	Advanced Control Plan - Aetna
Prescription drug out-of-pocket limit	Prescription drug expenses apply to your medical out-of-pocket limit.
Preferred generic drugs	
Retail	$10 copay
Mail order	$20 copay
Preferred brand-name drugs	
Retail	$30 copay
Mail order	$60 copay
Non-preferred generic and brand-name drugs	
Retail	$60 copay
Mail order	$120 copay
Specialty drugs	
Preferred specialty	$40 copay
Non-preferred specialty	$40 copay
Pharmacy day supply and requirements	
Retail	You can get up to a 30-day supply from Aetna National Network
Mail order	You can get a 31-90-day supply from CVS Caremark® Mail Service Pharmacy.
Specialty	You can get up to a 30-day supply of specialty drugs You may fill your first prescription at any retail or specialty pharmacy. After that, all other fills must be through our preferred specialty pharmacy network. Advanced Control Formulary Aetna Insured List

Your prescription drug plan also includes:
• Diabetic supplies
• A limited list of over-the-counter medications when filled with a prescription

Family planning
• Oral fertility drugs included.

The following are covered 100% in-network:
• Oral chemotherapy drugs
• Seasonal vaccinations
• Affordable Care Act (ACA) eligible preventive medications
Refer to **Aetna.com** for a complete list of eligible prescription drugs.

Precertification requirements -
Some covered prescription drugs need approval from us before we will cover the drug.
Some covered prescription drugs require step therapy before we cover them. With step therapy, you must first try one or more drugs before we will pay for drugs that require step therapy.
To get the most up-to-date precertification requirements and a list of drugs that require step therapy, see your plan documents or go online to your member website.

Choose generics with dispense as written (DAW) override - Sometimes your physician may say you need a brand-name prescription drug even if a generic is available. If so, you will pay the brand-name copay. If you ask for a brand-name prescription drug when a generic is available, you will pay the applicable brand-name copay plus the difference between the generic price and the brand-name price.

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GENERAL PROVISIONS	
Dependents who are eligible to be on your plan	Spouse, children from birth to age 28. Student status of children does not matter.

In no event shall a member's annual cost sharing charges, including copayments and deductibles, exceed 40% of the total annual cost to the HMO of providing all covered healthcare services when applied to a standard population expected to be covered under the HMO.

Exclusions and Limitations

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. Each insurer has sole financial responsibility for its own products.

This material is for information only. Health benefits 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.
• Durable medical equipment.
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a clinical trial with respect to the treatment of cancer or other life-threatening disease or condition.
• 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.
• Orthotics except diabetic orthotics.
• 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.

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• Services for the treatment of sexual dysfunction or inadequacies 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.

If you require language assistance, please call the member services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).

Si requiere la asistencia de un representante que hable su idioma, por favor llame al número de Servicios al Miembro que aparece en su tarjeta de identificación y se le comunicará con la línea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intérprete). TDD-1-800-628-3323 (sólo para las personas con impedimentos auditivos).

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **www.aetna.com.** While this material is believed to be accurate as of the production date, it is subject to change.

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.