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

PLAN FEATURES	IN-NETWORK
Benefit Limitations - 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.	
Deductible (per calendar year)	$500 Individual $1,000 Family
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 do not 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.	
Out-of-Pocket Maximum (per calendar year)	$1,000 Individual $2,000 Family
All basic health care services apply toward the out-of-pocket maximum. However, member cost sharing for certain supplemental services may not apply toward the out-of-pocket maximum. In-network expenses include coinsurance/copays and deductibles. Pharmacy expenses apply towards the Out-of-Pocket-Maximum. The family Out-of-Pocket Maximum is a cumulative Out-of-Pocket Maximum for all family members. The family Out-of-Pocket Maximum can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Out-of-Pocket Maximum 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	Optional
Referral Requirement	None
PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived
1 exam per 12 months for members age 22 and older.	
Routine Well Child Exams (Age and frequency schedules apply)	Covered 100%; deductible waived
Childhood Immunizations	Covered 100%; deductible waived
Routine Gynecological Care Exams	Covered 100%; deductible waived
1 exam per 12 months Includes routine tests and related lab fees.	
Diagnostic Mammograms	Covered 100%; deductible waived
Routine Screening Mammograms	Covered 100%; deductible waived
Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	

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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 Exams / Prostate Specific Antigen Test	Covered 100%; deductible waived
Recommended for males age 40 and over.	
Colorectal Cancer Screening	Covered 100%; deductible waived
Recommended: For all members age 45 and over. Frequency schedule applies.	
Routine Eye Exams	Covered 100%; deductible waived
1 routine exam per 24 months.	
Routine Hearing Screening	Covered 100%; deductible waived
Children covered from birth to age 9	
PHYSICIAN SERVICES	**IN-NETWORK**
Primary Care Physician Visits	$15 office visit copay; deductible waived
Includes services of an internist, general physician, family practitioner or pediatrician.	
Specialist Office Visits	$15 office visit copay; deductible waived
Pre-Natal Maternity	Covered 100%; deductible waived
Walk-in Clinics	$15 copay; deductible waived
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.	
Allergy Testing	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed. Covered 100% when an office visit charge is not applicable.
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic Laboratory	Covered 100%; 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.	
Diagnostic X-ray	$15 copay; 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.	
Diagnostic X-ray for Complex Imaging Services	Covered 100%; 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.	
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care Provider	$35 office visit copay; deductible waived
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	$100 copay; deductible waived
Copay waived if admitted	

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Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	Covered 100%; after deductible
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK**
Inpatient Hospital Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$15 for Physician Maternity Services; deductible waived; Covered 100% for Facility services; after deductible
Outpatient Hospital Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible
Mental Health Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$15 copay; deductible waived
Other Mental Health Services	Covered 100%; deductible waived
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible
Residential Treatment Facility	Covered 100%; after deductible
Substance Abuse Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$15 copay; deductible waived
Other Substance Abuse Services	Covered 100%; deductible waived
OTHER SERVICES	**IN-NETWORK**
Skilled Nursing Facility Limited to 60 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible
Home Health Care Limited to 60 visits per year Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	$15 copay; after deductible
Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$15 copay; after deductible
Outpatient Rehabilitative Speech Therapy	$15 copay; after deductible
Outpatient Physical and Occupational Therapy	$15 copay; after deductible
Spinal Manipulation Therapy Limited to 20 visits per year	$25 copay; after deductible

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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 Behavioral Therapy	Refer to MBH Outpatient Mental Health
Covered same as any other Outpatient Mental Health benefit	
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health Other Services
Covered same as any other Outpatient Mental Health Other Services benefit	
Autism Physical Therapy	Refer to MBH Outpatient Mental Health All Other
Autism Occupational Therapy	Refer to MBH Outpatient Mental Health All Other
Autism Speech Therapy	Refer to MBH Outpatient Mental Health All Other
Durable Medical Equipment	50%; after deductible
Prosthetics	Covered 100%; after deductible
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived
Transplants	Covered 100%; after deductible Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery	Covered 100%; after deductible Limited to $10,000 per lifetime
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Acupuncture	$15 copay; deductible waived
Limited to 10 visits per year	
FAMILY PLANNING	**IN-NETWORK**
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed
Diagnosis and treatment of the underlying medical condition only.	
Advanced Reproductive Technology (ART)	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	
Comprehensive Infertility Services	Not Covered
Artificial insemination and ovulation induction	

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Vasectomy	Your cost sharing is based on the type of service and where it is performed
Tubal Ligation	Covered 100%; deductible waived
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK**
Pharmacy Plan Type	Advanced Control Plan - Aetna
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	Up to a 30 day supply from Aetna National Network
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy
Specialty	Up to a 30 day supply First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network. Advanced Control Formulary Aetna Insured List

Choose Generics with Dispense as Written (DAW) override - 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.

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
Oral fertility drugs included.
A limited list of over-the-counter medications are covered when filled with a prescription.
Oral chemotherapy drugs covered 100%
Precertification and quantity limits included
Step Therapy included
Seasonal Vaccinations covered 100% in-network
Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 28 regardless of student status.

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.

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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.
• 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).

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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.