PLAN DESIGN & BENEFITS
PROVIDED BY AETNA HEALTH OF ILLINOIS 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)	None Individual None Family
Out-of-Pocket Maximum(per calendar year)	$1,500 Individual $3,000 Family
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.	
Lifetime Maximum	Unlimited except where otherwise indicated.
Primary Care Physician Selection	Required
Referral Requirement	Required
PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam per 12 months for members age 22 and older.	Covered 100%
Routine Well Child Exams (Age and frequency schedules apply)	Covered 100%
Childhood Immunizations HPV Immunizations covered to age 27.	Covered 100%
Routine Gynecological Care Exams 1 exam per 12 months Includes routine tests and related lab fees.	Covered 100%
Routine Mammograms Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	Covered 100%
Women's Health 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.	Covered 100%
Routine Digital Rectal Exams / Prostate Specific Antigen Test Recommended for males age 40 and over.	Covered 100%
Colorectal Cancer Screening Recommended: For all members age 45 and over. Frequency schedule applies.	Covered 100%
Routine Eye Exams 1 routine exam per 24 months. Direct access to participating providers without a referral.	Covered 100%
Routine Hearing Screening	Covered 100%

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PHYSICIAN SERVICES	IN-NETWORK
Primary Care Physician Visits	$25 copay
Includes services of an internist, general physician, family practitioner or pediatrician.	
Specialist Office Visits	$25 copay
Pre-Natal Maternity	Covered 100%
Walk-in Clinics	$25 copay
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%
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	$25 copay
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	$100 copay
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 copay
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	$100 copay
Copay waived if admitted	
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	Covered 100%
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK**
Inpatient Coverage	$500 copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Inpatient Maternity Coverage (includes delivery and postpartum care)	$25 for Physician Maternity Services; $500 for Facility services
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Outpatient Hospital	$250 copay
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient	$500 copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Mental Health Office Visits	$25 copay
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Mental Health Services	Covered 100%

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SUBSTANCE ABUSE	IN-NETWORK
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$500 copay
Residential Treatment Facility	$500 copay
Substance Abuse Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$25 copay
Other Substance Abuse Services	Covered 100%
OTHER SERVICES	**IN-NETWORK**
Skilled Nursing Facility Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$500 copay
Home Health Care Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	Covered 100%
Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$500 copay
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%
Outpatient Short-Term Rehabilitation Limited to 60 visits per year Includes speech, physical, occupational therapy	$25 copay
Spinal Manipulation Therapy	$25 copay
Habilitative Services (Physical/Occupational/Speech Therapy)	Cost sharing same as any other physical, occupational, speech therapy expense.
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Refer to MBH Outpatient Mental Health Other Services
Autism Physical Therapy	$25 copay
Autism Occupational Therapy	$25 copay
Autism Speech Therapy	$25 copay
Durable Medical Equipment	20%
Prosthetics	Covered 100%
Orthotics Orthotic Appliances and Services	Covered 100%
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%

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Affordable Care Act mandated Women's Contraceptives	Covered 100%
Hearing Aids 1 hearing aid for each impaired ear per 36 month period to age 18	Covered 100%
Infusion Therapy Administered in the home or physician's office	Your cost sharing is based on the type of service and where it is performed
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed
Transplants	$500 copay Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$500 copay
FAMILY PLANNING	**IN-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed
Comprehensive Infertility Services Coverage includes artificial insemination and ovulation. Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law.	$25 copay
Advanced Reproductive Technology (ART) ART coverage includes: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Limited to 4 completed oocyte retrievals per lifetime, if live birth only 2 additional attempts covered.	$25 copay
Vasectomy	Covered 100%
Tubal Ligation	Covered 100%
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK**
Pharmacy Plan Type	Advanced Control Plan
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
Pharmacy Day Supply and Requirements	
Retail	Up to a 30 day supply from Aetna National Network For a 31-90 day supply you will be responsible for the Mail Order Drug copay.
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

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Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
Contraceptives covered up to a 12 month supply. Contraceptive copay strategy applies.
Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).
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
Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

GENERAL PROVISIONS

Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.

Exclusions and Limitations

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health of Illinois 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 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.
• 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.

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• 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.
• Treatment of behavioral disorders.
• 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.

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. Aetna Rx Home Delivery and Aetna Specialty Pharmacy refer to Aetna Rx Home Delivery, LLC and Aetna Specialty Pharmacy, LLC, respectively. Aetna Rx Home Delivery and Aetna Specialty Pharmacy are licensed pharmacy subsidiaries of Aetna Inc. that operate through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery and Aetna Specialty 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 pharmacies' 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.

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.