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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
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)	$1,500 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	Optional
Referral Requirement	None
PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%
1 exam per 12 months for members age 22 and older.	
Routine Well Child Exams/Immunizations	Covered 100%
(Age and frequency schedules apply)	
Routine Gynecological Care Exams	Covered 100%
1 exam per 12 months Includes routine tests and related lab fees.	
Routine Mammograms	Covered 100%
Recommended: One annual mammogram for covered females age 40 and over.	
Women's Health	Covered 100%
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%
Recommended for males age 40 and over.	
Colorectal Cancer Screening	Covered 100%
Recommended: For all members age 45 and over. Frequency schedule applies.	

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Routine Eye Exams 1 routine exam per 24 months.	$30 copay
Routine Hearing Screening	Covered 100%
PHYSICIAN SERVICES	**IN-NETWORK**
Office Visits to member's selected Primary Care Physician	$20 office visit copay
Specialist Office Visits Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.	$30 copay
Pre-Natal Maternity	Covered 100%
Walk-in Clinics 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.	$20 copay
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 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.	Covered 100%
Diagnostic X-ray 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.	Covered 100%
Diagnostic X-ray for Complex Imaging Services 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.	$30 copay
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care Provider	$30 copay
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room Copay waived if admitted	$75 copay
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 Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$250 copay
Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$30 for Physician Maternity Services; $250 for Facility services
Outpatient Hospital Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$100 copay
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$250 copay

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Mental Health Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$30 copay
Other Mental Health Services	Covered 100%
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$250 copay
Residential Treatment Facility	$250 copay
Substance Abuse Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$30 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.	$250 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.	$30 copay
Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$250 copay
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%
Outpatient Short-Term Rehabilitation Treatment over a 60 day consecutive period per incident of illness or injury beginning with the first day of treatment. Includes speech, physical, occupational therapy	$30 copay
Spinal Manipulation Therapy Limited to 20 visits per year	$30 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	$30 copay
Autism Occupational Therapy	$30 copay
Autism Speech Therapy	$30 copay
Durable Medical Equipment	Covered 100%
Prosthetics	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%
Affordable Care Act mandated Women's Contraceptives	Covered 100%
Transplants	$250 copay Preferred coverage is provided at an IOE contracted facility only.

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Bariatric Surgery	Not Covered
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.	
Comprehensive Infertility Services	Not Covered
Artificial insemination and ovulation induction	
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	
Vasectomy	Your cost sharing is based on the type of service and where it is performed
Tubal Ligation	Covered 100%; deductible waived

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PRESCRIPTION DRUG BENEFITS	IN-NETWORK
Pharmacy Plan Type	Aetna Standard Plan opt out with ACSF
Generic Drugs	
Retail	$10 copay
Mail Order	$20 copay
Preferred Brand-Name Drugs	
Retail	$15 copay
Mail Order	$30 copay
Non-Preferred Brand-Name Drugs	
Retail	$30 copay
Mail Order	$60 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. Standard Opt Out Aetna Insured List

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 for specialty drugs 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 Inc., Aetna Health Insurance Company, Aetna Life Insurance Company and/or Aetna HealthAssurance Pennsylvania, Inc. Each insurer has sole financial responsibility for its own plans and products.

This material is for information only. Health benefits plans contain exclusions and limitations.

This managed care plan may not cover all of your health care expenses. Read your contract carefully to determine which health care services are covered. To contact the plan if you are a member, call the number on your ID card; all others, call 1-888-982-3862.

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.
• 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.
• 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.

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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.