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

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)	$250 per Individual $500 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.	
Member coinsurance	You pay 10%
Applies to all expenses except as noted.	
Out-of-pocket limit (per calendar year)	$2,000 per Individual $4,000 per Family
Some of your cost sharing may not count toward the out-of-pocket limit. Your pharmacy expenses do not 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.	
Lifetime maximum	
Unlimited except where otherwise indicated.	
Primary care physician selection	Optional
Referral requirement	Not required
Telehealth consultations - You can access covered services for telehealth visits from different kinds of providers in your network. 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	Covered 100%; no deductible
1 exam per calendar year	
Routine well child exams/immunizations	Covered 100%; no deductible
• 7 exams in the first 12 months • 3 exams from age 13 months to 24 months • 3 exams from age 25 months to 36 months • 1 exam every 12 months thereafter until age 22	
Routine gynecological care exams	Covered 100%; no deductible
1 exam and pap smear per year, includes related fees.	
Routine mammogram	Covered 100%; no deductible
Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	
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.	

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Pre-natal maternity	Covered 100%; no deductible
Routine digital rectal exam Recommended: For members age 40 and over	Covered 100%; no deductible
Prostate-specific antigen test Recommended: For members age 40 and over	Covered 100%; no deductible
Colorectal cancer screening Recommended: For members age 45 and over	Covered 100%; no deductible
Routine eye exams 1 routine exam per 24 months.	Covered 100%
Routine hearing screening	Covered 100%; no deductible
PHYSICIAN SERVICES	**IN-NETWORK**
Office visits to primary care physician (PCP) Includes services of an internist, general physician, family practitioner or pediatrician. *Dermatology, Podiatry, OB/GYN and Chiropractic services will follow this copay.	*$25 office visit copay; no deductible
Telehealth consultation with non-specialist	$25 office visit copay; no deductible
Specialist office visits	$45 office visit copay; no deductible
Telehealth consultation with specialist	$45 office visit copay; no deductible
Hearing exams	Not Covered
Walk-in clinics 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.	$25 copay; no deductible **Designated Walk-in clinics** Covered 100%; no deductible
Telehealth consultations for non-emergency services through a walk-in clinic We pay telehealth screenings and counseling services from a walk-in-clinic as a preventive care benefit.	Your cost sharing amount depends on the type of service and where you receive it. **Designated Walk-in clinics** Covered 100%; no deductible
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.
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic X-ray (Other than complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	10% coinsurance; after deductible
Diagnostic laboratory When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	Covered 100%; no deductible
Diagnostic complex imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	No deductible after $150 Copay in OP Hospital No deductible after $45 Copay in free standing facility

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EMERGENCY MEDICAL CARE	IN-NETWORK
Urgent care provider	Covered 100%; no deductible after $40 office visit copay
Non-urgent use of urgent care provider	Not Covered
Emergency room Copay waived if admitted	$300 copay; no deductible
Non-emergency care in an emergency room	Not Covered
Emergency use of ambulance	$300 copay; no deductible
Non-Emergency but Medically Necessary Use of Ambulance	$300 copay; no deductible
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.	$250 copay, no 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.	$250 copay
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.	10% coinsurance; after deductible
Outpatient surgery - 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.	$250 copay, no deductible
Outpatient surgery - freestanding facility 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.	$50 copay; no 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.	$250 copay
Mental health office visits	$25 copay; no deductible
Mental health telehealth consultations 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.	$25 office visit copay; 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.	$250 copay
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.	$250 copay
Substance abuse office visits	$25 copay
Substance abuse telehealth consultations	$25 office visit copay

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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.

THERAPY SERVICES	IN-NETWORK
Spinal manipulation therapy	$25 copay; no deductible
Outpatient short-term rehabilitation Includes physical, occupational, and speech therapies.	$25 copay; no deductible
Habilitative physical therapy	$25 copay; no deductible
Habilitative occupational therapy	$25 copay; no deductible
Habilitative speech therapy	$25 copay; no deductible
Autism related physical therapy	$25 copay; no deductible
Autism related occupational therapy	$25 copay; no deductible
Autism related speech therapy	$25 copay; no deductible
Autism related behavioral therapy These benefits are combined with outpatient mental health visits	$25 copay; no deductible
Autism related applied behavior analysis Your benefits for these services are the same as any other outpatient mental health other services benefit	Covered 100%; no deductible
OTHER SERVICES	**IN-NETWORK**
Skilled nursing facility Limited to 100 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.	10% coinsurance; after deductible
Home health care Private duty nursing not included. One visit equals a period of four hours or less	$10 copay; after deductible
Hospice care - inpatient Limited to 210 days lifetime maximum combined for inpatient and outpatient. When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	10% coinsurance; after deductible
Hospice care - outpatient Limited to 210 days lifetime maximum combined for inpatient and 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.	10%coinsurance; after deductible
Private duty nursing	Not Covered
Durable medical equipment	10% coinsurance; after 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.
Infusion therapy - home/office	Covered 100%
Infusion therapy - outpatient hospital/freestanding facility	Covered 100%
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: after deductible for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.
Transplants	$250 copay In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.

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Bariatric surgery	Covered 100%; after $250 Copay no deductible for Inpatient/Outpatient Covered 100%; after $50 Copay no deductible for Ambulatory Surg. Center
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 20 visits per year	$25 copay; no deductible
FAMILY PLANNING	**IN-NETWORK**
Basic Infertility	Your cost sharing amount depends on the type of service and where you receive it.
You have coverage for the diagnosis and treatment of the underlying cause of infertility.	
Comprehensive Infertility Services (Includes Artificial Insemination and Ovulation Induction. Both Comprehensive and ART services are combined to a maximum of 3 cycles per lifetime.)	40% coinsurance
Advanced Reproductive Technology (ART)	40% coinsurance
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), ovulation induction (OI), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	
Fertility preservation	Not Covered
Vasectomy	$200 Copay
Tubal ligation	Covered 100%; no deductible
PHARMACY	**IN-NETWORK**
Pharmacy Plan Type **Pharmacy Maximum** $4,500 / Individual $9,000 Family	Aetna Standard Formulary
Retail	$6 copay for tier 1A formulary generic drugs, $10 copay for formulary generic drugs; $50 copay for formulary brand-name drugs, and $75 copay for non-formulary brand-name and non-formulary generic drugs up to a 30 day supply at participating pharmacies.
Mail Order	$6 copay for tier 1A formulary generic drugs, $10 copay for formulary generic drugs; $100 copay for formulary brand-name drugs, and $150 copay for non-formulary brand-name and non-formulary generic drugs Up to a 31-90 day supply from Aetna Rx Home Delivery®.
Aetna Standard Specialty Drugs	$10 copay for formulary generic drugs; $50 copay for formulary brand-name drugs, and $75 copay for non-formulary brand-name and non-formulary generic drugs from Aetna Specialty Pharmacy Network.
CVS Maintenance Choice (90) Day Supply at Retail	$6 copay for tier 1A formulary generic drugs, $10 copay for formulary generic drugs; $100 copay for formulary brand-name drugs, and $150 copay for non-formulary brand-name and non-formulary generic drugs

All prescription fills must be through our preferred Aetna Specialty Pharmacy network.

Standard Specialty Drug List

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Choose Generics - If the member or the physician requests brand-name when 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. Diabetic Supplies and Insulin - $0 copay. Oral and injectable fertility drugs included. A limited list of over-the-counter medications are covered when filled with a prescription. Standard Pre-certification included Standard Step Therapy included One transition fill allowed within 90 days of member's effective date Formulary generic FDA - approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.

GENERAL PROVISIONS	
Dependents who are eligible to be on your plan	Spouse, children from birth to age 26. Student status of children does not matter.

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.

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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
• 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 this material into another language may be available. Please call Member Services at the number on the back of your ID card.
Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**
Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com.**
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.

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