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)	$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.	
Member coinsurance	You pay 20%
Applies to all expenses except as noted.	
Out-of-pocket limit (per calendar year)	$2,500 per Individual $5,000 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 every 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 calendar 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	

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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 exam	Covered 100%; no deductible
Recommended: For members age 40 and over	
Prostate-specific antigen test	Covered 100%; no deductible
Recommended: For members age 40 and over	
Colorectal cancer screening	Covered 100%; no deductible
Recommended: For members age 45 and over	
Routine eye exams	Covered 100%; no deductible
1 routine exam per 24 months.	
Routine hearing screening	Covered 100%; no deductible
PHYSICIAN SERVICES	**IN-NETWORK**
Office visits to primary care physician (PCP)	*$25 office visit copay; no deductible
Includes services of an internist, general physician, family practitioner or pediatrician. *Dermatology, Podiatry, OB/GYN and Chiropractic services will follow this copay.	
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	$25 copay; no deductible **Designated Walk-in clinics** Covered 100%; 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.	
Telehealth consultations for non-emergency services through a walk-in clinic	Your cost sharing amount depends on the type of service and where you receive it. **Designated Walk-in clinics** Covered 100%; no deductible
We pay telehealth screenings and counseling services from a walk-in-clinic as a preventive care benefit.	
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)	20% coinsurance; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	
Diagnostic laboratory	20% coinsurance; after deductible

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When your physician performs and bills for this service at their office, you pay your office visit cost share amount.

Diagnostic complex imaging	20% coinsurance; after deductible

When your physician performs and bills for this service at their office, you pay your office visit cost share amount.

EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent care provider	$45 Copay
Non-urgent use of urgent care provider	Not Covered
Emergency room Copay waived if admitted	$350 copay; no deductible
Non-emergency care in an emergency room	Not Covered
Emergency use of ambulance	$350 copay; no deductible
Non-emergency use of ambulance	Not Covered

HOSPITAL CARE	**IN-NETWORK**
Inpatient coverage	20%; after deductible

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

Inpatient maternity coverage (includes delivery and postpartum care – no separate office copay for postnatal)	$200 per confinement, thereafter covered 100%

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

Outpatient hospital	20% coinsurance; after deductible

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.

Outpatient surgery - hospital	20% coinsurance; after deductible

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.

Outpatient surgery - freestanding facility	20% coinsurance; after deductible

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.

MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient	20%; after deductible

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

Mental health office visits	$25 copay
Mental health telehealth consultations	$25 office visit copay

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.

SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient	20% coinsurance; after deductible

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

Residential treatment facility	20% coinsurance; after deductible

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

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Substance abuse office visits	$25 copay
Substance abuse telehealth consultations	$25 office visit copay
THERAPY SERVICES	**IN-NETWORK**
Spinal manipulation therapy	$25 copay; no deductible
Outpatient short-term rehabilitation Limited to 60 visits per year 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.	20% coinsurance; after deductible
Home health care Home health care services include private duty nursing. 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.	20% 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.	20% coinsurance; after deductible
Private duty nursing	Not covered
Durable medical equipment	20% 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%; no deductible
Infusion therapy - outpatient hospital/freestanding facility	Your cost sharing amount depends on the type of service and where you receive it.
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	20%; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.

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Bariatric surgery	20%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Acupuncture	$25 copay; no deductible
Limited to 20 visits per year	
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.)	20% coinsurance; after deductible
Advanced Reproductive Technology (ART)	20% coinsurance; after deductible
Both Comprehensive and ART services are combined to a maximum of $6,000 per lifetime. ART coverage includes: 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	Aetna Standard Formulary **Pharmacy Maximum** $4,500 / Individual $9,000 Family
Retail	$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	$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®.

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Aetna Standard Specialty Drugs CVS Maintenance Choice (90) Day Supply at Retail	$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 from Aetna Specialty Pharmacy Network. $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

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 30. 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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