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

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
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%
Payment Limit (per calendar year) Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses do not apply towards the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.	$1,500 Individual $3,000 Family
Lifetime Maximum Unlimited except where otherwise indicated.	
Primary Care Physician Selection	Optional
Referral Requirement	None
PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%
Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%
Routine Gynecological Care Exams 1 exam and pap smear per year, includes related fees.	Covered 100%
Routine Mammograms	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 Exam Recommended: For covered males age 40 and over.	Covered 100%
Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%
Colorectal Cancer Screening Recommended: For all members age 45 and over.	Covered 100%
Routine Eye Exams 1 routine exam per 12 months.	Covered 100%
Routine Hearing Screening	Covered 100%

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PHYSICIAN SERVICES	IN-NETWORK
Primary Care Physician Visits Includes services of an internist, general physician, family practitioner or pediatrician.	$20 copay
Specialist Office Visits	$30 copay
Hearing Exams 1 routine exam every 24 months	Covered 100%
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 **Designated Walk-in Clinics** Covered 100%
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 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 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 Complex Imaging 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%
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care Provider	$20 copay
Non-Urgent Use of Urgent Care Provider	$20 copay
Emergency Room Copay waived if admitted	$150 copay
Non-Emergency Care in an Emergency Room	$400 copay
Emergency Use of Ambulance	Covered 100%
Non-Emergency Use of Ambulance	Not Covered

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HOSPITAL CARE	IN-NETWORK
Inpatient Coverage	$150 copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Inpatient Maternity Coverage (includes delivery and postpartum care)	$150 copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Outpatient Hospital	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	
Outpatient Surgery - Hospital	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	
Outpatient Surgery - Freestanding Facility	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient	$150 copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Mental Health Office Visits	$20 copay
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Mental Health Services	Covered 100%
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient	$150 copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Residential Treatment Facility	$150 copay
Substance Abuse Office Visits	$20 copay
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Substance Abuse Services	Covered 100%
OTHER SERVICES	**IN-NETWORK**
Skilled Nursing Facility	$150 copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Home Health Care	Covered 100%
Private Duty Nursing not covered Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	
Hospice Care - Inpatient	Covered 100%
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Hospice Care - Outpatient	Covered 100%
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Private Duty Nursing	Not Covered
Outpatient Short-Term Rehabilitation Limited to 60 visits per year Includes Speech, Physical, and Occupational Therapy	$30 copay
Spinal Manipulation Therapy	$30 copay
Habilitative Physical Therapy	$30 copay
Habilitative Occupational Therapy	$30 copay
Habilitative Speech Therapy	$30 copay
Autism Behavioral Therapy Combined with outpatient mental health visits	Refer to MBH Outpatient Mental Health

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Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health All Other
Covered same as any other Outpatient Mental Health All Other benefit	
Autism Physical Therapy	$30 copay
Autism Occupational Therapy	$30 copay
Autism Speech Therapy	$30 copay
Durable Medical Equipment	Covered 100%
Acupuncture	$30 copay
Hearing Aids	Covered 100%
Coverage includes 2 hearing aids every 24 months	
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.
Affordable Care Act Mandated Women's Contraceptives	Covered 100%
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%
Infusion Therapy Administered in the home or physician's office	$30 copay
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	$150 copay Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery	$150 per admission copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
FAMILY PLANNING	**IN-NETWORK**
Infertility Treatment	Applicable cost sharing based on the type of service performed and place of service where rendered
Diagnosis and treatment of the underlying medical condition only.	
Comprehensive Infertility Services	Covered 100%
Coverage includes artificial insemination and ovulation induction limited to six courses of treatment combined, per member lifetime. Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law.	
Advanced Reproductive Technology (ART)	Covered 100%
ART coverage includes: In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Limited to 4 attempts per year, except that if a live birth follows a completed attempt, then 2 more attempts per year.	
Vasectomy	Covered 100%
Tubal Ligation	Covered 100%

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PHARMACY	IN-NETWORK
Pharmacy Plan Type	Aetna Standard Open Formulary
Generic Drugs	
Retail	$10 copay
Mail Order	$20 copay
Preferred Brand-Name Drugs	
Retail	$40 copay
Mail Order	$80 copay
Non-Preferred Brand-Name Drugs	
Retail	$60 copay
Mail Order	$120 copay
Retail Out-of-Network Coverage	Not Covered
Specialty Drugs	
Preferred Specialty	$100 copay
Non-Preferred Specialty	$100 copay
Pharmacy Day Supply and Requirements	
Retail	Up to a 34 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. Aetna Specialty Network Drug List
Choose Generics with Dispense as Written (DAW) override - The member pays the applicable copay only, if the physician requires brand-name. 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, blood glucose monitors, prescription weight loss drugs and contraceptive drugs and devices obtainable from a pharmacy. Oral fertility drugs included. Precertification for specialty drugs included Seasonal Vaccinations covered 100% in-network Preventive Vaccinations covered 100% in-network Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.	
Prescription Drug Annual Out of Pocket Maximum	$1,000 Individual $3,000 Family

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GENERAL PROVISIONS

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

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.
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.
• 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.

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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. CVS Caremark ® Mail Service Pharmacy refers to CVS Caremark ® Mail Service Pharmacy, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with CVS Caremark ® Mail Service 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 pharmacy's 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.

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 traduccion 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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