



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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
<b>Deductible</b> (per calendar year)	\$1,000 Individual \$2,000 Family	\$1,500 Individual \$3,000 Family
<p>All covered expenses accumulate separately toward the preferred or non-preferred Deductible.            Unless otherwise indicated, the deductible must be met prior to benefits being payable.            Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible.            Pharmacy expenses do not apply towards the Deductible.            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.</p>		
<b>Member Coinsurance</b>	20%	40%
<p>Applies to all expenses unless otherwise stated.</p>		
<b>Payment Limit</b> (per calendar year)	\$3,500 Individual \$7,000 Family	\$5,500 Individual \$11,000 Family
<p>All covered expenses accumulate separately toward the preferred or non-preferred 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.            Pharmacy expenses do not apply towards 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.</p>		
<b>Lifetime Maximum</b>	Unlimited except where otherwise indicated.	
<b>Primary Care Physician Selection</b>	Optional	Not Applicable
<p><b>Certification Requirements -</b>            Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is \$400 per occurrence.</p>		
<b>Referral Requirement</b>	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
<b>Routine Adult Physical Exams/ Immunizations</b>	Covered 100%; deductible waived	40%; after deductible
<p>1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.</p>		
<b>Routine Well Child Exams/Immunizations</b>	Covered 100%; deductible waived	40%; after deductible
<p>7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 22.</p>		
<b>Routine Gynecological Care Exams</b>	Covered 100%; deductible waived	40%; after deductible
<p>Recommended: One exam per calendar year. Includes routine tests and related lab fees.</p>		
<b>Routine Mammograms</b>	Covered 100%; deductible waived	40%; after deductible
<b>Women's Health</b>	Covered 100%; deductible waived	40%; after deductible
<p>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.</p>		
<b>Routine Digital Rectal Exam</b>	Covered 100%; deductible waived	40%; after deductible
<p>Recommended: For covered males age 40 and over.</p>		



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<b>Prostate-specific Antigen Test</b> Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	40%; after deductible
<b>Colorectal Cancer Screening</b> Recommended: For all members age 45 and over.	Covered 100%; deductible waived	Covered under Routine Adult Exams
<b>Routine Eye Exams</b> 1 routine exam per 12 months.	Covered 100%; deductible waived	Not Covered
<b>Routine Hearing Screening</b>	Covered 100%; deductible waived	40%; after deductible
<b>PHYSICIAN SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Office Visits to Non-Specialist</b> Includes services of an internist, general physician, family practitioner or pediatrician.	\$30 copay; deductible waived	40%; after deductible
<b>Specialist Office Visits</b>	\$30 copay; deductible waived	40%; after deductible
<b>Non-Routine OB/GYN Office Visits</b>	\$30 copay; deductible waived	40%; after deductible
<b>Non-Routine Mammogram Office Visits</b>	Covered 100%; deductible waived	40%; after deductible
<b>Audiometric Hearing Exam</b>	Not Covered	Not Covered
<b>Pre-Natal Maternity</b>	Covered 100%; deductible waived	Covered according to standard claim practice.
<b>Walk-in Clinics</b>	<b>Designated Walk-in Clinics</b> Covered 100%; deductible waived	Not Covered
	<b>All Other Network Providers</b> \$30 copay; deductible waived	Not Covered
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.		
<b>Allergy Testing</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
<b>Allergy Injections</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
<b>DIAGNOSTIC PROCEDURES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Diagnostic X-ray</b> (other than 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.	20%; after deductible	40%; after deductible
<b>Diagnostic Laboratory</b> 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.	20%; after deductible	40%; after deductible
<b>Diagnostic Complex Imaging</b>	20%; after deductible	40%; after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Urgent Care Provider</b>	\$30 copay; deductible waived	40%; after deductible
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered	Not Covered
<b>Emergency Room</b>	20%; after deductible	Same as in-network care
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered	Not Covered
<b>Emergency Use of Ambulance</b>	20%; after deductible	Same as in-network care
<b>Non-Emergency Use of Ambulance</b>	Not Covered	Not Covered



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<b>HOSPITAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient Coverage</b> The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20%; after deductible	40%; after deductible
<b>Inpatient Maternity Coverage</b> (includes delivery and postpartum care) The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20%; after deductible	40%; after deductible
<b>Outpatient Hospital Expenses</b> The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	20%; after deductible	40%; after deductible
<b>Outpatient Surgery - Hospital</b> The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	20%; after deductible	40%; after deductible
<b>Outpatient Surgery - Freestanding Facility</b> The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	20%; after deductible	40%; after deductible
<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient</b> The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20%; after deductible	40%; after deductible
<b>Outpatient</b> The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	\$20 copay; deductible waived	40%; after deductible
<b>ALCOHOL/DRUG ABUSE SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient</b> The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20%; after deductible	40%; after deductible
<b>Residential Treatment Facility</b>	20%; after deductible	40%; after deductible
<b>Outpatient</b> The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	\$20 copay; deductible waived	40%; after deductible
<b>OTHER SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Convalescent Facility</b> Limited to 100 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20%; after deductible	40%; after deductible
<b>Home Health Care</b> Limited to 90 visits per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.	20%; after deductible	40%; after deductible
<b>Hospice Care - Inpatient</b> The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20%; after deductible	40%; after deductible
<b>Hospice Care - Outpatient</b> The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	20%; after deductible	40%; after deductible
<b>Private Duty Nursing</b>	Not Covered	Not Covered
<b>Outpatient Speech Therapy</b> Limited to 30 days per calendar year.	20%; after deductible	40%; after deductible
<b>Outpatient Physical and Occupational Therapy</b> Limited to 30 visits per calendar year combined.	20%; after deductible	40%; after deductible
<b>Spinal Manipulation Therapy</b> Limited to 30 visits per calendar year.	20%; after deductible	40%; after deductible
<b>Autism Behavioral Therapy</b> Combined with outpatient mental health visits	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health



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<b>Autism Applied Behavior Analysis</b>	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
<b>Autism Physical Therapy</b>	\$30 copay; deductible waived	40%; after deductible
<b>Autism Occupational Therapy</b>	\$30 copay; deductible waived	40%; after deductible
<b>Autism Speech Therapy</b>	\$30 copay; deductible waived	40%; after deductible
<b>Durable Medical Equipment</b>	20%; after deductible	40%; after deductible
<b>Diabetic Supplies</b>	Covered same as any other medical expense.	Covered same as any other medical expense.
<b>Generic FDA-approved Women's Contraceptives</b>	Covered 100%; deductible waived	40%; after deductible
<b>Contraceptive drugs and devices not obtainable at a pharmacy</b>	Covered 100%; deductible waived	Covered same as any other medical expense.
<b>Vision Eyewear</b>	Not Covered	Same as preferred care.
<b>Transplants</b>	20%; after deductible Preferred coverage is provided at an IOE contracted facility only.	40%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
<b>Bariatric Surgery</b>	Not Covered	Not Covered
<b>Early Intervention Services</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
<b>FAMILY PLANNING</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Infertility Treatment</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Diagnosis and treatment of the underlying medical condition.		
<b>Comprehensive Infertility Services</b>	Not Covered	Not Covered
<b>Advanced Reproductive Technology (ART)</b>	Not Covered	Not Covered
<b>Vasectomy</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
<b>Tubal Ligation</b>	Covered 100%; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
<b>PHARMACY</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Pharmacy Plan Type</b>	Aetna Advanced Control Formulary	
<b>Retail</b> (Up to a 31-60 day supply available for 2x copay and up to a 61-90 day supply available for 3x copay).	\$10 copay for formulary generic drugs, \$30 copay for formulary brand-name drugs, and \$50 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.	Not Covered
<b>Mail Order</b>	\$20 copay for formulary generic drugs, \$60 copay for formulary brand-name drugs, and \$100 copay for non-formulary brand-name and generic drugs. Up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not Covered



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<b>Aetna Advanced Control Specialty Drugs</b>	\$10 copay for formulary generic drugs, \$30 copay for formulary brand-name drugs, and \$50 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.	Not Covered
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All prescription fills must be through our preferred Aetna Specialty Pharmacy network.

**Advanced Control Specialty Drug List**

**Choose Generics** - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.

**Plan Includes:** Contraceptive drugs and devices obtainable from a pharmacy.

A limited list of over-the-counter medications are covered when filled with a prescription.

Performance Enhancing Drugs limited to 6 tablets per month.

Advanced Control Pre-certification included

Advanced Control Step Therapy included

Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.

<b>Prescription Drug Annual Out of Pocket Maximum</b>	\$2,850 Individual \$5,700 Family	Not Covered
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**GENERAL PROVISIONS**

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

Plans are provided by: Aetna Life Insurance Company. 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.



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- 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 receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery 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 the material into another language may be available. Please call Member Services at **1-888-982-3862**.

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](http://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.