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)	$100 Individual $200 Family
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.	
Member Coinsurance	10%
Applies to all expenses unless otherwise stated.	
Payment Limit (per calendar year)	$3,500 Individual $7,000 Family
Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses 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.	
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%; deductible waived
1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived
7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	
Routine Gynecological Care Exams	Covered 100%; deductible waived
1 exam and pap smear per year, includes related fees.	
Routine Mammograms	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived
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 Exam	Covered 100%; deductible waived
Recommended: For covered males age 40 and over.	
Prostate-specific Antigen Test	Covered 100%; deductible waived
Recommended: For covered males age 40 and over.	
Colorectal Cancer Screening	Covered 100%; deductible waived
Recommended: For all members age 45 and over.	

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Routine Hearing Screening	Covered 100%; deductible waived
Medications	Certain over-the-counter preventive medications covered 100% in network.
PHYSICIAN SERVICES	**IN-NETWORK**
Primary Care Physician Visits	$25 office visit copay; after deductible
Specialist Office Visits	$40 office visit copay; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.	
Hearing Exams	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived
Walk-in Clinics	$25 copay; after deductible **Designated Walk-in Clinics** Covered 100%; deductible waived
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.	
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	10%; after deductible
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.	
Diagnostic Laboratory	10%; after deductible
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.	
Diagnostic Complex Imaging	10%; after deductible
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.	
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care Provider	$75 office visit copay; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	$100 copay; after deductible
Copay waived if admitted	
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	10%; after deductible
Non-Emergency Use of Ambulance	10%; after deductible
HOSPITAL CARE	**IN-NETWORK**
Inpatient Coverage	$125 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Inpatient Maternity Coverage (includes delivery and postpartum care)	$125 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Outpatient Hospital	10%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	
Outpatient Surgery - Hospital	$100 copay; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	

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Outpatient Surgery - Freestanding Facility	$100 copay; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient	$125 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Mental Health Office Visits	$40 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Mental Health Services	Covered 100%; deductible waived
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient	$125 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Residential Treatment Facility	$125 copay; after deductible
Substance Abuse Office Visits	$40 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Substance Abuse Services	Covered 100%; deductible waived
OTHER SERVICES	**IN-NETWORK**
Skilled Nursing Facility	$125 copay; after deductible
Limited to 30 days per year	
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Home Health Care	10%; after deductible
Limited to 90 visits per year	
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	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Hospice Care - Outpatient	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Private Duty Nursing	Not Covered
Outpatient Short-Term Rehabilitation	$40 copay; after deductible
Limited to 90 visits per year	
Includes speech, physical, occupational therapy	
Spinal Manipulation Therapy	$40 copay; after deductible
Limited to 20 visits per year	
Habilitative Physical Therapy	Refer to MBH Outpatient Mental Health All Other
Habilitative Occupational Therapy	Refer to MBH Outpatient Mental Health All Other
Habilitative Speech Therapy	Refer to MBH Outpatient Mental Health All Other
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health
Combined with outpatient mental health visits	
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	Refer to MBH Outpatient Mental Health All Other
Autism Occupational Therapy	Refer to MBH Outpatient Mental Health All Other
Autism Speech Therapy	Refer to MBH Outpatient Mental Health All Other
Durable Medical Equipment	10%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived

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Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived
Infusion Therapy Administered in the home or physician's office	$40 copay; after deductible
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	$125 copay; after deductible Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery	$125 copay; after deductible
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 Artificial insemination and ovulation induction.	10%; after deductible
Advanced Reproductive Technology (ART)	10%; after deductible
ART coverage includes: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Limited to $10,000 per lifetime. Maximum applies to all procedures covered by any of our plans except where prohibited by law.	
Vasectomy	10%; after deductible
Tubal Ligation	Covered 100%; deductible waived
GENERAL PROVISIONS	
Dependents Eligibility - Spouse, Domestic Partner and 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.

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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 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.