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)	$1,750 Individual $5,000 Family
Unless otherwise indicated, the deductible must be met prior to benefits being payable. 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	20%
Applies to all expenses unless otherwise stated.	
Payment Limit (per calendar year)	$7,900 Individual $15,800 Family
Certain member cost sharing elements may not apply toward 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	Covered 100%; deductible waived
7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per year 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
Recommended:1 per calendar year age 40 and over	
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.	
Routine Eye Exams	Covered 100%; deductible waived
1 routine exam per 24 months.	
Routine Hearing Screening	Covered 100%; deductible waived
Medications	Certain over-the-counter preventive medications covered 100% in network.

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PHYSICIAN SERVICES	IN-NETWORK
Office Visits to member's selected Primary Care Physician	$30 copay; deductible waived
Specialist Office Visits Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.	$50 copay; deductible waived
Hearing Exams 1 routine exam per 24 months.	$50 copay; deductible waived
Pre-Natal Maternity	Covered 100%; deductible waived
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.	$30 copay; deductible waived
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
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.	Preventative X-Ray covered in Full. Diagnostic X-Ray 20%; after deductible for Free Standing Facility 30%; after deductible for Hospital Based
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.	Preventative Lab covered in Full Diagnostic Lab 20%; after deductible for Free Standing Facility 30%; after deductible for Hospital Based
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.	15%; after deductible for Free Standing Facility 25%; after deductible for Hospital Based
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care Provider	$150 copay; deductible waived
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room Copay waived if admitted	$300 copay; deductible waived
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	20%; after deductible
Non-Emergency Use of Ambulance	Not Covered

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HOSPITAL CARE	IN-NETWORK
Inpatient Coverage Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible
Outpatient Hospital The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	20%; after deductible
Outpatient Surgery - Hospital The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	20%; after deductible
Outpatient Surgery - Freestanding Facility The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	20%; after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible
Mental Health Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$50 copay; deductible waived
Other Mental Health Services	Covered 100%; deductible waived
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible
Residential Treatment Facility	20%; after deductible
Substance Abuse Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$50 copay; deductible waived
Other Substance Abuse Services	Covered 100%; deductible waived
OTHER SERVICES	**IN-NETWORK**
Skilled Nursing Facility Limited to 60 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible
Home Health Care Limited to 80 visits per year Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	20%; after deductible
Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible
Private Duty Nursing Limited to 70 eight-hour shifts per year. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.	20%; after deductible
Outpatient Rehabilitative Speech Therapy Limited to 30 visits per year	$50 copay; deductible waived
Spinal Manipulation Therapy Limited to 20 visits per year	$50 copay; deductible waived
Outpatient Physical Therapy Limited to 30 visits per calendar year.	$50 copay; deductible waived

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Outpatient Occupational Therapy Limited to 30 visits per calendar year.	$50 copay; deductible waived
Habilitative Physical Therapy	Not Covered
Habilitative Occupational Therapy	Not Covered
Habilitative Speech Therapy	Not Covered
Autism Behavioral Therapy Combined with outpatient mental health visits	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered the same as any other Mental Health Other services benefit.	Refer to MBH Mental Health Other Services
Autism Physical Therapy	$50 copay; deductible waived
Autism Occupational Therapy	$50 copay; deductible waived
Autism Speech Therapy	$50 copay; deductible waived
Durable Medical Equipment	20%; after deductible
Hearing Aids Limited to $1,000 maximum per 24 months for child to age 13 years.	Covered 100%; deductible waived
Nutritional Support Limited to 3 visits per calendar year.	Your cost sharing is based on the type of service and where it is performed
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
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	Your cost sharing is based on the type of service and where it is performed
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	20%; after deductible Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery	Not Covered
FAMILY PLANNING	**IN-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Applicable cost sharing based on the type of service performed and place of service where rendered
Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered
Vasectomy	20%; after deductible
Tubal Ligation	Covered 100%; deductible waived
PHARMACY	**IN-NETWORK**
Pharmacy Plan Type	None

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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.
• 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.

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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.