PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-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 the effective date of the plan unless otherwise mandated. Refer to your plan documents for more information.		
Deductible (per plan year)	$3,000 Individual $6,000 Family	$15,000 Individual $45,000 Family
All covered expenses accumulate simultaneously toward both the in-network and out-of-network 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 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 Applies to all expenses unless otherwise stated.	30%	50%
Payment Limit (per plan year)	$4,000 Individual $8,000 Family	$30,000 Individual $90,000 Family
All covered expenses accumulate simultaneously toward both the in-network and out-of-network Payment Limit. 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.		
Payment for Out-of-Network Care**	Not Applicable	Provider: 100% of Medicare Facility: 100% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network 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.		
Referral Requirement	None	None
Network Designations- In order to be covered at the preferred in-network benefit level you must use a designated provider for care. If you receive care from a non-designated provider your care may be paid at the out-of-network benefit level or may not be covered at all.		
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65 and older	Covered 100%; deductible waived	50%; after deductible
Routine Well Child Exams 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%; deductible waived	50%; after deductible
Childhood Immunizations	Covered 100%; deductible waived	50%; after deductible. Covered 100% from birth to age 6; deductible waived

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Routine Gynecological Care Exams 1 obgyn exam and pap smear per year	Covered 100%; deductible waived	50%; after deductible
Routine Mammograms	Covered 100%; deductible waived	50%; after deductible
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%; deductible waived	50%; after deductible
Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	50%; after deductible
Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	50%; after deductible
Colorectal Cancer Screening Recommended: For all members age 45 and over.	Covered 100%; deductible waived	50%; after deductible
Routine Eye Exams 1 routine exam per 12 months.	Covered 100%; deductible waived	50%; after deductible
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician.	30%; after deductible	50%; after deductible
Specialist Office Visits	30%; after deductible	50%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
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%; after deductible	50%; after deductible
Allergy Testing	Your cost sharing depends on the type of service and where you receive it.	Your cost sharing depends on the type of service and where you receive it.
Allergy Injections	Your cost sharing depends on the type of service and where you receive it.	Your cost sharing depends on the type of service and where you receive it.
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-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.	30%; after deductible	50%; after deductible
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.	30%; after deductible	50%; after deductible
Diagnostic Outpatient 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.	30%; after deductible	50%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	30%; after deductible	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered

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Emergency Room	30%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	30%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	30%; after deductible	50%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	30%; after deductible	50%; after deductible
Substance Abuse Office Visits	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	30%; after deductible	50%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	30%; after deductible	50%; after deductible
Limited to 60 visits per year. Home health care services include private duty nursing 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	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing – Outpatient	Covered as part of Home Health Care	Covered as part of Home Health Care
Chiropractic Care	30%; after deductible	50%; after deductible

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Early Intervention Services	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of services and where it is performed
Children from birth to age 3; includes short-term rehabilitation services, up to $3,000 per year and $9,000 maximum per child.		
Outpatient Speech Therapy	30%; after deductible	50%; after deductible
Outpatient Physical and Occupational Therapy Limited to 60 visits per year combined.	30%; after deductible	50%; after deductible
Habilitative Physical Therapy	30%; after deductible	50%; after deductible
Habilitative Occupational Therapy	30%; after deductible	50%; after deductible
Habilitative Speech Therapy	30%; after deductible	50%; after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	30%; after deductible	50%; after deductible
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	30%; after deductible	50%; after deductible
Autism Physical Therapy	30%; after deductible	50%; after deductible
Autism Occupational Therapy	30%; after deductible	50%; after deductible
Autism Speech Therapy	30%; after deductible	50%; after deductible
Durable Medical Equipment	30%; after deductible	50%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Affordable Care Act Mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Hearing Aids Limited for hearing aid per ear, to Age 18 per every 4 year	30%; after deductible	50%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	30%; after deductible	50%; after deductible
Vision Eyewear	Not Covered	Not Covered
Transplants	30%; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Acupuncture Limited to 10 visits per year	30%; after deductible	50%; after deductible
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	Your cost sharing depends on the type of service and where you receive it.	Your cost sharing depends on the type of service and where you receive it.
Diagnosis and treatment of the underlying medical condition only same as any other covered expense and 70% after deductible 6 cycles maximum per lifetime for artificial insemination, ovulation induction and $10,000 maximum per lifetime for advanced reproductive technology.		

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Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART) 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.	Not Covered	Not Covered
Vasectomy	Your cost sharing depends on the type of service and where you receive it.	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Pharmacy Plan Type	Advanced Control Plan - Aetna	
Preferred Generic Drugs		
Retail	$15 copay	50% of submitted cost; after applicable in-network cost share
Mail Order	$37.50 copay	50% of submitted cost; after applicable in-network cost share
Preferred Brand-Name Drugs		
Retail	$40 copay	50% of submitted cost; after applicable in-network cost share
Mail Order	$100 copay	50% of submitted cost; after applicable in-network cost share
Non-Preferred Generic and Brand-Name Drugs		
Retail	$60 copay	50% of submitted cost; after applicable in-network cost share
Mail Order	$150 copay	50% of submitted cost; after applicable in-network cost share
Specialty Drugs		
Preferred Specialty	$120 copay after deductible	Not Covered
Non-Preferred Specialty	$120 copay after deductible	Not Covered
Pharmacy Day Supply and Requirements		
Retail	Up to a 34 day supply from Aetna National Network For a 35-101 day supply you will be responsible for the Mail Order Drug copay.	
Mail Order	A 35-101 day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	Up to a 30 day supply Advanced Control Formulary Aetna Insured List A 35-101 day supply from CVS Caremark® Mail Service Pharmacy	
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: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. A limited list of over-the-counter medications are covered when filled with a prescription. Oral fertility drugs included. Oral chemotherapy drugs covered 100% Precertification and quantity limits included Advanced Control Formulary Aetna Insured Step Therapy		

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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.

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

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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
• 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 the material into another language may be available. Please call Member Services at **1-888-982-3862.**

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.