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

PLAN FEATURES	
Benefit limitations - Some service or supplies have limits on them per year. There might be a maximum number of visits or days, or a dollar limit per year. In such cases, the benefit year begins on January 1 (unless otherwise noted). Refer to your plan documents to learn more.	
Deductible	$300 per Individual $600 per Family
You must first meet the deductible before the plan begins paying benefits, unless otherwise noted. The amount you pay (cost sharing) for some medical services does not count toward your deductible. Prescription drug costs do not count toward the deductible. Refer to your plan documents for details. Your family will have one deductible. You will meet it when the expenses of several family members add up to the family deductible. No one person will have to pay more than the individual deductible.	
Member coinsurance	You pay 20%
Applies to all expenses except as noted.	
Out-of-pocket limit (per calendar year)	$2,500 per Individual $5,000 per Family
Some of your cost sharing may not count toward the out-of-pocket limit. Your pharmacy expenses count toward your out-of-pocket limit. Out-of-network expenses include coinsurance. Penalty amounts do not apply Your family will have one out-of-pocket limit. You will meet it when the expenses of several family members add up to the family out-of-pocket limit. No one person will have to pay more than the individual out-of-pocket limit amount.	
Lifetime maximum	Unlimited except where otherwise indicated.
Primary care physician selection	Encouraged
Referral requirement	Not required
PREVENTIVE CARE	
Routine adult physical exams/ immunizations	Covered 100%; no deductible
1 exam every calendar year	
Routine well child exams/immunizations	Covered 100%; no deductible
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 calendar year thereafter to age 22.	
Routine gynecological care exams	Covered 100%; no deductible
Routine mammogram	Covered 100%; no deductible
Women's health	Covered 100%; no deductible
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. Also includes: contraceptive methods (ACA mandated contraceptives, including contraceptives and devices you can't get at a pharmacy), sterilization procedures (including tubal ligation), patient education and counseling. Limits may apply.	
Pre-natal maternity	Covered 100%; no deductible
Routine digital rectal exam	Covered 100%; no deductible
Recommended: For members age 40 and over	
Prostate-specific antigen test	Covered 100%; no deductible
Recommended: For members age 40 and over	
Colorectal cancer screening	Covered 100%; no deductible
Recommended: For members age 45 and over	
Routine eye exams	Not Covered
Routine hearing screening	Covered 100%; no deductible

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PHYSICIAN SERVICES	
Office visits to non-specialist	20%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.	
Specialist office visits	20%; after deductible
Hearing exams	Covered 100%; no deductible
Walk-in clinics	Not Covered
Allergy testing	Your cost sharing amount depends on the type of service and where you receive it.
Allergy injections	Your cost sharing amount depends on the type of service and where you receive it.
DIAGNOSTIC PROCEDURES	
Diagnostic X-ray (Other than complex imaging services)	20%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	
Diagnostic laboratory	20%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	
Diagnostic complex imaging	20%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	
EMERGENCY MEDICAL CARE	
Urgent care provider	20%; after deductible
Non-urgent use of urgent care provider	Not Covered
Emergency room	20%; after deductible
Non-emergency care in an emergency room	50%; after deductible
Emergency use of ambulance	20%; after deductible
Non-emergency use of ambulance	Not Covered
HOSPITAL CARE	
Inpatient coverage	20% after $100 copay; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Inpatient maternity coverage (includes delivery and postpartum care)	20% after $100 copay; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Outpatient hospital expenses	20%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	
MENTAL HEALTH SERVICES	
Inpatient	20% after $100 copay; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Mental health office visits	20%; after deductible
Other mental health services	20%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	

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SUBSTANCE ABUSE	
Inpatient	20% after $100 copay; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Residential treatment facility	20% after $100 copay; after deductible
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Substance abuse office visits	20%; after deductible
Other substance abuse services	20%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	
THERAPY SERVICES	
Spinal manipulation therapy	20%; after deductible
Outpatient short-term rehabilitation	20%; after deductible
Includes physical, occupational, and speech therapies.	
Habilitative physical therapy	20%; after deductible
Habilitative occupational therapy	20%; after deductible
Habilitative speech therapy	20%; after deductible
Autism related physical therapy	20%; after deductible
Autism related occupational therapy	20%; after deductible
Autism related speech therapy	20%; after deductible
Autism related behavioral therapy	20%; after deductible
These benefits are combined with outpatient mental health visits	
Autism related applied behavior analysis	20%; after deductible
Your benefits for these services are the same as any other outpatient mental health other services benefits.	
OTHER SERVICES	
Skilled nursing facility	20% after $100 copay; after deductible
Limited to 60 days per year	
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Home health care	20%; after deductible
Limited to 120 visits per year	
Private duty nursing not included.	
Limited to three visits per day by staff from a home health care agency. One visit equals a period of four hours or less.	
Hospice care - inpatient	20% after $100 copay; after deductible
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Hospice care - outpatient	20%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	
Aetna Compassionate Care Program (ACCP) Inpatient and Outpatient - Enrollment available to members with a 12 month terminal prognosis. Members would be able to continue receiving curative care.	
Private duty nursing - outpatient	20%; after deductible
Limited to 70 eight hour shifts per year.	
We count each period of up to 8 hours as one private duty nursing shift.	
Durable medical equipment	20%; after deductible

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Diabetic supplies -- (if not covered under the prescription drug benefit)	Covered same as any other medical expense. You pay your prescription drug cost sharing amount if you have prescription drug coverage. If not, you pay your PCP visit cost sharing amount.
Infusion therapy Administered in the home or physician's office	20%; after deductible
Infusion therapy Administered in an outpatient hospital department or freestanding facility	20%; after deductible
Hearing aids	Not Covered
Transplants	20% after $100 copay; after deductible
Bariatric surgery	20% after $100 copay; after deductible
Acupuncture Limited to 10 visits per year	20%; after deductible
FAMILY PLANNING	
Infertility treatment	Your cost sharing amount depends on the type of service and where you receive it.
You have coverage for the diagnosis and treatment of the underlying cause of infertility.	
Comprehensive infertility services Artificial insemination and ovulation induction	20%; after deductible
Advanced Reproductive Technology (ART)	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	
Tubal ligation	Covered 100%; no deductible
Vasectomy	Your cost sharing depends on the type of service and where you receive it.
PHARMACY	
Pharmacy plan type	None
GENERAL PROVISIONS	
Dependents who are eligible to be on your plan	Spouse, children from birth to age 26. Student status of children does not matter.

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. 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.

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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 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.