The Segal Company
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PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK
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 (per calendar year)	$100 per Individual $200 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 Applies to all expenses except as noted.	Covered 100%
Out-of-pocket limit (per calendar year)	$2,000 per Individual $4,000 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. In-network expenses include coinsurance/copays and deductibles. 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
Telehealth consultations - You can access covered services for telehealth visits from different kinds of providers in your plan. Log on to **Aetna.com** to see a list of telehealth providers. You'll also find more about your options, including cost share amounts.	
PREVENTIVE CARE	**IN-NETWORK**
Routine adult physical exams/ immunizations 1 exam every year	Covered 100%; no deductible
Routine well child exams/immunizations • 7 exams in the first 12 months • 3 exams from age 13 through 24 months • 3 exams from age 25 through 36 months • 1 exam every 12 months from age 3 until age 22 years	Covered 100%; no deductible
Routine gynecological care exams 2 exams and pap smears per year, including related fees	Covered 100%; no deductible
Virtual primary care (VPC) preventive care consultations Includes screening and counseling services for members age 18 and older	Covered 100%; no deductible
Routine mammogram Recommended: One per year for members age 40 and over	Covered 100%; no deductible

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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	Covered 100%; no deductible
1 routine exam per 24 months.	
Routine hearing screening	Covered 100%; no deductible
PHYSICIAN SERVICES	**IN-NETWORK**
Office visits to primary care physician (PCP)	$25 office visit copay; no deductible
Includes services of an internist, general physician, family practitioner or pediatrician.	
Virtual primary care (VPC) consultations	Covered 100%; no deductible
Includes basic medical service consultations for members age 18 and older	
Telehealth consultation with non-specialist	$25 office visit copay; no deductible
Specialist office visits	$40 office visit copay; no deductible
Telehealth consultation with specialist	$40 office visit copay; no deductible
Hearing exams	Not Covered
Walk-in clinics	$25 copay; no deductible
Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services. Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices.	
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. Covered 100% when an office visit charge is not applicable.
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic X-ray (Other than complex imaging services)	$50 copay; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	
Diagnostic laboratory	$50 copay; 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	$50 copay; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	

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EMERGENCY MEDICAL CARE	IN-NETWORK
Urgent care provider	$50 office visit copay; no deductible
Non-urgent use of urgent care provider	Not Covered
Emergency room Copay waived if admitted	$100 copay; no deductible
Non-emergency care in an emergency room	Not Covered
Emergency use of ambulance	Covered 100%; no deductible
Non-emergency use of ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK**
Inpatient coverage	$500 copay; after deductible
Per confinement charge applied per admission, 3x limit per year, waived if readmitted to a hospital, regardless of cause, within 90 days. 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)	$500 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	Covered 100%; 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.	
Outpatient surgery - hospital	Covered 100%; 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.	
Outpatient surgery - freestanding facility	Covered 100%; 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	**IN-NETWORK**
Inpatient	$500 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 non-biologically based	$500 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Mental health office visits	$25 copay; no deductible
Crisis intervention services	$25 copay; no deductible
Mental health telehealth consultations	$25 office visit copay; no deductible
Other mental health services	Covered 100%; no 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	IN-NETWORK
Inpatient	$500 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	$500 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	$25 copay; no deductible
Substance abuse telehealth consultations	$25 office visit copay; no deductible
Other substance abuse services	Covered 100%; no 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	**IN-NETWORK**
Spinal manipulation therapy	$40 copay; no deductible
Outpatient rehabilitative physical and occupational therapy	$40 copay; no deductible
Outpatient rehabilitative speech therapy	$40 copay; no deductible
Habilitative physical therapy	Covered 100%; no deductible
Habilitative occupational therapy	Covered 100%; no deductible
Habilitative speech therapy	Covered 100%; no deductible
Autism related physical therapy	Covered 100%; no deductible
Autism related occupational therapy	Covered 100%; no deductible
Autism related speech therapy	Covered 100%; no deductible
Autism related behavioral therapy	$25 copay; no deductible
These benefits are combined with outpatient mental health visits	
Autism related applied behavior analysis	Covered 100%; no deductible
Covered same as any other Outpatient Mental Health benefit	
OTHER SERVICES	**IN-NETWORK**
Skilled nursing facility	$500 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.	
Home health care	Covered 100%; no deductible
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	$500 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	Covered 100%; no 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.	
Private duty nursing	Not Covered
Durable medical equipment	Covered 100%; after deductible
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.

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Infusion therapy - home/office	$40 copay; no deductible
Infusion therapy - outpatient hospital/freestanding facility	Your cost sharing amount depends on the type of service and where you receive it.
Hearing aids 1 hearing aid per ear every 3 years	Covered 100%; after deductible
Transplants	$500 copay; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.
Bariatric surgery	$500 per admission 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.	
Acupuncture Limited to 10 visits per year	$25 copay; no deductible
FAMILY PLANNING	**IN-NETWORK**
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	Covered 100%; no deductible
Advanced Reproductive Technology (ART)	Covered 100%; no deductible
Limited to 3 courses of treatment per member's lifetime. Maximum applies to all procedures covered by any of our plans except where prohibited by law. Coverage includes cryopreservation, storage and for iatrogenic only unlimited storage and cryopreservation. ART coverage includes Invitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery, and cryopreservation, unlimited storage.	
Vasectomy	Covered 100%; no deductible
Tubal ligation	Covered 100%; no deductible

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PHARMACY	IN-NETWORK
Pharmacy plan type	Advanced Control Plan - Aetna
Prescription drug out-of-pocket limit	Prescription drug expenses apply to your medical out-of-pocket limit.
Preferred generic drugs	
Retail	$15 copay
Mail order	$30 copay
Preferred brand-name drugs	
Retail	$30 copay
Mail order	$60 copay
Non-preferred generic and brand-name drugs	
Retail	$50 copay
Mail order	$100 copay
Pharmacy day supply and requirements	
Retail	You can get up to a 30-day supply from Aetna National Network
Mail order	You can get a 31-90-day supply from CVS Caremark® Mail Service Pharmacy.
Specialty	You can get up to a 30-day supply of specialty drugs You may fill your first prescription at any retail or specialty pharmacy. After that, all other fills must be through our preferred specialty pharmacy network. Advanced Control Formulary Aetna Insured List

Your prescription drug plan also includes:
• Diabetic supplies
• Insulin up to a $100 member payment maximum per fill per 30-day supply
• Sexual dysfunction drugs, including daily dose, additional 6 tablets a month for erectile dysfunction
• A limited list of over-the-counter medications when filled with a prescription

Family planning
• Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).
• Contraceptives covered up to a 12-month supply. Contraceptive copay strategy applies.

The following are covered 100% in-network:
• Oral chemotherapy drugs
• Seasonal vaccinations
• Preventive vaccinations
• Affordable Care Act (ACA) eligible preventive medications and contraceptives
Refer to **Aetna.com** for a complete list of eligible prescription drugs.

Precertification requirements
Some covered prescription drugs need approval from us before we will cover the drug.
Some covered prescription drugs require step therapy before we cover them. With step therapy, you must first try one or more drugs before we will pay for drugs that require step therapy.
To get the most up-to-date precertification requirements and a list of drugs that require step therapy, see your plan documents or go online to your member website.

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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. 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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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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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.