

PLAN DESIGN & BENEFITS
MEDICAL PLAN 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)	\$500 per Individual \$1,000 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 10%	
Applies to all expenses except as noted.		
Out-of-pocket limit (per calendar year)	\$5,000 per Individual \$10,000 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	
PREVENTIVE CARE	IN-NETWORK	
Routine adult physical exams/immunizations	Covered 100%; no deductible	
1 exam every 12 months until age 65, then 1 exam every 12 months age 65 and older		
Routine well child exams/immunizations	Covered 100%; no deductible	
<ul style="list-style-type: none">• 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		
Routine gynecological care exams	Covered 100%; no deductible	
1 exam and pap smear every 12 months, including HPV screening and related fees		
Routine mammogram	Covered 100%; no deductible	
Recommended: One per year for members age 40 and over		
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		

PLAN DESIGN & BENEFITS
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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 12 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.	
Specialist office visits	\$50 office visit copay; no deductible
Hearing exams	Not Covered
Walk-in clinics	\$25 copay; no deductible
	Designated Walk-in clinics
	Covered 100%; 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.
DIAGNOSTIC PROCEDURES	IN-NETWORK
Diagnostic X-ray (Other than complex imaging services)	10%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	
Diagnostic laboratory	10%; 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	10%; 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	IN-NETWORK
Urgent care provider	\$50 office visit copay; no deductible
Non-urgent use of urgent care provider	Not Covered
Emergency room	10% after \$300 copay; no deductible
Copay waived if admitted	
Non-emergency care in an emergency room	Not Covered
Emergency use of ambulance	10%; no deductible
Non-emergency use of ambulance	Not Covered
HOSPITAL CARE	IN-NETWORK
Inpatient coverage	10% after \$250 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	10% after \$250 copay; after deductible
(includes delivery and postpartum care)	
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Outpatient hospital	10%; 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	10%; 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	10%; 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	10% after \$250 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	\$15 copay; no deductible
Other mental health services	10%; 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.	
SUBSTANCE ABUSE	IN-NETWORK
Inpatient	10% after \$250 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	10% after \$250 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	\$15 copay; no deductible
Other substance abuse services	10%; 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	IN-NETWORK
Spinal manipulation therapy	\$50 copay; no deductible
Limited to 100 visits per year	
Outpatient short-term rehabilitation	10%; after deductible
Includes physical, occupational, and speech therapies.	
Habilitative physical therapy	10%; after deductible
Habilitative occupational therapy	10%; after deductible
Habilitative speech therapy	10%; after deductible
Autism related physical therapy	10%; after deductible
Autism related occupational therapy	10%; after deductible
Autism related speech therapy	10%; after deductible
Autism related behavioral therapy	\$15 copay; no deductible
These benefits are combined with outpatient mental health visits	
Autism related applied behavior analysis	10%; after deductible
Your benefits for these services are the same as any other outpatient mental health other services benefit	

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

OTHER SERVICES		IN-NETWORK
Skilled nursing facility		10%; after deductible
Limited to 120 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		10%; after deductible
Limited to 120 visits per year		
Home health care services include private duty nursing		
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		Covered 100%; no 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		Covered as part of home health care
We count each period of up to 8 hours as one private duty nursing shift.		
Durable medical equipment		10%; after deductible
Orthotics		10%; after deductible
Orthotics and special footwear covered for persons with foot disfigurement.		
Hearing Aids		10%; after deductible
Limited to a pair of hearing aids every 36 months.		
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 - home/office		\$50 copay; no deductible
Infusion therapy - outpatient hospital/freestanding facility		10%; after deductible
Transplants		10% after \$250 copay; after deductible
In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.		
Bariatric surgery		10% after \$250 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		\$25 copay; no deductible
Limited to 20 visits per year		
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		10%; after deductible
Artificial insemination and ovulation induction. Limited to a lifetime maximum of \$15,000 combined with Advanced Reproductive Technology (ART).		
Advanced Reproductive Technology (ART)		10%; after deductible
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery. Limited to a lifetime maximum of \$15,000 combined with Comprehensive infertility services.		
Vasectomy		Your cost sharing amount depends on the type of service and where you receive it.

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Tubal ligation	Covered 100%; no deductible	
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	\$50 copay
	Mail order	\$100 copay
Non-preferred generic and brand-name drugs		
	Retail	\$85 copay
		\$170 copay
Specialty drugs		
	Preferred specialty	20% Maximum \$200
	Non-preferred specialty	20% Maximum \$200
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 must fill all specialty drugs through our preferred specialty pharmacy network. Advanced Control Formulary Aetna Insured List
Your prescription drug plan also includes:		
	<ul style="list-style-type: none"> • Diabetic supplies • Prescription weight loss drugs • 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		
	• Contraceptives covered up to a 12-month supply. Contraceptive copay strategy applies.	
The following are covered 100% in-network:		
	<ul style="list-style-type: none"> • 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. If you are currently taking one of these drugs when you switch to this plan, you may get one fill of your prescription within the first 90 days of starting the plan.	
	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. If you are currently taking one of these drugs when you switch to this plan, you may get one fill of your prescription within the first 90 days of starting this plan.	
	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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Choose generics - Sometimes you or your provider may ask for a brand-name prescription drug when a generic is available. If so, you will pay the brand-name copay plus the difference between the generic price and the brand-name price.

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.
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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.



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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 traducción 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.