PLAN DESIGN & BENEFITS
PROVIDED BY AETNA HEALTH INC. - FULL RISK

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)	None None
Out-of-Pocket Maximum (per calendar year)	$1,500 Individual $3,000 Family
In-Network expenses include coinsurance/copays and deductibles. Pharmacy expenses apply towards the Out-of-Pocket-Maximum. The family Out-of-Pocket Maximum is a cumulative Out-of-Pocket Maximum for all family members. The family Out-of-Pocket Maximum can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Out-of-Pocket Maximum amount.	
Lifetime Maximum	Unlimited
Primary Care Physician Selection	Required
Referral Requirement	Required
Telehealth consultations - Covered services for telemedicine consultations are available from a number of different kinds of providers under your plan. Log onto your secure Aetna website at https://www.aetna.com to review our telemedicine provider listings and get more information about your options, including specific cost sharing amounts.	
PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members age 22 and older. Includes coverage for travel immunizations and any other medically necessary immunizations.	Covered 100%
Routine Well Child Exams/Immunizations (Age and frequency schedules apply)	Covered 100%
Routine Gynecological Care Exams 1 exam per 12 months Includes Pap smear, HPV screening, and related lab fees.	Covered 100%
Routine Mammograms Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	Covered 100%
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
Routine Digital Rectal Exams / Prostate Specific Antigen Test Recommended for males age 40 and over.	Covered 100%
Colorectal Cancer Screening Recommended: For all members age 50 and over. Frequency schedule applies.	Covered 100%

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Routine Eye Exams 1 routine exam per 24 months. Direct access to participating providers without a referral.	Covered 100%
Routine Hearing Screening	Covered 100%
PHYSICIAN SERVICES	**IN-NETWORK**
Primary Care Physician Visits Includes services of an internist, general physician, family practitioner or pediatrician.	$10 office visit copay. After office hours/home $15 copay
Specialist Office Visits	$10 copay
Pre-Natal Maternity	Covered 100%
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.	$10 copay
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 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.	Covered 100%
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.	$10 copay
Diagnostic X-ray for Complex Imaging Services 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.	$100 copay
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care Provider	$35 copay
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room Copay waived if admitted	$100 copay
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	$100 copay
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK**
Inpatient Coverage Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$100 copay
Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$10 for Physician Maternity Services; deductible waived $100 copay for Facility Services
Outpatient Hospital Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$100 copay
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$100 copay

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Mental Health Office Visits	$10 copay
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient Detoxification	$100 copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Outpatient Detoxification	$10 copay
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Inpatient Rehabilitation	$100 copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Residential Treatment Facility	$100 copay
Outpatient Rehabilitation	$10 copay
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
OTHER SERVICES	**IN-NETWORK**
Skilled Nursing Facility	$100 copay
Limited to 100 days; per calendar year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Home Health Care	Covered at 100%
Hospice Care - Inpatient	$100 copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Hospice Care - Outpatient	Covered at 100%
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Outpatient Rehabilitation Therapy	$10 per visit
Treatment over a 60 day consecutive period per incident of illness or injury beginning with the first day of treatment. Includes speech, physical, occupational therapy	
Spinal Manipulation Therapy	$15 per visit
Limited to 20 days; per calendar year	
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health
Covered same as any other Outpatient Mental Health benefit	
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health Other Services
Covered same as any other Outpatient Mental Health Other Services benefit	
Autism Physical Therapy	$10 per visit
Visits combined with Short Term Rehabilitation.	
Autism Occupational Therapy	$10 per visit
Visits combined with Short Term Rehabilitation.	
Autism Speech Therapy	$10 per visit
Visits combined with Short Term Rehabilitation.	
Durable Medical Equipment	20%
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered at 100%
Affordable Care Act mandated Women's Contraceptives	Covered at 100%
Transplants	$100 copay Preferred coverage is provided at an IOE contracted facility only.

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Bariatric Surgery	$100 copay The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.
Acupuncture Limited to 20 visits per year	$10 per visit
FAMILY PLANNING	**IN-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing amount depends on the type of service and where you receive it.
Comprehensive Infertility Services Artificial insemination and ovulation induction	100% covered after $10 copay, 6 cycle maximum per lifetime
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	Your cost sharing amount depends on the type of service and where you receive it.
Tubal Ligation	100% covered

PRESCRIPTION DRUG BENEFITS	**IN-NETWORK**
Pharmacy Plan Type	Advanced Control Plan - Aetna
Preferred Generic Drugs	
Retail	$15 Copay
Mail Order	$30 copay
Preferred Brand-Name Drugs	
Retail	$25 copay
Mail Order	$50 copay
Non-Preferred Generic and Brand-Name Drugs	
Retail	$40 copay
Mail Order	$80 copay
Pharmacy Day Supply and Requirements	
Retail	Up to a 30-day supply from Aetna National Network Percentage copays will not be doubled

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Mail Order	A 31-90-day supply from CVS Caremark® Mail Service Pharmacy
Specialty	Up to a 30-day supply First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network. Advanced Control Formulary Aetna Insured List

Choose Generics - If the member or the physician requests brand-name when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.

GENERAL PROVISIONS

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

Exclusions and Limitations

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. Each insurer has sole financial responsibility for its own products.

This material is for information only. Health benefits 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.

• 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.
• Durable medical equipment.
• 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.

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• Orthotics except diabetic orthotics.
• 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 or inadequacies including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Treatment of behavioral disorders.
• 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.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery and Aetna Specialty Pharmacy refer to Aetna Rx Home Delivery, LLC and Aetna Specialty Pharmacy, LLC, respectively. Aetna Rx Home Delivery and Aetna Specialty Pharmacy are licensed pharmacy subsidiaries of Aetna Inc. that operate through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery and Aetna Specialty 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 pharmacies' 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.

A medical emergency shall include those services provided to a member in a licensed facility by a provider after the recent onset of a medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in any of the following:
a. Serious jeopardy to the member's health.
b. Serious impairment to bodily functions.
c. Serious dysfunction of any bodily organ or part.

If you require language assistance, please call the Member Services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).

Si requiere la asistencia de un representante que hable su idioma, por favor llame al número de Servicios al Miembro que aparece en su tarjeta de identificación y se le comunicará con la línea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intérprete). TDD-1-800-628-3323 (sólo para las personas con impedimentos auditivos).

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **www.aetna.com.** While this material is believed to be accurate as of the production date, it is subject to change.