



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

<b>PLAN FEATURES</b>	<b>IN-NETWORK</b>
<b>Deductible</b> (per calendar year)	None
<b>Out-of-Pocket Maximum</b> (per calendar year)	None \$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.	
<b>Lifetime Maximum</b>	Unlimited
<b>Primary Care Physician Selection</b>	Required
<b>Referral Requirement</b>	Required
<b>PREVENTIVE CARE</b>	<b>IN-NETWORK</b>
<b>Routine Adult Physical Exams/ Immunizations</b> 1 exam every 12 months for members age 22 and older. Includes coverage for travel immunizations and any other medically necessary immunizations.	Covered 100%
<b>Routine Well Child Exams/Immunizations</b> (Age and frequency schedules apply)	Covered 100%
<b>Routine Gynecological Care Exams</b> 1 exam per 12 months Includes routine tests and related lab fees.	Covered 100%
<b>Routine Mammograms</b> Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	Covered 100%
<b>Women's Health</b> 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%
<b>Routine Digital Rectal Exams / Prostate Specific Antigen Test</b> Recommended for males age 40 and over.	Covered 100%
<b>Colorectal Cancer Screening</b> Recommended: For all members age 50 and over. Frequency schedule applies.	Covered 100%
<b>Routine Eye Exams</b> 1 routine exam per 24 months. Direct access to participating providers without a referral.	Covered 100%
<b>Routine Hearing Screening</b>	Covered 100%
<b>PHYSICIAN SERVICES</b>	<b>IN-NETWORK</b>
<b>Primary Care Physician Visits</b> Includes services of an internist, general physician, family practitioner or pediatrician.	\$10 office visit copay. After office hours/home \$15 copay



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<b>Specialist Office Visits</b>	\$10 copay
<b>Pre-Natal Maternity</b>	Covered 100%
<b>Walk-in Clinics</b>	\$10 copay
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.	
<b>Allergy Testing</b>	Your cost sharing is based on the type of service and where it is performed
<b>Allergy Injections</b>	Your cost sharing is based on the type of service and where it is performed
<b>DIAGNOSTIC PROCEDURES</b>	<b>IN-NETWORK</b>
<b>Diagnostic Laboratory</b>	Covered 100%
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.	
<b>Diagnostic X-ray</b>	\$10 copay
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.	
<b>Diagnostic X-ray for Complex Imaging Services</b>	\$100 copay
<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>
<b>Urgent Care Provider</b>	\$35 copay
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered
<b>Emergency Room</b>	\$100 copay
Copay waived if admitted	
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered
<b>Emergency Use of Ambulance</b>	\$100 copay
<b>Non-Emergency Use of Ambulance</b>	Not Covered
<b>HOSPITAL CARE</b>	<b>IN-NETWORK</b>
<b>Inpatient Coverage</b>	\$100 copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
<b>Inpatient Maternity Coverage</b> (includes delivery and postpartum care)	\$10 for Physician Maternity Services; deductible waived \$100 copay for Facility Services
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
<b>Outpatient Hospital</b>	\$100 copay
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK</b>
<b>Inpatient</b>	\$100 copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
<b>Mental Health Office Visits</b>	\$10 copay
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	



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



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<b>Bariatric Surgery</b>	\$100 copay
<b>Acupuncture</b>	\$10 per visit; Limited to 20 visits per year
<b>FAMILY PLANNING</b>	<b>IN-NETWORK</b>
<b>Infertility Treatment</b>	Your cost sharing is based on the type of service and where it is performed
Diagnosis and treatment of the underlying medical condition only.	
<b>Comprehensive Infertility Services</b>	Not Covered
Artificial insemination and ovulation induction	
<b>Advanced Reproductive Technology (ART)</b>	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	
<b>Vasectomy</b>	Your cost sharing is based on the type of service and where it is performed
<b>Tubal Ligation</b>	Covered 100%
<b>PRESCRIPTION DRUG BENEFITS</b>	<b>IN-NETWORK</b>

**Pharmacy Plan Type**                      Advanced Control Plan - Aetna

**Preferred Generic Drugs**

<b>Retail</b>	\$15 Copay
<b>Mail Order</b>	\$30 copay

**Preferred Brand-Name Drugs**

<b>Retail</b>	\$25 copay
<b>Mail Order</b>	\$50 copay

**Non-Preferred Generic and Brand-Name Drugs**

<b>Retail</b>	\$40 copay
<b>Mail Order</b>	\$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

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**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.

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

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**GENERAL PROVISIONS**

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

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**Exclusions and Limitations**

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**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.



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- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- 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](http://www.aetna.com). While this material is believed to be accurate as of the production date, it is subject to change.



California Institute of Technology  
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Aetna HMO

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