



PLAN DESIGN & BENEFITS  
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

<p>This plan only provides access to covered benefits when provided by a network provider. The plan does not provide access to covered benefits when provided by an out-of-network provider, except for emergency care provided for an emergency medical condition. This plan will pay for the emergency care subject to in-network benefits.</p>		
PLAN FEATURES	NETWORK CARE	OUT-OF-NETWORK CARE
<b>Primary Care Physician Selection</b>	Not required	Not applicable
<b>Deductible</b> (per plan year)	\$1,500 Individual \$3,000 Family	Not applicable
<p>Unless otherwise indicated, the deductible must be met before benefits can be paid.</p>		
<p>As indicated in the plan, member cost sharing for certain services are excluded from the charges to meet the deductible.</p>		
<p>No one family member may contribute more than the individual deductible amount to the family deductible.</p>		
<b>Member Coinsurance</b> (applies to all expenses unless otherwise stated)	20%	Not applicable
<b>Out-of-Pocket (OOP) Maximum</b> (per plan year, includes deductible)	\$5,000 Individual \$10,000 Family	Not applicable
<p>Pharmacy expenses apply towards the Out-of-Pocket Maximum. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and copays (except any penalty amounts) may be used to satisfy the out-of-pocket maximum.</p>		
<p>No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum.</p>		
<b>Referral Requirement</b>	Not Required	Not applicable
PHYSICIAN SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
<b>Office Visits to Non-Specialist</b>	\$25 copay deductible waived	Not covered
<p>Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illness or injury.</p>		
<b>Telemedicine Consultations to Non-Specialist</b>	\$25 copay deductible waived	Not covered
<b>Non-Specialist Telemedicine Provider Consultations</b>	Covered in full	Not covered
<b>Specialist Office Visits</b>	\$75 copay deductible waived	Not covered
<b>Telemedicine Consultations to Specialist</b>	\$75 copay deductible waived	Not covered
<b>Specialist Telemedicine Provider Consultations</b>	Covered in full	Not covered
<b>Walk-in Clinics</b>	<b>Designated Walk-in Clinics:</b> Covered in full  <b>All Other Network Providers:</b> \$25 copay deductible waived	Not covered
<p>Walk-in clinics are freestanding 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.</p>		
<b>Prenatal Maternity</b>	Covered in full	Not covered
<b>Maternity - Delivery and Post-Partum Care</b>	20% after deductible	Not covered
<b>Allergy Testing</b> (given by a physician)	Member cost sharing is based on the type of service performed and the place rendered.	Not covered
<b>Allergy Injections</b> (not given by a physician)	20% after deductible	Not covered
PREVENTIVE CARE	NETWORK CARE	OUT-OF-NETWORK CARE
<p>Preventive care services are covered in accordance with Health Care Reform.</p>		
<b>Routine Adult Physical Exams and Immunizations</b> Limited to 1 exam every 12 months.	Covered in full	Not covered



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<b>Well Child Exams and Immunizations</b> Provides coverage for 7 exams in the first year of life; 3 exams in the second year; 3 exams in the third year; and 1 exam per 12 months from age 3 to age 22.	Covered in full	Not covered
<b>Routine Gynecological Exams</b> Includes routine tests and related lab fees. Limited to 1 exam every 12 months.	Covered in full	Not covered
<b>Routine Mammograms</b>	Covered in full	Not covered
<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 in full	Not covered
<b>Routine Digital Rectal Exam / Prostate-Specific Antigen Test</b> Recommended: For covered males age 40 and over.	Covered in full	Not covered
<b>Colorectal Cancer Screening</b> Recommended: For all members age 45 and over.	Covered in full	Not covered
<b>VISION SERVICES</b>		
	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Routine Eye Exams (Refraction)</b> Coverage is limited to 1 exam every 12 months.	Covered in full	Not covered
<b>DIAGNOSTIC PROCEDURES</b>		
	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Diagnostic Laboratory</b>	20% after deductible	Not covered
<b>Diagnostic X-ray (except for Complex Imaging Services)</b>	20% after deductible	Not covered
<b>Diagnostic X-ray for Complex Imaging Services</b> (Including, but not limited to, MRI, MRA, PET and CT Scans)	20% after deductible	Not covered
<b>EMERGENCY MEDICAL CARE</b>		
	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Urgent Care Provider</b>	\$75 copay deductible waived	Not covered
<b>Non-Urgent Use of Urgent Care Provider</b>	Not covered	Not covered
<b>Emergency Room</b> Copay waived if admitted.	\$500 copay deductible waived	Paid as In-Network
<b>Non-Emergency Care in an Emergency Room</b>	Not covered	Not covered
<b>Emergency Use of Ambulance</b>	20% after deductible	Paid as In-Network
<b>Non-Emergency Use of Ambulance</b>	20% after deductible	Not covered
<b>HOSPITAL CARE</b>		
	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Inpatient Coverage</b> Including maternity (delivery and postpartum care). The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% after deductible	Not covered
<b>Outpatient Surgery</b> Provided in an outpatient hospital department or freestanding surgical facility.	20% after deductible	Not covered
<b>Transplants</b> Coverage is limited to IOE facilities only.	20% after deductible	Not covered



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BEHAVIORAL HEALTH SERVICES (MENTAL HEALTH and SUBSTANCE RELATED DISORDERS)	NETWORK CARE	OUT-OF-NETWORK CARE
<b>Inpatient Services (including inpatient residential treatment facility)</b> The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% after deductible	Not covered
<b>Outpatient Office Visits</b> The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered in full	Not covered
<b>Physician or Behavioral Health Provider Telemedicine Consultations</b>	Covered in full	Not covered
<b>Telemedicine Provider Consultations</b>	Covered in full	Not covered
<b>Other Outpatient Services</b> (Includes partial hospitalization treatment, intensive outpatient program and behavioral therapies.)	20% after deductible	Not covered
OTHER SERVICES AND PLAN DETAILS	NETWORK CARE	OUT-OF-NETWORK CARE
<b>Skilled Nursing Facility</b> Coverage is limited to 60 days per year.  The member cost sharing applies to all covered benefits incurring during a member's inpatient stay.	20% after deductible	Not covered
<b>Home Health Care</b> Coverage is limited to 60 visits per year. Network and Out-of-Network combined; 1 visit equals a period of 4 hours or less.	20% after deductible	Not covered
<b>Infusion Therapy</b> Provided in the home or physician's office.	20% after deductible	Not covered
<b>Infusion Therapy</b> Provided in the outpatient hospital department of freestanding facility.	20% after deductible	Not covered
<b>Gene-Based, Cellular and Other Innovative Therapies (GCIT)</b> Coverage is limited to GCIT-designated facilities only.	Cost sharing is based on the type of service and where it is performed.	Not covered
<b>Inpatient Hospice Care</b>  The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% after deductible	Not covered
<b>Outpatient Hospice Care</b>  The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	20% after deductible	Not covered
<b>Outpatient Short-Term Rehabilitation - Physical Therapy</b> Coverage is limited to 60 visits per year PT/OT/ST/Chiro combined.	\$75 copayment after deductible	Not covered
<b>Outpatient Short-Term Rehabilitation - Occupational Therapy</b> Coverage is limited to 60 visits per year PT/OT/ST/Chiro combined.	\$75 copayment after deductible	Not covered
<b>Outpatient Short-Term Rehabilitation - Speech Therapy</b> Coverage is limited to 60 visits per year PT/OT/ST/Chiro combined.	\$75 copayment after deductible	Not covered
<b>Outpatient Chiropractic</b> Coverage is limited to 60 visits per year PT/OT/ST/Chiro combined.	\$75 copayment after deductible	Not covered
<b>Habilitative Physical, Occupational and Speech Therapy</b>	20% after deductible	Not covered



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**True Accumulation** - Some specialty prescription drugs may qualify for third-party copay assistance programs, like a manufacturer coupon or a rebate. These could lower out-of-pocket costs. Any amount received through one of these programs will not apply towards the Deductible or Out-of-Pocket Maximum.

**Choose Generics with Dispense as Written (DAW) override** - The member pays the applicable cost-sharing only if the physician requires brand. If the member requests brand when a generic is available, the member pays the applicable cost-sharing plus the cost difference between the generic and brand. The cost difference between the generic and brand does not count toward the Deductible or Out-of-Pocket Maximum.

**Precertification** - Included. See formulary for details.

**Step Therapy** - Included. See formulary for details.

**Pharmacy Plan includes:**

Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs, Diabetic supplies.

Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

Preventive and seasonal vaccinations covered 100% in-network.

Not all drugs are covered. It is important to look at the Drug List (Advanced Control Plan - Aetna Formulary) to understand which drugs are covered.

**What's Not Covered**

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial 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 or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; Custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, 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; Nonmedically necessary services or supplies; Orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. 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.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract.

Not all services are covered. See plan documents for a complete description of benefits, exclusions and limitations 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.

Medications on the Aetna Drug Guide, precertification, step-therapy and quantity limits lists are subject to change.

Aetna, CVS Pharmacy<sup>®</sup> and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are part of the CVS Health<sup>®</sup> family of companies. CVS Caremark<sup>®</sup> Mail Service Pharmacy and Aetna are part of the CVS Health<sup>®</sup> family of companies.

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

Aetna Funding Advantage<sup>SM</sup> plans are self-funded, meaning the benefits coverage is provided by the employer. Plans are administered by Aetna Life Insurance Company.