



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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
<b>Benefit Limitations</b> - 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.		
<b>Deductible</b> (per calendar year)	\$750 Individual \$1,500 Family	\$5,000 Individual \$10,000 Family
All covered expenses accumulate separately toward the in-network or out-of-network Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount.		
<b>Member Coinsurance</b>	10%	50%
Applies to all expenses unless otherwise stated.		
<b>Payment Limit</b> (per calendar year)	\$3,000 Individual \$9,000 Family	\$8,000 Individual \$24,000 Family
All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses apply towards the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.		
<b>Lifetime Maximum</b>		
Unlimited except where otherwise indicated.		
<b>Payment for Out-of-Network Care**</b>	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
<b>Primary Care Physician Selection</b>	Optional	Not Applicable
<b>Certification Requirements -</b>		
Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is \$400 per occurrence.		
<b>Referral Requirement</b>	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
<b>Routine Adult Physical Exams/ Immunizations</b>	Covered 100%; deductible waived	50%; after deductible
1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older		
<b>Routine Well Child Exams/Immunizations</b>	Covered 100%; deductible waived	50%; after deductible
7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.		
<b>Routine Gynecological Care Exams</b>	Covered 100%; deductible waived	50%; after deductible
1 obgyn exam and pap smear per year Members may choose ob/gyns as PCP's		



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<b>Routine Mammograms</b>	Covered 100%; deductible waived	50%; after deductible
<b>Women's Health</b>	Covered 100%; deductible waived	50%; after 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. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		
<b>Routine Digital Rectal Exam</b>	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males age 40 and over.		
<b>Prostate-specific Antigen Test</b>	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males age 40 and over.		
<b>Colorectal Cancer Screening</b>	Covered 100%; deductible waived	Covered under Routine Adult Exams
Recommended: For all members age 45 and over.		
<b>Routine Eye Exams</b>	Covered 100%; deductible waived	50%; after deductible
1 routine exam per 24 months.		
<b>Routine Hearing Screening</b>	Covered 100%; deductible waived	50%; after deductible
<b>PHYSICIAN SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Office Visits to PCP</b>	\$20 copay; deductible waived	50%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
<b>Specialist Office Visits</b>	\$40 copay; deductible waived	50%; after deductible
<b>Hearing Exams</b>	Not Covered	Not Covered
<b>Pre-Natal Maternity</b>	Covered 100%; deductible waived	50%; after deductible
<b>Walk-in Clinics</b>	\$20 copay; deductible waived	50%; after deductible
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.		
<b>Allergy Testing</b>	Your cost sharing is based on the type of service and where it is performed	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; Covered 100% when an office visit charge is not applicable.	Your cost sharing is based on the type of service and where it is performed
<b>DIAGNOSTIC PROCEDURES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Diagnostic X-ray</b>	10%; after deductible	50%; after deductible
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 Laboratory</b>	10%; after deductible	50%; after deductible
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 Outpatient Complex Imaging</b>	10%; after deductible	50%; after deductible
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.		



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<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Urgent Care Provider</b>	\$25 copay; deductible waived	50%; after deductible
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered	Not Covered
<b>Emergency Room</b> Copay waived if admitted	\$200 copay; deductible waived	Same as in-network care
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered	Not Covered
<b>Emergency Use of Ambulance</b>	10%; after deductible	Same as in-network care
<b>Non-Emergency Use of Ambulance</b>	Not Covered	Not Covered
<b>HOSPITAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient Coverage</b>	\$200 per day for the first 3 days per confinement, thereafter Covered 100%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
<b>Inpatient Maternity Coverage</b> (includes delivery and postpartum care)	\$200 per day for the first 3 days per confinement, thereafter Covered 100%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
<b>Outpatient Hospital Expenses</b>	10%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
<b>Outpatient Surgery - Hospital</b>	\$200 copay; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
<b>Outpatient Surgery - Freestanding Facility</b>	\$200 copay; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Mental Health Inpatient</b>	\$200 per day for the first 3 days per confinement, thereafter Covered 100%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
<b>Mental Health Office Visits</b>	\$40 copay; deductible waived	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
<b>Other Mental Health Services</b>	Covered 100%; deductible waived	50%; after deductible
<b>SUBSTANCE ABUSE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Substance Abuse Inpatient</b>	\$200 per day for the first 3 days per confinement, thereafter Covered 100%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
<b>Residential Treatment Facility</b>	\$200 per day for the first 3 days per confinement, thereafter Covered 100%; after deductible	50%; after deductible
<b>Substance Abuse Office Visits</b>	\$40 copay; deductible waived	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
<b>Other Substance Abuse Services</b>	Covered 100%; deductible waived	50%; after deductible



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<b>OTHER SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Skilled Nursing Facility</b>  Limited to 100 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	\$200 per day for the first 3 days per confinement, thereafter Covered 100%; after deductible	50%; after deductible
<b>Home Health Care</b>  Limited to 120 visits per year Private Duty Nursing not covered Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	10%; after deductible	50%; after deductible
<b>Hospice Care - Inpatient</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	50%; after deductible
<b>Hospice Care - Outpatient</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	50%; after deductible
<b>Private Duty Nursing - Outpatient</b>	Not Covered	Not Covered
<b>Spinal Manipulation Therapy</b> Limited to 30 visits per year	\$40 copay; deductible waived	50%; after deductible
<b>Outpatient Speech Therapy</b>	\$40 copay; deductible waived	50%; after deductible
<b>Outpatient Physical and Occupational Therapy</b>	\$40 copay; deductible waived	50%; after deductible
<b>Habilitative Services (Physical/Occupational/Speech Therapy)</b>	Covered 100%; deductible waived	50%; after deductible
<b>Autism Behavioral Therapy</b> Covered same as any other Outpatient Mental Health benefit	\$40 copay; deductible waived	50%; after deductible
<b>Autism Applied Behavior Analysis</b> Covered same as any other Outpatient Mental Health Other Services benefit	Covered 100%; deductible waived	50%; after deductible
<b>Autism Physical Therapy</b>	Covered 100%; deductible waived	50%; after deductible
<b>Autism Occupational Therapy</b>	Covered 100%; deductible waived	50%; after deductible
<b>Autism Speech Therapy</b>	Covered 100%; deductible waived	50%; after deductible
<b>Durable Medical Equipment</b>	20%; after deductible	50%; after deductible
<b>Diabetic Supplies -- (if not covered under Pharmacy benefit)</b>	Covered same as any other medical expense.	Covered same as any other medical expense.
<b>Orthotics</b> Orthotics and special footwear covered for persons with foot disfigurement.	10%; after deductible	50%; after deductible
<b>Women's Contraceptive drugs and devices not obtainable at a pharmacy</b>	Covered 100%; deductible waived	Covered same as any other expense.
<b>Affordable Care Act mandated Women's Contraceptives</b>	Covered 100%; deductible waived	Covered same as any other expense.
<b>Infusion Therapy</b> Administered in the home or physician's office	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
<b>Infusion Therapy</b> Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed



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<b>Vision Eyewear</b>	Not Covered	Not Covered
<b>Transplants</b>	\$200 per day for the first 3 days per confinement, thereafter Covered 100%; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
<b>Bariatric Surgery</b>	\$200 per day for the first 3 days per confinement, thereafter Covered 100%; after deductible	Not Covered
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
<b>Acupuncture</b> Limited to 20 visits per year	\$40 copay; deductible waived	50%; after deductible
<b>Out of Area Dependents</b>	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	
<b>FAMILY PLANNING</b>	<b>IN-NETWORK</b>	<b>OUT-OF-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.	Your cost sharing is based on the type of service and where it is performed
<b>GIFT</b>	Not Covered	Not Covered
<b>Comprehensive Infertility Services</b> Artificial insemination and ovulation induction	Not Covered	Not Covered
<b>Advanced Reproductive Technology (ART)</b> ART coverage includes: In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery.	Not Covered	Not Covered
<b>Vasectomy</b>	Covered 100%; deductible waived	50%; after deductible
<b>Tubal Ligation</b>	Covered 100%; deductible waived	50%; after deductible



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PHARMACY	IN-NETWORK	OUT-OF-NETWORK
<b>Pharmacy Plan Type</b>	Advanced Control Plan - Aetna	
<b>Preferred Generic Drugs</b>		
<b>Retail</b>	\$20 copay	20% of submitted cost Maximum \$250
<b>Mail Order</b>	\$40 copay	Not Applicable
<b>Preferred Brand-Name Drugs</b>		
<b>Retail</b>	\$40 copay	20% of submitted cost Maximum \$250
<b>Mail Order</b>	\$80 copay	Not Applicable
<b>Non-Preferred Generic and Brand-Name Drugs</b>		
<b>Retail</b>	\$70 copay	20% of submitted cost Maximum \$250
<b>Mail Order</b>	\$140 copay	Not Applicable
<b>Specialty Drugs</b>		
<b>Preferred Specialty</b>	20% Maximum \$250	Not Covered
<b>Non-Preferred Specialty</b>	20% Maximum \$250	Not Covered
<b>Pharmacy Day Supply and Requirements</b>		
<b>Retail</b>	Up to a 30 day supply from Aetna National Network	
<b>Mail Order</b>	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
<b>Specialty</b>	Up to a 30 day supply All prescription 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 when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.

**Plan Includes:** Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.  
 Contraceptives covered up to a 12 month supply. Contraceptive copay strategy applies.  
 A limited list of over-the-counter medications are covered when filled with a prescription.  
 Includes sexual dysfunction drugs for females and males, including daily dose, additional 6 tablets a month for males for erectile dysfunction.  
 Oral fertility drugs included.  
 Oral chemotherapy drugs covered 100%  
 Precertification and quantity limits included  
 Step Therapy included  
 Seasonal Vaccinations covered 100% in-network  
 Preventive Vaccinations covered 100% in-network  
 Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.



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**GENERAL PROVISIONS**

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

\*\*We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

- For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.
- For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

Plans are provided by: Aetna Life Insurance Company. 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. 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.

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.





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Aetna, or its affiliate(s), receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates may reduce the amount a member pays the pharmacy for covered prescriptions. CVS Caremark ® Mail Service Pharmacy refers to CVS Caremark ® Mail Service Pharmacy, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with CVS Caremark ® Mail Service 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 pharmacy's 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.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862**.

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](http://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.

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