**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) | $100 Individual<br>$200 Family |
| Unless otherwise indicated, the deductible must be met prior to benefits being payable.<br>Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible.<br>Pharmacy expenses do not apply towards the Deductible.<br>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. | |
| **Out-of-Pocket Maximum**(per calendar year) | $3,000 Individual<br>$9,000 Family |
| In-Network expenses include coinsurance/copays and deductibles.<br>Pharmacy expenses apply towards the Out-of-Pocket-Maximum.<br>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 except where otherwise indicated. |
| **Primary Care Physician Selection** | Required |
| **Referral Requirement** | Required |
| **PREVENTIVE CARE** | **IN-NETWORK** |
| **Routine Adult Physical Exams/ Immunizations** | Covered 100%; deductible waived |
| 1 exam per 12 months for members age 22 and older. | |
| **Routine Well Child Exams/Immunizations** | Covered 100%; deductible waived |
| (Age and frequency schedules apply) | |
| **Routine Gynecological Care Exams** | Covered 100%; deductible waived |
| 1 exam per 12 months<br>Includes routine tests and related lab fees. | |
| **Routine Mammograms** | Covered 100%; deductible waived |
| Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over. | |
| **Women's Health** | Covered 100%; deductible waived |
| 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.<br>Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply. | |
| **Routine Digital Rectal Exams / Prostate Specific Antigen Test** | Covered 100%; deductible waived |
| Recommended for males age 40 and over. | |
| **Colorectal Cancer Screening** | Covered 100%; deductible waived |
| Recommended: For all members age 45 and over.<br>Frequency schedule applies. | |
| **Routine Eye Exams** | Covered 100%; deductible waived |
| 1 routine exam per 24 months.<br>Direct access to participating providers without a referral. | |

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|---|---|
| **Routine Hearing Screening** | Covered 100%; deductible waived |
| **PHYSICIAN SERVICES** | **IN-NETWORK** |
| **Primary Care Physician Visits** | $20 office visit copay; deductible waived |
| Includes services of an internist, general physician, family practitioner or pediatrician. | |
| **Specialist Office Visits** | $40 copay; deductible waived |
| **Pre-Natal Maternity** | Covered 100%; deductible waived |
| **Walk-in Clinics** | $20 copay; deductible waived |
| 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. | |
| **Allergy Testing** | Your cost sharing is based on the type of service and where it is performed |
| **Allergy Injections** | 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. |
| **DIAGNOSTIC PROCEDURES** | **IN-NETWORK** |
| **Diagnostic Laboratory** | $40 copay; deductible waived |
| 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. | |
| **Diagnostic X-ray** | $40 copay; deductible waived |
| 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. | |
| **Diagnostic X-ray for Complex Imaging Services** | $40 copay; deductible waived |
| 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. | |
| **EMERGENCY MEDICAL CARE** | **IN-NETWORK** |
| **Urgent Care Provider** | $25 copay; deductible waived |
| **Non-Urgent Use of Urgent Care Provider** | Not Covered |
| **Emergency Room** | $200 copay; deductible waived |
| Copay waived if admitted | |
| **Non-Emergency Care in an Emergency Room** | Not Covered |
| **Emergency Use of Ambulance** | Covered 100%; deductible waived |
| **Non-Emergency Use of Ambulance** | Not Covered |
| **HOSPITAL CARE** | **IN-NETWORK** |
| **Inpatient Coverage** | $100 per day for the first 3 days, thereafter Covered 100%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | |
| **Inpatient Maternity Coverage** (includes delivery and postpartum care) | Covered 100% for Physician maternity services; deductible waived; Covered 100% for Facility services; deductible waived |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | |
| **Outpatient Hospital** | $150 copay; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | |

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| MENTAL HEALTH SERVICES | IN-NETWORK |
|---|---|
| **Inpatient** | $100 per day for the first 3 days, thereafter Covered 100%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | |
| **Mental Health Office Visits** | $40 copay; deductible waived |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | |
| **Other Mental Health Services** | Covered 100%; deductible waived |
| **SUBSTANCE ABUSE** | **IN-NETWORK** |
| **Inpatient** | $100 per day for the first 3 days, thereafter Covered 100%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | |
| **Residential Treatment Facility** | $100 per day for the first 3 days, thereafter Covered 100%; after deductible |
| **Substance Abuse Office Visits** | $40 copay; deductible waived |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | |
| **Other Substance Abuse Services** | Covered 100%; deductible waived |
| **OTHER SERVICES** | **IN-NETWORK** |
| **Skilled Nursing Facility** | $100 per day for the first 3 days, thereafter Covered 100%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | |
| **Home Health Care** | $40 copay; deductible waived |
| Limited to 120 visits per year<br>Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less. | |
| **Hospice Care - Inpatient** | $100 per day for the first 3 days, thereafter Covered 100%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | |
| **Hospice Care - Outpatient** | Covered 100%; deductible waived |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | |
| **Outpatient Short-Term Rehabilitation** | $40 copay; deductible waived |
| Limited to 60 visits per year<br>Includes speech, physical, occupational therapy | |
| **Chiropractic Coverage** | $40 copay; deductible waived |
| Direct access to participating providers without a referral. | |
| **Habilitative Services (Physical/Occupational/Speech Therapy)** | Covered 100%; deductible waived |
| **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** | Refer to MBH Outpatient Mental Health Other Services |
| **Autism Occupational Therapy** | Refer to MBH Outpatient Mental Health Other Services |
| **Autism Speech Therapy** | Refer to MBH Outpatient Mental Health Other Services |
| **Durable Medical Equipment** | Covered 100%; deductible waived |
| **Prosthetics** | Covered 100%; deductible waived |
| **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 100%; deductible waived |

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|---|---|
| **Affordable Care Act mandated Women's Contraceptives** | Covered 100%; deductible waived |
| **Hearing Aids** | 20%; deductible waived |
| 1 hearing aid per ear to a maximum of $1,000 per ear every 3 years for covered dependents under age 18. | |
| **Transplants** | $100 per day for the first 3 days, thereafter Covered 100%; after deductible<br>Preferred coverage is provided at an IOE contracted facility only. |
| **Bariatric Surgery** | $100 per day for the first 3 days, thereafter Covered 100%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | |
| **FAMILY PLANNING** | **IN-NETWORK** |
| **Infertility Treatment** | Your cost sharing is based on the type of service and where it is performed |
| Diagnosis and treatment of the underlying medical condition only. | |
| **Comprehensive Infertility Services** | Not Covered |
| Artificial insemination and ovulation induction | |
| **Advanced Reproductive Technology (ART)** | Not Covered |
| In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery | |
| **Vasectomy** | Your cost sharing is based on the type of service and where it is performed |
| **Tubal Ligation** | Covered 100%; deductible waived |

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| PRESCRIPTION DRUG BENEFITS | IN-NETWORK |
|---|---|
| **Pharmacy Plan Type** | Advanced Control Plan - Aetna |
| **Preferred Generic Drugs** | |
| **Retail** | $20 copay |
| **Mail Order** | $40 copay |
| **Preferred Brand-Name Drugs** | |
| **Retail** | $40 copay |
| **Mail Order** | $80 copay |
| **Non-Preferred Generic and Brand-Name Drugs** | |
| **Retail** | $70 copay |
| **Mail Order** | $140 copay |
| **Specialty Drugs** | |
| **Preferred Specialty** | 20%<br>Maximum $250 |
| **Non-Preferred Specialty** | 20%<br>Maximum $250 |
| **Pharmacy Day Supply and Requirements** | |
| **Retail** | Up to a 30 day supply from Aetna National Network<br>For a 31-90 day supply you will be responsible for the Mail Order Drug copay. |
| **Mail Order** | A 31-90 day supply from CVS Caremark® Mail Service Pharmacy |
| **Specialty** | Up to a 30 day supply<br>Advanced Control Formulary Aetna Insured List |

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

| 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.

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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.
• 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.
• 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.

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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.

**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.

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.