

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

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.

PLAN FEATURES	NETWORK CARE DESIGNATED PROVIDER	NETWORK CARE NON-DESIGNATED PROVIDER
Primary Care Physician Selection	Not required	Not required
Deductible (per calendar year)	\$6,750 Individual \$13,500 Family	\$7,350 Individual \$14,700 Family
Unless otherwise indicated, the deductible must be met before benefits can be paid.		
Claims from designated and non-designated providers cross-accumulate to satisfy the deductible.		
As indicated in the plan, member cost sharing for certain services are excluded from the charges to meet the deductible.		
No one family member may contribute more than the individual deductible amount to the family deductible. Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the year.		
Member Coinsurance (applies to all expenses unless otherwise stated)	0%	20%
Out-of-Pocket (OOP) Maximum (per calendar year, includes deductible)	\$8,750 Individual \$17,500 Family	\$9,100 Individual \$18,200 Family
Claims from designated and non-designated providers cross-accumulate to satisfy the out-of-pocket limits.		
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 may be used to satisfy the out-of-pocket maximum.		
No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, all family members will be considered as having met their out-of-pocket maximum for the remainder of the year.		
Referral Requirement	Not Required	Not Required
PHYSICIAN SERVICES	NETWORK CARE DESIGNATED PROVIDER	NETWORK CARE NON-DESIGNATED PROVIDER
Office Visits to Non-Specialist	\$35 copay deductible waived	20% after deductible
Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illness or injury.		
Telemedicine Consultations with Non-Specialist	\$35 copay deductible waived	20% after deductible
Virtual Primary Care Telemedicine Provider Consultations Includes basic medical and preventive health care services for persons 18 years of age or older. Telemedicine preventive screening and counseling services are subject to the preventive care benefit.	Covered in full	Not Covered
Non-Specialist Telemedicine Provider Consultations	Covered in full	Not covered
Specialist Office Visits	\$75 copayment after deductible	20% after deductible
Telemedicine Consultations with Specialist	\$75 copayment after deductible	20% after deductible
Specialist Telemedicine Provider Consultations	Covered in full	Not covered
Non-Specialist and Specialist Surgical Services	Covered in full after deductible	20% after deductible
Walk-in Clinics	Designated Walk-in Clinics: Covered in full All Other Network Providers: \$35 copay deductible waived	Paid at the designated level
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.		

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Telemedicine Consultations for Non-Emergency Services through a Walk-in Clinic If telemedicine preventive screening and counseling services are provided through a walk-in clinic, these services are paid under the preventive care benefit.	Cost-sharing is based on type of service and where it is received	Not covered
Maternity - Delivery and Post-Partum Care	Covered in full after deductible	20% after deductible
Allergy Testing	Cost-sharing is based on type of service and where it is received.	Cost-sharing is based on type of service and where it is received.
Allergy Injections	Covered in full after deductible	20% after deductible
PREVENTIVE CARE	NETWORK CARE DESIGNATED PROVIDER	NETWORK CARE NON-DESIGNATED PROVIDER
Preventive care services are covered in accordance with Health Care Reform.		
Routine Adult Physical Exams and Immunizations Limited to 1 exam every 12 months.	Covered in full	Covered in full
Well Child Exams and Immunizations 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	Covered in full
Routine Gynecological Exams Includes routine tests and related lab fees. Limited to 1 exam every 12 months.	Covered in full	Covered in full
Routine Mammograms	Covered in full	Covered in full
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 in full	Covered in full
Prenatal Maternity	Covered in full	Covered in full
Routine Digital Rectal Exam / Prostate-Specific Antigen Test Recommended: For covered males age 40 and over.	Covered in full	Covered in full
Colorectal Cancer Screening Recommended: For all members age 45 and over.	Covered in full	Covered in full
Routine Eye and Hearing Screenings	Paid as part of routine physical exam.	Paid as part of routine physical exam.
HEARING SERVICES	NETWORK CARE DESIGNATED PROVIDER	NETWORK CARE NON-DESIGNATED PROVIDER
Hearing Exam (by Specialist)	Not covered	Not covered
Hearing Aid	Not covered	Not covered
VISION SERVICES	NETWORK CARE DESIGNATED PROVIDER	NETWORK CARE NON-DESIGNATED PROVIDER
Adult Routine Eye Exams (Refraction) Coverage is limited to 1 exam every 12 months.	Covered in full	Paid at the designated level
Pediatric Routine Eye Exams (Refraction) Coverage is limited to 1 exam every 12 months.	Covered in full	Paid at the designated level
Adult Vision Hardware	Not covered	Not covered
Pediatric Vision Hardware	Not covered	Not covered
DIAGNOSTIC PROCEDURES	NETWORK CARE DESIGNATED PROVIDER	NETWORK CARE NON-DESIGNATED PROVIDER

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Diagnostic Laboratory	Covered in full after deductible	20% after deductible
Diagnostic X-ray (except for Complex Imaging Services)	Covered in full after deductible	20% after deductible
Diagnostic X-ray for Complex Imaging Services (Including, but not limited to, MRI, MRA, PET and CT Scans)	Covered in full after deductible	20% after deductible
EMERGENCY MEDICAL CARE	NETWORK CARE DESIGNATED PROVIDER	NETWORK CARE NON-DESIGNATED PROVIDER
Urgent Care Provider	\$100 copay deductible waived	20% after deductible
Non-Urgent Use of Urgent Care Provider	Not covered	Not covered
Emergency Room Copay waived if admitted.	\$500 copayment after deductible	Paid at the designated level
Non-Emergency Care in an Emergency Room	Not covered	Not covered
Emergency Use of Ambulance	Covered in full after deductible	Paid at the designated level
Non-Emergency Use of Ambulance	Covered in full after deductible	Paid at the designated level
HOSPITAL CARE	NETWORK CARE DESIGNATED PROVIDER	NETWORK CARE NON-DESIGNATED PROVIDER
Inpatient Coverage Including maternity (delivery and postpartum care). The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	\$500 copayment per admission after deductible	20% after deductible
Outpatient Surgery Provided in an outpatient hospital department or freestanding surgical facility.	\$250 copayment after deductible	20% after deductible
Colonoscopy (non-preventive)	Cost-sharing is based on type of service and where it is received.	Cost-sharing is based on type of service and where it is received.
Transplants Coverage is limited to IOE facilities only.	\$500 copayment per admission after deductible	Not covered
BEHAVIORAL HEALTH SERVICES (MENTAL HEALTH and SUBSTANCE RELATED DISORDERS)	NETWORK CARE DESIGNATED PROVIDER	NETWORK CARE NON-DESIGNATED PROVIDER
Inpatient Services (including inpatient residential treatment facility) The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	\$500 copayment per admission after deductible	20% after deductible
Outpatient Office Visits The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered in full	Covered in full
Physician or Behavioral Health Provider Telemedicine Consultations	Covered in full	Covered in full
Telemedicine Provider Consultations	Covered in full	Not covered
Other Outpatient Services (Includes partial hospitalization treatment, intensive outpatient program.)	Covered in full after deductible	20% after deductible
THERAPY SERVICES	NETWORK CARE DESIGNATED PROVIDER	NETWORK CARE NON-DESIGNATED PROVIDER



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Outpatient Chiropractic/Spinal Manipulation Therapy Coverage is limited to 60 visits per year PT/OT/ST/Chiro combined.	\$75 copayment after deductible	20% after deductible
Outpatient Short-Term Rehabilitation - Physical Therapy Coverage is limited to 60 visits per year PT/OT/ST/Chiro combined.	\$75 copayment after deductible	20% after deductible
Outpatient Short-Term Rehabilitation - Occupational Therapy Coverage is limited to 60 visits per year PT/OT/ST/Chiro combined.	\$75 copayment after deductible	20% after deductible
Outpatient Short-Term Rehabilitation - Speech Therapy Coverage is limited to 60 visits per year PT/OT/ST/Chiro combined.	\$75 copayment after deductible	20% after deductible
Habilitative Physical, Occupational and Speech Therapy	Covered in full after deductible	20% after deductible
Autism Physical, Occupational and Speech Therapy	Covered in full after deductible	20% after deductible
Autism Behavioral Therapy	Covered in full	Covered in full
Autism Applied Behavior Analysis	Covered in full after deductible	20% after deductible
OTHER SERVICES NETWORK CARE DESIGNATED PROVIDER NETWORK CARE NON-DESIGNATED PROVIDER		
Skilled Nursing Facility Coverage is limited to 60 days per year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay.	Covered in full after deductible	20% after deductible
Home Health Care Coverage is limited to 60 visits per year.	Covered in full after deductible	20% after deductible
Infusion Therapy Provided in the home or physician's office.	Covered in full after deductible	20% after deductible
Infusion Therapy Provided in the outpatient hospital department of freestanding facility.	Covered in full after deductible	20% after deductible
Gene-Based, Cellular and Other Innovative Therapies (GCIT) Coverage is limited to GCIT-designated facilities only.	Cost-sharing is based on type of service and where it is received.	Not Covered
Inpatient Hospice Care The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	\$500 copayment per admission after deductible	20% after deductible
Outpatient Hospice Care The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered in full after deductible	20% after deductible
Private Duty Nursing - Outpatient	Not covered	Not covered
Acupuncture Coverage is limited to 10 visits per year.	\$35 copay deductible waived	Paid as Designated
Durable Medical Equipment	50% after deductible	50% after deductible
Prosthetics	50% after deductible	50% after deductible
Diabetic Supplies not obtainable at a pharmacy	Covered same as any other medical expense.	Covered same as any other medical expense.

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Mouth, Jaws and Teeth Coverage for medical in nature oral surgery only. No coverage for dental in nature oral surgery or for removal of impacted teeth.	Cost-sharing is based on type of service and where it is received.	Cost-sharing is based on type of service and where it is received.
Bariatric Surgery	Not Covered	Not Covered
FAMILY PLANNING	NETWORK CARE DESIGNATED PROVIDER	NETWORK CARE NON-DESIGNATED PROVIDER
Basic Infertility Coverage is limited to the diagnosis and treatment of the underlying medical condition, including artificial insemination.	Cost-sharing is based on type of service and where it is received.	Cost-sharing is based on type of service and where it is received.
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 and ovulation induction	Not Covered	Not Covered
Fertility preservation	Not Covered	Not Covered
Vasectomy	Cost-sharing is based on type of service and where it is received.	Cost-sharing is based on type of service and where it is received.
Tubal Ligation	Covered in full	Covered in full
PHARMACY DEDUCTIBLE	NETWORK CARE	OUT-OF-NETWORK CARE
Prescription drug calendar year deductible	Prescription drugs purchased at a network pharmacy are subject to the in-network medical deductible which must be satisfied before any prescription drug benefits are paid.	Not applicable
PHARMACY - PRESCRIPTION DRUG BENEFITS	NETWORK CARE	OUT-OF-NETWORK CARE
Generic Drugs		
Retail	Generic - T1A: \$3 copay deductible waived Generic - T1: \$10 copay deductible waived	Not covered
Mail Order	Generic - T1A: \$6 copay deductible waived Generic - T1: \$20 copay deductible waived	Not covered
Preferred Brand Drugs		
Retail	\$50 copayment after deductible	Not covered
Mail Order	\$100 copayment after deductible	Not covered
Non-Preferred Generic and Brand Drugs Deductible waived for generics on all tiers		
Retail	\$80 copayment after deductible	Not covered
Mail Order	\$160 copayment after deductible	Not covered
Specialty Drugs		
Preferred Specialty	20% up to \$250 after deductible	Not covered
Non-Preferred Specialty	40% up to \$500 after deductible	Not covered
Pharmacy Day Supply and Requirements		
Retail Up to 30 day supply from the Aetna National Pharmacy Network		
Mail Order 31-90 day supply from a participating mail service pharmacy or at selected participating retail providers		



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Maintenance Choice® with Opt Out - After two retail fills, members must choose to fill a 90-day supply of their maintenance drugs at a participating mail service pharmacy or at selected participating retail providers. If the member wants to continue to fill their 30-day supply at any other network pharmacy, they simply need to call us at the number on their member ID card. If they do not notify us that they want to opt out of the 90-day supply at a participating mail service pharmacy or at selected participating retail providers, they'll be responsible for 100 percent of their medication cost. The member may call us any time, even from the pharmacy, to let us know that they intend to opt out of the benefit.

Specialty- Up to a 30 day supply. All prescription fills must be through our preferred specialty pharmacy network, Aetna Specialty Network.

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.

Preventive Medications - Deductible is waived for certain preventive medications.

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.

Contraceptives may be dispensed for up to a 12 month supply at one time.

Preventive and seasonal vaccinations covered 100% in-network.

Cost-share is \$0 copay, deductible waived, for preferred generic and brand diabetic supplies and preferred generic and brand insulin.

Performance Enhancing Drugs - Coverage is excluded for lifestyle/performance drugs.

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; Custodial care; Dental services; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, 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, except diabetic 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® and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are part of the CVS Health® family of companies. CVS Caremark® Mail Service Pharmacy and Aetna are part of the CVS Health® family of companies.



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In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

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 AdvantageSM plans are self-funded, meaning the benefits coverage is provided by the employer. Plans are administered by Aetna Life Insurance Company.