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	OUT-OF-NETWORK CARE
Primary Care Physician Selection	Not required	Not applicable
Deductible (per calendar year)	$2,500 Individual $5,000 Family	Not applicable
Unless otherwise indicated, the deductible must be met before benefits can be paid.		
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)	20%	Not applicable
Out-of-Pocket (OOP) Maximum (per calendar year, includes deductible)	$6,500 Individual $13,000 Family	Not applicable
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 applicable
PHYSICIAN SERVICES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Office Visits to Non-Specialist	$35 copay deductible waived	Not covered
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	Not covered
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 copay deductible waived	Not covered
Telemedicine Consultations with Specialist	$75 copay deductible waived	Not covered
Specialist Telemedicine Provider Consultations	Covered in full	Not covered
Non-Specialist and Specialist Surgical Services	20% after deductible	Not covered
Walk-in Clinics	**Designated Walk-in Clinics:** Covered in full **All Other Network Providers:** $35 copay deductible waived	Not covered
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.		
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

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Maternity - Delivery and Post-Partum Care	20% after deductible	Not covered
Allergy Testing	Cost-sharing is based on type of service and where it is received.	Not covered
Allergy Injections	20% after deductible	Not covered
PREVENTIVE CARE	NETWORK CARE	OUT-OF-NETWORK CARE
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	Not covered
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	Not covered
Routine Gynecological Exams Includes routine tests and related lab fees. Limited to 1 exam every 12 months.	Covered in full	Not covered
Routine Mammograms	Covered in full	Not covered
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	Not covered
Prenatal Maternity	Covered in full	Not covered
Routine Digital Rectal Exam / Prostate-Specific Antigen Test Recommended: For covered males age 40 and over.	Covered in full	Not covered
Colorectal Cancer Screening Recommended: For all members age 45 and over.	Covered in full	Not covered
Routine Eye and Hearing Screenings	Paid as part of routine physical exam.	Not covered
HEARING SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Hearing Exam (by Specialist)	Not covered	Not covered
Hearing Aid	Not covered	Not covered
VISION SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Adult Routine Eye Exams (Refraction) Coverage is limited to 1 exam every 12 months.	Covered in full	Not covered
Pediatric Routine Eye Exams (Refraction) Coverage is limited to 1 exam every 12 months.	Covered in full	Not covered
Adult Vision Hardware	Not covered	Not covered
Pediatric Vision Hardware	Not covered	Not covered
DIAGNOSTIC PROCEDURES	NETWORK CARE	OUT-OF-NETWORK CARE
Diagnostic Laboratory	20% after deductible	Not covered
Diagnostic X-ray (except for Complex Imaging Services)	20% after deductible	Not covered

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Diagnostic X-ray for Complex Imaging Services (Including, but not limited to, MRI, MRA, PET and CT Scans)	20% after deductible	Not covered
EMERGENCY MEDICAL CARE	NETWORK CARE	OUT-OF-NETWORK CARE
Urgent Care Provider	$75 copay deductible waived	Not covered
Non-Urgent Use of Urgent Care Provider	Not covered	Not covered
Emergency Room Copay waived if admitted.	$300 copayment after deductible, then 20%	Paid as In-Network
Non-Emergency Care in an Emergency Room	Not covered	Not covered
Emergency Use of Ambulance	20% after deductible	Paid as In-Network
Non-Emergency Use of Ambulance	20% after deductible	Not covered
HOSPITAL CARE	NETWORK CARE	OUT-OF-NETWORK CARE
Inpatient Coverage 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
Outpatient Surgery Provided in an outpatient hospital department or freestanding surgical facility.	20% after deductible	Not covered
Colonoscopy (non-preventive)	Cost-sharing is based on type of service and where it is received.	Not covered
Transplants Coverage is limited to IOE facilities only.	20% after deductible	Not covered
BEHAVIORAL HEALTH SERVICES (MENTAL HEALTH and SUBSTANCE RELATED DISORDERS)	NETWORK CARE	OUT-OF-NETWORK CARE
Inpatient Services (including inpatient residential treatment facility) The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% after deductible	Not covered
Outpatient Office Visits The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered in full	Not covered
Physician or Behavioral Health Provider Telemedicine Consultations	Covered in full	Not covered
Telemedicine Provider Consultations	Covered in full	Not covered
Other Outpatient Services (Includes partial hospitalization treatment, intensive outpatient program.)	20% after deductible	Not covered
THERAPY SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Outpatient Chiropractic/Spinal Manipulation Therapy Coverage is limited to 60 visits per year PT/OT/ST/Chiro combined.	$75 copayment after deductible	Not covered
Outpatient Short-Term Rehabilitation - Physical Therapy Coverage is limited to 60 visits per year PT/OT/ST/Chiro combined.	$75 copayment after deductible	Not covered
Outpatient Short-Term Rehabilitation - Occupational Therapy Coverage is limited to 60 visits per year PT/OT/ST/Chiro combined.	$75 copayment after deductible	Not covered

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Outpatient Short-Term Rehabilitation - Speech Therapy Coverage is limited to 60 visits per year PT/OT/ST/Chiro combined.	$75 copayment after deductible	Not covered
Habilitative Physical, Occupational and Speech Therapy	20% after deductible	Not covered
Autism Physical, Occupational and Speech Therapy	20% after deductible	Not covered
Autism Behavioral Therapy	Covered in full	Not covered
Autism Applied Behavior Analysis	20% after deductible	Not covered
OTHER SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
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.	20% after deductible	Not covered
Home Health Care Coverage is limited to 60 visits per year.	20% after deductible	Not covered
Infusion Therapy Provided in the home or physician's office.	20% after deductible	Not covered
Infusion Therapy Provided in the outpatient hospital department of freestanding facility.	20% after deductible	Not covered
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.	20% after deductible	Not covered
Outpatient Hospice Care The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	20% after deductible	Not covered
Private Duty Nursing - Outpatient	Not covered	Not covered
Acupuncture Coverage is limited to 10 visits per year.	$35 copay deductible waived	Not covered
Durable Medical Equipment	50% after deductible	Not covered
Prosthetics	50% after deductible	Not covered
Diabetic Supplies not obtainable at a pharmacy	Covered same as any other medical expense.	Not covered
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.	Not covered
Bariatric Surgery	Not covered	Not covered
FAMILY PLANNING	NETWORK CARE	OUT-OF-NETWORK CARE
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.	Not covered

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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.	Not covered
Tubal Ligation	Covered in full	Not covered
PHARMACY DEDUCTIBLE	NETWORK CARE	OUT-OF-NETWORK CARE
Prescription drug calendar year deductible	Not Applicable under both the network care and out-of-network columns.	Not Applicable under both the network care and out-of-network columns.
PHARMACY - PRESCRIPTION DRUG BENEFITS	NETWORK CARE	OUT-OF-NETWORK CARE
Generic Drugs		
Retail	Generic - T1A: $3 copayment Generic - T1: $10 copayment	Not covered
Mail Order	Generic - T1A: $6 copayment Generic - T1: $20 copayment	Not covered
Preferred Brand Drugs		
Retail	$50 copayment	Not covered
Mail Order	$100 copayment	Not covered
Non-Preferred Generic and Brand Drugs		
Retail	$80 copayment	Not covered
Mail Order	$160 copayment	Not covered
Specialty Drugs		
Preferred Specialty	20% up to $250	Not covered
Non-Preferred Specialty	40% up to $500	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		
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.

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.

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.