PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	NETWORK CARE	OUT-OF-NETWORK CARE
Primary Care Physician Selection	Not required	Not required
Deductible (per calendar year)	$2,500 Individual $5,000 Family	$10,000 Individual $30,000 Family
Unless otherwise indicated, the deductible must be met before benefits can be paid.		
All covered expenses accumulate separately toward the network and out-of-network Deductible.		
As indicated in the plan, member cost sharing for certain services are excluded from the charges to meet the deductible.		
Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the calendar year.		
Member Coinsurance (applies to all expenses unless otherwise stated)	0%	50%
Out-of-Pocket (OOP) Maximum (per calendar year, includes deductible)	$3,275 Individual $6,550 Family	$20,000 Individual $60,000 Family
All covered expenses accumulate separately toward the network and out-of-network Out of Pocket Limit.		
Pharmacy expenses apply towards the Out of Pocket Limit. 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.		
Once the family payment limit is met, all family members will be considered as having met their payment limit for the remainder of the calendar year.		
Payment for Out-of-Network Care*	Not applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Certification Requirements		
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 and Hospice Care is required - excluded amount applied separately to each type of expense is $400 per occurrence		
Referral Requirement	Not Required	Not applicable
PHYSICIAN SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Office Visits to Non-Specialist	Covered in full after deductible	50% after deductible
Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illness or injury.		
Specialist Office Visits	Covered in full after deductible	50% after deductible
Walk-in Clinics	**Designated Walk-in Clinics:** Covered in full after deductible **All Other Network Providers:** Covered in full after deductible	50% after deductible
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.		
Prenatal Maternity	Covered in full	50% after deductible
Maternity - Delivery and Post-Partum Care	Covered in full after deductible	50% after deductible
Allergy Testing (given by a physician)	Member cost sharing is based on the type of service performed and the place rendered.	50% after deductible
Allergy Injections (not given by a physician)	Covered in full after deductible	50% after deductible
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	50% after deductible

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	50% after deductible
Routine Gynecological Exams Includes routine tests and related lab fees. Limited to 1 exam every 12 months.	Covered in full	50% after deductible
Routine Mammograms For covered females age 40 and over.	Covered in full	50% after deductible
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	50% after deductible
Routine Digital Rectal Exam / Prostate-Specific Antigen Test For covered males age 40 and over.	Covered in full	50% after deductible
Colorectal Cancer Screening For all members age 45 and over.	Covered in full	50% after deductible
VISION SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Routine Eye Exams (Refraction) Coverage is limited to 1 exam every 12 months.	Covered in full	50% after deductible
DIAGNOSTIC PROCEDURES	NETWORK CARE	OUT-OF-NETWORK CARE
Outpatient Diagnostic Laboratory	Covered in full after deductible	50% after deductible
Outpatient Diagnostic X-ray (except for Complex Imaging Services)	Covered in full after deductible	50% after deductible
Outpatient Diagnostic X-ray for Complex Imaging Services (Including, but not limited to, MRI, MRA, PET and CT Scans)	Covered in full after deductible	50% after deductible
EMERGENCY MEDICAL CARE	NETWORK CARE	OUT-OF-NETWORK CARE
Urgent Care Provider (Benefit Availability may vary by location.)	Covered in full after deductible	50% after deductible
Non-Urgent Use of Urgent Care Provider	Not covered	Not covered
Emergency Room	Covered in full after deductible	Paid as in-network
Non-Emergency care in an Emergency Room	Not covered	Not covered
Emergency Use of Ambulance	Covered in full after deductible	Paid as in-network
Non-Emergency Use of Ambulance	Covered in full after deductible	Paid as in-network
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.	Covered in full after deductible	50% after deductible

Outpatient Surgery Provided in an outpatient hospital department or freestanding surgical facility.	Covered in full after deductible	50% after deductible
Transplants Coverage at the in-network cost share is limited to IOE only. Non-IOE par facilities and out-of-network facilities are covered at out-of-network cost sharing.	Covered in full after deductible	50% after deductible
MENTAL HEALTH and ALCOHOL/DRUG ABUSE SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Inpatient Mental Health The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered in full after deductible	50% after deductible
Outpatient Mental Health The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered in full after deductible	50% after deductible
Inpatient Detoxification The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered in full after deductible	50% after deductible
Outpatient Detoxification The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered in full after deductible	50% after deductible
Inpatient Rehabilitation The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered in full after deductible	50% after deductible
Outpatient Rehabilitation The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered in full after deductible	50% after deductible
All Other Outpatient Services Includes Mental Health, Substance Abuse and Behavioral Therapies.	Covered in full after deductible	50% after deductible
OTHER SERVICES AND PLAN DETAILS	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 Network and Out-of-Network combined.	Covered in full after deductible	50% after deductible
Home Health Care Coverage is limited to 60 visits per year. Network and Out-of-Network combined; 1 visit equals a period of 4 hours or less. Network and Out-of-Network combined.	Covered in full after deductible	50% after deductible
Infusion Therapy Provided in the home or physician's office.	Covered in full after deductible	50% after deductible
Infusion Therapy Provided in the outpatient hospital department of freestanding facility.	Covered in full after deductible	50% after deductible
Inpatient Hospice Care The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered in full after deductible	50% 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	50% after deductible
Outpatient Short-Term Rehabilitation - Physical Therapy Coverage is limited to 60 visits per year PT/OT/ST/Chiro combined. Network and Out-of-Network combined.	Covered in full after deductible	50% after deductible

Outpatient Short-Term Rehabilitation - Occupational Therapy Coverage is limited to 60 visits per year PT/OT/ST/Chiro combined. Network and Out-of-Network combined.	Covered in full after deductible	50% after deductible
Outpatient Short-Term Rehabilitation - Speech Therapy Coverage is limited to 60 visits per year PT/OT/ST/Chiro combined. Network and Out-of-Network combined.	Covered in full after deductible	50% after deductible
Outpatient Chiropractic Coverage is limited to 60 visits per year PT/OT/ST/Chiro combined. Network and Out-of-Network combined.	Covered in full after deductible	50% after deductible
Habilitative Physical, Occupational and Speech Therapy	Covered in full after deductible	50% after deductible
Autism Behavioral Therapy	Covered in full after deductible	50% after deductible
Autism Applied Behavior Analysis	Not covered	Not covered
Autism Physical, Occupational and Speech Therapy	Covered in full after deductible	50% after deductible
Durable Medical Equipment	Covered in full 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.
Mouth, Jaws and Teeth (oral surgery procedures, medical in nature)	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	50% after deductible
FAMILY PLANNING	NETWORK CARE	OUT-OF-NETWORK CARE
Infertility Treatment - Diagnostic only Covered only for the diagnosis and treatment of the underlying medical condition.	Member cost sharing is based on the type of service performed and the place rendered.	50% after deductible
Voluntary Sterilization - Vasectomy	Member cost sharing is based on the type of service performed and the place rendered.	50% after deductible
Voluntary Sterilization - Tubal Ligation	Covered in full	50% after deductible
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.	Prescription drugs purchased at an out-of-network pharmacy are subject to the out-of-network medical deductible which must be satisfied before any prescription drug benefits are paid.
PHARMACY - PRESCRIPTION DRUG BENEFITS	NETWORK CARE	OUT-OF-NETWORK CARE
Retail Up to a 30-day supply		
Generic Drugs	Generic - T1A: $3 copayment after deductible Generic - T1: $10 copayment after deductible	50% after deductible
Preferred Brand Drugs	$45 copayment after deductible	50% after deductible
Non-Preferred Generic and Brand Drugs	$75 copayment after deductible	50% after deductible

Specialty Drugs Includes self-injectable, infused and oral specialty drugs, excludes insulin (Up to a 30-day supply)	Specialty Preferred: 20% up to $250 after deductible Specialty Nonpreferred: 40% up to $500 after deductible	Not covered
Mail Order Delivery 31-90 days – excludes specialty drugs		
Generic Drugs	Generic - T1A: $6 copayment after deductible Generic - T1: $20 copayment after deductible	Not covered
Preferred Brand Drugs	$90 copayment after deductible	Not covered
Non-Preferred Generic and Brand Drugs	$150 copayment after deductible	Not covered
Specialty- First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.		

Choose Generics with Dispense as Written (DAW) override - Included. See Aetna Formulary for details.
The cost difference between the generic and brand does not count toward the Deductible or Out-of-Pocket Maximum.

Precertification - Included. See Aetna Formulary for details.

Step Therapy - Included. See Aetna Formulary for details.

Mandatory Maintenance Choice - Members can choose the most convenient place to fill 90-day supplies of their maintenance drugs – from CVS Caremark® Mail Service Pharmacy or CVS pharmacy retail locations. A 90-day supply of maintenance drugs is required to be filled at CVS Caremark® Mail Service Pharmacy or CVS pharmacy retail locations after two retail fills. Otherwise, the member will be responsible for 100 percent of the cost-share

Pharmacy Plan includes:

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

Formulary generic FDA-approved Womens Contraceptives 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 (Small Group Value Plus Formulary) to understand which drugs are covered.

***How out-of-network care is reimbursed:**

We cover the cost of services based on whether doctors are “in network” or “out of network.” We want to help members understand how much Aetna pays for their out-of-network care. At the same time, we want to make it clear how much more members will need to pay for this "out-of-network" care.

Members may choose a provider (doctor or hospital) in our network. Members may choose to visit an out-of-network provider. If a member chooses a doctor who is out of network, their Aetna health plan may pay some of that doctor's bill. Most of the time, members will pay a lot more money out of their own pocket if they choose to use an out-of-network doctor or hospital.

When members choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount.

The members' doctor sets his or her own rate to charge members. These rates may be higher -- sometimes much higher -- than what the members' Aetna plan "recognizes." Members' doctors may bill them for the dollar amount that their plan doesn't "recognize." Members must also pay any copayments, coinsurance and deductibles under their plan. No dollar amount above the "recognized charge" counts toward their deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit Aetna.com. Type "how Aetna pays" in the search box.

Members can avoid these extra costs by getting their care from Aetna's network of health care providers. Go to **www.aetna.com** and click on "Find a Doctor" on the left side of the page. Members can sign on to the Aetna member site.

This applies when members choose to get care out of network. When members have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if the member got care in network. Members pay cost sharing and deductibles for their in-network level of benefits. Members should contact Aetna if their health care provider asks them to pay more. Members are not responsible for any outstanding balance billed by their providers for emergency services beyond their cost sharing and deductibles.

What's Not Covered

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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. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan.

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. Aetna is not responsible or liable in any manner for services received at CVS MinuteClinic locations. CVS Caremark® Mail Service Pharmacy and Aetna are part of the CVS Health family of companies. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are available under plans with an open formulary.

They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are administered by Aetna Life Insurance Company.