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) | $500 Individual<br>$1,000 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. | | |
| **Member Coinsurance**<br>(applies to all expenses unless otherwise stated) | 0% | Not applicable |
| **Out-of-Pocket (OOP) Maximum**<br>(per calendar year, includes deductible) | $3,500 Individual<br>$7,000 Family | Not applicable |
| Pharmacy expenses apply towards the Out of Pocket Limit.<br>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. | | |
| **Referral Requirement** | Not Required | Not applicable |
| **PHYSICIAN SERVICES** | **NETWORK CARE** | **OUT-OF-NETWORK CARE** |
| **Office Visits to Non-Specialist** | $30 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. | | |
| **Specialist Office Visits** | $60 copay deductible waived | Not covered |
| **Walk-in Clinics** | **Designated Walk-in Clinics:**<br>Covered in full<br><br>**All Other Network Providers:**<br>$30 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. | | |
| **Prenatal Maternity** | Covered in full | Not covered |
| **Maternity - Delivery and Post-Partum Care** | Covered in full after deductible | Not covered |
| **Allergy Testing** (given by a physician) | Member cost sharing is based on the type of service performed and the place rendered. | Not covered |
| **Allergy Injections** (not given by a physician) | Covered in full 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**<br>Limited to 1 exam every 12 months. | Covered in full | Not covered |
| **Well Child Exams and Immunizations**<br>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**<br>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 |

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| **Women's Health**<br>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 |
| **Routine Digital Rectal Exam / Prostate-Specific Antigen Test**<br>For covered males age 40 and over. | Covered in full | Not covered |
| **Colorectal Cancer Screening**<br>For all members age 45 and over. | Covered in full | Not covered |
| VISION SERVICES | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Routine Eye Exams (Refraction)**<br>Coverage is limited to 1 exam every 12 months. | Covered in full | Not covered |
| DIAGNOSTIC PROCEDURES | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Outpatient Diagnostic Laboratory** | Covered in full after deductible | Not covered |
| **Outpatient Diagnostic X-ray (except for Complex Imaging Services)** | Covered in full after deductible | Not covered |
| **Outpatient Diagnostic X-ray for Complex Imaging Services**<br>(Including, but not limited to, MRI, MRA, PET and CT Scans) | Covered in full 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**<br>Copay waived if admitted. | $500 copay deductible waived | 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 | Not covered |
| HOSPITAL CARE | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Inpatient Coverage**<br>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 | Not covered |
| **Outpatient Surgery**<br>Provided in an outpatient hospital department or freestanding surgical facility. | Covered in full after deductible | Not covered |
| **Transplants**<br>Coverage is limited to IOE facilities only. | Covered in full after deductible | Not covered |
| MENTAL HEALTH and SUBSTANCE ABUSE SERVICES | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Inpatient Mental Health and Substance Abuse (including inpatient residential treatment facility)**<br>The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | Covered in full after deductible | Not covered |

| | | |
|---|---|---|
| **Outpatient Mental Health and Substance Abuse Office Visits**<br>The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. | $60 copay deductible waived | Not covered |
| **Other Outpatient Mental Health and Substance Abuse Services**<br>(Includes partial hospitalization treatment, intensive outpatient program and behavioral therapies.) | Covered in full after deductible | Not covered |
| OTHER SERVICES AND PLAN DETAILS | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Skilled Nursing Facility**<br>Coverage is limited to 60 days per year.<br><br>The member cost sharing applies to all covered benefits incurring during a member's inpatient stay. | Covered in full after deductible | Not covered |
| **Home Health Care**<br>Coverage is limited to 60 visits per year.<br>Network and Out-of-Network combined; 1 visit equals a period of 4 hours or less. | Covered in full after deductible | Not covered |
| **Infusion Therapy**<br>Provided in the home or physician's office. | Covered in full after deductible | Not covered |
| **Infusion Therapy**<br>Provided in the outpatient hospital department of freestanding facility. | Covered in full after deductible | Not covered |
| **Inpatient Hospice Care**<br><br>The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | Covered in full after deductible | Not covered |
| **Outpatient Hospice Care**<br><br>The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. | Covered in full after deductible | Not covered |
| **Outpatient Short-Term Rehabilitation - Physical Therapy**<br>Coverage is limited to 60 visits per year<br>PT/OT/ST/Chiro combined. | $60 copayment after deductible | Not covered |
| **Outpatient Short-Term Rehabilitation - Occupational Therapy**<br>Coverage is limited to 60 visits per year<br>PT/OT/ST/Chiro combined. | $60 copayment after deductible | Not covered |
| **Outpatient Short-Term Rehabilitation - Speech Therapy**<br>Coverage is limited to 60 visits per year<br>PT/OT/ST/Chiro combined. | $60 copayment after deductible | Not covered |
| **Outpatient Chiropractic**<br>Coverage is limited to 60 visits per year<br>PT/OT/ST/Chiro combined. | $60 copayment after deductible | Not covered |
| **Habilitative Physical, Occupational and Speech Therapy** | Covered in full after deductible | Not covered |
| **Autism Behavioral Therapy** | $60 copay deductible waived | Not covered |
| **Autism Applied Behavior Analysis** | Covered in full after deductible | Not covered |
| **Autism Physical, Occupational and Speech Therapy** | Covered in full after deductible | Not covered |
| **Durable Medical Equipment** | 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**<br>(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. | Not covered |
| FAMILY PLANNING | NETWORK CARE | OUT-OF-NETWORK CARE |

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|---|---|---|
| **Infertility Treatment - Diagnostic only**<br>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. | Not covered |
| **Voluntary Sterilization - Vasectomy** | Member cost sharing is based on the type of service performed and the place rendered. | Not covered |
| **Voluntary Sterilization - 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 |
| **Retail**<br>Up to a 30-day supply from the Aetna National Pharmacy Network | | |
| **Generic Drugs** | Generic - T1A: $3 copayment<br>Generic - T1: $10 copayment | Not covered |
| **Preferred Brand Drugs** | $45 copayment | Not covered |
| **Non-Preferred Generic and Brand Drugs** | $75 copayment | Not covered |
| **Specialty Drugs**<br>Includes self-injectable, infused and oral specialty drugs, excludes insulin (Up to a 30-day supply) | Specialty Preferred: 20% up to $250<br>Specialty Nonpreferred: 40% up to $500 | Not covered |
| **Mail Order Delivery**<br>31-90 days – excludes specialty drugs | | |
| **Generic Drugs** | Generic - T1A: $6 copayment<br>Generic - T1: $20 copayment | Not covered |
| **Preferred Brand Drugs** | $90 copayment | Not covered |
| **Non-Preferred Generic and Brand Drugs** | $150 copayment | Not covered |
| **Specialty-**<br>First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Performance Network. | | |

**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.

**Mandatory Maintenance Choice -** After two retail fills, members are required to fill a 90-day supply of maintenance drugs at CVS Caremark® Mail Service Pharmacy or at a CVS Pharmacy. Otherwise, the member will be responsible for 100 percent of the cost.

**Opt Out -** After the member obtains the second fill at a network retail pharmacy, the member must notify us of whether they want to continue to fill their prescription at a network retail pharmacy by calling the number on the member ID card. If they do not notify us and do not switch to a 90-day supply, they will be responsible for 100 percent of the cost until they notify us. The member may call us at any time, even from the pharmacy, to let us know that they intend to use a network retail pharmacy for future prescription refills.

**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.

Preventive and seasonal vaccinations covered 100% in-network.

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**

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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.