



PLAN DESIGN & BENEFITS
PROVIDED BY AETNA HEALTH OF CALIFORNIA 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) None Individual
None Family

Out-of-Pocket Maximum (per calendar year) \$1,500 Individual
\$3,000 Family

In-Network expenses include coinsurance/copays and deductibles.
Pharmacy expenses apply towards the Out-of-Pocket-Maximum.
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%
1 exam per 12 months for members age 22 and older.

Routine Well Child Exams Covered 100%
(Age and frequency schedules apply)

Childhood Immunizations Covered 100%

Routine Gynecological Care Exams Covered 100%
1 exam per 12 months
Includes Pap smear, HPV screening, and related lab fees.

Routine Mammograms Covered 100%
Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.

Women's Health Covered 100%
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.

Routine Digital Rectal Exams / Prostate Specific Antigen Test Covered 100%
Recommended for males age 40 and over.

Colorectal Cancer Screening Covered 100%
Recommended: For all members age 45 and over.
Frequency schedule applies.

Routine Eye Exams Covered 100%
1 routine exam per 24 months.
Direct access to participating providers without a referral.

Routine Hearing Screening Covered 100%

PHYSICIAN SERVICES IN-NETWORK

Primary Care Physician Visits \$20 office visit copay
Includes services of an internist, general physician, family practitioner or pediatrician.



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Specialist Office Visits	\$20 office visit copay
Pre-Natal Maternity	Covered 100%
Walk-in Clinics	\$20 copay
	Designated Walk-in Clinics
	Covered 100%
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	Covered 100%
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	Covered 100%
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	Covered 100%
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 office visit copay
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	\$50 copay
Copay waived if admitted	
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	Covered 100%
Non-Emergency Use of Ambulance	Covered 100%
HOSPITAL CARE	IN-NETWORK
Inpatient Hospital	Covered 100%
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Inpatient Maternity Coverage (includes delivery and postpartum care)	\$20 for Physician Maternity Services; Covered 100% for Facility services
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Outpatient Hospital	Covered 100%
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
MENTAL HEALTH SERVICES	IN-NETWORK
Mental Health Inpatient	Covered 100%
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Mental Health Office Visits	\$20 copay
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Mental Health Services	Covered 100%



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Table with 2 columns: Service Category and Benefit Details. Rows include Substance Abuse (Inpatient, Residential Treatment Facility, Office Visits, Other Services), Other Services (Skilled Nursing Facility, Home Health Care, Hospice Care - Inpatient/Outpatient, Outpatient Short-Term Rehabilitation, Spinal Manipulation Therapy, Habilitative Physical/Occupational/Speech Therapy, Autism Behavioral/Physical/Occupational/Speech Therapy), Durable Medical Equipment (Hearing Aids, Prosthetics, Orthotics), Diabetic Supplies, and Women's Contraceptive drugs and devices.



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Table with columns for service name and coverage details. Includes sections for Affordable Care Act Mandated Women's Contraceptives, Infusion Therapy, Transplants, Bariatric Surgery, Acupuncture, FAMILY PLANNING (IN-NETWORK), Infertility Treatment, Fertility Preservation, Comprehensive Infertility Services, Advanced Reproductive Technology (ART), Vasectomy, Tubal Ligation, PRESCRIPTION DRUG BENEFITS (IN-NETWORK), Pharmacy Plan Type, Generic Drugs, Brand-Name Drugs, and Pharmacy Day Supply and Requirements.



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Choose Generics with Dispense as Written (DAW) override - The member pays the applicable copay. If the physician requires brand-name, member would pay brand-name copay. If the member requests brand-name when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. Contraceptives covered up to a 12 month supply. Contraceptive copay strategy applies. 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. A limited list of over-the-counter medications are covered when filled with a prescription. 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 of California 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.

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.



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- 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.

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.

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