



PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PLAN FEATURES	IN-NETWORK	OUT-OF-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)	\$5,350 Individual \$10,600 Family	\$10,000 Individual \$20,000 Family
You must first meet the deductible before the plan begins paying benefits, unless otherwise noted. The amount you pay (cost sharing) for some medical services does not count toward your deductible. Prescription drug cost count toward the deductible. Refer to your plan documents for details. Your family will have one deductible. You will meet it when the expenses of several family members add up to the family deductible. No one person will have to pay more than the individual deductible. You must first meet the deductible before the plan begins paying benefits, unless otherwise noted.		
Member Coinsurance	100%	100%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	\$5,350 Individual \$10,600 Family	\$10,000 Individual \$20,000 Family
All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. Pharmacy expenses apply towards the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum	Unlimited except where otherwise indicated.	
Primary Care Physician Selection	Optional	Not Applicable
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, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is \$400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%; deductible waived	Covered 100%; deductible waived
Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%; deductible waived	Covered 100%; deductible waived
Routine Gynecological Care Exams 1 exam and pap smear per calendar year, includes related fees.	Covered 100%; deductible waived	Covered 100%; deductible waived
Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
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 100%; deductible waived	Covered 100%; deductible waived
Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	Covered 100%; deductible waived



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Prostate-specific Antigen Test	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered under Routine Adult Exams
Recommended: For all members age 45 and over.		
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to Non-Specialist	100%; after deductible	100%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	100%; after deductible	100%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	100%; after deductible
Walk-in Clinics	Designated Walk-in Clinics	100%; after deductible
	Covered 100%; after deductible	
	All Other Network Providers	
	100%; after deductible	
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	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	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray	100%; after deductible	100%; after deductible
(other than Complex Imaging Services)		
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 Laboratory	100%; after deductible	100%; after deductible
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 Complex Imaging	100%; after deductible	100%; after deductible
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	OUT-OF-NETWORK
Urgent Care Provider	100%; after deductible	100%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	100%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	100%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	100%; after deductible	100%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		



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Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	100%; after deductible	100%; after deductible
Outpatient Hospital Expenses Your cost sharing applies to all covered benefits incurred during your outpatient visit.	100%; after deductible	100%; after deductible
Outpatient Surgery - Hospital Your cost sharing applies to all covered benefits incurred during your outpatient visit.	100%; after deductible	100%; after deductible
Outpatient Surgery - Freestanding Facility Your cost sharing applies to all covered benefits incurred during your outpatient visit.	100%; after deductible	100%; after deductible
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	100%; after deductible	100%; after deductible
Mental Health Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	100%; after deductible	100%; after deductible
Other Mental Health Services	100%; after deductible	100%; after deductible
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	100%; after deductible	100%; after deductible
Residential Treatment Facility	100%; after deductible	100%; after deductible
Substance Abuse Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	100%; after deductible	50%; after deductible
Other Substance Abuse Services	100%; after deductible	100%; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility Limited to 60 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	100%; after deductible	100%; after deductible
Home Health Care Limited to 100 visits per year. Home health care services include private duty nursing Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	100%; after deductible	100%; after deductible
Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	100%; after deductible	100%; after deductible
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	100%; after deductible	100%; after deductible
Private Duty Nursing Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.	Covered as part of Home Health Care	Covered as part of Home Health Care
Spinal Manipulation Therapy Limited to 20 visits per year	100%; after deductible	100%; after deductible
Outpatient Short-Term Rehabilitation Includes speech, physical, occupational therapy; limited to 60 visits per year	100%; after deductible	100%; after deductible



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Habilitative Physical Therapy	100%; after deductible	100%; after deductible
Habilitative Occupational Therapy	100%; after deductible	100%; after deductible
Habilitative Speech Therapy	100%; after deductible	100%; after deductible
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Combined with outpatient mental health visits		
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Covered same as any other Outpatient Mental Health All Other benefit		
Autism Physical Therapy	100%; after deductible	100%; after deductible
Autism Occupational Therapy	100%; after deductible	100%; after deductible
Autism Speech Therapy	100%; after deductible	100%; after deductible
Durable Medical Equipment	100%; after deductible	100%; after deductible
Orthotics Excludes foot orthotics; orthopedic shoes and supportive devices of the feet.	100%; after deductible	100%; after deductible
Hearing Aids Limited to 2 devices per 36 months, coverage to age 18	100%; after deductible	100%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Diabetic supplies covered by HEB-MedImpact and not covered under AETNA Medical Plan. Except monitors (Glucometers), Insulin Pumps and supplies related to the pump covered. Supplies related to the monitor not eligible.	
Affordable Care Act Mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.
Infusion Therapy Administered in the home or physician's office	100%; after deductible	100%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	100%; after deductible	100%; after deductible
Vision Eyewear	Not Covered	Not Covered
Transplants	100%; after deductible Preferred coverage is provided at an IOE contracted facility only.	100%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery- Institutes of Quality Required	100%; after deductible	Not Covered
*Covered up to \$15,000 Lifetime Maximum Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Diagnosis and treatment of the underlying medical condition only.		
Comprehensive Infertility Services	100%; after deductible	100%; after deductible
Artificial insemination and ovulation induction: Maximum of 6 sessions.		



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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	Not Covered	Not Covered
Vasectomy	Your cost sharing is based on the type of service and where it is performed	100%; after deductible
Tubal Ligation	Covered 100%; deductible waived	100%; after deductible

GENERAL PROVISIONS

Dependents Eligibility Spouse, children from birth to age 26 regardless of student status. (Any Dependent child born while you are insured will become insured on the date of his/her birth if you elect Dependent Insurance no later than 31 days after his/her birth) Eligible dependent grandchildren under the age of 25 may be covered if you provide required documentation. Please check with your employer for required documents.

Plans are provided by Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.
 Health benefits and health insurance 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. 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.



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- 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
- 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.
- 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.
- 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/enhancement, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- 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.

Aetna, or its affiliate(s), receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates may reduce the amount a member pays the pharmacy for covered prescriptions. CVS Caremark ® Mail Service Pharmacy refers to CVS Caremark ® Mail Service Pharmacy, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with CVS Caremark ® Mail Service Pharmacy may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

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

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862**.

Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862**.

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **www.aetna.com**.

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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