

**PLAN DESIGN & BENEFITS (Marketing Purposes Only)
PROVIDED BY AETNA HEALTH OF CALIFORNIA INC.**

PLAN FEATURES	IN-NETWORK
Deductible (per calendar year)	Individual = None Family = None
Out-of-Pocket Maximum (per calendar year)	\$2,000 Individual \$4,000 Family
<p>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.</p>	
Lifetime Maximum	Unlimited except where otherwise indicated.
Primary Care Physician Selection	Required
Referral Requirement	Required
PREVENTIVE CARE	IN-NETWORK
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members age 22 and older.	Covered 100%
Routine Well Child Exams/Immunizations (Age and frequency schedules apply)	Covered 100%
Routine Gynecological Care Exams 1 exam per 12 months Includes Pap smear, HPV screening, and related lab fees.	Covered 100%
Routine Mammograms Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	Covered 100%
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%
Routine Digital Rectal Exams / Prostate Specific Antigen Test Recommended for males age 40 and over.	Covered 100%
Colorectal Cancer Screening Recommended: For all members age 45 and over. Frequency schedule applies.	Covered 100%
Routine Eye Exams 1 routine exam per 24 months. Direct access to participating providers without a referral.	Covered 100%
Routine Hearing Screening	Covered 100%
PHYSICIAN SERVICES	IN-NETWORK
Primary Care Physician Visits Includes services of an internist, general physician, family practitioner or pediatrician.	\$20 copay

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Specialist Office Visits	\$20 copay
Pre-Natal Maternity	Covered 100%
Allergy Testing	\$20 copay
Allergy Injections	\$20 copay
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%
EMERGENCY MEDICAL CARE IN-NETWORK	
Urgent Care Provider	\$20 copay
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	\$100 copay
Copay waived if admitted	
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	\$100 copay
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE IN-NETWORK	
Inpatient Coverage	20%, after \$100 copay per admission
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Inpatient Maternity Coverage (includes delivery and postpartum care)	Covered 100% for Physician maternity services; Covered 20%, after \$100 copay per admission for Facility services
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Outpatient Hospital	20%
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
MENTAL HEALTH SERVICES IN-NETWORK	
Mental Health Inpatient	20%, after \$100 copay per admission
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Mental Health Office Visits	Covered 100%
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
SUBSTANCE ABUSE IN-NETWORK	
Inpatient Detoxification	20%, after \$100 copay per admission
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Outpatient Detoxification	Covered 100%
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	

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Inpatient Rehabilitation	20%, after \$100 copay per admission Your cost sharing applies to all covered benefits incurred during your inpatient stay.
Residential Treatment Facility	20%, after \$100 copay per admission
Outpatient Rehabilitation	Covered 100% Your cost sharing applies to all covered benefits incurred during your outpatient visit.
OTHER SERVICES	
IN-NETWORK	
Skilled Nursing Facility	20%, after \$100 copay per admission Limited to 100 days; per calendar year Your cost sharing applies to all covered benefits incurred during your inpatient stay.
Home Health Care	\$20 copay Limited to 120 visits; per calendar year Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.
Hospice Care - Inpatient	Covered 100% Your cost sharing applies to all covered benefits incurred during your inpatient stay.
Hospice Care - Outpatient	Covered 100% Your cost sharing applies to all covered benefits incurred during your outpatient visit.
Outpatient Rehabilitation Therapy	\$20 copay Includes speech, physical, occupational therapy
Spinal Manipulation Therapy	\$10 copay Limited to 30 visits per calendar year,
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health Covered same as any other Outpatient Mental Health benefit
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health Other Services Covered same as any other Outpatient Mental Health Other Services benefit
Autism Physical Therapy	\$20 copay
Autism Occupational Therapy	\$20 copay
Autism Speech Therapy	\$20 copay
Durable Medical Equipment	Covered 100%
Hearing Aids - every 24 mo's.	Covered 100%
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%
Affordable Care Act Mandated Women's Contraceptives	Covered 100%
Transplants	20%, after \$100 copay per admission Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery	20%, after \$100 copay per admission Your cost sharing applies to all covered benefits incurred during your inpatient stay.
FAMILY PLANNING	
IN-NETWORK	
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed Diagnosis and treatment of the underlying medical condition only.
GIFT	Not Covered Limited to 1 attempt per lifetime
Comprehensive Infertility Services	Not Covered Artificial insemination and ovulation induction

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Advanced Reproductive Technology (ART)	Not Covered	
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery		
Vasectomy	Your cost sharing is based on the type of service and where it is performed	
Tubal Ligation	Covered 100%	
PRESCRIPTION DRUG BENEFITS IN-NETWORK		
Pharmacy Plan Type	Advanced Control Plan - Aetna or Standard Opt-Out Plan – Aetna	
Generic Drugs	Retail	\$10 copay
	Mail Order	\$20 copay
Preferred Brand-Name Drugs	Retail	\$30 copay
	Mail Order	\$60 copay
Non-Preferred Brand-Name Drugs	Retail	50% up to Maximum \$100
	Mail Order	50% up to Maximum \$200
Specialty Drugs	Preferred Specialty	20% up to Maximum \$100
	Non-Preferred Specialty	20% up to Maximum \$100
Pharmacy Day Supply and Requirements		
	Retail	Up to a 30-day supply
	Mail Order	Up to a 31-90-day supply from CVS Caremark® Mail Service Pharmacy.
	Specialty	Up to a 30-day supply from CVS Specialty® Pharmacy. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through CVS Specialty® Pharmacy.
Choose Generics with Dispense as Written (DAW) override - member pays applicable copay of the physician required brand. If the member requests brand when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. Performance Enhancing Drugs limited to 4 tablets per month. Oral fertility drugs included. Oral chemotherapy drugs covered 100% Pre-certification Included Step Therapy included Formulary Exclusions Apply 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.

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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.
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- 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.
- 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.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery and Aetna Specialty Pharmacy refer to Aetna Rx Home Delivery, LLC and Aetna Specialty Pharmacy, LLC, respectively. Aetna Rx Home Delivery and Aetna Specialty Pharmacy are licensed pharmacy subsidiaries of Aetna Inc. that operate through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery and Aetna Specialty 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 pharmacies' 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.

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).



High Desert & Inland Employee-Employer Trust – AVN or HMO Plan 5
Effective Date: 07-01-2020
Aetna Value Network or HMO - California

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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.

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