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)	Individual = None Family = None
Out-of-Pocket Maximum (per calendar year)	$1,000 Individual $2,000 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 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%
Hearing Aids (every 24 months)	Covered 100%

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PHYSICIAN SERVICES	IN-NETWORK
Primary Care Physician Visits Includes services of an internist, general physician, family practitioner or pediatrician.	$10 office visit copay
Specialist Office Visits	$10 office visit copay
Pre-Natal Maternity	Covered 100%
Walk-in Clinics	$10 copay
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 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.	Covered 100%
Diagnostic X-ray 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.	Covered 100%
Diagnostic X-ray for 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.	Covered 100%
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care Provider	$10 office visit copay
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room Copay waived if admitted	$100 copay
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	Covered 100%
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK**
Inpatient Coverage Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%
Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100% for Physician maternity services and Facility services
Outpatient Hospital Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%
MENTAL HEALTH SERVICES	**IN-NETWORK**
Mental Health Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%
Mental Health Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%
Other Mental Health Services	Covered 100%

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SUBSTANCE ABUSE	IN-NETWORK
Inpatient/Outpatient Detoxification	Covered 100%
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Residential Treatment Facility	Covered 100%
Substance Abuse Office Visits	Covered 100%
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Substance Abuse Services	Covered 100%
OTHER SERVICES	**IN-NETWORK**
Skilled Nursing Facility	Covered 100%
Limited to 100 days; per calendar year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Home Health Care	$10 copay
Limited to 120 visits; per calendar year Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit = 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 Short-Term Rehabilitation	$10 copay
Includes speech, physical, occupational therapy	
Spinal Manipulation Therapy	$10 copay
Limited to 30 visits per calendar year. Direct access to participating providers without a referral.	
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
Covered same as any other Outpatient Mental Health Other Services benefit	
Autism Physical Therapy	Refer to MBH Outpatient Mental Health All Other
Autism Occupational Therapy	Refer to MBH Outpatient Mental Health All Other
Autism Speech Therapy	Refer to MBH Outpatient Mental Health All Other
Durable Medical Equipment	Covered 100%
Prosthetics	Covered 100%
Orthotics	Covered 100%
Orthotics and special footwear covered for persons with foot disfigurement.	
Diabetic Supplies	Pharmacy 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%
Infusion Therapy	$10 copay
Administered in the home or physician's office	
Transplants	Covered 100% Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery	Covered 100%
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.	

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GIFT	Not Covered
Comprehensive Infertility Services Artificial insemination and ovulation induction	$10 Copay; 6 Cycles Maximum Per Lifetime
Advanced Reproductive Technology (ART)	$10 Copay; 2 Cycles Maximum Per Lifetime for Iatrogenic Infertility Only Includes In Vitro Fertilization, Cryopreservation and unlimited for storage.
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
Generic Drugs	
Retail	$8 copay
Mail Order	$16 copay
Preferred Brand-Name Drugs	
Retail	$25 copay
Mail Order	$50 copay
Non-Preferred Brand-Name Drugs	
Retail	$40 copay
Mail Order	$80 copay
Advanced Control Specialty Drugs	
Preferred Specialty	20%; up to $100 max. copay per prescription
Non-Preferred Specialty	20%; up to $100 max. copay per prescription
Pharmacy Day Supply and Requirements	
Retail	1x retail copay for 30-day supply, 2x retail copay for 31-60-day supply, and 3x retail copay for 61-90-day supply from Aetna National Network.
Mail Order	Up to a 31-90-day supply from CVS Caremark® Mail Service Pharmacy.
Advanced Control 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 - The member pays the applicable copay. If the physician requires brand-name, member will 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.
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
One transition fill allowed within 90 days of member's effective date
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.

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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.
• 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.
• 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.

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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.

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.