HMO
CA22 $15/30 Copay H RX4 (200 ded)

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)	$3,500 Individual $7,000 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 per 12 months for members age 22 and older.	Covered 100%
Routine Well Child Exams (Age and frequency schedules apply)	Covered 100%
Childhood Immunizations	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%

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Routine Hearing Screening	Covered 100%
PHYSICIAN SERVICES	**IN-NETWORK**
Primary Care Physician Visits	$15 office visit copay
Includes services of an internist, general physician, family practitioner or pediatrician.	
Specialist Office Visits	$30 office visit copay
Pre-Natal Maternity	Covered 100%
Walk-in Clinics	$15 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
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic Laboratory	$20 copay
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	$40 copay
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	$150 copay
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	$50 office visit copay
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	$250 copay
Copay waived if admitted	
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	$150 copay
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK**
Inpatient Hospital	$150 per day for the first5 days, thereafter Covered 100%
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Inpatient Maternity Coverage (includes delivery and postpartum care)	$15 for Physician Maternity Services; $150 per day for the first 5 days, thereafter Covered 100% for Facility services
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Outpatient Surgery - Hospital	$100 copay
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Outpatient Surgery - Freestanding Facility	$100 copay
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	

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MENTAL HEALTH SERVICES	IN-NETWORK
Mental Health Inpatient	$150 per day for the first 5 days per admission, thereafter Covered 100%
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Mental Health Office Visits	$30 copay
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Mental Health Services	Covered 100%
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient	$150 per day for the first 5 days per admission, thereafter Covered 100%
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Residential Treatment Facility	$150 per day for the first5 days, thereafter Covered 100%
Substance Abuse Office Visits	$30 copay
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	$150 per day for the first5 days, thereafter Covered 100%
Limited to 100 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Home Health Care	$30 copay
Limited to 120 visits per 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	$150 per day for the first 5 days, thereafter Covered 100%
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Hospice Care - Outpatient	$30 copay
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Outpatient Short-Term Rehabilitation	$30 copay
Includes speech, physical, occupational therapy	
Spinal Manipulation Therapy	$15 copay
Limited to 20 visits per year Direct access to participating providers without a referral.	
Habilitative Physical Therapy	Refer to MBH Outpatient Mental Health All Other
Habilitative Occupational Therapy	Refer to MBH Outpatient Mental Health All Other
Habilitative Speech Therapy	Refer to MBH Outpatient Mental Health All Other
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	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	$15 copay
Prosthetics	Covered 100%
Orthotics	Covered 100%
Orthotics and special footwear covered for persons with foot disfigurement.	
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.

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Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%
Affordable Care Act mandated Women's Contraceptives	Covered 100%
Infusion Therapy Administered in the home or physician's office	$30 copay
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed
Transplants	$150 per day for the first5 days, thereafter Covered 100% Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery Your cost sharing applies to all covered benefits incurred during your inpatient stay.	$150 per day for the first 5 days per admission, thereafter Covered 100%
Acupuncture Limited to 20 visits per year	$15 copay
FAMILY PLANNING	**IN-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed
Fertility Preservation Includes coverage for cryopreservation and storage for iatrogenic infertility Iatrogenic infertility is infertility that may occur as a result of certain types of medical treatment	Your cost sharing is based on the type of service and where it is performed
Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered
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
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
Preferred Generic Drugs	
Retail	$10 copay
Mail Order	$20 copay
Preferred Brand-Name Drugs	
Retail	$30 copay
Mail Order	$60 copay
Non-Preferred Generic and Brand-Name Drugs	
Retail	$55 copay
Mail Order	$110 copay
Specialty Drugs	
Preferred Specialty	30% Maximum $250
Non-Preferred Specialty	30% Maximum $250

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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	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy
Specialty	Up to a 30 day supply All prescription fills must be through our preferred specialty pharmacy network. Advanced Control Formulary Aetna Insured List

Deductible waived for generics

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
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.

Prescription Drug Deductible(per calendar year)	$200 Individual $400 Family

All covered pharmacy expenses accumulate toward the pharmacy deductible.
Unless otherwise indicated, the pharmacy deductible must be met prior to pharmacy benefits being payable.
Once family pharmacy deductible is met, all family members will be considered as having met their pharmacy deductible for the remainder of the year.

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.
• 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.
• 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).

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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.
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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