



Aetna Choice® POS II -- ASC
 Aetna Funding Advantage
 CA22 750 80/60 \$20/40 C RX4 (200 ded)

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)	\$750 Individual \$1,500 Family	\$1,500 Individual \$3,000 Family
All covered expenses accumulate simultaneously toward both the in-network and out-of-network Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount.		
Member Coinsurance	20%	40%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	\$3,000 Individual \$6,000 Family	\$7,000 Individual \$14,000 Family
All covered expenses accumulate simultaneously toward both the in-network and 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	Covered 100%; deductible waived	40%; after deductible
1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	40%; after deductible
7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	40%; after deductible
1 obgyn exam and pap smear per year		
Routine Mammograms	Covered 100%; deductible waived	40%; after deductible



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Women's Health	Covered 100%; deductible waived	40%; after deductible
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 Exam	Covered 100%; deductible waived	40%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	40%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	40%; after deductible
Recommended: For all members age 45 and over.		
Routine Eye Exams	Covered 100%; deductible waived	40%; after deductible
1 routine exam per 24 months.		
Routine Hearing Screening	Covered 100%; deductible waived	40%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to Primary Care Physician (PCP)	\$20 office visit copay; deductible waived	40%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	\$40 office visit copay; deductible waived	40%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	40%; after deductible
Walk-in Clinics	\$20 copay; deductible waived	40%; after deductible
	Designated Walk-in Clinics	
	Covered 100%; deductible waived	
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 (other than Complex Imaging Services)	20%; after deductible	40%; 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 Laboratory	20%; after deductible	40%; 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	20%; after deductible	40%; 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



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Urgent Care Provider	\$50 office visit copay; deductible waived	40%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	20% after \$250 copay; deductible waived	Same as in-network care
Copay waived if admitted		
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	20%; 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	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES		
	IN-NETWORK	OUT-OF-NETWORK
Inpatient	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	\$40 copay; deductible waived	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	20%; after deductible	40%; after deductible
SUBSTANCE ABUSE		
	IN-NETWORK	OUT-OF-NETWORK
Inpatient	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	20%; after deductible	40%; after deductible
Substance Abuse Office Visits	\$40 copay; deductible waived	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	20%; after deductible	40%; after deductible
OTHER SERVICES		
	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility Limited to 60 days per year	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care Limited to 120 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.	20%; after deductible	40%; after deductible

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The benefits listed are for illustrative purposes. Please refer to the benefits listed on the Summary of Benefits and Coverage (SBC) or the contract provided upon enrollment in the plan.



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Hospice Care - Inpatient	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing	Covered as part of Home Health Care	Covered as part of Home Health Care
Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.		
Spinal Manipulation Therapy	\$40 copay; deductible waived	40%; after deductible
Limited to 20 visits per year		
Outpatient Short-Term Rehabilitation	\$40 copay; deductible waived	40%; after deductible
Includes speech, physical, occupational therapy; limited to 60 visits per year		
Habilitative Physical Therapy	20%; after deductible	40%; after deductible
Habilitative Occupational Therapy	20%; after deductible	40%; after deductible
Habilitative Speech Therapy	20%; after deductible	40%; after deductible
Autism Behavioral Therapy	\$40 copay; deductible waived	40%; after deductible
Combined with outpatient mental health visits		
Autism Applied Behavior Analysis	20%; after deductible	40%; after deductible
Covered same as any other Outpatient Mental Health All Other benefit		
Autism Physical Therapy	20%; after deductible	40%; after deductible
Autism Occupational Therapy	20%; after deductible	40%; after deductible
Autism Speech Therapy	20%; after deductible	40%; after deductible
Durable Medical Equipment	20%; after deductible	40%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
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	\$40 copay; deductible waived	40%; after deductible
Administered in the home or physician's office		
Infusion Therapy	20%; after deductible	40%; after deductible
Administered in an outpatient hospital department or freestanding facility		
Acupuncture	\$20 copay; deductible waived	40%; after deductible
Limited to 10 visits per year		
Gene-based, Cellular, and other Innovative Therapies (GCIT™)	Your cost sharing is based on the type of service and where it is performed \$50 copay; deductible waived for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.	Not Covered
Vision Eyewear	Not Covered	Not Covered



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Transplants	20%; after deductible Preferred coverage is provided at an IOE contracted facility only.	40%; after deductible
Bariatric Surgery	Not Covered	Not Covered
FAMILY PLANNING	IN-NETWORK	OUT-OF-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.	Your cost sharing is based on the type of service and where it is performed
Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation induction		
Advanced Reproductive Technology (ART)	Not Covered	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	40%; after deductible
Tubal Ligation	Covered 100%; deductible waived	40%; after deductible
PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	Advanced Control Plan - Aetna	
Preferred Generic Drugs		
	Retail \$10 copay	Not Covered
	Mail Order \$20 copay	Not Applicable
Preferred Brand-Name Drugs		
	Retail \$30 copay	Not Covered
	Mail Order \$60 copay	Not Applicable
Non-Preferred Generic and Brand-Name Drugs		
	Retail \$55 copay	Not Covered
	Mail Order \$110 copay	Not Applicable
Specialty Drugs		
Preferred Specialty	30% Maximum \$250	Not Covered
Non-Preferred Specialty	30% Maximum \$250	Not Covered



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Pharmacy Day Supply and Requirements

Retail	Up to a 30 day supply from Aetna National Network
Mandatory Maintenance Choice	After two retail fills, members are required to fill a 90-day supply of maintenance drugs at CVS Caremark® Mail Service Pharmacy or at a CVS Pharmacy. Otherwise, the member will be responsible for 100 percent of the cost-share.
Opt Out	The member must notify us of whether they want to continue to fill at a network retail pharmacy by calling the number on the member ID card.
Specialty	Up to a 30 day supply All prescription fills must be through our preferred specialty pharmacy network. Aetna 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.

A limited list of over-the-counter medications are covered when filled with a prescription.

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.

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.

Prescription Drug Per Year	\$200 Individual	\$200 Individual
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Deductible (must be satisfied before any drug benefits are paid)

	\$400 Family	\$400 Family
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All covered pharmacy expenses accumulate toward both the preferred and non-preferred 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.

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.

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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