



MEDICAL

The medical programs, administered by Aetna, provides the framework for your health and well-being. To better meet the varying needs of our employees, Cameron County offers the medical plan described below:

Medical Plan Summary	Aetna Choice POS II--ASC
Active Employee	Monthly Rate
Employee Only	\$15.00
Employee & Spouse	\$168.75
Employee + 1 Child	\$93.75
Employee + Children	\$125.00
Employee + Fam	\$250.00

Plan Features	Max Savings	Standard Savings	Out-of-Network
Deductible (please read plan design & benefits for detail information)			
Individual	\$500	\$1,000	\$2,000
Family	\$1,500	3,000	\$6,000
Member coinsurance	You pay 15%	You pay 30%	You pay 50%
Out-of-pocket limit (please read plan design & benefits for detail information)			
Individual	\$3,000	\$4,500	\$8,000
Family	\$7,000	\$10,000	\$18,000
Payment for out-of-network care	Not applicable	Not applicable	Professional: Prevailing charges Facility: Facility charge review
Primary care physician selection	Optional	Not applicable	Does not apply
Referral requirements	Not required	Not required	None
Telehealth consultations	You can access covered services for telehealth visits from different kinds of providers in your plan. Log on to Aetna.com to see a list of telehealth providers. You'll also find more about your options, including cost share amounts.		
PREVENTIVE CARE	Max Savings	Standard Savings	Out-of-Network
Preventive services	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Medications	Certain over-the-counter preventative medications covered 100% in network		

PHYSICIAN SERVICES		Max Savings	Standard Savings	Out-of-Network
Office Visits Copay (PCP)	\$10; no deductible	\$30; no deductible	50%; after deductible	
Telehealth Consultations	You can access covered services for telehealth visits from different kinds of providers in your plan Log on to Aetna.com to see list of telehealth providers. You'll also find more about your options, including cost share amounts			
Specialist office visit	\$45; no deductible	\$65; no deductible	50%; after deductible	
DIAGNOSTIC PROCEDURES		Max Savings	Standard Savings	Out-of-Network
Diagnostic X-ray	Covered 100%; deductible waived	Covered 100%; deductible waived	50%; after deductible	
Diagnostic laboratory	Covered 100%; deductible waived	Covered 100%; deductible waived	50%; after deductible	
EMERGENCY MEDICAL CARE		Max Savings	Standard Savings	Out-of-Network
Urgent Care provider	\$75 office visit; no deductible	\$75 office visit; no deductible	50%; after deductible	
Emergency room	15% after \$250 copay; no deductible	15% after \$250 copay; no deductible	same as in-network care	
HOSPITAL CARE		Max Savings	Standard Savings	Out-of-Network
Inpatient coverage	15%; after deductible	30%; after deductible	50%; after deductible	
when you're admitted into a hospital for the care you need, your cost amount counts toward all covered benefits you receive				
Outpatient hospital	15%; after deductible	30%; after deductible	50%; after deductible	
When you receive outpatient care at a hospital but don't stay overnight, your cost amount counts toward all covered benefits during your visit				
PHARMACY		IN-NETWORK	OUT-OF-NETWORK	
Generic Drugs				
Retail	\$15 copay	NOT COVERED		
Mail order	\$30 copay	NOT COVERED		
Preferred Brand-Named Drugs				
Retail	\$40 copay	NOT COVERED		
Mail order	\$80 copay	NOT COVERED		
Non-preferred Brand-Named Drugs				
Retail	\$60 copay	NOT COVERED		
Mail order	\$120 copay	NOT COVERED		

Specialty Drugs		
Preferred Brand-Named Drugs	\$80 copay	NOT COVERED
Non-preferred Brand-Named Drugs	\$80 copay	NOT COVERED
If eligible and enrolled in Prudent Rx program		
If eligible and not enrolled in Prudent Rx program	30% coinsurance	

WORKING SPOUSE PREMIUM

The working spouse premium is a monthly charge in addition to your regular medical coverage contribution/premium for a spouse who is working or who is eligible for medical coverage through their employer or former employer.

The Working Spouse Premium for this year is \$100/month



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

PLAN FEATURES	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Benefit limitations - Some service or supplies have limits on them per year. There might be a maximum number of visits or days, or a dollar limit per year. In such cases, the benefit year begins on January 1 (unless otherwise noted). Refer to your plan documents to learn more.			
Deductible (per calendar year)	\$500 per Individual \$1,500 per Family	\$1,000 per Individual \$3,000 per Family	\$2,000 per Individual \$6,000 per Family
Covered expenses add up separately toward your maximum savings, standard savings, and out-of-network deductible. 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 costs do not 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.			
Member coinsurance	You pay 15%	You pay 30%	You pay 50%
Applies to all expenses except as noted.			
Out-of-pocket limit (per calendar year)	\$3,000 per Individual \$7,000 per Family	\$4,500 to per Individual \$10,000 per Family	\$8,000 per Individual \$18,000 per Family
Covered expenses add up separately toward your maximum savings, standard savings, and out-of-network out-of-pocket limit. Some of your cost sharing may not count toward the out-of-pocket limit. Your pharmacy expenses do not count toward your out-of-pocket limit. In-network expenses include coinsurance/copays and deductibles. Out-of-network expenses include coinsurance and deductibles. Penalty amounts do not apply. Your family will have one out-of-pocket limit. You will meet it when the expenses of several family members add up to the family out-of-pocket limit. No one person will have to pay more than the individual out-of-pocket limit amount.			
Lifetime maximum Unlimited except where otherwise indicated.			
Payment for out-of-network care**	Not Applicable	Not Applicable	Professional: Prevailing Charges Facility: Facility Charge Review
Primary care physician selection	Optional	Not Applicable	Does not apply
Precertification requirements - Some out-of-network services need approval by us in advance (precertification). Without this approval, we reduce benefits by \$250. Refer to your plan documents for a full list of services that need this approval.			
Referral requirement	Not required	Not required	None
Telehealth consultations - You can access covered services for telehealth visits from different kinds of providers in your plan. Log on to Aetna.com to see a list of telehealth providers. You'll also find more about your options, including cost share amounts.			
PREVENTIVE CARE	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Routine adult physical exams/ immunizations 1 exam every 12 months until age 65, then 1 exam every 12 months age 65 and older	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Routine well child exams/immunizations	Covered 100%; no deductible	Covered 100%; no deductible	Covered 100%; after deductible



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

- 7 exams in the first 12 months
- 3 exams from age 13 to 24 months
- 3 exams from age 25 to 36 months
- 1 exam every 12 months thereafter until age 22

Routine gynecological care exams 1 exam and pap smear per year, includes related fees.	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Routine mammogram Recommended: One per year for members	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
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. Also includes: contraceptive methods (ACA mandated contraceptives, including contraceptives and devices you can't get at a pharmacy), sterilization procedures (including tubal ligation), patient education and counseling. Limits may apply.	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Pre-natal maternity	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Routine digital rectal exam Recommended: For members age 40 and over	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Prostate-specific antigen test Recommended: For members recommended age 45 & over	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Colorectal cancer screening Recommended: For members no age limit	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Routine eye exams	Covered 100%; no deductible	Covered 100%; no deductible	Not Covered
Routine hearing screening	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Medications	Certain over-the-counter preventive medications covered 100% in network.		
PHYSICIAN SERVICES	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Office visits to member's selected primary care physician (PCP)	\$10 office visit copay; no deductible	\$30 office visit copay; no deductible	50%; after deductible
Telehealth consultation with non-specialist	\$35 office visit copay; no deductible	\$35 office visit copay; no deductible	50%; after deductible
Specialist office visits This is how much you pay for the services of an internist, general physician, family practitioner, or pediatrician if the physician is not your PCP.	\$45 office visit copay; no deductible	\$65 office visit copay; no deductible	50%; after deductible
Telehealth consultation with specialist This is how much you pay for routine care from an internist, general physician, family practitioner, or pediatrician. Also includes the diagnosis and treatment of an illness or injury.	\$45 office visit copay; no deductible	\$65 office visit copay; no deductible	50%; after deductible
Hearing exams	Not Covered	Not Covered	Not Covered
Walk-in clinics	\$35 copay; no deductible	\$35 copay; no deductible	50%; after deductible



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

Designated Walk-in clinics
 Does not apply

Designated Walk-in clinics
 Does not apply

Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services.

Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices.

Telehealth consultations for non-emergency services through a walk-in clinic	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.	50%; after deductible
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Designated Walk-in clinics
 Does not apply

Designated Walk-in clinics
 Does not apply

We pay telehealth screenings and counseling services from a walk-in-clinic as a preventive care benefit.

Teladoc – 24/7/365 access to doctors by telephone & online	\$10 copay; deductible waived	\$10 copay; deductible waived	Not covered
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Allergy testing	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
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Allergy injections	Covered 100%; deductible waived.	Covered 100%; deductible waived	Your cost sharing amount depends on the type of service and where you receive it.
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DIAGNOSTIC PROCEDURES	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
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Diagnostic X-ray (Other than complex imaging services)	Covered 100%; deductible waived	Covered 100%; deductible waived	50%; after deductible
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When your physician performs and bills for this service at their office, you pay your office visit cost share amount.

Diagnostic laboratory	Covered 100%; deductible waived	Covered 100%; deductible waived	50%; after deductible
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When your physician performs and bills for this service at their office, you pay your office visit cost share amount.

Diagnostic complex imaging	15%; after deductible	30%; after deductible	50%; after deductible
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When your physician performs and bills for this service at their office, you pay your office visit cost share amount.

EMERGENCY MEDICAL CARE	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
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Urgent care provider	\$75 office visit copay; no deductible	\$75 office visit copay; no deductible	50%; after deductible
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Non-urgent use of urgent care provider	\$75 office visit copay; no deductible	\$75 office visit copay; no deductible	50%; after deductible
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Emergency room	15% after \$250 copay; no deductible	15% after \$250 copay; no deductible	Same as in-network care
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Copay waived if admitted

Non-emergency care in an emergency room	15% after \$250 copay. No Deductible	15% after \$250 copay. No deductible	50%; after deductible
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Emergency use of ambulance	15%; no deductible	15%; no deductible	15%; no deductible
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PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

Non-emergency use of ambulance	Not Covered	Not Covered	Not Covered
HOSPITAL CARE	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Inpatient coverage When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	15%; after deductible	30%; after deductible	50%; after deductible
Inpatient maternity coverage (includes delivery and postpartum care) When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	15%; after deductible	30%; after deductible	50%; after deductible
Outpatient hospital When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	15%; after deductible	30%; after deductible	50%; after deductible
Outpatient surgery - hospital When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	15%; after deductible	30%; after deductible	50%; after deductible
Outpatient surgery - freestanding facility When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	15%; after deductible	30%; after deductible	50%; after deductible
MENTAL HEALTH SERVICES	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Inpatient When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	15%; after deductible	30%; after deductible	50%; after deductible
Mental health office visits	\$45 copay; no deductible	\$45 copay; no deductible	50%; after deductible
Mental health telehealth consultations	\$45 office visit copay; no deductible	\$45 office visit copay; no deductible	50%; after deductible
Other mental health services When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
SUBSTANCE ABUSE	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Inpatient When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	15%; after deductible	30%; after deductible	50%; after deductible
Residential treatment facility When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	15%; after deductible	30%; after deductible	50%; after deductible
Substance abuse office visits	\$45 copay; no deductible	\$45 copay; no deductible	50%; after deductible
Substance abuse telehealth consultations	\$45 office visit copay; no deductible	\$45 office visit copay; no deductible	50%; after deductible
Other substance abuse services When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible



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

THERAPY SERVICES	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Spinal manipulation therapy Limited to 35 visits per year (Airrosti Rehab Centers have a reduced copay to \$35)	\$45 copay; no deductible	\$45 copay; no deductible	50%; after deductible
Outpatient short-term rehabilitation Limited to 30 visits per year Includes physical, occupational, and speech therapies.	\$45 copay; no deductible	\$65 copay; no deductible	50%; after deductible
Habilitative physical therapy	100%; no deductible	100%; no deductible	50%; after deductible
Habilitative occupational therapy	100%; no deductible	100%; no deductible	50%; after deductible
Habilitative speech therapy	100%; no deductible	100%; no deductible	50%; after deductible
Autism related physical therapy	100%; no deductible	100%; no deductible	50%; after deductible
Autism related occupational therapy	100%; no deductible	100%; no deductible	50%; after deductible
Autism related speech therapy	100%; no deductible	100%; no deductible	50%; after deductible
Autism related behavioral therapy These benefits are combined with outpatient mental health visits	100%; no deductible	100%; no deductible	50%; after deductible
Autism related applied behavior analysis Your benefits for these services are the same as any other outpatient mental health other services benefit	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
OTHER SERVICES	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Skilled nursing facility Limited to 25 days per year When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Home health care Limited to 60 visits per year Home health care services include private duty nursing Limited to three visits per day by staff from a home health care agency. One visit equals a period of four hours or less.	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Hospice care - inpatient When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Hospice care - outpatient When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible
Private duty nursing We count each period of up to 8 hours as one private duty nursing shift.	Not Covered	Not Covered	Not Covered
Durable medical equipment (ie: foot orthotics under diabetic mandate)	15%; after deductible	30%; after deductible	50%; after deductible

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

Diabetic supplies -- (if not covered under the prescription drug benefit)	Follows Diabetic Mandate	Follows Diabetic Mandate	50%; after deductible
Infusion therapy - home/office	\$45 copay; no deductible	\$65 copay; no deductible	50%; after deductible
Infusion therapy - outpatient hospital/freestanding facility	15%; after deductible	30%; after deductible	50%; after deductible
Gene-based, Cellular, and other Innovative Therapies (GCIT™)	Your cost sharing amount depends on the type of service and where you receive it. 15%: after deductible for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.	Your cost sharing amount depends on the type of service and where you receive it. 30%: after deductible for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.	Not Covered
Transplants	15%; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.	30%; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.	50%; after deductible Out-of-network coverage applies when you use a non-IOE facility. You will pay more out of pocket when using a non-IOE facility.
Bariatric surgery	Not covered	Not covered	Not covered
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.			
Acupuncture- use of needles to alleviate pain and to treat various conditions	100%; after \$10 copay	100%; after \$30 copay	Not covered
FAMILY PLANNING	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Infertility treatment	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
You have coverage for artificial insemination and the diagnosis and treatment of the underlying cause of infertility.			
Advanced Reproductive Technology (ART)	Not covered	Not covered	Not covered
ART coverage is limited to three cycles per member's lifetime and includes in vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Ovulation induction (OI) limited to six cycles per member's lifetime. Maximum applies to all procedures covered by any of our plans except where prohibited by law.			
Fertility preservation	Not covered	Not covered.	Not covered.
Includes coverage for cryopreservation for iatrogenic infertility Iatrogenic infertility is infertility that may occur as a result of certain types of medical treatment			
Vasectomy	15%; after deductible	30%; after deductible	50%; after deductible
Tubal ligation	Covered 100%; no deductible	Covered 100%; no deductible	50%; after deductible



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

GENERAL PROVISIONS		
Dependents who are eligible to be on your plan	Spouse, children from birth to age 26. Student status of children does not matter.	
PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	Aetna Standard Open Formulary	
If the drug cost is lower than the copay, the member pays the lower cost.		
Generic Drugs		
	Retail \$15 copay	NOT COVERED – Member pays total cost of prescription Not Applicable
	Mail Order \$30 copay	
Preferred Brand-Name Drugs		
	Retail \$40 copay	NOT COVERED – Member pays total cost of prescription Not Applicable
	Mail Order \$80 copay	
Non-Preferred Brand-Name Drugs		
	Retail \$60 copay	NOT COVERED – Member pays total cost of prescription Not Applicable
	Mail Order \$120 copay	
Specialty Drugs		
Preferred Brand Specialty	\$80 copay	NOT COVERED – Member pays total cost of prescription
Non-Preferred Brand Specialty	\$80 copay	NOT COVERED – Member pays total cost of prescription
If eligible and enrolled in the Prudent Rx program	\$0 copay	
If eligible and not enrolled in the Prudent Rx program	30% coinsurance	
Pharmacy Day Supply and Requirements		
	Retail	Up to a 30 day supply with 1 x retail copay or a 31-90 day supply for 2 x retail copay option available from Aetna National with Extended Day Supply Network
	Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy
	Specialty	Up to a 30 day supply CVS Caremark® Specialty Pharmacy Specialty fills must be through our preferred specialty pharmacy network. Aetna Standard Plan Specialty Drug List
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Diabetic supplies, blood glucose monitors, prescription weight loss drugs and contraceptive drugs and devices obtainable from a pharmacy. Includes sexual dysfunction drugs for females and males, including daily dose, additional 8 tablets a month for males for erectile dysfunction. Oral fertility drugs included. Precertification for specialty drugs 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.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

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

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.

****We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.**

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.

This amount is based on the out-of-network plan you or your employer picks.

- For doctors and other professionals the amount is based on the "prevailing" charges. We get this data from an external database.

- For hospitals and other facilities, the amount is based on the Facility Fee Schedule.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Navigator member site.

This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in-network. You pay your plan's copayments and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments and deductibles.

Plans are provided by: Aetna Health Inc. 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.

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

- 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 this material into another language may be available. Please call Member Services at the number on the back of your ID card.

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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