





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

PLAN FEATURES	IN-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)	None Individual None Family
Prescription drug costs do not count toward the deductible. Refer to your plan documents for details.	
Member coinsurance	Covered 100%
Applies to all expenses except as noted.	
Out-of-pocket limit (per calendar year)	\$5,000 per Individual \$10,000 per Family
Your pharmacy expenses count toward your out-of-pocket limit. In-network expenses include coinsurance/copays and deductibles. 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.	
Primary care physician selection	Encouraged
Referral requirement	Not required
Virtual care consultations - You can access covered services for virtual care visits from different kinds of providers in your network. Log on to Aetna.com to see a list of virtual care providers. You'll also find more about your options, including cost share amounts.	
CVS VIRTUAL CARE	IN-NETWORK
CVS Health Virtual Primary Care (VPC) - preventive care consultations	Covered 100%
Includes screening and counseling services through CVS Health Virtual Primary Care for members age 18 and older; refer to Aetna.com for more information.	
CVS Health Virtual Primary Care (VPC) - consultations	Covered 100%
Includes basic medical service consultations through CVS Health Virtual Primary Care for members age 18 and older; refer to Aetna.com for additional information.	
CVS Health Virtual Care (VC) - general medicine	Covered 100%
CVS Health Virtual Care (VC) - mental health	Covered 100%
PREVENTIVE CARE	IN-NETWORK
Routine adult physical exams/immunizations	Covered 100%
1 exam every 12 months until age 65, then 1 exam every 12 months age 65 and older	
Routine well child exams/immunizations	Covered 100%
<ul style="list-style-type: none"> • 7 exams in the first 12 months • 3 exams from age 13 months to 24 months • 3 exams from age 25 months to 36 months • 1 exam every 12 months thereafter until age 22 	
Routine gynecological care exams	Covered 100%
1 exam and pap smear per year, includes related fees.	



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Routine mammogram	Covered 100%
Recommended: One per year for members age 40 and over	
Women's health	Covered 100%
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.	
Pre-natal maternity	Covered 100%
Routine digital rectal exam	Covered 100%
Recommended: For members age 40 and over	
Prostate-specific antigen test	Covered 100%
Recommended: For members age 40 and over	
Colorectal cancer screening	Covered 100%
Recommended: For members age 45 and over	
Routine eye exams	Covered 100%
1 routine exam per 24 months.	
Routine hearing screening	Covered 100%
PHYSICIAN SERVICES	IN-NETWORK
Office visits to primary care physician (PCP)	\$30 office visit copay
Includes services of an internist, general physician, family practitioner or pediatrician.	
Specialist office visits	\$50 office visit copay
Hearing exams	\$50 copay
1 routine exam per 24 months.	
Walk-in clinics	\$30 copay
	Designated Walk-in clinics
	Covered 100%
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.	
Allergy testing	Your cost sharing amount depends on the type of service and where you receive it.
Allergy injections	Your cost sharing amount depends on the type of service and where you receive it. Covered 100% when an office visit charge is not applicable.
DIAGNOSTIC PROCEDURES	IN-NETWORK
Diagnostic X-ray (Other than complex imaging services)	\$100 copay
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	
Diagnostic laboratory	Covered 100%
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	
Diagnostic complex imaging	\$250 copay
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	
EMERGENCY MEDICAL CARE	IN-NETWORK
Urgent care provider	\$50 office visit copay
Non-urgent use of urgent care provider	Not Covered



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Emergency room	\$200 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	\$300 copay per day with max 5 days
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Inpatient maternity coverage (includes delivery and postpartum care)	\$300 copay per day with max 5 days
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Outpatient hospital	Covered 100%
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.	
Outpatient surgery - hospital	\$150 copay
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.	
Outpatient surgery - freestanding facility	\$150 copay
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.	
MENTAL HEALTH SERVICES	IN-NETWORK
Inpatient	\$300 copay per day with max5 days
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Mental health office visits	\$30 copay
Other mental health services	Covered 100%
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.	
SUBSTANCE ABUSE	IN-NETWORK
Inpatient	\$300 copay per day with max5 days
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Residential treatment facility	\$300 copay per day with max 5 days
Substance abuse office visits	\$30 copay
Other substance abuse services	Covered 100%
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.	
THERAPY SERVICES	IN-NETWORK
Spinal manipulation therapy	\$50 copay
Limited to 20 visits per year	



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Outpatient short-term rehabilitation	\$50 copay
Limited to 30 visits per year Includes physical, occupational, and speech therapies.	
Habilitative physical therapy	Covered 100%
Habilitative occupational therapy	Covered 100%
Habilitative speech therapy	Covered 100%
Autism related physical therapy	Covered 100%
Autism related occupational therapy	Covered 100%
Autism related speech therapy	Covered 100%
Autism related behavioral therapy	\$30 copay
These benefits are combined with outpatient mental health visits	
Autism related applied behavior analysis	Covered 100%
Your benefits for these services are the same as any other outpatient mental health other services benefit	
OTHER SERVICES	IN-NETWORK
Skilled nursing facility	\$250 copay
Limited to 60 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.	
Home health care	\$50 copay
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.	
Hospice care - inpatient	\$250 copay
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Hospice care - outpatient	\$50 copay
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.	
Private duty nursing	Covered as part of home health care
We count each period of up to 8 hours as one private duty nursing shift.	
Durable medical equipment	50%
Diabetic supplies	
• If not covered under the prescription drug benefit	You pay your PCP visit cost sharing amount
• If covered under the prescription drug benefit	You pay your applicable prescription drug cost sharing amount
Infusion therapy - home/office	\$50 copay
Infusion therapy - outpatient hospital/freestanding facility	Your cost sharing amount depends on the type of service and where you receive it.
Gene-based, Cellular, and other Innovative Therapies (GCIT™)	Your cost sharing amount depends on the type of service and where you receive it. \$50 copay In-network coverage is provided at GCIT™ designated facilities only.
Hearing aids	Not Covered
Transplants	\$300 copay per day with max5 days Preferred coverage is provided at an IOE contracted facility only.



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Bariatric surgery	Not Covered
Acupuncture Limited to 10 visits per year	\$30 copay
FAMILY PLANNING	IN-NETWORK
Basic Infertility	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
Fertility preservation	Not Covered
Vasectomy	Covered 100%
Tubal ligation	Covered 100%
PHARMACY	IN-NETWORK
Pharmacy plan type	Advanced Control Plan - Aetna
Prescription drug out-of-pocket limit	Prescription drug expenses apply to your medical out-of-pocket limit.
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 \$60 copay
	Mail order \$120 copay
Pharmacy day supply and requirements	
Mandatory maintenance choice	Retail You can get up to a 30-day supply from Aetna National Network Maintenance drugs are prescriptions commonly used to treat conditions that require regular, daily use of medicines. If you take a maintenance drug, you can get two retail fills. Then you must fill a 31-90-day supply of the maintenance drug at CVS Caremark® Mail Service Pharmacy, a designated network pharmacy, or a CVS Pharmacy®.
Opt Out	If you do not, you will need to pay 100% of the drug cost. You must notify us if you want to continue to fill the medicine at a network retail pharmacy. Just call the number on the member ID card.
Specialty	You can get up to a 30-day supply of specialty drugs You must fill all specialty drugs through our preferred specialty pharmacy network. Advanced Control Formulary AFA List



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Your prescription drug plan also includes:

- Diabetic supplies
- \$25 copay maximum per fill per 30 day supply for formulary insulin drugs
- Sexual dysfunction drugs, including daily dose, additional 6 tablets a month for erectile dysfunction
- A limited list of over-the-counter medications when filled with a prescription

Family planning

- Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).
- Contraceptives covered up to a 12-month supply. Contraceptive copay strategy applies.

The following are covered 100% in-network:

- Oral chemotherapy drugs
- Seasonal vaccinations
- Preventive vaccinations
- Affordable Care Act (ACA) eligible preventive medications and contraceptives

Refer to Aetna.com for a complete list of eligible prescription drugs.

Precertification requirements

Some covered prescription drugs need approval from us before we will cover the drug.

Some covered prescription drugs require step therapy before we cover them. With step therapy, you must first try one or more drugs before we will pay for drugs that require step therapy.

To get the most up-to-date precertification requirements and a list of drugs that require step therapy, see your plan documents or go online to your member website.

Choose generics - Sometimes you or your provider may ask for a brand-name prescription drug when a generic is available. If so, you will pay the brand-name copay plus the difference between the generic price and the brand-name price.

The cost difference that you pay will not apply to your out-of-pocket limit.

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.

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.



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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.
- 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**.



The Artcraft Group, Inc
Proposed Effective Date: 01-01-2026
Aetna Open Access® Aetna SelectSM
Aetna Funding Advantage

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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.

*****This plan document provides you with an overview of some of your benefits and your cost share obligations. This information is for illustrative purposes ONLY. This document is not an official document and may differ from your Certificate of Coverage (COC), which is your official document. Refer to your COC for your coverage and services and any obligations on your part.**

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