aetna

Air Group, LLC
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PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PLAN FEATURES	MAXIMUM SAVINGS	STANDARD SAVINGS
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 the day your plan coverage takes effect (unless otherwise noted). Refer to your plan documents to learn more.		
Deductible (per plan year)	$1,200 per Individual $2,400 per Family	$2,500 per Individual $5,000 per Family
Covered expenses add up toward both your maximum savings and standard savings deductible at the same time. 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 Applies to all expenses except as noted.	You pay 10%	You pay 30%
Out-of-pocket limit (per plan year)	$4,000 per Individual $8,000 per Family	$6,500 per Individual $13,000 per Family
Covered expenses add up toward both your maximum savings and standard savings out-of-pocket limit at the same time. 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	Optional	Not applicable
Referral requirement	Not required	Not required
Telehealth consultations - You can access covered services for telehealth visits from different kinds of providers in your network. Log on to **Aetna.com** to see a list of telehealth providers. You'll also find more about your options, including cost share amounts.		
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	MAXIMUM SAVINGS	STANDARD SAVINGS
CVS Health Virtual Care (VC) - general medicine	Covered 100%; no deductible	Covered 100%; no deductible
CVS Health Virtual Care (VC) - mental health	Covered 100%; no deductible	Covered 100%; no deductible
PREVENTIVE CARE	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
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
Routine well child exams/immunizations • 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	Covered 100%; no deductible	Covered 100%; no deductible
Routine gynecological care exams 1 exam and pap smear per year, includes related fees.	Covered 100%; no deductible	Covered 100%; no deductible

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Routine mammogram Recommended: One per year for members age 40 and over	Covered 100%; no deductible	Covered 100%; no 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
Pre-natal maternity	Covered 100%; no deductible	Covered 100%; no deductible
Routine digital rectal exam Recommended: For members age 40 and over	Covered 100%; no deductible	Covered 100%; no deductible
Prostate-specific antigen test Recommended: For members age 40 and over	Covered 100%; no deductible	Covered 100%; no deductible
Colorectal cancer screening Recommended: For members age 45 and over	Covered 100%; no deductible	Covered 100%; no deductible
Routine eye exams 1 routine exam per 12 months.	Covered 100%; no deductible	Covered 100%; no deductible
Routine hearing screening	Covered 100%; no deductible	Covered 100%; no deductible
Medications	Certain over-the-counter preventive medications covered 100% in network.	
PHYSICIAN SERVICES	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
Office visits to member's selected primary care physician (PCP)	$20 office visit copay; no deductible	$40 office visit copay; no deductible
Telehealth consultation with non-specialist	$10 office visit copay; no deductible	$10 office visit copay; no 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.	$40 office visit copay; no deductible	$50 office visit copay; no 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.	$10 office visit copay; no deductible	$10 office visit copay; no deductible
Hearing exams	Not Covered	Not Covered
Walk-in clinics 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.	$20 copay; no deductible **Designated Walk-in clinics** Covered 100%; no deductible	$40 copay; after deductible **Designated Walk-in clinics** Covered 100%; no deductible
Allergy testing	$40 office visit copay; no deductible	$50 office visit copay; no deductible
Allergy injections	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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DIAGNOSTIC PROCEDURES	MAXIMUM SAVINGS	STANDARD SAVINGS
Diagnostic X-ray (Other than complex imaging services)	Covered 100%; no deductible	Covered 100%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.		
Diagnostic laboratory	Covered 100%; no deductible	Covered 100%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.		
Diagnostic complex imaging	Covered 100%; no deductible	Covered 100%; after deductible
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**
Urgent care provider	$40 office visit copay; no deductible	$50 office visit copay; no deductible
Non-urgent use of urgent care provider	$40 office visit copay; no deductible	$50 office visit copay; no deductible
Emergency room Copay waived if admitted	10% after $100 copay; after deductible	10% after $100 copay; after deductible
Non-emergency care in an emergency room	Not Covered	Not Covered
Emergency use of ambulance	Covered 100%; after deductible	Covered 100%; after deductible
Non-emergency use of ambulance	Not Covered	Not Covered
HOSPITAL CARE	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
Inpatient coverage	10%; after deductible	30%; after deductible
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)	10%; after deductible	30%; after deductible
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	10%; after deductible	30%; after deductible
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	10%; after deductible	30%; after deductible
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	10%; after deductible	30%; after deductible
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	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
Inpatient	10%; after deductible	30%; after deductible
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	$40 copay; no deductible	$50 copay; no deductible
Mental health telehealth consultations	$10 office visit copay; no deductible	$50 office visit copay; after deductible
Other mental health services	Covered 100%; no deductible	Covered 100%; no deductible
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.		

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SUBSTANCE ABUSE	MAXIMUM SAVINGS	STANDARD SAVINGS
Inpatient	10%; after deductible	30%; after deductible
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		30%; after deductible
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Substance abuse office visits	$40 copay; no deductible	$50 copay; no deductible
Substance abuse telehealth consultations	$10 office visit copay; no deductible	$50 office visit copay; after deductible
Other substance abuse services	Covered 100%; no deductible	Covered 100%; no deductible
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	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
Spinal manipulation therapy	$30 copay; no deductible	$30 copay; no deductible
Limited to 25 visits per year		
Outpatient rehabilitative physical and occupational therapy	10%; after deductible	30%; after deductible
Limited to 30 visits per year		
Outpatient rehabilitative speech therapy	10%; after deductible	30%; after deductible
Limited to 30 visits per year		
Habilitative physical therapy	Covered 100%; no deductible	Covered 100%; no deductible
Habilitative occupational therapy	Covered 100%; no deductible	Covered 100%; no deductible
Habilitative speech therapy	Covered 100%; no deductible	Covered 100%; no deductible
Autism related physical therapy	Covered 100%; no deductible	Covered 100%; no deductible
Autism related occupational therapy	Covered 100%; no deductible	Covered 100%; no deductible
Autism related speech therapy	Covered 100%; no deductible	Covered 100%; no deductible
Autism related behavioral therapy	$40 copay; no deductible	$50 copay; after deductible
These benefits are combined with outpatient mental health visits		
Autism related applied behavior analysis	Covered 100%; no deductible	Covered 100%; no deductible
Your benefits for these services are the same as any other outpatient mental health other services benefit		
OTHER SERVICES	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
Skilled nursing facility	10%; after deductible	30%; after deductible
Limited to 100 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	$20 copay; no deductible	$40 copay; no deductible
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	10%; after deductible	30%; after deductible
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	10%; after deductible	30%; after deductible
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	Covered as part of home health care
We count each period of up to 8 hours as one private duty nursing shift.		

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Durable medical equipment	10%; after deductible	30%; after deductible
Prosthetics	$20 copay; no deductible	$40 copay; no deductible
Orthotics	$20 copay; no deductible	$40 copay; no deductible
Diabetic supplies		
• If not covered under the prescription drug benefit	You pay your PCP visit cost sharing amount	You pay your PCP visit cost sharing amount
• If covered under the prescription drug benefit	You pay your applicable prescription drug cost sharing amount	You pay your applicable prescription drug cost sharing amount
Infusion therapy - home/office	10%; after deductible	30%; after deductible
Infusion therapy - outpatient hospital/freestanding facility	Your cost sharing depends on the type of service and where you receive it.	Your cost sharing 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: 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. $50 copay: after deductible for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.
Hearing aids 1 hearing aid every 24 months; to age 16	Covered 100%; no deductible	Covered 100%; no deductible
Transplants	10%; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.	10%; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.
Bariatric surgery When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	10%; after deductible	30%; after deductible
Acupuncture Limited to 10 visits per year	$40 copay; no deductible	$50 copay; no deductible
FAMILY PLANNING	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
Infertility treatment You have coverage for artificial insemination and the diagnosis and treatment of the underlying cause of infertility.	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.
Advanced Reproductive Technology (ART) 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.	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.
Fertility preservation Includes coverage for cryopreservation for iatrogenic infertility Iatrogenic infertility is infertility that may occur as a result of certain types of medical treatment	Your cost sharing depends on the type of service and where you receive it.	Your cost sharing depends on the type of service and where you receive it.
Vasectomy	10%; after deductible	30%; after deductible
Tubal ligation	Covered 100%; no deductible	Covered 100%; no deductible

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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.
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.

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Puede estar disponible la traduccion 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.

*****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.**