



**PLAN DESIGN AND BENEFITS**  
**AWH Southern CA HMO Silver**  
**CA \$55/90 2500 wINF**

**CA Group Business 1-100 Employees**

This plan only provides access to covered benefits when provided by a network provider. The plan does not provide access to covered benefits when provided by an out-of-network provider, except for emergency care provided for an emergency medical condition. This plan will pay for the emergency care subject to in-network benefits.

PLAN FEATURES	NETWORK CARE	OUT-OF-NETWORK CARE
<b>Primary Care Physician Selection</b>	Required	Not applicable
<b>Deductible</b> (per calendar year)	\$2,500 Individual \$5,000 Family	Not applicable
Unless otherwise indicated, the deductible must be met before benefits can be paid.		
As indicated in the plan, member cost sharing for certain services are excluded from the charges to meet the deductible.		
No one family member may contribute more than the individual deductible amount to the family deductible. Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the year.		
<b>Member Coinsurance</b> (applies to all expenses unless otherwise stated)	35%	Not applicable
<b>Out-of-Pocket (OOP) Maximum</b> (per calendar year, includes deductible)	\$8,750 Individual \$17,500 Family	Not applicable
Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and copays (except any penalty amounts) may be used to satisfy the Out-of-Pocket Maximum.		
No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, all family members will be considered as having met their out-of-pocket maximum for the remainder of the year.		
<b>Referral Requirement</b>	Required	Not applicable
PHYSICIAN SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
<b>Office Visits to Non-Specialist</b>	\$55 copay deductible waived	Not covered
Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illness or injury.		
<b>Telemedicine Consultations to Non-Specialist</b>	\$55 copay deductible waived	Not covered
<b>Non-Specialist Telemedicine Provider Consultations</b>	\$55 copay deductible waived	Not covered
<b>Specialist Office Visits</b>	\$90 copay deductible waived	Not covered
<b>Telemedicine Consultations to Specialist</b>	\$90 copay deductible waived	Not covered
<b>Specialist Telemedicine Provider Consultations</b>	\$90 copay deductible waived	Not covered
<b>Walk-in Clinics</b>	<b>Designated Walk-in Clinics:</b> Covered in full  <b>All Other Network Providers:</b> \$55 copay deductible waived	Not covered
Walk-in clinics are freestanding 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.		
<b>Telemedicine Consultations for Non-Emergency Services through a Walk-in Clinic</b> If telemedicine preventive screening and counseling services are provided through a walk-in clinic, these services are paid under the preventive care benefit.	<b>Designated Walk-in Clinics:</b> Covered in full  <b>All Other Network Providers:</b> Cost sharing is based on the type of service and where it is performed.	Not covered
<b>Maternity - Delivery and Post-Partum Care</b>	35% deductible waived	Not covered
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
<b>Allergy Testing</b>	Cost-sharing is based on type of service and where it is received.	Not covered

<b>Allergy Injections</b> Copay waived if no physician encounter.	Cost-sharing is based on type of service and where it is received.	Not covered
<b>PREVENTIVE CARE</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
Preventive care services are covered in accordance with Health Care Reform.		
<b>Routine Adult Physical Exams and Immunizations</b> Coverage is limited to 1 exam every 12 months.	Covered in full	Not covered
<b>Routine Well Child Exams and Immunizations</b> Coverage is limited 7 exams in the first 12 months of life; 3 exams in the second 12 months of life; 3 exams in the third 12 months of life; 1 exam every 12 months thereafter to age 22.	Covered in full	Not covered
<b>Routine Gynecological Exams</b> Includes Pap smear, HPV screening and related lab fees. Coverage is limited to 1 exam every 12 months.	Covered in full	Not covered
<b>Routine Mammograms</b>	Covered in full	Not covered
<b>Women's Health</b> 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; Limitations may apply.	Covered in full	Not covered
<b>Prenatal Maternity</b>	Covered in full	Not covered
<b>Routine Digital Rectal Exam / Prostate-Specific Antigen Test</b> Recommended: For covered males age 40 and over. Frequency schedule applies.	Covered in full	Not covered
<b>Colorectal Cancer Screening</b> Recommended: For all members age 45 and over. Frequency schedule applies.	Covered in full	Not covered
<b>Routine Eye and Hearing Screenings</b>	Paid as part of routine physical exam.	Not covered
<b>HEARING SERVICES</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Hearing Exam (by Specialist)</b>	Covered in full	Not covered
<b>Hearing Aid</b>	Not covered	Not covered
<b>VISION SERVICES</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Adult Routine Eye Exams (Refraction)</b>	Not covered	Not covered
<b>Pediatric Routine Eye Exams (Refraction)</b> Coverage is limited to age 0-19.	Covered in full	Not covered
<b>Adult Vision Hardware</b>	Not covered	Not covered
<b>Pediatric Vision Hardware</b> Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per calendar year age 0-19.	Covered in full	Not covered
<b>DIAGNOSTIC PROCEDURES</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Outpatient Diagnostic Laboratory</b>	\$55 copay deductible waived	Not covered
<b>Outpatient Diagnostic X-ray (except for Complex Imaging Services)</b>	\$90 copay deductible waived	Not covered
<b>Outpatient Diagnostic X-ray for Complex Imaging Services</b> Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required.	\$300 copayment after deductible	Not covered

<b>Outpatient Diagnostic Laboratory Performed in a PCP Office Visit</b>	Included in OV Copay	Not covered
<b>Outpatient Diagnostic X-ray Performed in a PCP Office Visit (except for Complex Imaging Services)</b>	Included in OV Copay	Not covered
<b>Outpatient Diagnostic X-ray for Complex Imaging Services Performed in a PCP Office Visit</b> Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required.	Included in OV Copay	Not covered
<b>Outpatient Diagnostic Laboratory Performed in a Specialist Office Visit</b>	Included in OV Copay	Not covered
<b>Outpatient Diagnostic X-ray Performed in a Specialist Office Visit (except for Complex Imaging Services)</b>	Included in OV Copay	Not covered
<b>Outpatient Diagnostic X-ray for Complex Imaging Services Performed in a Specialist Office Visit</b> Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required.	Included in OV Copay	Not covered
<b>EMERGENCY MEDICAL CARE</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Urgent Care Provider</b>	\$55 copay deductible waived	Not covered
<b>Non-Urgent Use of Urgent Care Provider</b>	Not covered	Not covered
<b>Emergency Room</b>	35% after deductible	Paid as In-Network
<b>Non-Emergency Care in an Emergency Room</b>	Not covered	Not covered
<b>Emergency Use of Ambulance</b>	35% after deductible	Paid as In-Network
<b>Non-Emergency Use of Ambulance</b>	35% after deductible	Not covered
<b>HOSPITAL CARE</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Inpatient Coverage</b> Including maternity (prenatal, delivery and postpartum) and transplants.	35% after deductible	Not covered
<b>Outpatient Surgery</b> Provided in an outpatient hospital department or freestanding surgical facility.	35% after deductible	Not covered
<b>Colonoscopy</b> (non-preventive)	Cost-sharing is based on type of service and where it is received.	Not covered
<b>Transplants</b> Coverage is limited to IOE facilities only.	35% after deductible	Not covered
<b>BEHAVIORAL HEALTH SERVICES (MENTAL HEALTH and SUBSTANCE RELATED DISORDERS)</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Inpatient Services</b>	35% after deductible	Not covered
<b>Outpatient Office Visits</b>	\$55 copay deductible waived	Not covered
<b>Physician or Behavioral Health Provider Telemedicine Consultations</b>	\$55 copay deductible waived	Not covered
<b>Telemedicine Provider Consultations</b>	\$55 copay deductible waived	Not covered
<b>Other Outpatient Services</b> (e.g.:partial hospitalization treatment, intensive outpatient programs)	Covered in full	Not covered
<b>THERAPY SERVICES</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>

<b>Outpatient Chiropractic/Spinal Manipulation Therapy</b> Accumulation and Cost Share- Coverage is limited to 20 visits per calendar year, separate from habilitation and includes all outpatient places of service for Chiro.	\$35 copay deductible waived	Not covered
<b>Outpatient Short-Term Rehabilitation - Physical Therapy</b> Accumulation and Cost Share- No visit limits per calendar year PT, OT and ST, separate from habilitation and includes all outpatient places of service for PT, OT and ST.	\$55 copay deductible waived	Not covered
<b>Outpatient Short-Term Rehabilitation - Occupational Therapy</b> Accumulation and Cost Share- No visit limits per calendar year PT, OT and ST, separate from habilitation and includes all outpatient places of service for PT, OT and ST.	\$55 copay deductible waived	Not covered
<b>Outpatient Short-Term Rehabilitation - Speech Therapy</b> Accumulation and Cost Share- No visit limits per calendar year PT, OT and ST, separate from habilitation and includes all outpatient places of service for PT, OT and ST.	\$55 copay deductible waived	Not covered
<b>Habilitative Physical, Occupational and Speech Therapy</b>	\$55 copay deductible waived	Not covered
<b>Autism Physical, Occupational and Speech Therapy</b>	Covered in full	Not covered
<b>Autism Behavioral Therapy</b>	\$55 copay deductible waived	Not covered
<b>Autism Applied Behavior Analysis</b>	Covered in full	Not covered
<b>OTHER SERVICES AND PLAN DETAILS</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Skilled Nursing Facility</b> Coverage is limited to 100 days per confinement.	35% after deductible	Not covered
<b>Home Health Care</b> Coverage is limited to 100 visits per calendar year.	\$45 copay deductible waived	Not covered
<b>Infusion Therapy</b> Provided in the home or physician's office.	\$90 copay deductible waived	Not covered
<b>Infusion Therapy</b> Provided in the outpatient hospital department or freestanding facility.	35% deductible waived	Not covered
<b>Gene-Based, Cellular and Other Innovative Therapies (GCIT)</b> Coverage is limited to GCIT designated facilities only.	Cost-sharing is based on type of service and where it is received.	Not covered
<b>Hospice Care - Inpatient</b>	Covered in full	Not covered
<b>Hospice Care Outpatient</b>	Covered in full	Not covered
<b>Private Duty Nursing - Outpatient</b>	Not covered	Not covered
<b>Acupuncture</b>	\$55 copay deductible waived	Not covered
<b>Durable Medical Equipment</b>	35% deductible waived	Not covered
<b>Diabetic Supplies not obtainable at a pharmacy</b>	Covered same as any other medical expense.	Not covered
<b>Bariatric Surgery</b>	35% after deductible	Not covered
<b>FAMILY PLANNING</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Infertility Treatment - Diagnostic only</b> Covered only for the diagnosis and treatment of the underlying medical condition.	Cost-sharing is based on type of service and where it is received.	Not covered

<b>Infertility Treatment - Artificial Insemination or Ovulation Induction</b> Coverage is limited to 6 courses of treatment for AI and 6 courses of treatment for OI per lifetime.	35% deductible waived	Not covered
<b>Advanced Reproductive Technology.</b> Can include GIFT, ZIFT, IVF, ICSI, ovum microsurgery and cryopreserved embryo transfers, see the Certificate of Coverage for full details.  Coverage is limited to services for fertility preservation see plan booklet for details. GIFT is limited to 2 cycles per lifetime.	35% deductible waived	Not covered
<b>Vasectomy</b>	Covered in full	Not covered
<b>Tubal Ligation</b>	Covered in full	Not covered
<b>PEDIATRIC DENTAL SERVICES</b>		
<b>NETWORK CARE</b>		
<b>OUT-OF-NETWORK CARE</b>		
<b>Preventive &amp; Diagnostic</b> (includes exams, cleanings, x-rays, fluoride, sealants) Coverage is limited to age 0-19.	Covered in full	Not covered
<b>Basic</b> (includes space maintainers, fillings, anesthesia, denture adjustments) Coverage is limited to age 0-19.	20% deductible waived	Not covered
<b>Major</b> (includes crowns, endodontics, periodontics, oral surgery, dentures, bridges) Coverage is limited to age 0-19.	50% deductible waived	Not covered
<b>Orthodontia</b> (limited to medically necessary orthodontia) Coverage is limited to age 0-19.	50% deductible waived	Not covered
<b>PHARMACY DEDUCTIBLE</b>		
<b>NETWORK CARE</b>		
<b>OUT-OF-NETWORK CARE</b>		
<b>Prescription drug calendar year deductible</b>	Individual: \$300 Family: \$600	Not applicable
<b>PHARMACY - PRESCRIPTION DRUG BENEFITS</b>		
<b>NETWORK CARE</b>		
<b>OUT-OF-NETWORK CARE</b>		
<b>Generic Drugs</b>		
<b>Retail</b>	Generic: \$19 copay deductible waived	Not covered
<b>MailOrder</b>	Generic: \$38 copay deductible waived	Not covered
<b>Preferred Brand Drugs</b>		
<b>Retail</b>	\$85 copayment after deductible	Not covered
<b>MailOrder</b>	\$170 copayment after deductible	Not covered
<b>Non-Preferred Drugs</b>		
<b>Retail Generic</b>	\$110 copayment deductible waived	Not covered
<b>Retail Brand</b>	\$110 copayment after deductible	Not covered
<b>MailOrder Generic</b>	\$220 copayment deductible waived	Not covered
<b>MailOrder Brand</b>	\$220 copayment after deductible	Not covered
<b>Specialty Drugs</b>		
<b>Preferred Specialty</b>	30% up to \$250 after deductible	Not covered
<b>Non-Preferred Specialty</b>	30% up to \$250 after deductible	Not covered
<b>Pharmacy Day Supply and Requirements</b>		
<b>Retail :</b> Up to a 30 day supply.		
<b>Mail Order :</b> A 31-90 day supply from CVS Caremark Mail Service Pharmacy™ or a CVS Pharmacy at the Mail Order Drug copay.		
<b>Specialty :</b> Up to a 30 day supply		

**Specialty Drugs** - All prescription fills must be through our preferred specialty pharmacy network.

**True Accumulation** - Some specialty prescription drugs may qualify for third-party copay assistance programs, like a manufacturer coupon or a rebate. These could lower out-of-pocket costs. Any amount received through one of these programs will not apply towards the Deductible or Out-of-Pocket Maximum.

**Full Choose Generics** - If the member or the physician requests brand when generic is available, the member pays the applicable cost-sharing plus the cost difference between the generic and brand.

**Precertification** - Included. See formulary for details.

**Step Therapy** - Included. See formulary for details.

**Maintenance Choice® with Opt Out** - After two retail fills, members must choose to fill a 90-day supply of their maintenance drugs at CVS Caremark Mail Service Pharmacy™ or at a CVS retail pharmacy. If the member wants to continue to fill their 30-day supply at any other network pharmacy, they simply need to call us at the number on their member ID card. If they do not notify us that they want to opt out of the 90-day supply at a CVS Pharmacy, they'll be responsible for 100 percent of their medication cost. The member may call us any time, even from the pharmacy, to let us know that they intend to opt out of the benefit.

**Pharmacy Plan includes:**

Diabetic supplies obtainable from a pharmacy (Including: needles, syringes, test strips, lancets and alcohol swabs - available at retail or mail order).

**Performance Enhancing Drugs** - Coverage is included for up to 30 pills per month or 27 pills per 90 days for lifestyle/performance drugs. See Aetna Formulary for details on precertification.

Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

Preventive and seasonal vaccinations covered 100% in-network.

**Network and Non-network Providers**

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 Aetna pays 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 provider who is out-of-network, your Aetna health plan will not pay any of that provider's bill. You will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to [www.aetna.com](http://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 Aetna 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 the network. You pay cost sharing and deductibles for your in-network level of benefits. Contact Aetna 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.

**What's Not Covered**

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial 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 purchased.

- All medical or hospital services not specifically covered in or which are limited or excluded in the plan documents
- Charges related to any eye surgery mainly to correct refractive errors
- Cosmetic surgery, including breast reduction
- Custodial care
- Adult dental care and x-rays
- Donor egg retrieval
- Experimental and investigational procedures
- Immunizations for travel or work
- Infertility services, including, but not limited to, 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
- Non-medically necessary services or supplies
- Orthotics except as specified in the plan
- Over-the-counter medications and supplies
- Reversal of sterilization

- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs
- Special duty nursing
- Weight reduction programs, or dietary supplements

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. 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. Aetna is not responsible or liable in any manner for services received at CVS MinuteClinic locations. CVS Caremark® Mail Service Pharmacy and Aetna are part of the CVS Health family of companies. Preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

If your plan covers outpatient prescription drugs, your plan includes a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step therapy, please refer to our website at [www.aetna.com](http://www.aetna.com), or the Aetna Medication Formulary Guide. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage.

While this information is believed to be accurate as of the print date, it is subject to change.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Plans are provided by Aetna Health Inc.

For more information about Aetna plans, refer to [www.aetna.com](http://www.aetna.com).