EL CAMINO HOSPITAL
Effective Date: 01-01-2025
HMO

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA HEALTH OF CALIFORNIA INC. - FULL RISK

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)	$250 per Individual $250 per Family
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.	
Out-of-pocket limit (per calendar year)	$1,000 per Individual $3,000 per Family
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. 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	Required
Referral requirement	You'll need a PCP referral for most in-network services
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	**IN-NETWORK**
Routine adult physical exams/ immunizations 1 exam every 12 months	Covered 100%; no deductible
Routine well child exams • 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	Covered 100%; no deductible
Childhood immunizations	Covered 100%; no deductible
Routine gynecological care exams 1 exam and pap smear per year, including HPV screening and related fees	Covered 100%; no deductible
Routine mammogram Recommended: One per year for members age 40 and over	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
Pre-natal maternity	Covered 100%; no deductible
Routine digital rectal exams / Prostate specific antigen test Recommended: For members age 40 and over	Covered 100%; no deductible

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Colorectal cancer screening Recommended: For all members age 45 and over. Frequency schedule applies.	Covered 100%; no deductible
Routine eye exams 1 routine exam per 24 months. Direct access to participating providers without a referral.	Covered 100%; no deductible
Routine hearing screening	Covered 100%; no deductible
PHYSICIAN SERVICES	**IN-NETWORK**
Primary care physician visits Includes services of an internist, general physician, family practitioner or pediatrician.	$25 office visit copay; no deductible
Telehealth consultation with non-specialist	$25 office visit copay; no deductible
Specialist office visits	$40 office visit copay; no deductible
Telehealth consultation with specialist	$40 office visit copay; no deductible
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.	$25 copay; no deductible
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) When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	Covered 100%; no deductible
Diagnostic laboratory When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	Covered 100%; no deductible
Diagnostic complex imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	$100 copay; no deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent care provider	$25 office visit copay; no deductible
Non-urgent use of urgent care provider	Not Covered
Emergency room Copay waived if admitted	$150 copay; no deductible
Non-emergency care in an emergency room	Not Covered
Emergency use of ambulance	Covered 100%; no deductible
Non-emergency use of ambulance	Not Covered
HOSPITAL CARE	**IN-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.	$750 copay; 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.	$25 for Physician Maternity Services; no deductible; $750 copay for Facility Services; after deductible

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Outpatient hospital	$100 copay; 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	**IN-NETWORK**
Mental health inpatient	$600 copay; 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	$25 copay; no deductible
Mental health telehealth consultations	$25 office visit copay; no deductible
Other mental health services	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.	
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient	$600 copay; 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	$600 copay; 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	$25 copay; no deductible
Substance abuse telehealth consultations	$25 office visit copay; no deductible
Other substance abuse services	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	**IN-NETWORK**
Spinal manipulation therapy	$15 copay; no deductible
Limited to 20 visits per year Direct access to participating providers without a referral.	
Outpatient short-term rehabilitation	$25 copay; no deductible
Includes speech, physical, occupational therapy	
Habilitative physical therapy	Covered 100%; no deductible
Habilitative occupational therapy	Covered 100%; no deductible
Habilitative speech therapy	Covered 100%; no deductible
Autism related physical therapy	Covered 100%; no deductible
Autism related occupational therapy	Covered 100%; no deductible
Autism related speech therapy	Covered 100%; no deductible
Autism related behavioral therapy	$25 copay; no deductible
These benefits are combined with outpatient mental health visits.	
Autism related applied behavior analysis	Covered 100%; no deductible
Your benefits for these services are the same as any other outpatient mental health other services benefit	

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OTHER SERVICES	IN-NETWORK
Skilled nursing facility 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.	Covered 100%; no deductible
Home health care Limited to 120 visits per year Limited to three visits per day by staff from a home health care agency. One visit equals a period of four hours or less.	$25 copay; no 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.	$750 copay; 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
Durable medical equipment	Covered 100%; no deductible
Hearing aids Limited to 1 benefit maximum per 36 months.	Covered 100%; no deductible
Prosthetics	Covered 100%; no deductible
Orthotics Orthotics and special footwear covered for persons with foot disfigurement.	Covered 100%; no deductible
Diabetic supplies -- (if not covered under the prescription drug benefit)	Covered same as any other medical expense. You pay your prescription drug cost sharing amount if you have prescription drug coverage. If not, you pay your PCP visit cost sharing amount.
Infusion therapy Administered in the home or physician's office	$40 copay; no deductible
Infusion therapy - outpatient hospital/freestanding facility	Your cost sharing amount depends on the type of service and where you receive it.
Transplants	$750 copay; 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.	$750 copay; after deductible
Acupuncture Limited to 10 visits per year	$15 copay; no deductible

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FAMILY PLANNING	IN-NETWORK
Infertility treatment	Your cost sharing 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)	Your cost sharing depends on the type of service and where you receive it.
ART coverage includes gamete intrafallopian transfer (GIFT) only. 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	Your cost sharing depends on the type of service and where you receive it.
Includes coverage for cryopreservation and storage for iatrogenic infertility Iatrogenic infertility is infertility that may occur as a result of certain types of medical treatment	
Vasectomy	Covered 100%; no deductible
Tubal ligation	Covered 100%; no deductible
• Affordable Care Act (ACA) eligible preventive medications	
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.

Exclusions and Limitations

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health of California Inc. Each insurer has sole financial responsibility for its own products.

This material is for information only. Health benefits 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.

You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.
• Durable medical equipment.
• 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.

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• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Orthotics except diabetic orthotics.
• 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 or inadequacies including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Treatment of behavioral disorders.
• 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.

If you require language assistance, please call the member services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).

Si requiere la asistencia de un representante que hable su idioma, por favor llame al número de Servicios al Miembro que aparece en su tarjeta de identificación y se le comunicará con la línea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intérprete). TDD-1-800-628-3323 (sólo para las personas con impedimentos auditivos).

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **www.aetna.com.** While this material is believed to be accurate as of the production date, it is subject to change.
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.