



**PLAN DESIGN & BENEFITS**  
**MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY**

<b>PLAN FEATURES</b>	<b>IN-NETWORK</b>
<b>Benefit limitations</b> - 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.	
<b>Deductible</b> (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.	
<b>Member coinsurance</b>	Covered 100%
Applies to all expenses except as noted.	
<b>Out-of-pocket limit</b> (per calendar year)	\$1,000 per Individual \$3,000 per Family
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.	
<b>Lifetime maximum</b> Unlimited except where otherwise indicated.	
<b>Primary care physician selection</b>	Encouraged
<b>Referral requirement</b>	Not required
<b>Telehealth consultations</b> - You can access covered services for telehealth visits from different kinds of providers in your network. Log on to <b>Aetna.com</b> to see a list of telehealth providers. You'll also find more about your options, including cost share amounts.	
<b>Virtual care consultations</b> - You can access covered services for virtual care visits from different kinds of providers in your network. Log on to <b>Aetna.com</b> to see a list of virtual care providers. You'll also find more about your options, including cost share amounts.	
<b>CVS VIRTUAL CARE</b>	<b>IN-NETWORK</b>
<b>CVS Health Virtual Care (VC) - general medicine</b>	Covered 100%; no deductible
<b>CVS Health Virtual Care (VC) - mental health</b>	Covered 100%; no deductible
<b>PREVENTIVE CARE</b>	<b>IN-NETWORK</b>
<b>Routine adult physical exams/immunizations</b>	Covered 100%; no deductible
1 exam every 12 months until age 65, then 1 exam every 12 months age 65 and older	
<b>Routine well child exams/immunizations</b>	Covered 100%; no deductible
<ul style="list-style-type: none"> <li>• 7 exams in the first 12 months</li> <li>• 3 exams from age 13 months to 24 months</li> <li>• 3 exams from age 25 months to 36 months</li> <li>• 1 exam every 12 months thereafter until age 22</li> </ul>	
<b>Routine gynecological care exams</b>	Covered 100%; no deductible
1 exam and pap smear per year, including HPV screening and related fees	
<b>Routine mammogram</b>	Covered 100%; no deductible
Recommended: One per year for members age 40 and over	



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<b>Women's health</b>	Covered 100%; no deductible 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.
<b>Pre-natal maternity</b>	Covered 100%; no deductible
<b>Routine digital rectal exam</b>	Covered 100%; no deductible Recommended: For members age 40 and over
<b>Prostate-specific antigen test</b>	Covered 100%; no deductible Recommended: For members age 40 and over
<b>Colorectal cancer screening</b>	Covered 100%; no deductible Recommended: For members age 45 and over
<b>Routine eye exams</b>	Covered 100%; no deductible 1 routine exam per 24 months.
<b>Routine hearing screening</b>	Covered 100%; no deductible
<b>Medications</b>	Certain over-the-counter preventive medications covered 100% in network.
<b>PHYSICIAN SERVICES</b>	<b>IN-NETWORK</b>
<b>Office visits to primary care physician (PCP)</b>	\$25 office visit copay; no deductible Includes services of an internist, general physician, family practitioner or pediatrician.
<b>Telehealth consultation with non-specialist</b>	\$25 office visit copay; no deductible
<b>Specialist office visits</b>	\$40 office visit copay; no deductible
<b>Telehealth consultation with specialist</b>	\$40 office visit copay; no deductible
<b>Hearing exams</b>	Not Covered
<b>Walk-in clinics</b>	\$25 copay; no deductible <b>Designated Walk-in clinics</b> Covered 100%; no deductible 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.
<b>Allergy testing</b>	Your cost sharing amount depends on the type of service and where you receive it.
<b>Allergy injections</b>	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.
<b>DIAGNOSTIC PROCEDURES</b>	<b>IN-NETWORK</b>
<b>Diagnostic X-ray (Other than complex imaging services)</b>	Covered 100%; no deductible When your physician performs and bills for this service at their office, you pay your office visit cost share amount.
<b>Diagnostic laboratory</b>	Covered 100%; no deductible When your physician performs and bills for this service at their office, you pay your office visit cost share amount.
<b>Diagnostic complex imaging</b>	\$100 copay; no deductible When your physician performs and bills for this service at their office, you pay your office visit cost share amount.



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<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>
<b>Urgent care provider</b>	\$25 office visit copay; no deductible
<b>Non-urgent use of urgent care provider</b>	Not Covered
<b>Emergency room</b> Copay waived if admitted	\$150 copay; no deductible
<b>Non-emergency care in an emergency room</b>	Not Covered
<b>Emergency use of ambulance</b>	Covered 100%; no deductible
<b>Non-emergency use of ambulance</b>	Not Covered
<b>HOSPITAL CARE</b>	<b>IN-NETWORK</b>
<b>Inpatient coverage</b> 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
<b>Inpatient maternity coverage</b> (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.	\$750 copay; after deductible
<b>Outpatient hospital</b> 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.	Covered 100%; after deductible
<b>Outpatient surgery - hospital</b> 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.	\$100 copay; after deductible
<b>Outpatient surgery - freestanding facility</b> 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.	\$100 copay; after deductible
<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK</b>
<b>Inpatient</b> When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	\$600 copay; after deductible
<b>Mental health office visits</b>	\$25 copay; no deductible
<b>Mental health telehealth consultations</b>	\$25 office visit copay; no deductible
<b>Other mental health services</b> 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
<b>SUBSTANCE ABUSE</b>	<b>IN-NETWORK</b>
<b>Inpatient</b> When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	\$600 copay; after deductible
<b>Residential treatment facility</b> When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	\$600 copay; after deductible
<b>Substance abuse office visits</b>	\$25 copay; no deductible
<b>Substance abuse telehealth consultations</b>	\$25 office visit copay; no deductible



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<b>Other substance abuse services</b>	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.	
<b>THERAPY SERVICES</b>	<b>IN-NETWORK</b>
<b>Spinal manipulation therapy</b>	\$15 copay; no deductible
<b>Outpatient rehabilitative physical and occupational therapy</b>	\$25 copay; no deductible
<b>Outpatient rehabilitative speech therapy</b>	\$25 copay; no deductible
<b>Habilitative physical therapy</b>	Covered 100%; no deductible
<b>Habilitative occupational therapy</b>	Covered 100%; no deductible
<b>Habilitative speech therapy</b>	Covered 100%; no deductible
<b>Autism related physical therapy</b>	Covered 100%; no deductible
<b>Autism related occupational therapy</b>	Covered 100%; no deductible
<b>Autism related speech therapy</b>	Covered 100%; no deductible
<b>Autism related behavioral therapy</b>	\$25 copay; no deductible
These benefits are combined with outpatient mental health visits	
<b>Autism related applied behavior analysis</b>	Covered 100%; no deductible
Your benefits for these services are the same as any other outpatient mental health other services benefit	
<b>OTHER SERVICES</b>	<b>IN-NETWORK</b>
<b>Skilled nursing facility</b>	Covered 100%; no 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.	
<b>Home health care</b>	\$25 copay; no deductible
Private duty nursing not included.	
<b>Hospice care - inpatient</b>	\$750 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.	
<b>Hospice care - outpatient</b>	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.	
<b>Private duty nursing</b>	Not Covered
<b>Durable medical equipment</b>	Covered 100%; no deductible
<b>Prosthetics</b>	Covered 100%; no deductible
<b>Orthotics</b>	Covered 100%; no deductible
Orthotics and special footwear covered for persons with foot disfigurement.	
<b>Diabetic supplies</b>	
• 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
<b>Infusion therapy - home/office</b>	\$40 copay; no deductible
<b>Infusion therapy - outpatient hospital/freestanding facility</b>	Your cost sharing amount depends on the type of service and where you receive it.



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<b>Gene-based, Cellular, and other Innovative Therapies (GCIT™)</b>	Your cost sharing amount depends on the type of service and where you receive it. \$50 copay; no deductible for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.
<b>Hearing aids</b> Limited to 1 per 36 months per ear	Covered 100%; no deductible
<b>Transplants</b>	\$750 copay; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.
<b>Bariatric surgery</b> When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	\$750 per admission copay; after deductible
<b>Acupuncture</b> Limited to 10 visits per year	\$15 copay; no deductible
<b>FAMILY PLANNING</b>	
<b>IN-NETWORK</b>	
<b>Basic Infertility</b>	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.
<b>Advanced Reproductive Technology (ART)</b>	Your cost sharing amount depends on the type of service and where you receive it. ART coverage is limited to three egg retrievals 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, and ovulation induction (OI). Maximum applies to all procedures covered by any of our plans except where prohibited by law.
<b>Fertility preservation</b>	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
<b>Vasectomy</b>	Covered 100%; no deductible
<b>Tubal ligation</b>	Covered 100%; no deductible

**GENERAL PROVISIONS**

<b>Dependents who are eligible to be on your plan</b>	Spouse, children from birth to age 26. Student status of children does not matter.
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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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.



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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](http://www.aetna.com)**.



EL CAMINO HOSPITAL  
Effective Date: 01-01-2026  
OA Elect Choice® EPO

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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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