



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

<b>PLAN FEATURES</b>	<b>IN-NETWORK DESIGNATED PROVIDERS</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)	\$3,000 per Individual \$6,000 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>Out-of-pocket limit</b> (per calendar year)	\$6,500 per Individual \$13,000 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.	
<b>Lifetime maximum</b>	Unlimited except where otherwise indicated.
<b>Primary care physician selection</b>	Required
<b>Referral requirement</b>	You'll need a PCP referral for most in-network services
<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>Network Designations</b> - In order to be covered at the preferred in-network benefit level you must use a designated provider for care. If you receive care from a non-designated provider your care may not be covered.	
<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 DESIGNATED PROVIDERS</b>
<b>Routine adult physical exams/ immunizations</b> 1 exam every 12 months	Covered 100%; no deductible
<b>Routine well child exams</b> • 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
<b>Childhood immunizations</b>	Covered 100%; no deductible
<b>Routine gynecological care exams</b> 1 exam and pap smear per year, including HPV screening and related fees	Covered 100%; no deductible
<b>Breast Cancer Screening</b> Recommended: One per year for members age 40 and over	Covered 100%; no deductible



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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 exams / 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 all members age 45 and over. Frequency schedule applies.	
<b>Routine eye exams</b>	Covered 100%; no deductible
1 routine exam per 24 months. Direct access to participating providers without a referral.	
<b>Routine hearing screening</b>	Covered 100%; no deductible
<b>PHYSICIAN SERVICES</b>	<b>IN-NETWORK DESIGNATED PROVIDERS</b>
<b>Primary care physician visits</b>	\$50 office visit copay; no deductible
Includes services of an internist, general physician, family practitioner or pediatrician.	
<b>Specialist office visits</b>	\$50 office visit copay; no deductible
<b>Walk-in clinics</b>	\$50 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.
<b>DIAGNOSTIC PROCEDURES</b>	<b>IN-NETWORK DESIGNATED PROVIDERS</b>
<b>Diagnostic X-ray</b> (Other than complex imaging services)	\$50 copay; 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>	\$150 copay; no deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	
<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK DESIGNATED PROVIDERS</b>
<b>Urgent care provider</b>	\$50 office visit copay; no deductible
<b>Non-urgent use of urgent care provider</b>	Not Covered
<b>Emergency room</b>	\$200 copay; after deductible
Copay waived if admitted	



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<b>Non-emergency care in an emergency room</b>	Not Covered
<b>Emergency use of ambulance</b>	\$200 copay; no deductible
<b>Non-emergency use of ambulance</b>	Not Covered
<b>HOSPITAL CARE</b>	<b>IN-NETWORK DESIGNATED PROVIDERS</b>
<b>Inpatient coverage</b>	40%; 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.	
<b>Inpatient maternity coverage</b> (includes delivery and postpartum care)	\$50 for Physician Maternity Services; no deductible; 40% for Facility services; 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.	
<b>Outpatient surgery - hospital</b>	40%; 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.	
<b>Outpatient surgery - freestanding facility</b>	40%; 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.	
<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK DESIGNATED PROVIDERS</b>
<b>Mental health inpatient</b>	40% per admission; 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.	
<b>Mental health office visits</b>	\$50 copay; no deductible
<b>Other mental health 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>SUBSTANCE ABUSE</b>	<b>IN-NETWORK DESIGNATED PROVIDERS</b>
<b>Inpatient</b>	40%; 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.	
<b>Residential treatment facility</b>	40%; 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>Substance abuse office visits</b>	\$50 copay; no deductible
<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 DESIGNATED PROVIDERS</b>
<b>Spinal manipulation therapy</b>	\$15 copay; no deductible
Limited to 20 visits per year Direct access to participating providers without a referral.	



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<b>Outpatient short-term rehabilitation</b>	\$50 copay; no deductible
Includes speech, physical, occupational therapy	
<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%
<b>Autism related speech therapy</b>	Covered 100%; no deductible
<b>Autism related behavioral therapy</b>	Refer to MBH Outpatient Mental Health
These benefits are combined with outpatient mental health visits.	
<b>Autism related applied behavior analysis</b>	Refer to MBH Outpatient Mental Health Other Services
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>	40%; 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.	
<b>Home health care</b>	\$50 copay; no deductible
Limited to 120 visits per year Limited to three visits per day by staff from a home health care agency.	
<b>Hospice care - inpatient</b>	40%; 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>	\$50 copay; 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.	
<b>Durable medical equipment</b>	\$50 copay; no deductible
<b>Prosthetics</b>	Covered 100%; after deductible
<b>Orthotics</b>	Covered 100%; after 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	Applicable prescription drug cost sharing amount applies
<b>Infusion therapy</b>	\$50 copay; no deductible
Administered in the home or physician's office	
<b>Infusion therapy - outpatient hospital/freestanding facility</b>	Your cost sharing amount depends on the type of service and where you receive it.
<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: after deductible for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.
<b>Hearing aids</b>	Not Covered
<b>Transplants</b>	40%; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.

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<b>Bariatric surgery</b>	40% per admission; 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.	
<b>Acupuncture</b>	\$15 copay; no deductible
Limited to 20 visits per year	
<b>FAMILY PLANNING</b>	<b>IN-NETWORK DESIGNATED PROVIDERS</b>
<b>Basic Infertility</b>	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.
<b>Advanced Reproductive Technology (ART)</b>	Your cost sharing 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
<b>PRESCRIPTION DRUG BENEFITS</b>	<b>IN-NETWORK</b>
<b>Pharmacy plan type</b>	Advanced Control Plan - Aetna: California
<b>Prescription drug out-of-pocket limit</b>	Prescription drug expenses apply to your medical out-of-pocket limit.
<b>Generic drugs</b>	
	<b>Retail</b> \$10 copay
	<b>Mail order</b> \$20 copay
<b>Preferred brand-name drugs</b>	
	<b>Retail</b> \$30 copay
	<b>Mail order</b> \$60 copay
<b>Non-preferred brand-name drugs</b>	
	<b>Retail</b> \$50 copay
	<b>Mail order</b> \$100 copay
<b>Specialty drugs</b>	
<b>Preferred specialty</b>	30% Maximum \$250
<b>Non-preferred specialty</b>	30% Maximum \$250
<b>Pharmacy day supply and requirements</b>	
<b>Retail</b>	1x retail copay for 30 day supply, 2x retail copay for 31-60 day supply, and 3x retail copay for 61-90 day supply from Aetna National Network.
<b>Mail order</b>	You can get a 31-90-day supply from CVS Caremark® Mail Service Pharmacy.
<b>Specialty</b>	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 Aetna Insured 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
- Prescription weight loss drugs with precertification
- 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

Refer to [Aetna.com](http://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 with dispense as written (DAW) override** - Sometimes your physician may say you need a brand-name prescription drug even if a generic is available. If so, you will pay the brand-name copay. If you ask for a brand-name prescription drug when a generic is available, you will pay the applicable brand-name copay plus the difference between the generic price and the brand-name price.

**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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**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.



LIGHTHOUSE TREATMENT, INC.  
Effective Date: 07-01-2026  
AWH Southern CA HMO  
CA ACOC HMO 3000

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- 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.
- 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](http://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.

**\*\*\*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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