



TW VENTURES INC.
 Effective Date: 08-01-2023
 Open Choice® PPO HDHP
 Qualified High Deductible Health Plan

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

PLAN FEATURES	IN-NETWORK	OUT-OF-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)	\$4,250 per Individual \$8,500 per Family	\$8,500 per Individual \$17,000 per Family
Covered expenses in-network add up towards your in-network deductible. Covered expenses out-of-network add up towards your out-of-network deductible. 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 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 20%	You pay 40%
Out-of-pocket limit (per calendar year)	\$6,250 per Individual \$12,500 per Family	\$12,500 per Individual \$25,000 per Family
Covered expenses in-network add up towards your in-network out-of-pocket limit. Covered expenses out-of-network add up towards your out-of-network out-of-pocket limit. Some of your cost sharing may not count toward the out-of-pocket limit. Your pharmacy expenses count toward your out-of-pocket limit. In-network expenses include coinsurance/copays and deductibles. Out-of-network expenses include coinsurance and deductibles. Penalty amounts do not apply. 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.		
Payment for out-of-network care**	Does not apply	Professional: 105% of Medicare Facility: 140% of Medicare
Primary care physician selection	Encouraged	Does not apply
Precertification requirements - Some out-of-network services need approval by us in advance (precertification). Without this approval, we reduce benefits by \$400. Refer to your plan documents for a full list of services that need this approval.		
Referral requirement	Not required	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
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	40%; after deductible
Routine well child exams/immunizations <ul style="list-style-type: none"> • 7 exams in the first 12 months • 3 exams from age 13 through 24 months • 3 exams from age 25 through 36 months • 1 exam every 12 months from age 3 until age 22 years 	Covered 100%; no deductible	40%; after deductible
Routine gynecological care exams 1 exam and pap smear per year, including related fees	Covered 100%; no deductible	20%; after deductible
Routine mammogram Recommended: One per year for members age 40 and over	Covered 100%; no deductible	40%; after deductible



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Women's health	Covered 100%; no deductible	40%; after 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.		
Pre-natal maternity	Covered 100%; no deductible	40%; after deductible
Routine digital rectal exam	Covered 100%; no deductible	40%; after deductible
Recommended: For members age 40 and over		
Prostate-specific antigen test	Covered 100%; no deductible	40%; after deductible
Recommended: For members age 40 and over		
Colorectal cancer screening	Covered 100%; no deductible	40%; after deductible
Recommended: For members age 45 and over		
Routine eye exams	Covered 100%; no deductible	Not Covered
1 routine exam per 24 months.		
Routine hearing screening	Covered 100%; no deductible	40%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office visits to non-specialist	20%; after deductible	40%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist office visits	20%; after deductible	40%; after deductible
Hearing exams	Not Covered	Not Covered
Walk-in clinics	20%; after deductible	40%; after deductible
	Designated Walk-in clinics	
	Covered 100%; after 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.		
Allergy testing	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.
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.
DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray (Other than complex imaging services)	20%; after deductible	40%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.		
Diagnostic laboratory	20%; after deductible	40%; 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	20%; after deductible	40%; after 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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EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent care provider	20%; after deductible	40%; after deductible
Non-urgent use of urgent care provider	Not Covered	Not Covered
Emergency room	20%; after deductible	Same as in-network care
Non-emergency care in an emergency room	Not Covered	Not Covered
Emergency use of ambulance	20%; after deductible	Same as in-network care
Non-emergency use of ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-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.	20%; after deductible	40%; 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.	20%; after deductible	40%; after deductible
Outpatient hospital 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.	20%; after deductible	40%; after deductible
Outpatient surgery - hospital 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.	20%; after deductible	40%; after deductible
Outpatient surgery - freestanding facility 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.	20%; after deductible	40%; after deductible
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	20%; after deductible	40%; after deductible
Mental health office visits	20%; after deductible	40%; after deductible
Other mental health services 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.	20%; after deductible	40%; after deductible
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	20%; after deductible	40%; after deductible
Residential treatment facility When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	20%; after deductible	40%; after deductible
Substance abuse office visits	20%; after deductible	40%; after deductible
Other substance abuse services 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.	20%; after deductible	40%; after deductible



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THERAPY SERVICES	IN-NETWORK	OUT-OF-NETWORK
Spinal manipulation therapy Limited to 20 visits per year	20%; after deductible	40%; after deductible
Outpatient rehabilitative physical and occupational therapy	20%; after deductible	40%; after deductible
Outpatient rehabilitative speech therapy	20%; after deductible	40%; after deductible
Habilitative physical therapy	20%; after deductible	40%; after deductible
Habilitative occupational therapy	20%; after deductible	40%; after deductible
Habilitative speech therapy	20%; after deductible	40%; after deductible
Autism related physical therapy	20%; after deductible	40%; after deductible
Autism related occupational therapy	20%; after deductible	40%; after deductible
Autism related speech therapy	20%; after deductible	40%; after deductible
Autism related behavioral therapy These benefits are combined with outpatient mental health visits	20%; after deductible	40%; after deductible
Autism related applied behavior analysis Your benefits for these services are the same as any other outpatient mental health other services benefit	20%; after deductible	40%; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled nursing facility Limited to 60 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.	20%; after deductible	40%; after deductible
Home health care Limited to 120 visits per year 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.	20%; after deductible	40%; after 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.	20%; after deductible	40%; 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.	20%; after deductible	40%; after deductible
Private Duty Nursing - Outpatient Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.	Covered as part of Home Health Care	Covered as part of Home Health Care
Durable medical equipment	50%; after deductible	50%; after deductible
Orthotics Orthotics and special footwear covered for persons with foot disfigurement.	20%; after deductible	40%; after 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.	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 - home/office	20%; after deductible	40%; after deductible
Infusion therapy - outpatient hospital/freestanding facility	20%; after deductible	40%; after deductible



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Transplants	20%; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.	40%; after deductible Out-of-network coverage applies when you use a non-IOE facility. You will pay more out of pocket when using a non-IOE facility.
Bariatric surgery	Not Covered	Not Covered
Acupuncture Limited to 20 visits per year	20%; after deductible	40%; after deductible
"Other" health care - 20% member coinsurance, after deductible, for services that are neither in-network nor out-of-network.		
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility treatment	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.
You have coverage for the diagnosis and treatment of the underlying cause of infertility.		
Comprehensive infertility services Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered	Not Covered
Vasectomy	Your cost sharing amount depends on the type of service and where you receive it.	40%; after deductible
Tubal ligation	Covered 100%; no deductible	40%; after deductible



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PHARMACY	IN-NETWORK	OUT-OF-NETWORK
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Pharmacy plan type	Advanced Control Plan	
Prescription drug deductible	Prescription drug expenses apply to your medical deductible.	
Preventive medications - We waive the deductible for certain preventive medications. For a full list of these drugs, go to your secure member site or ask your employer.		
Prescription drug out-of-pocket limit	Prescription drug expenses apply to your medical out-of-pocket limit.	
Preferred generic drugs		
	Retail	20% Maximum \$250
	Mail order	20% Maximum \$250
Preferred brand-name drugs		
	Retail	20% Maximum \$250
	Mail order	20% Maximum \$250
Non-preferred generic and brand-name drugs		
	Retail	20% Maximum \$250
		20% Maximum \$250
Pharmacy day supply and requirements		
	Retail	You can get up to a 30-day supply from Aetna National Network Percentage copays will not be doubled
	Mail order	You can get a 31-90-day supply from CVS Caremark® Mail Service Pharmacy.
	Specialty	You can get up to a 30-day supply of specialty drugs You may fill your first prescription at any retail or specialty pharmacy. After that, all other fills must be through our preferred specialty pharmacy network. Advanced Control Formulary Aetna Insured List
Your prescription drug plan also includes:		
<ul style="list-style-type: none"> • Diabetic supplies • Prescription weight loss drugs • 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		
<ul style="list-style-type: none"> • Oral fertility drugs included. • Contraceptives covered up to a 12-month supply. Contraceptive copay strategy applies. 		
The following are covered 100% in-network:		
<ul style="list-style-type: none"> • Oral chemotherapy drugs • Seasonal vaccinations • Preventive vaccinations • Affordable Care Act (ACA) eligible preventive medications 		
Refer to Aetna.com for a complete list of eligible prescription drugs.		



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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

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

**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 we pay 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 doctor who is out of network, your health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.

- For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

- For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to 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 Navigator 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 network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us 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.

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in-network. You pay your plan's copayments and deductibles for your in-network level of benefits. Contact us 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 copayments and deductibles.



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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.

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.



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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**.

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.

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