ENDEAVOR PARENT, LLC DBS WME IMG HOLDINGS, LLC
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OA Aetna Select 80

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

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 $625 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.	
Member coinsurance Applies to all expenses except as noted.	You pay 20%
Out-of-pocket limit (per calendar year)	$4,000 per Individual $7,000 per Family
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. 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	Encouraged
Referral requirement	Not required
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 until age 65, then 1 exam every 12 months age 65 and older	Covered 100%; no deductible
Routine well child exams/immunizations • 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
Routine gynecological care exams 1 exam and pap smear per year, includes related fees.	Covered 100%; no deductible
Routine mammogram	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

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Routine digital rectal exam Recommended: For members age 40 and over	Covered 100%; no deductible
Prostate-specific antigen test Recommended: For members age 40 and over	Covered 100%; no deductible
Colorectal cancer screening Recommended: For members age 45 and over	Covered 100%; no deductible
Routine eye exams	Not Covered
Routine hearing screening	Covered 100%; no deductible
PHYSICIAN SERVICES	**IN-NETWORK**
Office visits to primary care physician (PCP) 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	$50 office visit copay; no deductible
Telehealth consultation with specialist	$50 office visit copay; no deductible
Hearing exams 1 routine exam per 24 months.	$50 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 **Designated Walk-in clinics** Covered 100%; 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.
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.	20%; after 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	$200 copay; no deductible
Non-emergency care in an emergency room	Not Covered
Emergency use of ambulance	$200 copay; no deductible
Non-emergency use of ambulance	Not Covered

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HOSPITAL CARE	IN-NETWORK
Inpatient coverage	20%; 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.	
Inpatient maternity coverage (includes delivery and postpartum care)	20%; 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.	
Outpatient hospital	20%; 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.	
Outpatient surgery - hospital	20%; 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.	
Outpatient surgery - freestanding facility	20%; 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**
Inpatient	20%; 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	$50 copay; no deductible
Mental health telehealth consultations	$50 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	20%; 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	20%; 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	$50 copay; no deductible
Substance abuse telehealth consultations	$50 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 Unlimited visits	$50 copay; no deductible
Outpatient physical therapy Limited to 90 visits per year.	$50 copay; no deductible
Outpatient speech and occupational therapy Limited to 90 visits per year combined.	$50 copay; no deductible

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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	$50 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	
OTHER SERVICES	**IN-NETWORK**
Skilled nursing facility	20%; 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.	
Home health care	20%; after deductible
Limited to 200 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.	
Hospice care - inpatient	20%; 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.	
Hospice care - outpatient	20%; 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.	
Private duty nursing	Covered as part of home health care
We count each period of up to 8 hours as one private duty nursing shift.	
Durable medical equipment	20%; after deductible
Hearing aids Limited to $5,000 lifetime max	20%; after deductible
Prosthetics	Your cost sharing amount depends on the type of service and where you receive it.
Orthotics	20%; 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.
Infusion therapy - home/office	$50 copay; no deductible
Infusion therapy - outpatient hospital/freestanding facility	Your cost sharing amount depends on the type of service and where you receive it.
Gene-based, Cellular, and other Innovative Therapies (GCIT™)	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.
Transplants	20%; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.

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Mouth, Jaws and Teeth (oral surgery procedures, whether medical or dental in nature) Includes surgical and non-surgical	Your cost sharing amount depends on the type of service and where you receive it.
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.	20%; after deductible
Acupuncture Unlimited visits	$50 copay; no deductible
FAMILY PLANNING	**IN-NETWORK**
Infertility treatment You have coverage for the diagnosis and treatment of the underlying cause of infertility.	Your cost sharing amount depends on the type of service and where you receive it.
Comprehensive infertility services Coverage includes artificial insemination and ovulation induction limited to a lifetime limit of $50,000 combined with ART. Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law.	20%; after deductible
Advanced Reproductive Technology (ART) ART coverage includes: In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Limited to a lifetime limit of $50,000 combined with Comprehensive Infertility. Maximum applies to all procedures covered by any of our plans except where prohibited by law.	20%; after deductible
Vasectomy	Your cost sharing amount depends on the type of service and where you receive it.
Tubal ligation	Covered 100%; no deductible
PHARMACY	**IN-NETWORK**
Pharmacy plan type	Aetna Standard Open Formulary
Prescription drug out-of-pocket limit	Prescription drug expenses apply to your medical out-of-pocket limit.
Generic drugs	
Retail	$20 copay
Mail order	$40 copay
Preferred brand-name drugs	
Retail	$30 copay
Mail order	$60 copay
Non-preferred brand-name drugs	
Retail	$40 copay
Mail order	$80 copay
Pharmacy day supply and requirements	
Retail	You can get up to a 30-day supply from Aetna National Network 3x copay 61-90 day supply from Aetna National Network
Mail order	You can get a 31-90-day supply from CVS Caremark® Mail Service Pharmacy. You must fill all specialty drugs through our preferred specialty pharmacy network. Aetna Specialty Network Drug List

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Your prescription drug plan also includes:
• Diabetic supplies and blood glucose monitors
• Prescription weight loss drugs
• Sexual dysfunction drugs, including daily dose, additional 6 tablets a month for erectile dysfunction

Family planning
• Oral fertility drugs included.

The following are covered 100% in-network:
• Seasonal vaccinations
• Preventive vaccinations
• Affordable Care Act (ACA) eligible preventive medications and contraceptives
Refer to **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.
To get the most up-to-date precertification requirements, 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.

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.

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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 traduccion 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.