AUTO LENDERS LIQUIDATION CENTER, INC.
Effective Date: 04-01-2025
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**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 the day your plan coverage takes effect (unless otherwise noted). Refer to your plan documents to learn more. | |
| **Deductible** (per plan year) | $1,500 per Individual<br>$3,000 per Family |
| You must first meet the deductible before the plan begins paying benefits, unless otherwise noted.<br>The amount you pay (cost sharing) for some medical services does not count toward your deductible.<br>Prescription drug costs do not count toward the deductible. Refer to your plan documents for details.<br>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** | You pay 20% |
| Applies to all expenses except as noted. | |
| **Out-of-pocket limit** (per plan year) | $4,000 per Individual<br>$8,000 per Family |
| Your pharmacy expenses do not count toward your out-of-pocket limit.<br>In-network expenses include coinsurance/copays and deductibles.<br>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 network. Log on to **Aetna.com** to see a list of telehealth providers. You'll also find more about your options, including cost share amounts. | |
| **Virtual care consultations** - You can access covered services for virtual care visits from different kinds of providers in your network. Log on to **Aetna.com** to see a list of virtual care providers. You'll also find more about your options, including cost share amounts. | |

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| CVS VIRTUAL CARE | IN-NETWORK |
|---|---|
| **CVS Health Virtual Care (VC) - general medicine** | Covered 100%; no deductible |
| **CVS Health Virtual Care (VC) - mental health** | Covered 100%; no deductible |
| **PREVENTIVE CARE** | **IN-NETWORK** |
| **Routine adult physical exams/ immunizations** | Covered 100%; no deductible |
| 1 exam every 12 months until age 65, then 1 exam every 12 months age 65 and older | |
| **Routine well child exams/immunizations** | Covered 100%; no deductible |
| • 7 exams in the first 12 months<br>• 3 exams from age 13 months to 24 months<br>• 3 exams from age 25 months to 36 months<br>• 1 exam every 12 months thereafter until age 22 | |
| **Routine gynecological care exams** | Covered 100%; no deductible |
| 1 exam and pap smear per year, includes related fees. | |
| **Routine mammogram** | Covered 100%; no deductible |
| Recommended: One per year for members age 40 and over | |
| **Women's health** | 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.<br>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 |
| **Routine digital rectal exam** | Covered 100%; no deductible |
| Recommended: For members age 40 and over | |
| **Prostate-specific antigen test** | Covered 100%; no deductible |
| Recommended: For members age 40 and over | |
| **Colorectal cancer screening** | Covered 100%; no deductible |
| Recommended: For members age 45 and over | |
| **Routine eye exams** | Covered 100%; no deductible |
| 1 routine exam per 12 months. | |
| **Routine hearing screening** | Covered 100%; no deductible |
| **Medications** | Certain over-the-counter preventive medications covered 100% in network. |

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| PHYSICIAN SERVICES | IN-NETWORK |
|---|---|
| **Office visits to primary care physician (PCP)**<br>Includes services of an internist, general physician, family practitioner or pediatrician. | $30 office visit copay; no deductible |
| **Telehealth consultation with non-specialist** | $30 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** | Not Covered |
| **Walk-in clinics**<br>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.<br>Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices. | $30 copay; no deductible<br>**Designated Walk-in clinics**<br>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)<br>When your physician performs and bills for this service at their office, you pay your office visit cost share amount. | 20%; no deductible |
| **Diagnostic laboratory**<br>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**<br>When your physician performs and bills for this service at their office, you pay your office visit cost share amount. | 20%; no deductible |
| **EMERGENCY MEDICAL CARE** | **IN-NETWORK** |
| **Urgent care provider** | $50 office visit copay; no deductible |
| **Non-urgent use of urgent care provider** | Not Covered |
| **Emergency room**<br>Copay waived if admitted | 20% after $250 copay; no deductible |
| **Non-emergency care in an emergency room** | Not Covered |
| **Emergency use of ambulance** | 20%; 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. | |

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| THERAPY SERVICES | IN-NETWORK |
|---|---|
| **Spinal manipulation therapy** | $50 copay; no deductible |
| **Outpatient short-term rehabilitation**<br>Limited to 60 visits per year<br>Includes physical, occupational, and speech therapies. | 20%; after deductible |
| **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**<br>These benefits are combined with outpatient mental health visits | $50 copay; no deductible |
| **Autism related applied behavior analysis**<br>Your benefits for these services are the same as any other outpatient mental health other services benefit | Covered 100%; no deductible |
| **OTHER SERVICES** | **IN-NETWORK** |
| **Skilled nursing facility**<br>Limited to 100 days per year<br>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 |
| **Home health care**<br>Home health care services include private duty nursing<br>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 |
| **Hospice care - inpatient**<br>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 |
| **Hospice care - outpatient**<br>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 |
| **Private duty nursing**<br>We count each period of up to 8 hours as one private duty nursing shift. | Covered as part of home health care |
| **Durable medical equipment** | 20%; after deductible |
| **Hearing aids**<br>Coverage is included for dependent age 15 or younger. | 20%; after deductible |
| **Diabetic supplies** | |
| • 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 |
| **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.<br>$50 copay; no deductible for gene therapy drugs, if applicable<br>In-network coverage is provided at GCIT™ designated facilities only. |

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| **Transplants** | 20%; after deductible<br>In-network coverage is only available at Institutes of Excellence (IOE) contracted facility. |
| **Bariatric surgery** | 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. | |
| **Acupuncture** | $30 copay; no deductible |
| **FAMILY PLANNING** | **IN-NETWORK** |
| **Infertility treatment** | 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. | |
| **Limited infertility** | 20%; after deductible |
| Coverage includes artificial insemination (AI) and ovulation induction (OI). | |
| **Advanced Reproductive Technology (ART)** | 20%; after deductible |
| ART coverage is limited to four cycles 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. Maximum applies to all procedures covered by any of our plans except where prohibited by law. | |
| **Fertility preservation** | 20%; after deductible |
| Includes coverage for cryopreservation for iatrogenic infertility<br>Iatrogenic infertility is infertility that may occur as a result of certain types of medical treatment | |
| **Vasectomy** | Your cost sharing amount depends on the type of service and where you receive it. |
| **Tubal ligation** | Covered 100%; no deductible |
| **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.**

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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.**