



PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY - INSURED

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	\$1,500 Individual \$3,000 Family	\$3,000 Individual \$6,000 Family
All covered expenses accumulate simultaneously toward both the preferred and non-preferred Deductible. Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Member cost sharing for certain services including member cost sharing for prescription drugs, as indicated in the plan, are excluded from charges to meet the Deductible. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.		
Member Coinsurance	20%	40%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year, excludes deductible)	\$3,500 Individual \$7,000 Family	\$7,000 Individual \$14,000 Family
All covered expenses accumulate simultaneously toward both the preferred and non-preferred Payment Limit. Certain member cost sharing elements including deductibles, copays, mental health, substance abuse, DME and pharmacy do not apply toward the Payment Limit. Only those preferred & non-preferred expenses resulting from an application of coinsurance percentage (except any penalty amounts) may be used to satisfy the Payment Limit. Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year.		
Lifetime Maximum	\$2,000,000	
Payment for Non-Preferred Care	N/A	Recognized Charge*
*Payment for Non-Preferred facility care is determined based upon Aetna's Allowable Fee Schedule, which is subject to change. Payment for other Non-Preferred care is determined based upon the negotiated charge that would apply if such service or supplies were received from a Preferred Provider. These charges are referred to in your plan documents as "recognized" charges.		
Primary Care Physician Selection	Optional	Not applicable
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is \$400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE		
Routine Adult Physical Exams/ Immunizations	\$35 office visit copay; deductible waived	40%
1 exam every 12 months. Limited to \$300 per exam excluding colonoscopy		
Routine Well Child Exams/Immunizations	\$35 office visit copay; deductible waived	40%
7 exams in the first 12 months of life, 2 exams in the 13th - 24th month of life, 1 exam per calendar year thereafter to age 18.		
Routine Gynecological Care Exams	\$45 office visit copay; deductible waived	40%
One annual routine exam.		
Routine Mammograms	\$35 office visit copay; deductible waived	40%
One mammogram per calendar year for covered females age 35 and above.		
Routine Digital Rectal Exam / Prostate-specific Antigen Test	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	40%
For covered males age 40 and over.		



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Colorectal Cancer Screening For all members age 50 and over.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	40%
Newborn Hearing Screening 1 in the first 30 days of life and follow-up diagnostic care until the age of 24 months	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	40%
Routine Eye Exams 1 routine exam per 24 months	\$45 office visit copay; deductible waived	40%
Routine Hearing Exams 1 routine exam per 24 months	\$45 office visit copay; deductible waived	40%
PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Office Visits to Non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.	\$35 office visit copay; deductible waived	40%
Specialist Office Visits	\$45 office visit copay; deductible waived	40%
Allergy Testing	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	40%
Allergy Injections	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	40%
DIAGNOSTIC PROCEDURES	PREFERRED CARE	NON-PREFERRED CARE
Diagnostic Laboratory Services If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing	Covered 100%; deductible waived	40%
Diagnostic X-ray Services	\$35 office visit copay; deductible waived	40%
Diagnostic X-ray for Complex Imaging Services	20%	40%
EMERGENCY MEDICAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Urgent Care Provider	\$75 copay; deductible waived	40%
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	\$150 copay; deductible waived	Same as preferred care.
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	20%	20%
HOSPITAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	20%	40%
Inpatient Maternity Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	20%	40%



PLAN DESIGN AND BENEFITS

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Outpatient Hospital Expenses (including surgery)	20%	40%
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
MENTAL HEALTH SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Serious Mental Illness	20%	40%
Limited to 45 combined days per calendar year The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Inpatient Non-Serious Mental Illness	20%	40%
Limited to 30 combined days per calendar year The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Serious Mental Illness	\$45 copay; deductible waived	40%
Limited to 60 combined visits per calendar year The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
Outpatient Non-Serious Mental Illness	\$45 copay; deductible waived	40%
Limited to 30 combined visits per calendar year The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Crisis Stabilization Units/Residential Treatment Centers (for children and adolescents)	20%	40%
Partial Hospitalization (for day/night care treatment)	20%	40%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
ALCOHOL/DRUG ABUSE SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Detoxification	20%	40%
Limited to 3 combined series of treatments for inpatient and outpatient care The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Detoxification	\$45 copay; deductible waived	40%
Limited to 3 combined series of treatments for inpatient and outpatient care The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Inpatient Rehabilitation	20%	40%
Limited to 3 combined series of treatments for inpatient and outpatient care The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Rehabilitation	\$45 copay; deductible waived	40%
Limited to 3 combined series of treatments for inpatient and outpatient care The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
OTHER SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Convalescent Facility	20%	40%
Limited to 60 combined days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay		
Home Health Care	20%	40%
Limited to 60 combined visits per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay		
Infusion Therapy-Home or Physician Office	20%	40%
Includes total parenteral nutrition, chemotherapy, drug therapy, pain management and hydration therapy.		Covered up to a maximum of \$50 per visit. Amounts over the allowable do not apply to the Out-of-pocket maximum. Prescription drugs will be covered 70% based on the Aetna Wholesale Price.
Infusion Therapy-Outpatient Facility	20%	40%



PLAN DESIGN AND BENEFITS

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Includes total parenteral nutrition, chemotherapy, drug therapy, pain management and hydration therapy.

Covered up to a maximum of \$50 per visit. Amounts over the allowable do not apply to the Out-of-pocket maximum. Prescription drugs will be covered 70% based on the Aetna Wholesale Price.

Hospice Care - Inpatient Limited to 30 combined days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	20%	40%
Hospice Care - Outpatient Limited to \$5,000 per lifetime.	20%	40%
Private Duty Nursing - Outpatient Limited to 70 combined eight hour shifts per calendar year	20%	40%
Outpatient Short-Term Rehabilitation Includes Physical, Occupational, and Spinal Manipulation Therapy limited to 20 combined visits per calendar year.	\$45 copay; deductible waived	40%
Outpatient Speech Therapy Limited to 20 combined visits per calendar year	\$45 copay; deductible waived	40%
Durable Medical Equipment Limited to \$2,500 combined per calendar year	20%	40%
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense ; deductible waived	Covered same as any other medical expense.
Mouth, Jaws and Teeth (oral surgery procedures, medical in nature only)	Member cost sharing is based on the type of service performed and the place of service where it is rendered	40%
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	20% (payable as any other covered expense); deductible waived	40% (payable as any other covered expense)
Transplants	20% Preferred coverage is provided at an IOE contracted facility only	40% Non-Preferred coverage is provided at a Non-IOE facility. Limited to a \$25,000 transplant specific maximum benefit
Bariatric Surgery	Not covered	Not covered
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan.	
FAMILY PLANNING		
	PREFERRED CARE	NON-PREFERRED CARE
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Member cost sharing is based on the type of service performed and the place of service where it is rendered	40%
Voluntary Sterilization Including tubal ligation and vasectomy.	Member cost sharing is based on the type of service performed and the place of service where it is rendered	40%
PHARMACY		
	PREFERRED CARE	NON-PREFERRED CARE
Retail	\$15 copay for generic drugs, \$35 copay for formulary brand-name drugs, and \$50 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	30% of submitted cost after \$15 copay for generic drugs, \$35 copay for formulary brand-name drugs, and \$50 copay for non-formulary brand-name drugs up to a 30 day supply.



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Mail Order	\$30 copay for generic drugs, \$70 copay for formulary brand-name drugs, and \$100 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.	30% of submitted cost after \$30 copay for generic drugs, \$70 copay for formulary brand-name drugs, and \$100 copay for non-formulary brand-name drugs up to a 31-90 day supply.
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No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only.

Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs, Diabetic supplies. Precert for growth hormones included

GENERAL PROVISIONS

Dependents Eligibility Spouse, children from birth to age 25 regardless of student status

Pre-existing Conditions Exclusion On effective date: Waived
After effective date: Full Postponement

This plan imposes a pre-existing condition exclusion, which may be waived in some circumstances and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to this plan, you may have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received or for which the individual took prescribed drugs within 90 days. Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, 90 days ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. If you had prior creditable coverage within 63 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.

If you had no prior creditable coverage within the 63 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 90 day gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion. In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any certificates of creditable coverage you have. Please contact Aetna Member Services at 1-888-982-3862 if you need assistance in obtaining a certificate of creditable coverage from your prior carrier or if you have any questions on the information noted above. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days of birth, adoption, or placement for adoption. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment, and the pre-existing condition exclusion will be applied from the individual's effective date of coverage.

Members may choose from a network of available providers (physicians and facilities) or may visit a nonparticipating provider. The nonparticipating provider will be paid based on Aetna's Recognized Charge (Aetna Market Fee Schedule (AMFS) and Aetna Facility Fee Schedule), which is the charge Aetna determines to be the usual charge level for the geographic area where the covered service is furnished. The member may be balance billed for the difference between the nonparticipating provider's usual fee and the amount allowed by the plan, in addition to any coinsurance or co-payments due under the plan provisions.

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial 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 or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges



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Nonmedically necessary services or supplies; Orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. 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.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary.

They may also be subject to precertification. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are provided by Aetna Life Insurance Company.