



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	\$1,500 Individual \$3,000 Family
All covered expenses including prescription drugs accumulate toward both the preferred and non-preferred Deductibles (Combined). Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. There is no individual Deductible to satisfy within the family Deductible.		
Member Coinsurance	20%	40%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	\$4,500 Individual \$9,000 Family	\$4,500 Individual \$9,000 Family
All covered expenses including deductible and prescription drugs accumulate toward both the preferred and non-preferred. Certain member cost sharing elements may not apply toward the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and prescription drug copays (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. There is no individual payment limit to satisfy within the family payment limit.		
Lifetime Maximum	\$6,000,000	
Primary Care Physician Selection	Required	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. Precertification for certain procedures/treatments - excluded amount is \$200 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months age 18 and over.	100%; deductible waived	40% after deductible
Routine Well Child Exams/Immunizations 7 exams in first 12 months of life, 2 exams in the 13th - 24th month of life, 1 exam per calendar year thereafter to age 18.	100%; deductible waived	40% after deductible
Routine Gynecological Care Exams One exam per calendar year. Includes pap smear, HPV screening, and related lab fees. Direct access to participating providers. Members may choose ob/gyns as PCPs.	100%; deductible waived	40% after deductible
Routine Mammograms One baseline mammogram for covered females age 35 but less than 40; one mammogram per calendar year for covered females age 40 and over.	100%; deductible waived	40% after deductible
Routine Digital Rectal Exam / Prostate-specific Antigen Test For covered males age 40 and over.	100%; deductible waived	40% after deductible
Colorectal Cancer Screening For all members age 50 and over.	100%; deductible waived	40% after deductible
Routine Eye Exams 1 routine exam per 24 months, no referral required.	100%; deductible waived	40% after deductible
Routine Hearing Exams 1 routine exam per 24 months	100%; deductible waived	40% after deductible



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PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	20% after deductible	40% after deductible
Specialist Office Visits	20% after deductible	40% after deductible
Allergy Testing	20% after deductible	40% after deductible
Allergy Injections	20% after deductible	40% after deductible
DIAGNOSTIC PROCEDURES	PREFERRED CARE	NON-PREFERRED CARE
Diagnostic Laboratory and X-ray	20% after deductible	40% after deductible
EMERGENCY MEDICAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Urgent Care Provider (benefit availability may vary by location)	20% after deductible	40% after deductible
Non-Urgent Use of Urgent Care Provider	20% after deductible	40% after deductible
Emergency Room	20% after deductible	Same as preferred care.
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	20% after deductible	40% after deductible
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; Unlimited.	20% after deductible	40% after deductible
Inpatient Maternity Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	20% after deductible	40% after deductible
Outpatient Hospital Expenses (including surgery) The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit	20% after deductible	40% after deductible
MENTAL HEALTH SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	20% after deductible	40% after deductible
Outpatient Unlimited visits per calendar year. The member cost sharing applies to all covered benefits incurred during a member's outpatient visit Maximums are combined limit for preferred and non-preferred services.	20% after deductible	40% after deductible
ALCOHOL/DRUG ABUSE SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Detoxification The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	20% after deductible	40% after deductible
Outpatient Rehabilitation Limited to 20 visits per calendar year. The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit Maximum are combined limit for preferred and non-preferred services.	20% after deductible	40% after deductible
OTHER SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Convalescent Facility Limited to 100 days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay	20% after deductible	20%
Home Health Care Limited to 100 visits per calendar year.	20% after deductible	40% after deductible
Hospice Care - Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	20% after deductible	40% after deductible



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Hospice Care - Outpatient	20% after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
Private Duty Nursing - Outpatient (Limited to 70 eight hour shifts per calendar year)	20% after deductible	40% after deductible
Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.		
Outpatient Short-Term Rehabilitation	20% after deductible	40% after deductible
Includes Speech, Physical, Occupational, and Spinal Manipulation Therapy, Unlimited number of visits per calendar year.		
Chiropractic Care	Up to 20% after deductible	40% after deductible
to 20 visits per calendar year combined in and out of network		
Durable Medical Equipment	20% after deductible	40% after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Transplants	20% after deductible Preferred coverage is provided at an IOE contracted facility only	40% after deductible Non-Preferred coverage is provided at a Non-IOE facility.
FAMILY PLANNING	PREFERRED CARE	NON-PREFERRED CARE
Infertility Treatment	20% after deductible	40% after deductible
Diagnosis and treatment of the underlying medical condition.		
Voluntary Sterilization	20% after deductible	40% after deductible
Including tubal ligation and vasectomy.		
PHARMACY	PREFERRED CARE	NON-PREFERRED CARE
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Retail	20%	20%
Mail Order	20%	Not applicable
Preventive Medications - Deductible is waived for certain preventive medications. A full list of these drugs is available on Aetna Navigator™ or from your employer.		
Pharmacy Managed Self Injectables (PMSI)		
Self Injectables covered 4th Tier, 20%, \$100 maximum		
First prescription fill at any retail or mail order drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®		
Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs, Diabetic supplies.		
GENERAL 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 related to any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; Custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, 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; Nonmedically necessary services or supplies; 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



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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 or step-therapy. 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.