



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

PLAN FEATURES	PREFERRED CARE		NON-PREFERRED CARE	
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Deductible (per calendar year)	None	Individual	\$250	Individual
	None	Family	\$750	Family

All covered expenses accumulate separately toward the preferred or non-preferred Deductible.

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.

Member Coinsurance	100%		20%	
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Applies to all expenses unless otherwise stated.

Payment Limit (per calendar year)	\$1,500	Individual	\$3,000	Individual
	\$4,500	Family	\$9,000	Family

All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit.

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, 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.

Lifetime Maximum

Unlimited except where otherwise indicated.

Primary Care Physician Selection	Not required		Not applicable	
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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	
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PREVENTIVE CARE	PREFERRED CARE		NON-PREFERRED CARE	
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Routine Adult Physical Exams/	100%		20% after deductible	
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Immunizations

1 exam every 12 months age 18 and over.

Routine Well Child Exams/Immunizations	100%		20% after deductible	
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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.

Routine Gynecological Care Exams	100%		20% after deductible	
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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.

Routine Mammograms	100%		20% after deductible	
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One baseline mammogram for covered females age 35 but less than 40; one mammogram per calendar year for covered females age 40 and over.

Routine Digital Rectal Exam / Prostate-	100%		20% after deductible	
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specific Antigen Test

For covered males age 40 and over.

Colorectal Cancer Screening	100%		20% after deductible	
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For all members age 50 and over.

PHYSICIAN SERVICES	PREFERRED CARE		NON-PREFERRED CARE	
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Office Visits to PCP	\$15 office visit copay		20% after deductible	
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Includes services of an internist, general physician, family practitioner or pediatrician.

Specialist Office Visits	\$15 office visit copay		20% after deductible	
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Allergy Testing	Member cost sharing is based on the type of service performed and the place of service where it is rendered	20% after deductible
Allergy Injections (Copay waived when an office visit charge is not made)	Member cost sharing is based on the type of service performed and the place of service where it is rendered	20% after deductible
DIAGNOSTIC PROCEDURES	PREFERRED CARE	NON-PREFERRED CARE
Diagnostic Laboratory and X-ray	100%	20% after deductible
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		
EMERGENCY MEDICAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Urgent Care Provider (benefit availability may vary by location)	\$15 copay	20% after deductible
Non-Urgent Use of Urgent Care Provider	\$15 copay	20% after deductible
Emergency Room	\$50 copay (waived if admitted)	Same as preferred care.
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	100%	20% after deductible
HOSPITAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Coverage	\$200 per admission copay	\$200 per admission copay + 20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Inpatient Maternity Coverage	\$200 per admission copay	\$200 per admission copay + 20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Hospital Expenses (including surgery)	100%	20% after deductible
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	\$200 per admission copay	\$200 per admission copay + 20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	\$15 copay	20% after deductible
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.		
ALCOHOL/DRUG ABUSE SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Detoxification	\$200 per admission copay	\$200 per admission copay + 20% after deductible
Unlimited visits per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Rehabilitation	\$15 copay	20% after deductible
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.		
OTHER SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Convalescent Facility	100%	20% after deductible
Limited to 100 days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay		
Home Health Care	100%	20% after deductible



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Limited to 100 visits per calendar year.

Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.

Hospice Care - Inpatient	100%	20% after deductible
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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay

Hospice Care - Outpatient	100%	20% after deductible
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The member cost sharing applies to all covered benefits incurred during a member's outpatient visit

Private Duty Nursing - Outpatient	100%	20% after deductible
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Limited to 70 eight -hour shifts per calendar year

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	\$15	20% after deductible
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Includes Speech, Physical and Occupational Therapy, Unlimited

Chiropractic Care	\$15 copay up to 30 visits per year	Not Covered
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Durable Medical Equipment	100%	20% after deductible
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Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	20% after deductible
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Transplants	\$200 per admission copay Preferred coverage is provided at an IOE contracted facility only	\$200 admission copay + 20% after deductible
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FAMILY PLANNING	PREFERRED CARE	NON-PREFERRED CARE
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Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Diagnosis and treatment of the underlying medical condition.		

Voluntary Sterilization	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Including tubal ligation and vasectomy.		

PHARMACY	PREFERRED CARE	NON-PREFERRED CARE
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Deductible	\$25 Annual brand/brand non-formulary	
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Retail	\$10 copay for generic drugs, \$20 copay for formulary brand-name drugs, and \$35 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	Not Covered
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Mail Order	\$20 copay for generic drugs, \$40 copay for formulary brand-name drugs, and \$70 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not applicable
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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.
 Precert for growth hormones included



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GENERAL PROVISIONS

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 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 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.