



PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE
Deductible (per calendar year)	\$1,000 Individual \$2,000 Family
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	30%
Applies to all expenses unless otherwise stated.	
Payment Limit (per calendar year)	\$3,000 Individual \$6,000 Family
Certain member cost sharing elements may not apply toward the Payment Limit. Only those preferred expenses resulting from the application of coinsurance percentage (except any deductibles, copays, and 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.	
Annual Benefit Maximum (per calendar year)	\$100,000
Maximum the plan will pay for covered expenses incurred by any one covered person in a calendar year. The annual benefit maximum applies to preferred care and non-preferred care expenses combined.	
Lifetime Maximum	\$1,000,000 per member's lifetime.
All covered expenses accumulate toward both the Preferred Care and Non-Preferred Care Lifetime Maximum.	
Primary Care Physician Selection	Required
Referral Requirement	Required
PREVENTIVE CARE	PREFERRED CARE
Routine Adult Physical Exams/ Immunizations 1 exam per 24 months for members age 18 to age 65; 1 exam per 12 months for adults age 65 and older.	\$40 office visit copay; deductible waived
Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 2 exams in the 13th-24th months of life; 1 exam per 12 months thereafter to age 18.	\$40 office visit copay; deductible waived
Routine Gynecological Care Exams Includes routine tests and related lab fees	\$50 office visit copay; deductible waived
Routine Mammograms For covered females age 40 and over.	Covered 100%; deductible waived
Routine Digital Rectal Exam / Prostate-specific Antigen Test For covered males age 40 and over.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived
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
Routine Eye Exams 1 routine exam per 24 months, no referral required.	\$50 office visit copay after deductible
PHYSICIAN SERVICES	PREFERRED CARE
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	\$40 office visit copay; deductible waived
Specialist Office Visits	\$50 office visit copay; deductible waived
Allergy Testing	Covered as either PCP or specialist office visit; deductible waived
Allergy Injections	Covered as either PCP or specialist office visit after deductible
DIAGNOSTIC PROCEDURES	PREFERRED CARE
Diagnostic Laboratory and X-ray	\$40 copay after deductible



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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
Urgent Care Provider (benefit availability may vary by location)	\$75 copay; deductible waived
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	\$150 copay; deductible waived
Non-Emergency care in an Emergency Room	Not Covered
Ambulance	Covered 100% after deductible
HOSPITAL CARE	PREFERRED CARE
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	30% after deductible
Inpatient Maternity Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	30% after deductible
Outpatient Surgery	30% after deductible
Outpatient Hospital Expenses (excluding surgery) The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit	30% after deductible
MENTAL HEALTH SERVICES	PREFERRED CARE
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	30% after deductible
Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	\$50 copay after deductible
ALCOHOL/DRUG ABUSE SERVICES	PREFERRED CARE
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	30% after deductible
Outpatient The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit	\$50 copay after deductible
OTHER SERVICES	PREFERRED CARE
Convalescent Facility Limited to 120 days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay	30% after deductible
Home Health Care Limited to 120 visits per calendar year. Includes Private Duty Nursing limited to 70 eight hour shifts 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.	Covered 100% after deductible
Hospice Care - Inpatient Limited to 30 days per lifetime. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	30% after deductible
Hospice Care - Outpatient Up to a maximum benefit of \$5,000 The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	30% after deductible
Outpatient Short-Term Rehabilitation Include Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year.	\$50 copay after deductible
Spinal Manipulation Therapy	\$50 copay after deductible
Durable Medical Equipment Maximum annual benefit of \$10,000 per member per calendar year	30% after deductible
Diabetic Supplies	Covered same as any other medical expense; after deductible
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	30% (payable as any other covered expense) after deductible
Transplants Coverage is provided at an IOE contracted facility only.	30% after deductible



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Mouth, Jaws and Teeth (oral surgery procedures, whether medical or dental in nature)	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Out of Area Dependents	No coverage for non-emergency care received outside the service area; after deductible
FAMILY PLANNING	
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Diagnosis and treatment of the underlying medical condition.	
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; after deductible
PHARMACY	
Retail	\$20 copay for generic drugs, \$40 copay for formulary brand-name drugs, and \$70 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.
Mail Order	\$40 copay for generic drugs, \$80 copay for formulary brand-name drugs, and \$140 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.
Pharmacy Managed Self Injectables (PMSI) First prescription fill at any retail or mail order drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®	
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. Precept for growth hormones included	
Prescription Drug Annual Out of Pocket Maximum	Individual
	Family

GENERAL PROVISIONS

Dependents Eligibility	Spouse, children from birth to age 19 or to age 25 if in
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 90 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.



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If you had no prior creditable coverage within the 90 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.

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 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

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 administered by Aetna Life Insurance Company.