



PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

FUND FEATURES

HealthFund Amount	\$500	Employee
	\$1,000	Employee + 1 Dependent
	\$1,000	Employee + 2 Dependents
	\$1,000	Family

Amount contributed to the Fund by the employer

Fund amount reflected is on a per calendar year basis. The fund received may be prorated based on your effective date of coverage.

Fund Coinsurance	100%
Percentage at which the Fund will reimburse	

Fund Administration	The Fund will be used to pay for your member responsibility, including your deductible and coinsurance. Once the deductible is met, the underlying medical plan provides coverage and if a Fund balance still exists, the Fund will pay your member responsibility (i.e. your share of coinsurance) until the Out-of-Pocket Maximum has been reached or the Fund has been exhausted, whichever comes first. Services covered at 100% with no deductible will be paid by the plan and not by the Fund.
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Employee Termination from Aetna HealthFund	Any remaining HealthFund benefit amount is forfeited (or terminated) when the employee's Aetna HealthFund coverage terminates.
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Fund Rollover	Any remaining HealthFund benefit amount at end of plan year is rolled over into next years HealthFund benefit amount.
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Annual Maximum Rollover	No maximum rollover applies. All remaining benefits at plan year end rollover.
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Cumulative Maximum Rollover	No maximum rollover applies. All remaining funds rollover.
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Fund Maximum (Cap)	No maximum rollover applies. All remaining benefits at plan year end rollover.
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Eligible Fund Expenses	Fund covers same expenses as the medical and if included, pharmacy plan. Expenses above the Reasonable & Customary limit, any plan limits, and any non covered expenses are not eligible for reimbursement under the Fund.
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Fund Payment/Assignment	Network Providers: Automatic Assignment to provider.
	Non-Network Providers: Member may assign payment to provider.

Pro-ration for New Employees	Monthly
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Pro-ration for Family Status Change	No pro-ration. Change to new tier based on new employee status.
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Prescription Drug Plan	Prescription Drug expenses are not integrated with the medical plan (not subject to deductible and not applied towards Out-of-Pocket Limit) or with the Fund (not eligible for reimbursement from the Fund). All covered expenses, including prescription drugs, accumulate toward either the Preferred or Non-Preferred Annual Benefit Maximum. All covered expenses, including prescription drugs, accumulate toward both the Preferred and Non-Preferred Lifetime Maximum.
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PLAN FEATURES

	PREFERRED CARE		NON-PREFERRED CARE	
Deductible (per calendar year)	\$3,000	Employee	\$6,000	Employee
	\$6,000	Employee + 1 Dependent	\$12,000	Employee + 1 Dependent
	\$6,000	Employee + 2 Dependents	\$12,000	Employee + 2 Dependents
	\$6,000	Family	\$12,000	Family

All covered expenses, excluding prescription drugs, accumulate toward both the preferred and non-preferred Deductible. Unless otherwise indicated, the Deductible must be met prior to benefits being payable.

Members with an Employee + 1, Employee + 2, or Family Deductible do not have an Individual Deductible to satisfy.



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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%
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Applies to all expenses unless otherwise stated.

Out-of-Pocket Maximum (per calendar yr)	\$4,500	Employee	\$9,000	Employee
	\$7,000	Employee + 1 Dependent	\$18,000	Employee + 1 Dependent
	\$7,000	Employee + 2 Dependents	\$18,000	Employee + 2 Dependents
	\$7,000	Family	\$18,000	Family

All covered expenses, excluding prescription drugs, accumulate toward both the preferred and non-preferred Out-of-Pocket. Certain member cost sharing elements may not apply toward the Out-of-Pocket Maximum.

Only those out-of-pocket expenses resulting from the application of coinsurance percentage and deductibles, (except any penalty amounts) may be used to satisfy the Out-of-Pocket Maximum.

Members with an Employee + 1, Employee + 2, or Family Out-of-Pocket Maximum do not have an Individual Out-of-Pocket Maximum to satisfy.

Once Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.

Annual Benefit Maximum (per calendar year)	\$100,000	\$100,000
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All covered expenses, including prescription drugs, accumulate toward either the Preferred or Non-Preferred Annual Benefit Maximum.

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.	\$1,000,000 per member's lifetime.
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All covered expenses, including prescription drugs, accumulate toward both the Preferred and Non-Preferred Lifetime Maximum.

Primary Care Physician Selection	Optional	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.

Referral Requirement	None	None
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	PREFERRED CARE	NON-PREFERRED CARE
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Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	40% after deductible
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1 exam per 24 months for members age 18 to age 65; 1 exam per calendar year for adults age 65 and older.

Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	40% after deductible
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7 exams in the first 12 months of life, 3 exams in the 13th-24th months of life; 3 exams in the 25th to 36 month of life and 1 exam per calendar year thereafter to age 18.

Routine Gynecological Care Exams	Covered 100%; deductible waived	40% after deductible
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Includes routine tests and related lab fees

Routine Mammograms	Covered 100%; deductible waived	40% after deductible
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For covered females age 40 and over.

Routine Digital Rectal Exam / Prostate-specific Antigen Test	Covered 100%; deductible waived	40% after deductible
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For covered males age 40 and over.

Colorectal Cancer Screening	Covered 100%; deductible waived	40% after deductible
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For all members age 50 and over.

Routine Eye Exams	Covered 100%; deductible waived	40% after deductible
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1 routine exam per 24 months

	PREFERRED CARE	NON-PREFERRED CARE
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Office Visits to PCP	20% after deductible	40% after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	20% after deductible	40% after deductible
Allergy Testing	Covered as either PCP or specialist office visit after deductible	40% after deductible
Allergy Injections	Covered as either PCP or specialist office visit after deductible	40% after deductible
DIAGNOSTIC PROCEDURES	PREFERRED CARE	NON-PREFERRED CARE
Diagnostic Laboratory and X-ray	20% after deductible	40% 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	20% after deductible	40% after deductible
(benefit availability may vary by location)		
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	20% after deductible	Same as preferred care; after deductible
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	20% after deductible	20% after deductible
HOSPITAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Coverage	20% after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Inpatient Maternity Coverage	20% after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Surgery	20% after deductible	40% after deductible
Outpatient Hospital Expenses (excluding surgery)	20% after deductible	40% 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	20% after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	20% after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
ALCOHOL/DRUG ABUSE SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient	20% after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	20% after deductible	40% after deductible
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% after deductible	40% after deductible
Limited to 120 days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay		
Home Health Care	20% after deductible	40% after deductible
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.		
Hospice Care - Inpatient	20% after deductible	40% after deductible
Limited to 30 days per lifetime. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Hospice Care - Outpatient	20% after deductible	40% after deductible
Up to a maximum benefit of \$5,000 The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		



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Outpatient Short-Term Rehabilitation	20% after deductible	40% after deductible
Include Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year.		
Spinal Manipulation Therapy	20% after deductible	40% after deductible
Durable Medical Equipment	20% after deductible	40% after deductible
Maximum annual benefit of \$10,000 per member per calendar year		
Diabetic Supplies	Covered same as any other medical expense; after deductible	Covered same as any other medical expense; after deductible
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	20% (payable as any other covered expense) after deductible	40% (payable as any other covered expense) after deductible
Transplants	20% Preferred coverage is provided at an IOE contracted facility only; after deductible	40% Non-Preferred coverage is provided at a Non-IOE facility; after deductible
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	40% after deductible
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan; after deductible	
FAMILY PLANNING		
	PREFERRED CARE	NON-PREFERRED CARE
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	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	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
PHARMACY		
	PREFERRED CARE	NON-PREFERRED CARE
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.	40% of submitted cost after \$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.
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
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, and Diabetic supplies.		
Precert for growth hormones included		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 19 or to age 25 if in school.	
Pre-existing Conditions Exclusion	On effective date: Waived	



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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.

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 in your plan documents; 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



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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.