PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	None Employee None Family	$500 Employee $1,000 Family
All covered medical expenses, excluding prescription drugs, accumulate separately toward the preferred and non-preferred 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 Applies to all expenses unless otherwise stated.	10%	40%
Payment Limit (per calendar year)	$1,500 Employee $3,000 Family	$3,000 Employee $6,000 Family
All covered medical expenses, excluding prescription drugs, accumulate separately towards the preferred and non-preferred preferred deductible. 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 (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.		
Lifetime Maximum Unlimited except where otherwise indicated.		1,000,000
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. 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 per 24 months for members age 18 to age 65; 1 exam per 12 months for adults age 65 and older.	$30 office visit copay	40%
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.	$30 office visit copay	40%
Routine Gynecological Care Exams Includes Pap smear and related lab fees	$30 office visit copay	40%
Routine Mammograms For covered females age 40 and over.	$30 office visit copay	40%
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	Member cost sharing is based on the type of service performed and the place of service where it is rendered
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	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Routine Eye Exams 1 routine exam per 24 months	$30 office visit copay	40%
PHYSICIAN SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Office Visits (non surgical) to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	$30 office visit copay	40%
Specialist Office Visits	$30 office visit copay	40%
Allergy Testing	Covered as either PCP or specialist office visit	40%

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Allergy Injections (Copay waived when an office visit charge is not made)	Covered as either PCP or specialist office visit	40%
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Diagnostic Laboratory and X-ray	$30 copay	40%
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)	$35 copay	40%
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	$75 copay	Same as preferred care.
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	Covered 100%	40%
HOSPITAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Coverage	10%	40%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Inpatient Maternity Coverage	10%	40%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Hospital Expenses (including surgery)	10%	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	10%	40%
Limited to 30 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	$30 copay	40%
Limited to 20 visits per calendar year. The member cost sharing applies to all covered benefits incurred during a member's outpatient visit Combined Mental Health and Alcohol/Drug maximum for preferred and non-preferred services		
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	10%	40%
Limited to 30 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	$30 copay	40%
Limited to 20 visits per calendar year. The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit Combined Mental Health and Alcohol/Drug maximum for preferred and non-preferred services		
OTHER SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Convalescent Facility	10%	40%
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	Covered 100%	40%
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	10%	40%
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	10%	40%
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	10% after $30 copay	40%
Includes Speech, Physical, Occupational Therapy, limited to 60 visits per calendar year.		Spinal Manipulation Therapy Unlimited
Durable Medical Equipment	100%	40%
Maximum annual benefit of $10,000 per member per calendar year		
Diabetic Supplies	Covered under Pharmacy Rider	Not Covered
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	10% (payable as any other covered expense)	40% (payable as any other covered expense)
Transplants	10% Preferred coverage is provided at an IOE contracted facility only	40% Non-Preferred coverage is provided at a Non-IOE facility.
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	40%
Out of Area Employees & Dependents	Coverage provided at the non-preferred benefit level of the plan.	
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	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 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	Member cost sharing is based on the type of service performed and the place of service where it is rendered
PHARMACY	**PREFERRED CARE**	**NON-PREFERRED CARE**
Retail	$15 copay for generic drugs, $25 copay for formulary brand-name drugs, and $40 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	Not Covered
Mail Order	$30 copay for generic drugs, $50 copay for formulary brand-name drugs, and $80 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not applicable
No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only.		
Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy. Diabetic Supplies and Oral fertility drugs are covered.		
Precert for growth hormones included, Step-Therapy included.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouseand children from birth to age 19, or to age 25 if in school.	
	Covered to the end of the plan year.	
Pre-existing Conditions Rule	On effective date: Waived After effective date: Waived	

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 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.