PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE
Deductible (per calendar year)	None
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%
Applies to all expenses unless otherwise stated.	
Payment Limit (per calendar year)	$2,500 Employee $5,000 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.	
Lifetime Maximum	
Unlimited except where otherwise indicated.	
Primary Care Physician Selection	Optional
Referral Requirement	None
PREVENTIVE CARE	**PREFERRED CARE**
Routine Adult Physical Exams/ Immunizations	$25 office visit copay
1 exam per 24 months for members age 18 to age 65; 1 exam per 12 months for adults age 65 and older.	
Routine Well Child Exams/Immunizations	$25 office visit copay
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.	
Routine Gynecological Care Exams Includes Pap smear and related lab fees	$25 office visit copay
Routine Mammograms For covered females age 40 and over.	$25 office visit copay
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
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
Routine Eye Exams 1 routine exam per 24 months, no referral required.	$25 office visit copay
PHYSICIAN SERVICES	**PREFERRED CARE**
Office Visits (non surgical) to PCP	$25 office visit copay
Includes services of an internist, general physician, family practitioner or pediatrician.	
Specialist Office Visits	$25 office visit copay
Allergy Testing	Covered as either PCP or specialist office visit
Allergy Injections (Copay waived when an office visit charge is not made)	Covered as either PCP or specialist office visit
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**
Diagnostic Laboratory and X-ray	$25 office visit copay
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)	20%
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	20%
Non-Emergency care in an Emergency Room	Not Covered
Ambulance	Covered 100%

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HOSPITAL CARE	PREFERRED CARE
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	20%
Inpatient Maternity Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	20%
Outpatient Hospital Expenses (including surgery) The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit	20%
MENTAL HEALTH SERVICES	**PREFERRED CARE**
Inpatient Limited to 30 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	20%
Outpatient Limited to 20 visits per calendar year. The member cost sharing applies to all covered benefits incurred during a member's outpatient visit Maximums are combined for Mental Health and Alcohol/Drug services	$25 office visit copay
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**
Inpatient Limited to 30 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	20%
Outpatient Limited to 20 visits per calendar year. The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit Maximums are combined for Mental Health and Alcohol/Drug services	$25 office visit copay
OTHER SERVICES	**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%
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%
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	20%
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	20%
Outpatient Short-Term Rehabilitation Includes Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year.	$25 copay
Spinal Manipulation Therapy	$25 copay
Durable Medical Equipment Maximum annual benefit of $10,000 per member per calendar year	Covered 100%
Diabetic Supplies	Covered same as any other medical expense.
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	20% (payable as any other covered expense)
Transplants Coverage is provided at an IOE contracted facility only.	20%
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
Out of Area Employees & Dependents	No coverage for non-emergency care received outside the service area.

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FAMILY PLANNING	**PREFERRED CARE**
Infertility Treatment	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
PHARMACY	**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.
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®.
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, Injectable fertility drugs (injections are not covered under RX, medical coverage is limited)	
Precert for growth hormones included, Step-Therapy included.	
GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 19 or to age 25 if in school.
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 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 provided by Aetna Life Insurance Company.