PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	$1,000 Individual $2,000 Family	$2,500 Individual $5,000 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. 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.	20%	40%
Payment Limit (per calendar year)	$2,000 Individual $4,000 Family	$5,000 Individual $10,000 Family
All covered expenses including Medical Deductible accumulate toward both the preferred and 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 medical coinsurance percentage and medical deductibles, (except copays and prescription drugs and 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 indicated.	Unlimited except where indicated.
Primary Care Physician Selection	Optional	Not applicable
Precertification Requirement Precertification is encouraged and may be required for certain services and procedures. No penalty		
Referral Requirement	None	None
PREVENTIVE CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Routine Adult Physical Exams/ Immunizations 1 exam per 12 months.	Covered 100%; deductible waived	Not Covered
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	Not Covered
7 exams in the 1st 12 months of life, 3 exams in the 2nd 12 months of life, 3 exams in the 3rd 12 months of life, 1 exam per 12 months thereafter to age 22.		
Routine Gynecological Care Exams Includes routine tests and related lab fees	Covered 100%; deductible waived	Not Covered
Routine Mammograms For covered females age 40 and over.	Covered 100%; deductible waived	Not Covered
Routine Digital Rectal Exam / Prostate-specific Antigen Test For covered males age 40 and over.	Covered 100%; deductible waived	Not Covered
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%; deductible waived	Not Covered
Routine Eye Exams 1 routine exam per 24 months	Covered 100%; deductible waived	Not Covered
PHYSICIAN SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	$25 copay; deductible waived	40% after deductible
Specialist Office Visits	$40 copay; deductible waived	40% after deductible
Allergy Testing	$40 copay; deductible waived	40% after deductible
Allergy Injections	$40 copay; deductible waived	40% after deductible
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**	**NON-PREFERRED CARE**

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Diagnostic Laboratory and X-ray	$40 copay; deductible waived	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 (benefit availability may vary by location)	$40 copay; deductible waived	Same as preferred care; deductible waived
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	$100 copay, then covered at 80% deductible waived	Same as preferred care; deductible waived
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	20% after deductible	40% after deductible
HOSPITAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Coverage	$200 copay per day up to maximum of $1,000 per admission; deductible waived	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Inpatient Maternity Coverage	$200 copay per day up to maximum of $1,000 per admission; deductible waived	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	Covered same as Inpatient Hospital services	Covered same as Inpatient Hospital services; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	$40 copay; deductible waived	Covered same as Specialist Office visit; after deductible
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	Covered same as Inpatient Hospital services	Covered same as Inpatient Hospital services; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	$40 copay; deductible waived	Covered same as Specialist Office visit; 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 Limited to 120 days per calendar year Combined In and Out of Network	$200 copay per day up to maximum of $1,000 per admission; deductible waived	40% after deductible
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 Combined In and Out of Network. Includes Private Duty Nursing limited to 70 eight hour 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.		

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Hospice Care - Inpatient Includes Compassionate Care	$200 copay per day up to maximum of $1,000 per admission; deductible waived	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Hospice Care - Outpatient Includes Compassionate Care	20% after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
Outpatient Short-Term Rehabilitation	$40 copay; deductible waived	40% after deductible
Include Speech, Physical, and Occupational Therapy, limited to 60 visits per condition per calendar year combined In and Out Out of Network.		
Spinal Manipulation Therapy Limited to 30 visits combined In and Out of Network per condition per calendar year.	$40 copay; deductible waived	40% after deductible
Durable Medical Equipment Includes Orthotics and Prosthetics	20% after deductible	40% after deductible
Diabetic Supplies	Covered same as any other medical expense; deductible waived	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	$200 copay per day up to maximum of $1,000 per admission; ded. waived Preferred coverage is provided at an IOE contracted facility only.	40% Non-Preferred coverage is provided at a Non-IOE facility; after deductible
Bariatric	$200 copay per day up to maximum of $1,000 per admission; ded. waived	Not Covered
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
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 Diagnosis and treatment of the underlying medical condition.	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; after deductible
Comprehensive Infertility Services	20% after deductible	Not Covered
Coverage includes Artificial Insemination (limited to six courses of treatment per member's lifetime) and Ovulation Induction (limited to six courses of treatment per member's lifetime). Lifetime maximum applies to all procedures covered by any Aetna plan except where prohibited by law.		
Advanced Reproductive Technology (ART)	20% after deductible	Not Covered
ART coverage includes: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery.		
Limited to 4 Egg retrievals in members lifetime. Maximum applies to all procedures covered by any Aetna plan except where prohibited by law.		

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 **(Pharmacy Plan administered by Express Scripts, Inc.)**	**PREFERRED CARE**	**NON-PREFERRED CARE**

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Waived

For members age 19 or over 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

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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.