**PLAN DESIGN & BENEFITS**
**PROVIDED BY AETNA LIFE INSURANCE COMPANY**

| PLAN FEATURES | PREFERRED CARE | NON-PREFERRED CARE |
|---|---|---|
| **Deductible** (per calendar year) | $1,200 Individual<br>$2,400 Family | $2,500 Individual<br>$5,000 Family |
| All covered expenses, excluding prescription drugs, accumulate separately toward the preferred or non-preferred Deductible.<br>Unless otherwise indicated, the deductible must be met prior to benefits being payable.<br>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** | 15% | 40% |
| Applies to all expenses unless otherwise stated. | | |
| **Payment Limit** (per calendar year) | $6,050 Individual<br>$12,100 Family | $6,050 Individual<br>$12,100 Family |
| All covered expenses, excluding prescription drugs, accumulate separately toward the preferred or non-preferred Payment Limit.<br>Certain member cost sharing elements may not apply toward the Payment Limit.<br>Only those preferred/non-preferred out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and copays (except any penalty amounts) may be used to satisfy the Payment Limit.<br>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** | Not Applicable | 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. | | |
| **Referral Requirement** | None | None |
| **PREVENTIVE CARE** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Routine Adult Physical Exams/ Immunizations** | Covered 100%; deductible waived | 40%; after deductible |
| 1 exam every 12 months for members age 21 and older. | | |
| **Routine Well Child Exams/Immunizations** | Covered 100%; deductible waived | 40%; after deductible |
| Unlimited exams for children up to age 12, 3 exams per calendar year thereafter to age 21. | | |
| **Routine Gynecological Care Exams** | Covered 100%; deductible waived | 40%; after deductible |
| **Pap Smear and related lab fees** | Covered 100% | 40%; after deductible |
| **Routine Mammograms** | Covered 100%; deductible waived | 40%; after deductible |
| One baseline mammogram for covered females age 35-39, one mammogram per calendar year for covered females age 40 and over. | | |

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| **Routine Digital Rectal Exam** | Covered 100% | Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible |
| **Prostate-specific Antigen Test** | Covered 100% | Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible |
| **Colorectal Cancer Screening**<br>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; after deductible |
| **Routine Eye Exams**<br>1 routine exam per 12 months. | Covered 100%; deductible waived | 40%; after deductible |
| **Routine Hearing Exams** | Covered 100%; deductible waived | Not Covered |
| **PHYSICIAN SERVICES** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Office Visits to non-Specialist** | 15%; after deductible | 40%; after deductible |
| Includes services of an internist, general physician, family practitioner or pediatrician. | | |
| **Specialist Office Visits** | 15%; after deductible | 40%; after deductible |
| **E-visit to non-Specialist** | 15%; after deductible | 40%; after deductible |
| An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor. | | |
| **E-visit to Specialist** | 15%; after deductible | 40%; after deductible |
| An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor. | | |
| **Walk-in Clinics** | 15%; after deductible | 40%; after deductible |
| Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic. | | |
| **Allergy Testing** | 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. |
| **Allergy Injections** | 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. |
| **DIAGNOSTIC PROCEDURES** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Diagnostic Laboratory and X-ray**<br>(other than Complex Imaging Services)<br>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. | 15%; after deductible | 40%; after deductible |
| **Diagnostic Outpatient Complex Imaging** | 15%; after deductible | 40%; after deductible |
| **EMERGENCY MEDICAL CARE** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Urgent Care Provider** | 15%; after deductible | 40%; after deductible |
| **Non-Urgent Use of Urgent Care Provider** | Not Covered | Not Covered |

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| **Emergency Room** | 15%; after deductible | Same as preferred care. |
| **Non-Emergency Care in an Emergency Room** | Not Covered | Not Covered |
| **Emergency Use of Ambulance** | 15%; after deductible | 15%; after deductible |
| **Non-Emergency Use of Ambulance** | Not Covered | Not Covered |
| **HOSPITAL CARE** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Inpatient Coverage** | 15%; after deductible | 40%; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | | |
| **Inpatient Maternity Coverage** | 15%; after deductible | 40%; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | | |
| **Outpatient Hospital Expenses** (including surgery) | 15%; 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** | 15%; after deductible | 40%; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | | |
| **Outpatient** | 15%; deductible waived | 40%;; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. Inpatient Mental Health and Alcohol/Drug day limits are combined. | | |
| **ALCOHOL/DRUG ABUSE SERVICES** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Inpatient** | 15%; after deductible | 40%; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | | |
| **Residential Treatment Facility** | 15%; after deductible | 40%; after deductible |
| **Outpatient** | 15%; after deductible | 40%;; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. Inpatient Mental Health and Alcohol/Drug day limits are combined. | | |
| **OTHER SERVICES** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Convalescent Facility** | 15%; after deductible | 40%; after deductible |
| Limited to 60 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | | |
| **Home Health Care** | 15%; after deductible | 40%; after deductible |
| Limited to 60 visits 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** | 15%; after deductible | 40%; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | | |
| **Hospice Care - Outpatient** | 15%; after deductible | 40%; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. | | |
| **Private Duty Nursing** - Outpatient | Not Covered | Not Covered |
| **Outpatient Short-Term Rehabilitation** | 15%; after deductible | 40%; after deductible |
| Includes Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year. Includes habilitative services for covered individuals to age 21 for services diagnosed with congenital and genetic birth defects. | | |
| **Habilitative Services** | 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. |
| Unlimited treatment for children under age 21 with congenital or genetic birth defects to enhance the child's ability to function. | | |
| **Spinal Manipulation Therapy** | 15%; after deductible | 40%; after deductible |
| Limited to 20 visits per calendar year. | | |

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| **Durable Medical Equipment** | 20%; after deductible | 40%; after deductible |
| **Diabetic Supplies** -- (if not covered under Pharmacy benefit) | Covered same as any other medical expense. | Covered same as any other medical expense. |
| **Contraceptive drugs and devices not obtainable at a pharmacy** (includes coverage for contraceptive visits) | Covered same as any other medical expense. | Covered same as any other medical expense. |
| **Vision Eyewear** | Covered 100% up to $100 every24 months | Same as preferred care |
| **Transplants** | 15%; after deductible<br>Preferred coverage is provided at an IOE contracted facility only. | 40%; after deductible<br>Non-Preferred coverage is provided at a Non-IOE facility. |
| **Bariatric Surgery** | 15%; after deductible | Not Covered |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | | |
| **"Other" Health Care --** 20% member coinsurance after the preferred (per calendar year) deductible for services that are neither "preferred" nor "non-preferred". | | |
| **FAMILY PLANNING** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Infertility Treatment**<br>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** | Not Covered | Not Covered |
| **Advanced Reproductive Technology (ART)** | Not Covered | Not Covered |
| **Voluntary Sterilization**<br>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. |
| **PHARMACY** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Retail** | $10 copay for generic drugs, $30 copay for formulary brand-name drugs, and $60 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies. | 20% of submitted cost after the applicable preferred copay |
| **Mail Order** | $20 copay for generic drugs, $60 copay for formulary brand-name drugs, and $120 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®. | Not Applicable |
| **Aetna Specialty CareRx** | | |
| First prescription fill at any retail 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:** Diabetic supplies, Contraceptive drugs and devices obtainable from a pharmacy and Performance Enhancing Medication. | | |
| Oral fertility drugs included. | | |
| Precert for growth hormones included. Expanded Precert included. | | |
| Step Therapy included | | |

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| GENERAL PROVISIONS | |
|---|---|
| **Dependents Eligibility** | Spouse, children from birth to age 26. |
| **Pre-existing Conditions Exclusion** | On effective date: Waived<br>After effective date: Full postponement |

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.

We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much Aetna "recognizes" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much Aetna "recognizes" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna plan "recognizes." Your doctor may bill you for the dollar amount that Aetna doesn't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit Aetna.com. Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site.

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This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.

Plans are provided by: Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services.

The following is a 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 and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental X-rays.
• Donor egg retrieval.
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Hearing aids
• Home births
• Immunizations for travel or work, except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Infertility services, including 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.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Orthotics except diabetic orthotics.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Weight control services including surgical procedures (unless indicated otherwise), 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.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at **1-888-98-AETNA (1-888-982-3862).**

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-98-AETNA (1-888-982-3862).**

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **www.aetna.com.**

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