PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY - Insured

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	$750 Individual $1,500 Family	$1,500 Individual $3,000 Family
All covered expenses accumulate simultaneously 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.	15%	25%
Payment Limit (per calendar year)	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 Family
All covered expenses accumulate simultaneously 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 coinsurance percentage and deductibles (except any 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.		
Payment for Non-Preferred	Not Applicable	Recognized Charge*
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 1 exam every 24 months age 21 - 65 and 1 exam every 12 months age 65 and over.	100%; deductible waived	100% deductible waived $150 Max
Routine Well Child Exams/ Immunizations Unlimited exams for children to age 12; 3 exams per year for children age 12 up to age 21	100%; deductible waived	25% after deductible
Routine Gynecological Care Exams One exam per calendar year. Includes routine tests and related lab fees	Covered 100%; deductible waived	100% deductible waived $150 Max
Pap Smear and related lab fees	Covered 100%; deductible waived	100% deductible waived
Routine Mammograms One mammogram per calendar year for covered females	Covered 100%; deductible waived	100% deductible waived
Women's Health Includes: Screening for gestational diabetes, HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for Human Immunodeficiency Virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies, and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	Covered 100%; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived

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Routine Digital Rectal Exam / Prostate-specific Antigen Test For covered males age 40 and over	Covered 100%; deductible waived	100%; deductible waived
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%; deductible waived	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 1 routine exam per 12 months	$30 office visit;deductible waived	Not Covered
Routine Hearing Exams 1 routine exam per 24 months	$30 office visit;deductible waived	Not Covered
PHYSICIAN SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Office Visits to Non-Specialist (non-surgical) Includes services of an internist, general physician, family practitioner or pediatrician.	$15 office visit copay; deductible waived	25% after deductible
Specialist Office Visits (non-surgical)	$30 office visit copay; deductible waived	25% after deductible
E-visit to non-Specialist 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.	$15 copay; deductible waived	Not Covered
E-visit to Specialist 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.	$30 copay; deductible waived	Not Covered
Walk-in Clinics 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.	$15 office visit copay; deductible waived	25% after deductible
Maternity/OB Visits	$30 Copay; initial visit only	25% after deductible
Office Visits for Surgery	15% After Deductible	25% after deductible
Allergy Testing	$30 office visit Copay	25% after deductible
Allergy Injections	$30 office visit copay	25% after deductible
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Diagnostic Laboratory and X-ray 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	Covered 100% if part of an office visit	25% after deductible
EMERGENCY MEDICAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Urgent Care Provider (benefit availability may vary by location)	$25 copay; deductible waived	25% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	$100 copay/waived if admitted	$100 copay/ after deductible
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	100% covered; deductible waived	25% after deductible

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HOSPITAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Coverage	Covered 100% after deductible	25% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Inpatient Maternity Coverage	Covered 100% after deductible	25% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Hospital Expenses (including surgery)	Covered 100% after deductible	25% 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 100% after deductible	25% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	$15 copay deductible waived	25% 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	Covered 100% after deductible	25% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	$15 copay deductible waived	25% after deductible
Includes treatment facility services		
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	Covered at 100% after deductible	25% after deductible
Limited to 60 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% after deductible	25% 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	Covered 100% after deductible	25% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Hospice Care - Outpatient	Covered 100% after deductible	25% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
Private Duty Nursing - Outpatient (Limited to 70 eight hour shifts per calendar year)	Covered 100% after deductible	25% after deductible
Outpatient Short-Term Rehabilitation	15% after deductible	25% after deductible
60 visit per calendar year maximum combined. Includes speech, physical, and occupational therapy.		
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; after deductible
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	25% after deductible
Durable Medical Equipment	20% after deductible	25% after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	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)	Excludes Oral Contraceptives.PCP or Specialist copay applies for administering supplies/injections	25% (payable as any other covered expense) after deductible. Excludes oral contraceptives.
Vision Eyewear	100% up to $100 every 24 months	Same as preferred care; after deductible

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Transplants	100% Preferred coverage is provided at an IOE contracted facility only; after deductible	25% Non-Preferred coverage is provided at a Non-IOE facility; after deductible
Bariatric	Limited Circumstances	Not Covered
Please contact member services for additional information. 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 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; after deductible	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	50% after deductible	No 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	50% 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. 3 Cycles per Lifetime Maximum. 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	**PREFERRED CARE**	**NON-PREFERRED CARE**
Retail	$10 copay for generic drugs, $20 copay for formulary brand-name drugs, and $40 copay for non-formulary brand-name drugs up to a 30 day supply at participating	Not Covered
Mail Order	$20 copay for generic drugs, $40 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
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, Oral fertility drugs, Diabetic supplies.		
Precert for growth hormones included, Step-Therapy included		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26	
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Waived	

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***Members may choose providers in our network (physicians and facilities) or may visit an out-of-network provider. Typically,
members will pay substantially more money out of their own pocket if they choose to use an out-of-network doctor. The
out-of-network provider will be paid based on Aetna's "recognized charge." This is not the same as the billed charge from the doctor.**

Aetna pays a percentage of the recognized charge, as defined in the member's plan. The member may have to pay the difference between the out-of-network provider's billed charge and Aetna's recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the doctor bills the member above Aetna's recognized charge does not count toward the member's deductible or out-of-pocket maximums.

For out-of-network physicians and other out-of-network providers, the recognized charge is based on the Aetna Market Fee Schedule, which are the standard rates for paying providers within the network. For out-of-network hospitals and other out-of-network facilities, Aetna pays a percentage as defined in the member's plan of the reasonable and customary charge as determined by Aetna. The member may have to pay the difference between the out-of-network facility's bill and the amount that Aetna pays, plus any coinsurance and deductibles due under the plan.

This benefit applies when members choose to get care out of network. When members have no choice in the doctors they see (for example, an emergency room visit after a car accident), they are generally not responsible for the extra out-of-network costs.

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.

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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.
- Durable medical Equipment
- 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 injectible drugs including injectible 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, 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**.