PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE		NON-PREFERRED CARE	
Deductible (per calendar year)	$3,000	Individual	$3,000	Individual
	$6,000	Family	$6,000	Family

All covered medical and pharmacy expenses accumulate toward the preferred or non-preferred deductibles.

Once family medical and pharmacy deductible is met, all family members will be considered as having met their medical and pharmacy deductible for the remainder of the calendar year. There is no Individual Deductible to satisfy within the Family Deductible.

Member Coinsurance	20%		40%	
Applies to all expenses unless otherwise stated.				
Payment Limit (per calendar year)	$5,000	Individual	$10,000	Individual
	$10,000	Family	$20,000	Family

All covered expenses including Deductible and prescription drugs 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 coinsurance percentage, deductibles, and prescription drug copays (except 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. There is no Individual Payment Limit to satisfy within the Family Payment Limit. Deductibles and out of pocket limits in the plan are not combined maximums between in-network and out-of-network care.

Lifetime Maximum	Unlimited	Unlimited
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.

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 per calendar year for members age 18 and older.		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	40% after deductible
7 exams in the first 12 months of life, 3 exams in the 13th-24th months of life; 1 exam per 12 calendar year thereafter to age 18.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	40% after deductible
Includes routine tests and related lab fees		
Routine Mammograms	Covered 100%; deductible waived	40% after deductible
For covered females age 40 and over.		
Routine Digital Rectal Exam / Prostate-specific Antigen Test	Covered 100%; deductible waived	40% after deductible
For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	40% after deductible
For all members age 50 and over.		
Routine Eye Exams	Covered 100%; deductible waived	40% after deductible
1 routine exam per calendar year		
Routine Hearing Exams	Covered 100%; deductible waived	40% after deductible
1 routine exam per 24 months		
PHYSICIAN SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Office Visits to PCP	20% after deductible	40% after deductible
Includes services of an internist, general physician, family practitioner, OB/GYN, or pediatrician.		
Specialist Office Visits	20% after deductible	40% after deductible
Allergy Testing	20% after deductible	40% after deductible
Allergy Injections	20% after deductible	40% after deductible

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DIAGNOSTIC PROCEDURES	PREFERRED CARE	NON-PREFERRED CARE
Diagnostic Laboratory and X-ray	20% after deductible	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		
Diagnostic X-ray for Complex Imaging Services	20% after deductible	50% after deductible
EMERGENCY MEDICAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Urgent Care Provider (benefit availability may vary by location)	20% after deductible	40% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	20% after deductible	Same as preferred care; after deductible
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	20% after deductible	20% after deductible
HOSPITAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Coverage	20% after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Inpatient Maternity Coverage	20% after deductible	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	20% after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	20% after deductible	40% 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	20% after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	20% after deductible	40% 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	20% after deductible	40% after deductible
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	20% after deductible	40% after deductible
Limited to 100 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	20% after deductible	40% after deductible
Unlimited days per lifetime.		
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Hospice Care - Outpatient	20% 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 (Limited to 70 eight hour shifts per calendar year)	20% after deductible	40% after deductible
Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.		
Each visiting nurse care or private duty nursing care shift of 4 hours or less counts as one home health visit. Each such shift of over 4 hours and up to 8 hours counts as two home health care visits.		
Outpatient Short-Term Rehabilitation	20% after deductible	40% after deductible
Physical, and Occupational Therapy, limited to 40 visits (combined) per calendar year. Unlimited for Speech Therapy.		

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Spinal Manipulation Therapy Limited to 26 visits per calendar year	20% after deductible	40% after deductible
Durable Medical Equipment	20% after deductible	50% after deductible
Diabetic Supplies	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)	20% (payable as any other covered expense) after deductible	40% (payable as any other covered expense) after deductible
Transplants	Covered 80% after deductible. Preferred coverage is provided at an IOE contracted facility only; after deductible	40% Non-Preferred coverage is provided at a Non-IOE facility; after deductible. Does not count towards payment limit
Mouth, Jaws and Teeth (oral surgery procedures, coveres medical in nature only)	20% after deductible	40% after deductible
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	20% after deductible	40% after deductible
Diagnosis and treatment of the underlying medical condition only subject to member cost sharing based on the type of service performed and the place of service it is rendered.		
Voluntary Sterilization Including tubal ligation and vasectomy.	20% after deductible	40% after deductible
PHARMACY	**PREFERRED CARE**	**NON-PREFERRED CARE**
The full cost of the drug is applied to the deductible before benefits are considered for payment under the pharmacy plan.		
Retail	Covered after combined medical/Rx plan deductible and 20% copay for generic drugs, 20% copay for formulary brand-name drugs, and 20% copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	40% copay for generic drugs, 40% copay for formulary brand-name drugs, and 40% copay for non-formulary brand-name drugs up to a 30 day supply.
Mail Order	Covered 100% after combined medical/Rx plan deductible and 20% copay for generic drugs, 20% copay for formulary brand-name drugs, and 20% copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not applicable
Self-Injectibles	20%	40%
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

All covered medical and pharmacy expenses accumulate toward the preferred or non-preferred deductibles. Unless otherwise indicated, the medical and pharmacy deductible must be met prior to pharmacy benefits being payable. Once family medical and pharmacy deductible is met, all family members will be considered as having met their medical and pharmacy deductible for the remainder of the calendar year.

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GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26

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.

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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.