



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

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	\$2,850 Individual	\$2,850 Individual
	\$5,650 Family	\$5,650 Family
All covered expenses including 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. There is no individual Deductible to satisfy within the family Deductible.		
Member Coinsurance	Covered 100%	20%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	\$2,850 Individual	\$5,500 Individual
	\$5,650 Family	\$11,000 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.		
Lifetime Maximum		
Lifetime Maximum is \$5,000,000.		
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 \$500 per occurrence. Precertification for certain procedures/treatments - excluded amount is \$200 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE
Routine Adult Physical Exams/ Immunizations	Covered 100%	20%
1 exam every 24 months age 18 - 65 and 1 exam every 12 months age 65 and over.		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	20%
7 exams in first 12 months of life, 2 exams in the 13th - 24th month of life, 1 exam per calendar year thereafter to age 18.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	20%
Includes Pap smear and related lab fees		
Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
One baseline mammogram for females age 35-39, and one annual mammogram for females age 40 and over.		
Routine Digital Rectal Exam / Prostate-specific Antigen Test	Covered 100%; deductible waived	20%
For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	20%
For all members age 50 and over.		
Routine Eye Exams	Covered 100%; deductible waived	20%
1 routine exam per 24 months		
Routine Hearing Exams	Covered 100%; deductible waived	20%
1 routine exam per 24 months		
PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Office Visits to PCP	Covered 100%	20%



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Includes services of an internist, general physician, family practitioner or pediatrician.

Specialist Office Visits	Covered 100%	20%
Allergy Testing	Covered as either PCP or specialist office visit	20%
Allergy Injections	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
DIAGNOSTIC PROCEDURES	PREFERRED CARE	NON-PREFERRED CARE
Diagnostic Laboratory and X-ray	Covered 100%	20%
EMERGENCY MEDICAL CARE	PREFERRED CARE	NON-PREFERRED CARE
	Covered 100%	20%
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	Covered 100%	Same as preferred care.
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	Covered 100%	20%
HOSPITAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Coverage	Covered 100%	20%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Maternity Coverage	Covered 100%	20%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Hospital Expenses (including surgery)	Covered 100%	20%
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%	20%
Lifetime Maximum is \$50k. Limited to 30 days per calendar year. The member cost sharing applies to all covered benefits during a member's inpatient stay.		
Outpatient	Covered 100%	20%
Lifetime Maximum is \$50k. Limited to 40 visits per calendar year. 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%	20%
Lifetime Maximum is \$50k. Limited to 30 days per calendar year. The member cost sharing applies to all covered benefits during a member's inpatient stay.		
Outpatient	Covered 100%	20%
Lifetime Maximum is \$50k. Limited to 40 visits per calendar year. 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 100%	20%
Limited to 120 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Home Health Care	Covered 100%	20%
Unlimited Visits 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%	Covered 100%
Unlimited Visits The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	Covered 100%	Covered 100%



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Unlimited Visits

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%	20%
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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	Covered 100%	20%
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Include Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year.

Spinal Manipulation Therapy	Covered 100%	20%
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Durable Medical Equipment	Covered 100%	20%
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Maximum annual benefit of \$10,000 per member per calendar year

Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
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Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	Covered 100%	20% (payable as any other covered expense)
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Transplants	Covered 100%	20%
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If procedure is performed through an Institute of Excellence[®] facility benefits would be paid at the preferred level. If procedure is not performed through Institutes of Excellence[®] facility benefits would be paid at the non-preferred level.

Preferred coverage is provided at an ICE contracted facility only. Non-preferred coverage is provided at a non-IOE facility.

Certain dental procedures for minors 8 years of age and younger or severely disabled are covered. Please see plan documents for details.

Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan.	
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FAMILY PLANNING	PREFERRED CARE	NON-PREFERRED CARE
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Infertility Treatment	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
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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	Member cost sharing is based on the type of service performed and the place of service where it is rendered
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PHARMACY	PREFERRED CARE	NON-PREFERRED CARE
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The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.

Retail	Covered 100% after combined medical/Rx plan deductible.	20% of submitted cost after combined medical/Rx plan deductible.
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Mail Order	Covered 100% after combined medical/Rx plan deductible.	Not applicable
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No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only.

Mandatory Generic (MG) - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.

Dependents Eligibility	Spouse, children from birth to age 21 or to age 25 if in school.
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Pre-existing Conditions Rule

On effective date: Waived

After effective date: Full Postponement

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.

Members may choose from a network of available providers (physicians and facilities) or may visit a nonparticipating provider. The nonparticipating provider will be paid based on Aetna's Recognized Charge (Aetna Market Fee Schedule (AMFS) and Aetna Facility Fee Schedule), which is the charge Aetna determines to be the usual charge level for the geographic area where the covered service is furnished. The member may be balance billed for the difference between the nonparticipating provider's usual fee and the amount allowed by the plan, in addition to any coinsurance or co-payments due under the plan provisions.

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 the 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;



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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;

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.

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 nonpreferred 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.