



PLAN DESIGN AND BENEFITS  
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE		NON-PREF
<b>Deductible</b> (per calendar year)	None	Employee	\$300
	None	Family	\$600

Unless otherwise indicated, the non-preferred Deductible must be met prior to benefits being payable. Members with a non-preferred Family Deductible do not have a non-preferred Individual Deductible to satisfy. Once non-preferred Family Deductible is met, all family members will be considered as having met their non-preferred Deductible for the remainder of the calendar year.

<b>Member Coinsurance</b> Applies to all expenses unless otherwise stated.	Covered 100%	20%
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<b>Payment Limit</b> (per calendar year)	\$500	Employee	\$1,000
	\$1,500	Family	\$3,000

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 copays (if applicable) may be used to satisfy the Payment Limit.

Members with a Family Out-of-Pocket Maximum do not have an Individual Out-of-Pocket Maximum to satisfy. 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.

<b>Lifetime Maximum</b> Unlimited except where otherwise indicated.		
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<b>Primary Care Physician Selection</b>	Not applicable	Not applicable
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**Certification Requirements -**  
Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, and Home Care. Duty Nursing is required - excluded amount applied separately to each type of expense is \$400 per occurrence.

<b>Referral Requirement</b>	None	None
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PREVENTIVE CARE	PREFERRED CARE	NON-PREF
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<b>Routine Adult Physical Exams/ Immunizations</b> 1 exam per 12 months	Covered 100% after \$15 office visit copay	20%
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<b>Routine Well Child Exams/Immunizations</b> 7 exams in the first 12 months of life, 2 exams in the 13th-24th months of life; 1 exam per 12 months thereafter	Covered 100% after \$15 office visit copay	20%
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<b>Routine Gynecological Care Exams</b> Included Pap smear and related lab fees	Covered 100% after \$15 office visit copay	20%
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<b>Routine Mammograms</b> One baseline age 35-39 and 1 exam per 12 months age 40 and over.	Covered 100%	20%
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<b>Routine Digital Rectal Exam / Prostate-specific Antigen Test</b> For covered males age 40 and over	Member cost sharing is based on the type of service performed and the place of service where it is rendered; 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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<b>Colorectal Cancer Screening</b> 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; 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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<b>Routine Eye Exams</b> 1 routine exam per 12 months	Covered 100% after \$20 office visit copay	Not Covered
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<b>Routine Hearing Exams</b>	Covered 100% after \$20 office visit copay	Not Covered
1 routine exam per 24 months		
<b>PHYSICIAN SERVICES</b>	<b>PREFERRED CARE</b>	<b>NON-PREF</b>
<b>Office Visits to Non-Specialist (non-surgical)</b>	Covered 100% after \$15 office visit copay	20%
Includes services of an internist, general physician, family practitioner or pediatrician.		
<b>Specialist Office Visits (non-surgical)</b>	Covered 100% after \$20 office visit copay	20%
<b>Office Visits for Surgery</b>	Covered 100%	20%
<b>Allergy Testing</b>	Covered as either PCP or specialist office visit	20%
<b>Allergy Injections</b>	Covered 100%	20%
<b>DIAGNOSTIC PROCEDURES</b>	<b>PREFERRED CARE</b>	<b>NON-PREF</b>
<b>Diagnostic Laboratory and X-ray</b>	Covered 100%	20%
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to office visit member cost sharing		
<b>EMERGENCY MEDICAL CARE</b>	<b>PREFERRED CARE</b>	<b>NON-PREF</b>
<b>Urgent Care Provider</b> (benefit availability may vary by location)	Covered 100% after \$25 copay	20%
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered	Not Covered
<b>Emergency Room</b>	Covered 100% after \$35 copay	Same as preferred
<b>Non-Emergency care in an Emergency Room</b>	50%	50%
<b>Ambulance</b>	Covered 100%	20%
<b>HOSPITAL CARE</b>	<b>PREFERRED CARE</b>	<b>NON-PREF</b>
<b>Inpatient Coverage</b>	Covered 100%	20%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
<b>Inpatient Maternity Coverage</b>	Covered 100%	20%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
<b>Outpatient Hospital Expenses (including surgery)</b>	Covered 100%	20%
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
<b>MENTAL HEALTH SERVICES</b>	<b>PREFERRED CARE</b>	<b>NON-PREF</b>
<b>Inpatient</b>	Covered 100%	20%
Unlimited Days The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
<b>Outpatient</b>	80% for 1st 5 visits, 65% for 6-30ths visits, 50% thereafter	80% after deductible, 65% after deductible, 50% after deductible
Unlimited Visits The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
<b>ALCOHOL/DRUG ABUSE SERVICES</b>	<b>PREFERRED CARE</b>	<b>NON-PREF</b>
<b>Inpatient</b>	Covered 100%	20%
Unlimited Days The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
<b>Outpatient</b>	80% for 1st 5 visits, 65% for 6-30ths visits, 50% thereafter	80% after deductible, 65% after deductible, 50% after deductible
Unlimited Visits		



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The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit

OTHER SERVICES	PREFERRED CARE	NON-PREF
<b>Convalescent Facility</b>	Covered 100%	20%

Limited to 120 days per calendar year.

The member cost sharing applies to all covered benefits incurring during a member's inpatient stay

<b>Home Health Care</b>	Covered 100%	20%
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Limited to 120 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

<b>Hospice Care - Inpatient</b>	Covered 100%	20%
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Unlimited Days

The member cost sharing applies to all covered benefits incurred during a member's inpatient stay

<b>Hospice Care - Outpatient</b>	Covered 100%	20%
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Unlimited Visits

The member cost sharing applies to all covered benefits incurred during a member's outpatient visit

<b>Private Duty Nursing - Outpatient (Limited to 70 eight hour shifts per calendar year)</b>	Covered 100%	20%
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<b>Outpatient Short-Term Rehabilitation</b>	Covered 100%	20%
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Physical, Occupational Therapy limited to 120 visits per calendar year.

Speech Therapy limited to 60 visits per calendar year.

<b>Spinal Manipulation Therapy</b>	Covered 100%	20%
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Limited to 30 visits per calendar year

<b>Durable Medical Equipment</b>	Covered 100%	20%
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Maximum annual benefit of \$10,000 per member per calendar year

<b>Diabetic Supplies</b>	Covered same as any other medical expense.	Covered same as any other medical expense.
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<b>Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)</b>	Covered 100% (payable as any other covered expense)	20% (payable as any other covered expense)
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<b>Transplants</b>	Covered 100% Preferred coverage is provided at an IOE contracted facility only	20% Non-Preferred coverage is provided at a Non-IOE contracted facility only
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FAMILY PLANNING	PREFERRED CARE	NON-PREF
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<b>Infertility Treatment</b> 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
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<b>Comprehensive Infertility Services</b>	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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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 an act that is prohibited by law.

PHARMACY	PREFERRED CARE	NON-PREF
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**Retail** \$10 copay for generic drugs, \$20 copay Not Covered for formulary brand-name drugs, and \$35 copay for non-formulary brand-name drugs up to a 90 day supply for 2x copay

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**Mail Order** \$20 copay for generic drugs, \$40 copay Not Covered for formulary brand-name drugs, and \$70 copay for non-formulary brand-name drugs up to a 90 day supply from Aetna Rx Home Delivery®.

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**No Mandatory Generic (NO MG)** - Member is responsible to pay the applicable copay only.

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**Mandatory Generic (MG)** - If the member or the physician requests brand when generic is available, the member will pay the applicable copay. No coverage for drugs on the Medication Formulary Exclusions List due to closed formulary.

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**Dependents Eligibility** Spouse, children from birth to age 19 or to age 25 if in

This plan does not cover all health care expenses and includes exclusions and limitations. Members should consult 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. 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: any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; Custodial care; Donor egg retrieval; Experimental and investigational procedures; Immunizations for travel or work.

Nonmedically necessary services or supplies; Over-the-counter medications and supplies; Reversal of sterilization; treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special diagnostic services including appetite suppressants and other medications; food or food supplements, exercise programs, and equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including 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 is a description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With Home Delivery, all preferred providers and vendors are independent contractors in private practice and are not agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of services 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 authorization. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some services requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing care, surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is available, the preferred provider will obtain the precertification. When the member utilizes a non-preferred provider, precertification is required. Precertification requirements may vary. Depending on the plan selected, new prescription drug reviews by our medication review committee are either available under plans with an open formulary or excluded from coverage. An exception is obtained under plans that use a closed formulary.



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They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limit of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available. 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.

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County Public School System  
and Effective Date: 01-01-2008  
Open Choice® (PPO) - ASC

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