PLAN DESIGN AND BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

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| **Deductible (per plan year)** | None<br>None | Employee<br>Family | $100<br>$300 | Employee<br>Family |

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

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| **Member Coinsurance**<br>Applies to all expenses unless otherwise stated. | Covered 100% | | 20% | |
| **Coinsurance Limit (per plan year)** | $500<br>$1,500 | Employee<br>Family | $1,000<br>$3,000 | Employee<br>Family |

Certain member cost sharing elements may not apply toward the Coinsurance Limit.
Only those 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.
Members with a Family Out-of-Pocket Maximum do not have an Individual Out-of-Pocket Maximum to satisfy.
Once Family Coinsurance Limit is met, all family members will be considered as having met their Coinsurance Limit for the remainder of the plan year. Once the Coinsurance is met, all copays no longer apply for the remainder of the calendar year.

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| **Lifetime Maximum** | Unlimited except where otherwise | Unlimited except where otherwise |
| **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.

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| **Referral Requirement** | None | None |
| **PREVENTIVE CARE** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Routine Adult Physical Exams/ Immunizations**<br>1 exam per calendar year. | Covered 100% | 20% after deductible |
| **Routine Well Child Exams/Immunizations** | Covered 100% | 20% after deductible |

7 exams in the first 12 months of life, 2 exams in the 13th-24th months of life; 1 exam per 12 months thereafter to age 18.

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| **Routine Gynecological Care Exams**<br>Included Pap smear and related lab fees | Covered 100% | 20% after deductible |
| **Routine Mammograms**<br>For covered females age 40 and over. | Covered 100% | 20% after deductible |
| **Routine Digital Rectal Exam / Prostate-specific Antigen Test**<br>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 | 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 |

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| **Routine Eye Exams**<br>1 routine exam per 12 months | $25 office visit copay | Not Covered |
| **Routine Hearing Exams**<br>1 routine exam per 12 months | $25 office visit copay | Not Covered |
| **PHYSICIAN SERVICES** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Office Visits to Non-Specialist** (non-surgical)<br><br>Includes services of an internist, general physician, family practitioner or pediatrician. | $15 office visit copay | 20% after deductible |
| **Specialist Office Visits** (non-surgical) | $25 office visit copay | 20% after deductible |
| **Office Visits for Surgery** | Covered 100% | 20% after deductible |
| **Allergy Testing** | Covered as either PCP or specialist office visit | 20% after deductible |
| **Allergy Injections** | Covered 100% | 20% after deductible |
| **DIAGNOSTIC PROCEDURES** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Diagnostic Laboratory and X-ray**<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 | Covered 100% | 20% after deductible |
| **EMERGENCY MEDICAL CARE** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Urgent Care Provider**<br>(benefit availability may vary by location) | $25 copay | 20% after deductible |
| **Non-Urgent Use of Urgent Care Provider** | Not Covered | Not Covered |
| **Emergency Room** | $50 copay | Same as preferred care |
| **Non-Emergency care in an Emergency Room** | Not Covered | Not Covered |
| **Ambulance** | Covered 100% | 20% after deductible |
| **HOSPITAL CARE** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Inpatient Coverage**<br>The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | Covered 100% | 20% after deductible |
| **Inpatient Maternity Coverage**<br>The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | Covered 100% | 20% after deductible |
| **Outpatient Hospital Expenses** (including surgery)<br>The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit | Covered 100% | 20% after deductible |
| **MENTAL HEALTH SERVICES** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Inpatient**<br>The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | Covered same as Inpatient Hospital services. | Covered same as Inpatient Hospital services; after deductible |
| **Outpatient**<br>The member cost sharing applies to all covered benefits incurred during a member's outpatient visit | $25 copay | Covered same as Specialist Office visit; after deductible |
| **ALCOHOL/DRUG ABUSE SERVICES** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Inpatient**<br>The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | Covered same as Inpatient Hospital services. | Covered same as Inpatient Hospital services; after deductible |
| **Outpatient**<br>The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit | $25 copay | Covered same as Specialist Office visit; after deductible |
| **OTHER SERVICES** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Convalescent Facility**<br>Limited to 120 days per calendar year.<br>The member cost sharing applies to all covered benefits incurring during a member's inpatient stay | Covered 100% | 20% after deductible |
| **Home Health Care**<br>Limited to 120 visits per calendar year.<br>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. | Covered 100% | 20% after deductible |

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| **Hospice Care - Inpatient**<br>Unlimited Days | Covered 100% | 20% after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | | |
| **Hospice Care - Outpatient**<br>Unlimited Visits | Covered 100% | 20% 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% | 20% after deductible |
| **Outpatient Short-Term Rehabilitation**<br>Physical, Occupational Therapy limited to 120 visits per calendar year<br>Speech Therapy limited to 60 visits per calendar year | Covered 100% | 20% after deductible |
| **Spinal Manipulation Therapy**<br>Limited to 30 visits per calendar year | Covered 100% | 20% after deductible |
| **Durable Medical Equipment** | Covered 100% | 20% after deductible |
| **Diabetic Supplies** | Covered same as any other medical expense. | Covered same as any other medical expense; after deductible |
| **Transplants** | Covered 100% Preferred coverage is provided at an IOE contracted facility only | 20% Non-Preferred coverage is provided at a Non-IOE facility; after deductible |
| **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; |
| **Comprehensive Infertility Services** | 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; |
| 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. | | |
| 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.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 1-888-982-3862. If your plan is governed by ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

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.

• 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.
• Treatment of behavioral disorders.

• 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.

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).**

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

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