



PLAN DESIGN AND BENEFITS ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

Deductible (per plan year)	None	Employee	\$100	Employee
	None	Family	\$300	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

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

Primary Care Physician Selection Not applicable Not applicable	Lifetime Maximum	Unlimited except where otherwise	Unlimited except where otherwise
11	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/	Covered 100%	20% after deductible
Immunizations		
1 exam per calendar year.		
Routine Well Child Exams/Immunizations	Covered 100%	20% after deductible

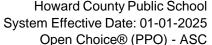
7 exams in the first 12 months of life, 2 exams in the 13th-24th months of life; 1 exam per 12 months thereafter to age 18.

Routine Gynecological Care Exams	Covered 100%	20% after deductible
Included Pap smear and related lab fees		
Routine Mammograms	Covered 100%	20% after deductible
For covered females age 40 and over.		
Routine Digital Rectal Exam / Prostate-	Member cost sharing is based on the	Member cost sharing is based on the
specific Antigen Test	type of service performed and the	type of service performed and the
For covered males age 40 and over	place of service where it is rendered	place of service where it is rendered; after deductible
Colorectal Cancer Screening	Member cost sharing is based on the	Member cost sharing is based on the
For all members age 50 and over.	type of service performed and the	type of service performed and the
-	place of service where it is rendered	place of service where it is rendered; after deductible



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imited 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.			wieit up to 4 hours by a home health or	are aide is one visit





Dependents Eligibility

PLAN DESIGN AND BENEFITS ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

Hospice Care - Inpatient Unlimited Days	Covered 100%	20% after deductible
The member cost sharing applies to all covered	benefits incurred during a member's inpa	atient stay
Hospice Care - Outpatient Unlimited Visits	Covered 100%	20% after deductible
The member cost sharing applies to all covered	benefits incurred during a member's outp	patient visit
Private Duty Nursing - Outpatient (Limited	Covered 100%	20% after deductible
to 70 eight hour shifts per calendar year)		
Outpatient Short-Term Rehabilitation	Covered 100%	20% after deductible
Physical, Occupational Therapy limited to 120 speech Therapy limited to 60 visits per calendar		
Spinal Manipulation Therapy 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	Covered same as any other medical
Transplants	expense. Covered 100% Preferred coverage is provided at an IOE contracted facility only	expense; after deductible 20% Non-Preferred coverage is provided at a Non-IOE facility; after deductible
FAMILY PLANNING	PREFERRED CARE	NON-PREFERRED CARE
Infertility Treatment Diagnosis and treatment of the underlying medical condition. Coverage includes Artificial Insemination	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
Advanced Reproductive Technology Ovulation Induction (limited to six courses of treatment per member's lifetime). Advanced Reproductive Technologies are covered up to 3 attempts per lifetime not to exceed \$100,000 per lifetime.	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;
Department Flights	On a control of the c	

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.

Spouse, children from birth to age 26.

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.
- · Home births
- Immunizations for travel or work except where medically necessary or indicated.
- Implantable drugs and certain injectible drugs including injectible infertility drugs.
- · 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. © 2024 Aetna Inc.