PLAN DESIGN AND BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

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

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

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.		
Referral Requirement	None	None
PREVENTIVE CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Routine Adult Physical Exams/ Immunizations 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.

Routine Gynecological Care Exams Included Pap smear and related lab fees	Covered 100%	20% after deductible
Routine Mammograms For covered females age 40 and over.	Covered 100%	20% after deductible
Routine Digital Rectal Exam / Prostate-specific Antigen Test 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 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 1 routine exam per 12 months	$25 office visit copay	Not Covered
Routine Hearing Exams 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) 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 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 (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 The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered 100%	20% after deductible
Inpatient Maternity Coverage 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) 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 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 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 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 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 Limited to 120 days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay	Covered 100%	20% after deductible
Home Health Care 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.	Covered 100%	20% after deductible

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Hospice Care - Inpatient Unlimited Days The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered 100%	20% after deductible
Hospice Care - Outpatient Unlimited Visits The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	Covered 100%	20% after deductible
Private Duty Nursing - Outpatient (Limited to 70 eight hour shifts per calendar year)	Covered 100%	20% after deductible
Outpatient Short-Term Rehabilitation Physical, Occupational Therapy limited to 120 visits per calendar year Speech Therapy limited to 60 visits per calendar year	Covered 100%	20% after deductible
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 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 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;

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.
• 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**.