PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

Deductible (per calendar year)	None
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%
Payment Limit (per calendar year) Certain member cost sharing elements may not apply toward 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.	$2,000 Individual $6,000 Family
Lifetime Maximum	Unlimited except where otherwise indicated.
Primary Care Physician Selection	Optional, but recommended
Referral Requirement	None
PREVENTIVE CARE	**PREFERRED CARE**
Routine Adult Physical Exams/ Immunizations 1 exam per year for members age 18 to age 65; 1 exam per year for adults age 65 and older.	Covered 100%
Routine Well Child Exams/Immunizations	Covered 100%
Routine Gynecological Care Exams Includes routine tests and related lab fees	Covered 100%
Routine Mammograms For covered females age 40 and over.	Covered 100%
Women's Health	Covered 100%
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
Routine Eye Exams 1 routine exam per 12 months	$20 office visit copay
Routine Hearing Exams 1 routine exam per 12 months	$20 office visit copay
PHYSICIAN SERVICES	**PREFERRED CARE**
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	$10 office visit copay
Specialist Office Visits	$20 office visit copay
Maternity Delivery and Post Partum care	Covered same as Specialist Office Visit;
Allergy Testing	Covered as either PCP or specialist office visit
Allergy Injections	Covered as either PCP or specialist office visit
DIAGNOSTIC PROCEDURES	**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	100%
EMERGENCY MEDICAL CARE	**PREFERRED CARE**
Urgent Care Provider (benefit availability may vary by location)	$15 copay
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	$50 copay
Non-Emergency care in an Emergency Room	Not Covered
Ambulance	Covered 100%

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HOSPITAL CARE	PREFERRED CARE
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered 100%
Inpatient Maternity Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered 100%
Outpatient Surgery	Covered 100%
Outpatient Hospital Expenses (excluding surgery) The member cost sharing applies to all Covered Benefits	Covered 100%
MENTAL HEALTH SERVICES	**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.
Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	$20 copay
ALCOHOL/DRUG ABUSE SERVICES	**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.
Outpatient The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit	$20 copay
OTHER SERVICES	**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%
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%
Hospice Care - Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. Limit 30 days per lifetime	Covered 100%
Hospice Care - Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	Covered 100%
Private Duty Nursing - Outpatient (Limited to 70 eight hour shifts per calendar year) 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.	Covered 100%
Outpatient Speech Therapy Limited to 60 visits per calendar year	$20 copay
Outpatient Physical and Occupational Therapy Limited to 120 visits per calendar year combined.	$20 copay
Spinal Manipulation Therapy Limited to 30 visits per calendar year	$20 copay

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Durable Medical Equipment	Covered 100%
Diabetic Supplies	Covered same as any other medical expense.
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100% (payable as any other covered expense)
Transplants Coverage is provided at an IOE contracted facility only.	Covered 100%
Mouth, Jaws and Teeth (oral surgery procedures, whether medical or dental in nature)	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Out of Area Dependents	No coverage for non-emergency care received outside the service area.
FAMILY PLANNING	**PREFERRED CARE**
Infertility Treatment Diagnosis and treatment of the underlying medical condition rendered. Includes Artificial Insemination.	Member cost sharing is based on the type of service performed and the place of service where it is
Comprehensive Infertility Services 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.	50%
Vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered;
Tubal Ligation	Member cost sharing is based on the type of service performed and the place of service where it is rendered

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.

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; Immunizations for travel or work.

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; and 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 non-preferred 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 administered by Aetna Life Insurance Company.