



PLAN DESIGN & BENEFITS  
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
<b>Deductible</b> (per calendar year)	None Individual None Family	\$1,000 Individual \$3,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.		
<b>Member Coinsurance</b>	Covered 100%	50%
Applies to all expenses unless otherwise stated.		
<b>Payment Limit</b> (per calendar year)	None Individual None Family	\$2,500 Individual \$5,000 Family
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 (except any deductibles, copays, and penalty amounts) may be used to satisfy 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.		
<b>Lifetime Maximum</b>	Unlimited except where otherwise indicated.	Unlimited except where otherwise indicated.
<b>Primary Care Physician Selection</b>	Optional	Not applicable
<b>Certification Requirements -</b> 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.		
<b>Referral Requirement</b>	None	None
PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE
<b>Routine Adult Physical Exams/ Immunizations</b> 1 exam per 12 months for members age 18 and older.	\$15 office visit copay	50% after deductible
<b>Routine Well Child Exams/Immunizations</b> 7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 18.	\$15 office visit copay	50% after deductible
<b>Routine Gynecological Care Exams</b> Includes routine tests and related lab fees	\$15 office visit copay	50% after deductible
<b>Routine Mammograms</b> For covered females age 40 and over.	Covered 100%	50% after deductible
<b>Routine Digital Rectal Exam / Prostate-specific Antigen Test</b> For covered males age 40 and over.	\$15 office visit copay	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
<b>Colorectal Cancer Screening</b> For all members age 50 and over.	\$15 office visit copay	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
<b>Routine Eye Exams</b> 1 routine exam per 12 months	\$15 office visit copay	50% after deductible
<b>Routine Hearing Exams</b> 1 routine exam per 24 months	\$15 office visit copay	50% after deductible
PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE
<b>Office Visits to PCP</b> Includes services of an internist, general physician, family practitioner or pediatrician.	\$15 office visit copay	50% after deductible
<b>Specialist Office Visits</b>	\$15 office visit copay	50% after deductible



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<b>Allergy Testing</b>	\$15 office visit copay	50% after deductible
<b>Allergy Injections</b> (Copay waived when an office visit charge is not made)	\$15 office visit copay	50% after deductible
<b>DIAGNOSTIC PROCEDURES</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Diagnostic Laboratory and X-ray</b>	\$15 copay	50% after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Urgent Care Provider</b> (benefit availability may vary by location)	\$20 copay	50% after deductible
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered	Not Covered
<b>Emergency Room</b>	\$75 copay	Same as preferred care
<b>Non-Emergency care in an Emergency Room</b>	Not Covered	Not Covered
<b>Ambulance</b>	Covered 100%	50% after deductible
<b>HOSPITAL CARE</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Inpatient Coverage</b>	Covered 100%	50% after \$500 per confinement deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
<b>Inpatient Maternity Coverage</b>	Covered 100%	50% after \$500 per confinement deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
<b>Outpatient Surgery</b>	Covered 100%	50% after deductible
<b>Outpatient Hospital Expenses</b> (excluding surgery)	Covered 100%	50% after deductible
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-PREFERRED CARE</b>
<b>Inpatient</b>	Covered 100%	50% after \$500 per confinement deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
<b>Outpatient</b>	\$15 copay	50% after deductible
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-PREFERRED CARE</b>
<b>Inpatient</b>	Covered 100%	50% after \$500 per confinement deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
<b>Outpatient</b>	\$15 copay	50% after deductible
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
<b>OTHER SERVICES</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Convalescent Facility</b>	Covered 100%	50% after deductible
Limited to 90 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%	50% after deductible
Limited to 120 visits per calendar year. Includes Private Duty Nursing limited to 70 eight hour shifts 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%	50% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
<b>Hospice Care - Outpatient</b>	Covered 100%	50% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		



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<b>Outpatient Short-Term Rehabilitation</b> Include Speech Therapy, limited to 60 visits per calendar year.	Covered 100% after \$15 copay	50% after deductible
<b>Outpatient Short-Term Rehabilitation</b> Include Physical, and Occupational Therapy, limited to 60 visits per calendar year.	Covered 100% after \$15 copay	50% after deductible
<b>Spinal Manipulation Therapy</b> Limited to 25 visits per calendar year	\$15 copay	50% after deductible
<b>Durable Medical Equipment</b>	Covered 100%	50% after deductible
<b>Diabetic Supplies</b>	Covered same as any other medical expense.	Covered same as any other medical expense; after deductible
<b>Contraceptive drugs and devices not obtainable at a pharmacy</b> (includes coverage for contraceptive visits)	Covered 100% (payable as any other covered expense)	50% (payable as any other covered expense) after deductible
<b>Vision Eyewear</b>	100% up to \$100 every 24 months.	Same as preferred care
<b>Transplants</b>	Covered 100% Preferred coverage is provided at an IOE contracted facility only	50% Non-Preferred coverage is provided at a Non-IOE facility; after deductible
<b>Bariatric</b>	Covered 100%	50% after \$500 per confinement deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Mouth, Jaws and Teeth</b> (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	50% after deductible
<b>Out of Area Dependents</b>	Coverage provided at 20%, all non-preferred benefits and limitations apply.	
<b>FAMILY PLANNING</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Infertility Treatment</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;
Diagnosis and treatment of the underlying medical condition.		
<b>Voluntary Sterilization</b> Including tubal ligation and vasectomy.	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;
<b>PHARMACY</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Retail</b>	\$10 copay for generic drugs, \$15 copay for formulary brand-name drugs, and \$30 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	50% of submitted cost after \$10 copay for generic drugs, \$15 copay for formulary brand-name drugs, and \$30 copay for non-formulary brand-name drugs up to a 30 day supply.
<b>Mail Order</b>	\$20 copay for generic drugs, \$30 copay for formulary brand-name drugs, and \$60 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not applicable
<b>No Mandatory Generic (NO MG)</b> - Member is responsible to pay the applicable copay only.		
<b>Plan Includes:</b> Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs, Injectable fertility drugs (injectable, physician charges for injections are not covered under RX, medical coverage may be limited), Diabetic supplies.		
Precert for growth hormones included		



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**GENERAL PROVISIONS**

<b>Dependents Eligibility</b>	Spouse, children from birth to age 26
<b>Pre-existing Conditions Exclusion</b>	On effective date: Full Postponement After effective date: Full Postponement

For members age 19 or over this plan imposes a pre-existing condition exclusion, which may be waived in some circumstances and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to this plan, you may have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received or for which the individual took prescribed drugs within 90 days. Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, 90 days ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. If you had prior creditable coverage within 90 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.

If you had no prior creditable coverage within the 90 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 90 day gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion. In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any certificates of creditable coverage you have. Please contact Aetna Member Services at 1-888-982-3862 if you need assistance in obtaining a certificate of creditable coverage from your prior carrier or if you have any questions on the information noted above. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days of birth, adoption, or placement for adoption. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment, and the pre-existing condition exclusion will be applied from the individual's effective date of coverage.

This health insurance issuer believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

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](http://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](http://www.healthreform.gov).

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.



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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; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, 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; 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.