PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	In-Network Designated Providers		No Out of Network Coverage
Deductible (per plan year)	$2,000	Individual	
	$6,000	Family	

All covered expenses, excluding prescription drugs, accumulate toward the preferred Deductible.
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 plan year.

Member Coinsurance	20%	

Applies to all expenses unless otherwise stated.

Payment Limit (per plan year)	$5,000	Individual
	$14,700	Family

All covered expenses accumulate toward the preferred Payment Limit.
Certain member cost sharing elements may not apply toward the Payment Limit. Additional in-network Federal OOP $7,150 for all copays.
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 plan year.

Lifetime Maximum	Unlimited except where otherwise indicated.
Primary Care Physician Selection	Optional

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
PREVENTIVE CARE	**In-Network Designated Providers**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived

1 exam per calendar year for members age 18 and older.

Routine Well Child Exams/Immunizations	Covered 100%; deductible waived

7 exams in the 1st 12 months of life, 3 exams in the 2nd 12 months of life, 3 exams in the 3rd 12 months of life, 1 exam per calendar year thereafter to age 18.

Routine Gynecological Care Exams	Covered 100%; deductible waived

1 exam per calendar year - Includes routine tests and related lab fees

All Mammograms	Covered 100%; deductible waived

1 exam per calendar year for covered females age 35 and over.

Routine Digital Rectal Exam / Prostate-specific Antigen Test	Covered 100%; deductible waived

1 exam per calendar year for covered males age 40 and over.

Colorectal Cancer Screening	Covered 100%; deductible waived

No age limit: Fecal occult blood test every year, Sigmoidoscopy (1 every 5 years), Double contrast barium enema (1 every 5 years), **All Colonoscopies**

Routine Eye Exams	Covered 100%; deductible waived

1 routine exam per calendar year

PHYSICIAN SERVICES	**In-Network Designated Providers**
Office Visits to PCP	100% after $40 office visit copay; deductible waived

Includes services of an internist, general physician, family practitioner or pediatrician.

Specialist Office Visits	100% after $60 office visit copay; deductible waived
Allergy Testing	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Allergy Injections	Member cost sharing is based on the type of service performed and the place of service where it is rendered

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DIAGNOSTIC PROCEDURES	PREFERRED CARE
Diagnostic Laboratory and X-ray*	Covered 100%; deductible waived
Complex Imaging	20% after deductible

*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

EMERGENCY MEDICAL CARE	In-Network Designated Providers
Walk-In Clinic Immunizations and routine consults performed by Nurse Practitioners outside of traditional office visit setting (benefit availability may vary by location)	100% after $40 copay; deductible waived
Urgent Care Provider (benefit availability may vary by location)	100% after $50 copay; deductible waived
Non-Urgent Use of Urgent Care Provider	100% after $50 copay; deductible waived
Emergency Room	20% after deductible and $500 copay; copay waived if admitted
Non-Emergency care in an Emergency Room	Not Covered
Ambulance	20% after deductible

HOSPITAL CARE	In-Network Designated Providers
Inpatient Coverage	20% after deductible and $200 per confinement copay
Inpatient Maternity Coverage	20% after deductible and $200 per confinement copay; Deductible & copay waived for newborns
Outpatient Hospital Expenses Hospitals and other facilities. Includes STR in a hospital outpatient setting (unless otherwise noted below the Short Term Rehab benefit below).	20% after deductible, deductible waived for newborn.
Outpatient Surgery Facility Charges Performed in outpatient dept. of hospital or ambulatory surgery center setting	20% after deductible and $100 copay

MENTAL HEALTH SERVICES	In-Network Designated Providers
Inpatient	20% after plan deductible and $200 copay per admission
Outpatient	100% after $60 copay; deductible waived

ALCOHOL/DRUG ABUSE SERVICES	In-Network Designated Providers
Inpatient	20% after plan deductible and $200 copay per admission
Outpatient	100% after $60 copay; deductible waived

OTHER SERVICES	In-Network Designated Providers
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	20% after deductible
Home Health Care 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.	20% after deductible
Hospice Care - Inpatient Unlimited	100%, deductible waived
Hospice Care - Outpatient Unlimited	100%, deductible waived
Outpatient Physical, Occupational and Speech Therapy performed in an office setting No visit limit per calendar year.	20% after deductible
Outpatient Physical, Occupational and Speech Therapy performed in an outpatient hospital / outpatient facility setting (non-office)	20% after deductible
Spinal Manipulation Therapy	100% after $60 copay; deductible waived
Durable Medical Equipment	20% after deductible
Contraceptive drugs and devices not obtainable at a pharmacy, including office visit	Covered 100%; deductible waived. Device obtained as part of the contraceptive office visit, it is covered at 100%.
Transplants Coverage is provided at an IOE contracted facility only.	20% after plan deductible and $200 copay per admission
Bariatric Surgery	20% after deductible, $12,000 maximum
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; after deductible
Out of Area Dependents	Preferred Plan Applies; dependent selects PCP from network of residence

FAMILY PLANNING	In-Network Designated Providers
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible

Diagnosis and treatment of the underlying medical condition.

Advanced Reproductive Technology (ART)	Not Covered
ART coverage includes: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery.	
Voluntary Sterilization 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; after deductible

Pharmacy	In-Network Designated Providers
Deductible (Generics and Mail Order are not subject to the Rx deductible)	Individual Rx Deductible $200, Family Rx Deductible $600
Retail	$10 for generics (retail), $35 for preferred brand (retail), and $75 for non-preferred brand (retail) 2X copay for 90 day supply at retail

Mail Order	2X the applicable copay based on formulary tier.
AetnaSpecialty Rx	$175 copay

GENERAL PROVISIONS	
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.

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

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.