



PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY - INSURED

PLAN FEATURES	PREFERRED CARE		NON-PREFERRED CARE	
Deductible (per calendar year)	\$500	Individual	\$750	Individual
	\$1,000	Family	\$1,500	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.

Member Coinsurance	10%		30%	
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Applies to all expenses unless otherwise stated.

Payment Limit (per calendar year)	\$3,000	Individual	\$6,000	Individual
	\$6,000	Family	\$12,000	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.

Lifetime Maximum	Unlimited except where otherwise indicated.			
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Primary Care Physician Selection	Optional		Not applicable	
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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.

Recertification for certain procedures/treatments - excluded amount is \$400 per occurrence.

Referral Requirement	None		None	
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PREVENTIVE CARE

	PREFERRED CARE	NON-PREFERRED CARE
Routine Adult Physical Exams/ Immunizations	\$15 office visit copay; deductible waived	30%

Age/ frequency schedule may apply.

Routine Well Child Exams/Immunizations	\$15 office visit copay; deductible waived	30%
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For children to age 18; Age/ frequency schedule may apply.

Routine Gynecological Care Exams	\$25 office visit copay; deductible waived	30%
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One exam per calendar year. Includes Pap smear and related lab fees.

Members may choose ob/gyns as PCPs.

Routine Mammograms	Covered 100%; deductible waived	30%
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One baseline mammogram for covered females age 35 but less than 40; one mammogram per calendar year for covered females age 40 and over.

Routine Digital Rectal Exam / Prostate-specific Antigen Test	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived
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For covered males age 40 and over.

Colorectal Cancer Screening	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived
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For all members age 50 and over.

Routine Eye Exams	\$25 office visit copay	30%
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1 routine exam per 24 months

Routine Hearing Exams	\$25 office visit copay	30%
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1 routine exam per 24 months

PHYSICIAN SERVICES

	PREFERRED CARE	NON-PREFERRED CARE
Office Visits (non surgical) to PCP	\$15 office visit copay; deductible waived	30%

Includes services of an internist, general physician, family practitioner or pediatrician for routine care as well as diagnosis and treatment of an illness or injury.

Specialist Office Visits (non-surgical)	\$25 office visit copay; deductible waived	30%
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Outpatient Surgery	10%	30%
Maternity OB Visits	Covered same as Specialist Office Visit for initial visit only; thereafter covered 100%; deductible waived	30%
Allergy Testing	Covered as either PCP or specialist office visit; deductible waived	30%
Allergy Injections	Covered as either PCP or specialist office visit; deductible waived	30%
DIAGNOSTIC PROCEDURES		
	PREFERRED CARE	NON-PREFERRED CARE
Diagnostic Laboratory and X-ray	10%	30%
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		
	PREFERRED CARE	NON-PREFERRED CARE
Emergency Room	10% after \$100 copay; deductible waived	Same as preferred care.
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	10%	30%
HOSPITAL CARE		
	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Coverage	10% after \$150 per confinement deductible	30% after \$300 per confinement deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Inpatient Maternity Coverage	10% after \$150 per confinement deductible	30% after \$300 per confinement deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Hospital Expenses (including surgery)	10%	30%
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
MENTAL HEALTH SERVICES		
	PREFERRED CARE	NON-PREFERRED CARE
Inpatient	10% after \$150 per confinement deductible	30% after \$300 per confinement deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	\$25 copay	30%
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit Maximums are combined limit for preferred and non-preferred services.		
ALCOHOL/DRUG ABUSE SERVICES		
	PREFERRED CARE	NON-PREFERRED CARE
Inpatient	10% after \$150 per confinement deductible	30% after \$300 per confinement deductible
Limited to 30 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	\$25 copay	30%
Limited to 20 visits per calendar year. The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit Maximum are combined limit for preferred and non-preferred services.		



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OTHER SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Convalescent Facility Limited to 60 days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay	10%	30%
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.	10%	30%
Hospice Care - Inpatient Limited to 30 days per lifetime. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	10%	30%
Hospice Care - Outpatient Up to a maximum benefit of \$5,000 The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	10%	30%
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.	10%	30%
Outpatient Short-Term Rehabilitation Include Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year.	10%	30%
Spinal Manipulation Therapy Chiropractic Care - Limited to 20 visits per calendar year	\$25 specialist office visit copay	30%
Durable Medical Equipment Maximum annual benefit of \$2,000 per member per calendar year	50%	50%
Diabetic Supplies	Covered same as any other medical expense.	Covered same as any other medical expense.
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	10% (payable as any other covered expense)	30% (payable as any other covered expense)
Transplants	10% Preferred coverage is provided at an IOE contracted facility only	30% Non-Preferred coverage is provided at a Non-IOE facility.
Out of Area Employees & Dependents	Coverage provided at 20%, all non-preferred benefits and limitations apply.	
FAMILY PLANNING	PREFERRED CARE	NON-PREFERRED CARE
Infertility Treatment Diagnosis and treatment of the underlying medical condition.	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
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	Member cost sharing is based on the type of service performed and the place of service where it is rendered
PHARMACY	PREFERRED CARE	NON-PREFERRED CARE
Retail	\$15 copay for generic drugs, \$25 copay for formulary brand-name drugs, and \$40 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	Not Covered
Mail Order	\$30 copay for generic drugs, \$50 copay for formulary brand-name drugs, and \$80 copay for non-formulary brand-name drugs up to a 31-90 day supply at participating pharmacies.	Not applicable
No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only.		
Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy, Diabetic supplies. Precertification for Growth Hormones and step-therapy* are included		
*Your plan includes our step-therapy programs, therefore, you need to try one or more prerequisite medications first before the step-therapy medication will be covered under your pharmacy benefit. Prerequisite medications and their corresponding step-therapy medications are FDA-approved and are used to treat the same conditions. Please consult your plan documents for further information or call Member Services.		



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GENERAL PROVISIONS

Dependents Eligibility

Spouse, children from birth to age 19 or to age 25 if in school.

Pre-existing Conditions Rule

On effective date: Waived

After effective date: Full Postponement

Waived for members covered under this plan, exclusive of any probationary period, within 180 days of termination of prior creditable coverage (90 days if covered under a prior plan of individual coverage). Does not apply to pregnancies, newborns covered within 31 days of birth, and adopted children covered within 31 days of placement. Lookback period is 90 days prior to enrollment date. Maximum exclusion period is 180 days after enrollment date.

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; 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.

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 provided by Aetna Life Insurance Company.