PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	NETWORK CARE	OUT-OF-NETWORK CARE
Deductible (per plan year)	$1,000 Individual $2,000 Family	$2,000 Individual $6,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. All covered expenses accumulate separately toward the network and out-of-network Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members, however, no single individual within the family will be subject to more than the individual Deductible amount.		
Member Coinsurance Applies to all expenses unless otherwise stated.	20%	40%
Out of Pocket Limit (per plan year, includes deductible)	$3,500 Individual $7,000 Family	$12,000 Individual $36,000 Family
All covered expenses accumulate separately toward the network and out-of-network Out of Pocket Limit. Pharmacy expenses apply towards the Out of Pocket Limit. Only those out-of-pocket expenses resulting from the application of deductibles, copays and coinsurance percentage (except any penalty amounts) may be used to satisfy the Out of Pocket Limit. The family Out of Pocket Limit is a cumulative Out of Pocket Limit for all family members. The family Out of Pocket Limit can be met by a combination of family members, however, no single individual within the family will be subject to more than the individual Out of Pocket Limit amount.		
Lifetime Maximum	Unlimited	Unlimited
Primary Care Physician Selection	Optional	Not applicable
Payment for Out-of-Network Care*	Not applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Certification Requirements - Certification for certain types of out-of-network 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 and Hospice Care is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Routine Adult Physical Exams/ Immunizations 1 exam per 12 months for members age 22 and older.	Covered 100%; deductible waived	40% after deductible
Routine Well Child Exams/Immunizations 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 12 months thereafter to age 22.	Covered 100%; deductible waived	40% after deductible
Routine Gynecological Care Exams Includes routine tests and related lab fees. Limited to 1 exam every 12 months.	Covered 100%; deductible waived	40% after deductible
Routine Mammograms For covered females age 40 and over.	Covered 100%; deductible waived	40% after deductible
Women's Health Includes: Screening for gestational diabetes, HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for Human Immunodeficiency Virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies, and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	Covered 100%; deductible waived	40% after deductible
Routine Digital Rectal Exam / Prostate-specific Antigen Test For covered males age 40 and over.	Covered 100%; deductible waived	40% after deductible
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%; deductible waived	40% after deductible

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PREVENTIVE CARE (Continued)	NETWORK CARE	OUT-OF-NETWORK CARE
Routine Eye Exams (Refraction) 1 routine exam per 12 months.	Covered 100%; deductible waived	40% after deductible
PHYSICIAN SERVICES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	$25 office visit copay; deductible waived	40% after deductible
Specialist Office Visits	$50 office visit copay; deductible waived	40% after deductible
Walk-in Clinics	$25 office visit copay; deductible waived	40% after deductible
Walk-in Clinics are free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor an outpatient department of a hospital, shall be considered a Walk-in Clinic.		
Pre-Natal Maternity	Covered 100%; deductible waived	40% after deductible
Allergy Testing	Covered as either PCP or specialist office visit; deductible waived	40% after deductible
Allergy Injections	20% after deductible	40% after deductible
DIAGNOSTIC PROCEDURES	**NETWORK CARE**	**OUT-OF-NETWORK 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.	20% after deductible	40% after deductible
Diagnostic X-ray for Complex Imaging Services (Including, but not limited to, MRI, MRA, PET and CT Scans)	20% after deductible	40% after deductible
EMERGENCY MEDICAL CARE	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Urgent Care Provider (benefit availability may vary by location)	$75 copay; deductible waived	40% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room (Copay waived if admitted.)	$200 copay; deductible waived	Same as network care
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	20% after deductible	40% after deductible
HOSPITAL CARE	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Inpatient Coverage Including maternity (delivery and postpartum care). The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% after deductible	40% after deductible
Outpatient Surgery Provided in an outpatient hospital department or a freestanding surgical facility.	20% after deductible	40% after deductible
MENTAL HEALTH SERVICES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% after deductible	40% after deductible
Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	$50 copay; deductible waived	40% after deductible
ALCOHOL/DRUG ABUSE SERVICES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% after deductible	40% after deductible
Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	$50 copay; deductible waived	40% after deductible

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OTHER SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Convalescent Facility Limited to 100 days per plan year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay.	20% after deductible	40% after deductible
Home Health Care Limited to 120 visits per plan 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	40% after deductible
Infusion Therapy Provided in the home or physician's office.	20% after deductible	40% after deductible
Infusion Therapy Provided in an outpatient hospital department or freestanding facility.	20% after deductible	40% after deductible
Hospice Care - Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% after deductible	40% after deductible
Hospice Care - Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	20% after deductible	40% after deductible
Outpatient Short-Term Rehabilitation / Spinal Manipulation Therapy Includes Speech, Physical, Occupational, and Spinal Manipulation Therapy, limited to 60 visits per plan year.	$50 copay after deductible	40% after deductible
Durable Medical Equipment	50% after deductible	50% after deductible
Diabetic Supplies not obtainable at a pharmacy	Covered same as any other medical expense.	Covered same as any other medical expense.
Transplants	20% after deductible Network coverage is provided at an IOE contracted facility only.	40% after deductible Out-of-network coverage is provided at a Non-IOE facility.
Mouth, Jaws and Teeth (oral surgery procedures, medical in nature)	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	40% after deductible

FAMILY PLANNING	NETWORK CARE	OUT-OF-NETWORK CARE
Infertility Treatment Covered only for the 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.	40% after deductible
Vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	40% after deductible
Tubal Ligation	Covered 100%; deductible waived	40% after deductible

PHARMACY	NETWORK CARE	OUT-OF-NETWORK CARE
Prescription drug deductible	Not applicable	Not applicable
Retail (Up to a 30-day supply)	Generic - T1A: $3 copay; Generic - T1: $10 copay; Preferred Brand: $35 copay; Non-Preferred Brand: $60 copay.	50%
Mail Order (31-90 day supply from Aetna Rx Home Delivery®)	Generic - T1A: $6 copay; Generic - T1: $20 copay; Preferred Brand: $70 copay; Non-Preferred Brand: $120 copay.	Not Covered

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PHARMACY (Continued)	NETWORK CARE	OUT-OF-NETWORK CARE
Aetna Specialty CareRx Includes self-injectable, infused and oral specialty drugs, excludes insulin (Up to a 30-day supply)	Preferred specialty drugs: 20% up to $250 maximum per prescription. Non-preferred specialty drugs: 40% up to $500 maximum per prescription.	Not Covered

First prescription fill at any retail drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®.

Choose Generics with Dispense as Written (DAW) override - Member pays the difference in cost between a brand and generic drug plus the applicable cost share if a generic drug is available and a brand-name drug is dispensed unless the physician indicated "Dispense as Written" on the prescription.

Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs, Diabetic supplies.

Precertification and step therapy included.

Formulary Generic FDA-approved Women's Contraceptives covered 100% in network.

Not all drugs are covered. It is important to look at the Drug List (Aetna Value Plus Formulary) to understand which drugs are covered.

***How out-of-network care is reimbursed:**

We cover the cost of services based on whether doctors are “in network” or “out of network.” We want to help members understand how much Aetna pays for their out-of-network care. At the same time, we want to make it clear how much more members will need to pay for this "out-of-network" care.

Members may choose a provider (doctor or hospital) in our network. Members may choose to visit an out-of-network provider. If a member chooses a doctor who is out of network, their Aetna health plan may pay some of that doctor's bill. Most of the time, members will pay a lot more money out of their own pocket if they choose to use an out-of-network doctor or hospital.

When members choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount.

The members' doctor sets his or her own rate to charge members. These rates may be higher -- sometimes much higher -- than what the members' Aetna plan "recognizes." Members' doctors may bill them for the dollar amount that their plan doesn't "recognize." Members must also pay any copayments, coinsurance and deductibles under their plan. No dollar amount above the "recognized charge" counts toward their deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit Aetna.com. Type "how Aetna pays" in the search box.

Members can avoid these extra costs by getting their care from Aetna's network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. Members can sign on to the Aetna Navigator member site.

This applies when members choose to get care out of network. When members have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if the member got care in network. Members pay cost sharing and deductibles for their in-network level of benefits. Members should contact Aetna if their health care provider asks them to pay more. Members are not responsible for any outstanding balance billed by their providers for emergency services beyond their cost sharing and deductibles.

What's Not Covered

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 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 limitations 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.