PLAN DESIGN AND BENEFITS
AETNA LIFE INSURANCE COMPANY - Insured

PLAN FEATURES		
Deductible (per calendar year)	Individual	*$1,500*
	Family	*$3,000*

All covered expenses accumulate simultaneously toward both the preferred and non-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 calendar year.

Payment Limit (per calendar year)	Individual	*$3,000*
	Family	*$6,000*

All covered expenses accumulate simultaneously toward both the preferred and non-preferred Payment Limit.
Certain member cost sharing elements may not apply toward the Payment Limit.
Pharmacy expenses apply towards the Payment Limit.
Medical out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and copays 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
Primary Care Physician Selection	Not applicable

Certification Requirements -
Certification for certain types of 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 *$300* per occurrence.

Referral Requirement	None	None
PLAN FEATURES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Member Coinsurance Applies to all expenses unless otherwise stated.	*20%*	*40%*
PREVENTIVE CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Routine Adult Physical Exams/ Immunizations *1 exam every 12 months*	*Covered 100%*	*40% after deductible*
Routine Well Child Exams/ Immunizations 7 exams in the first 12 months of life, 3 exams in the 13th - 24th month of life, 3 exams in the 25th - 36th month of life, 1 exam every 12 months thereafter to age 18.	*Covered 100%*	*40% after deductible*
Routine Gynecological Care Exams One exam per calendar year. Includes pap smear, HPV screening, and related lab fees.	*Covered 100%*	*40% after deductible*
Routine Mammograms	*Covered 100%*	*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%	40% after deductible
Routine Digital Rectal Exam / Prostate-specific Antigen Test	*Covered 100%*	*40% after deductible*
Routine Eye Exams	*Not Covered*	*Not Covered*
Routine Hearing Exams	*Not Covered*	*Not Covered*

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PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Office Visits to Non-Specialist (non-surgical)	*$40 copay*	*40% after deductible*
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits (non-surgical)	*$40 copay*	*40% after deductible*
Office Visits for Surgery	*$40 copay*	*40% after deductible*
Allergy Testing	*100% after office visit copay*	*40% after deductible*
Allergy Injections	*20% after deductible*	*40% after deductible*
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Diagnostic Laboratory and X-ray	*20% after deductible*	*40% 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	**PREFERRED CARE**	**NON-PREFERRED CARE**
Urgent Care Provider (benefit availability may vary by location)	*$40 copay*	*40% after deductible*
Non-Urgent Use of Urgent Care Provider	$40 copay	40% after deductible
Emergency Room	*20% after deductible*	20% after deductible
Non-Emergency care in an Emergency Room	50% after deductible	50% after deductible
Ambulance	*20% after deductible*	*40% after deductible*
HOSPITAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Coverage	*20% after individual/family deductible and $100 per confinement deductible*	*40% after individual/family deductible and $300 per confinement deductible*
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Inpatient Maternity Coverage	*20% after individual/family deductible and $100 per confinement deductible*	*40% after individual/family deductible and $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)	*20% after deductible*	*40% after deductible*
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	*20% after individual/family deductible and $100 per confinement deductible*	*40% after individual/family deductible and $300 per confinement deductible*
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	*$40 copay*	*40% after deductible*
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	*20% after individual/family deductible and $100 per confinement deductible*	*40% after individual/family deductible and $300 per confinement deductible*
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	*$40 copay*	*40% after deductible*
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
OTHER SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Skilled Nursing Facility	*20% after individual/family deductible and $100 per confinement deductible*	*40% after individual/family deductible and $300 per confinement deductible*
Limited to *60* days per calendar year The member cost sharing applies to all covered benefits incurring during a member's inpatient stay		

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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.	*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 individual/family deductible and $100 per confinement deductible*	*40% after individual/family deductible and $300 per confinement 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*
Private Duty Nursing - Outpatient (Limited to 70 eight hour shifts per calendar year)	*20% after deductible*	*40% after deductible*
Outpatient Short-Term Rehabilitation Includes speech, physical, and occupational therapy.	*20% after deductible*	*40% after deductible*
Spinal Manipulation Therapy	*Covered 100% after office visit copay*	*40% after deductible*
Durable Medical Equipment	*20% after deductible*	*40% after deductible*
Diabetic Supplies -- (if not covered under Pharmacy benefit)	20% after deductible	40% after deductible
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	*Contraceptive: 20% after deductible* *Office Visit: Covered 100% after office visit copay*	*40% after deductible*
Generic FDA-approved Women's Contraceptives	Covered 100%	Member cost sharing is based on the type of service performed and the place of service where it is rendered
OTHER SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Transplants If procedure is performed through an Institute of Excellence® facility benefits would be paid at the preferred level. If procedure is not performed through Institutes of Excellence® facility benefits would be paid at the non-preferred level.	*20% after deductible*	*40% after deductible*
Bariatric The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	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
"Other" Health Care – 20% member coinsurance after the preferred (per calendar year) deductible for services that are neither "preferred" nor "non-preferred"		
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
Comprehensive Infertility Services Coverage includes Artificial Insemination and Ovulation Induction limited to six attempts per lifetime. Lifetime maximum applies to all procedures covered by any Aetna plan except where prohibited by law.	*20% after deductible*	*40% after deductible*
Advanced Reproductive Technology 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. Limited to 3 attempts per lifetime. Maximum applies to all procedures covered by any Aetna plan except where prohibited by law.	*20% after deductible*	*40% after deductible*
Voluntary Sterilization Including tubal ligation	Covered 100%	40% after deductible

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Voluntary Sterilization Including vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered	40% after deductible

PHARMACY	PREFERRED CARE	NON-PREFERRED CARE
Retail	Covered 100% after a minimum of $40 or 30% to a maximum of $80 copay for generic drugs, a minimum of $60 or 30% to a maximum of $120 copay for formulary brand-name drugs, and a minimum of $90 or 50% to a maximum of $180 copay for non-formulary brand-name drugs	*Not Covered*
Mail Order	Covered 100% after a minimum of $80 or 30% to a maximum of $160 copay for generic drugs, a minimum of $120 or 30% to a maximum of $240 copay for formulary brand-name drugs, and a minimum of $180 or 50% to a maximum of $360 copay for non-formulary brand-name drugs	Not Covered
Self-Injectibles	Covered 100% after a minimum of $40 or 30% to a maximum of $80 copay for generic drugs, a minimum of $60 or 30% to a maximum of $120 copay for formulary brand-name drugs, and a minimum of $90 or 50% to a maximum of $180 copay for non-formulary brand-name drugs	Not Covered

Pharmacy Managed Self Injectables (PMSI)
First prescription fill at any retail or mail order drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®

Mandatory Generic with DAW override (MG W/DAW Override) - *The member pays the applicable copay. If the physician requires brand, member would pay brand name copay. If the member requests brand-name when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.*

Plan Includes : Performance Enhancing Medication, Contraceptive drugs and devices obtainable from a pharmacy, Diabetic supplies, *Oral fertility drugs, Injectable fertility drugs (physician charges for injections are not covered under RX, medical coverage is limited).*

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GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26
Pre-existing Conditions Exclusion	On effective date: *Waived* After effective date: *Waived*

*We cover the cost of care differently based on whether health care providers, such as doctors and hospitals, are "in network" or "out of network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this out-of-network care.

As an example, you may choose a doctor in our network. You may choose to visit an out-of-network doctor. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount. When you choose out-of-network care, Aetna "recognizes" an amount based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much Aetna "recognizes" depends on the plan you or your plan sponsor picks.

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 plan sponsor.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services.

The following is a 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 plan sponsor.

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental X-rays.
• Donor egg retrieval.
• Durable medical Equipment
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Hearing aids
• Home births
• Immunizations for travel or work except where medically necessary or indicated.
• Implantable drugs and certain injectible drugs including injectible infertility drugs.
• Infertility services, including 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.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Orthotics except diabetic orthotics.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-
• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens

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Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

If you require language assistance from an Aetna representative, please call Member Services' multilingual hotline at **1-888-982-3862** (140 languages are available. You must ask for an interpreter). **TDD 1-800-628-3323** (hearing impaired only).

Si necesita asistencia lingüística de un representante de Aetna, contamos con una línea directa de Servicios a Miembros disponible en varios idiomas. Comuníquese al **1-888-982-3862** (140 idiomas disponibles. Debe solicitar un intérprete). **TDD 1-800-628-3323** (para personas con problemas de audición únicamente).

Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com**.