

PREMIUM PLAN DESIGN & BENEFITS
 ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE		NON-PREFERRED CARE	
Deductible (per calendar year)	\$500	Individual	\$20,000	Individual
	\$1,500	Family	\$40,000	Family

All covered expenses accumulate 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.

Out-Of-Pocket Maximum (per calendar year)	\$7,350	Individual	Unlimited	Individual
	\$14,700	Family	Unlimited	Family

All covered expenses accumulate toward both the preferred and non-preferred Payment Limit.

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, deductibles, and copays (except any 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	Unlimited except where otherwise
Primary Care Physician Selection	Optional	Not applicable

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	None
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PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE
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Routine Adult Physical Exams/ Immunizations 1 exam per 12 months for members age 22 and older.	Covered 100%; deductible waived	30% after deductible
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Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life; 3 exams in the 2nd 12 months life; 3 exams in the 3rd 12 months of life; 1 exam per 12 months thereafter to age 22.	Covered 100%; deductible waived	30% after deductible
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Routine Gynecological Care Exams Includes routine tests and related lab fees	Covered 100%; deductible waived	30% after deductible
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Routine Mammograms For covered females age 40 and over.	Covered 100%; deductible waived	30% after deductible
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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.	Covered 100%; deductible waived	30% after deductible
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Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.

Routine Digital Rectal Exam / Prostate-specific Antigen Test For covered males age 40 and over.	Covered 100%; deductible waived	30% after deductible
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Colorectal Cancer Screening For all members age 50 and over.	Covered 100%; deductible waived	30% after deductible
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Routine Eye Exams 1 routine exam per 24 months	Covered 100%; deductible waived	30% after deductible
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PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE
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Office Visits to PCP	\$30 office visit copay; deductible waived	30% after deductible
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Includes services of an internist, general physician, family practitioner or pediatrician.

Specialist Office Visits	\$45 office visit copay; deductible waived	30% after deductible
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Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.

Pre-Natal Maternity	Covered 100%; deductible waived	30% after deductible
Allergy Testing	Covered as either PCP or specialist office visit; deductible waived	30% after deductible
Allergy Injections	Covered as either PCP or specialist office visit; deductible waived	30% after deductible

DIAGNOSTIC PROCEDURES	PREFERRED CARE	NON-PREFERRED CARE
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Diagnostic Laboratory and X-ray except for Complex Imaging Services	Preventative Lab and X-Ray covered in Full. Diagnostic Lab and X-Ray \$10 Copay- Free Standing Facility \$25 copay- Hospital Based	30% after deductible
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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

Diagnostic X-ray for Complex Imaging Services	\$250 copay- Free Standing Facility \$500 copay- Hospital Based	30% after deductible
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EMERGENCY MEDICAL CARE	PREFERRED CARE	NON-PREFERRED CARE
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Urgent Care Provider (benefit availability may vary by location)	\$50 copay; deductible waived	30% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	\$150 copay; deductible waived	Same as preferred care; deductible waived

Non-Emergency care in an Emergency Room	Not Covered	Not Covered
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Ambulance	Covered 100%; deductible waived	Covered 100%; deductible waived
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HOSPITAL CARE	PREFERRED CARE	NON-PREFERRED CARE
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Inpatient Coverage	\$500 copay after deductible	30% after deductible
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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay

Inpatient Maternity Coverage (includes delivery and postpartum care)	\$500 copay after deductible	30% after deductible
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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay

Outpatient Surgery	\$500 copay after deductible	30% after deductible
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Outpatient Surgery (Freestanding Facility)	\$500 copay after deductible	30% after deductible
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Outpatient Hospital Expenses (excluding surgery)	\$500 copay after deductible	30% after deductible
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The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit

MENTAL HEALTH SERVICES	PREFERRED CARE	NON-PREFERRED CARE
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Inpatient	\$500 copay after deductible	30% after deductible
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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay

Outpatient-Office Visit	\$45 copay; deductible waived	30% after deductible
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The member cost sharing applies to all covered benefits incurred during a member's outpatient visit

Outpatient-Facility	\$500 copay after deductible	30% after deductible
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The member cost sharing applies to all covered benefits incurred during a member's outpatient visit

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ALCOHOL/DRUG ABUSE SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient The member cost sharing applies to all covered	\$500 copay after deductible	30% after deductible
benefits incurred during a member's inpatient stay		
Outpatient-Office Visit	\$45 copay; deductible waived	30% after deductible
Outpatient-Facility The member cost sharing applies to all covered	\$500 copay after deductible	30% after deductible
benefits incurred during a member's outpatient visit		
OTHER SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Convalescent Facility Limited to 60 days per calendar year. The member cost sharing applies to all covered	\$250 copay; deductible waived	30% after deductible
benefits incurring during a member's inpatient stay		
Home Health Care Limited to 80 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.	Covered 100%; after deductible	30% after deductible
Hospice Care - Inpatient The member cost sharing applies to all covered	\$500 copay after deductible	30% after deductible
benefits incurred during a member's inpatient stay		
Hospice Care - Outpatient The member cost sharing applies to all covered	Covered 100%; deductible waived	30% after deductible
benefits incurred during a member's outpatient visit		
Outpatient Short-Term Rehabilitation Limited to 30 Speech Therapy, 30 Physical Therapy and 30 Occupational Therapy visits per calendar year.	Covered 100% after \$45 copay; deductible waived	30% after deductible
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit.	\$45 copay; deductible waived	30% after deductible
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health benefit with no age or visit limitation.	\$45 copay; deductible waived	30% after deductible
Autism Physical, Occupational and Speech Therapy Covered same as any other Short Term Rehabilitation expense. No age or visit limit restrictions.	\$45 copay; deductible waived	30% after deductible
Spinal Manipulation Therapy Limited to 20 visits per calendar year	Covered 100% after \$45 copay; deductible waived	30% after deductible
Routine Hearing Exams 1 routine exam per 24 months.	Member cost sharing is based on the type of service performed and the place of service where it is rendered	30% after deductible
Hearing Aids Covered children twelve years of age or younger.	Covered 100%; after deductible	30% after deductible
Nutritional Counseling Limited to 3 visits per calendar year.	Member cost sharing is based on the type of service performed and the place of service where it is rendered	30% after deductible
Durable Medical Equipment	Covered at 70%; deductible waived	30% after deductible
Teladoc™ Teladoc is available for minor acute, episodic illnesses or when your primary care physician is not available. Teladoc's U.S. board-certified doctors can resolve many of your medical issues, 24/7/365, via phone 1-855-Teladoc (835-2362); or online video consults from wherever you happen to be. Teladoc may not be available in certain states and service limitations may apply (e.g., limited telephonic services for pharmacy in California).	Covered at 100%	Not Covered
Transplants	Covered 100% Preferred coverage is provided at an IOE contracted facility only; after deductible	30% Non-Preferred coverage is provided at a Non-IOE facility; after deductible
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	30% after deductible

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Out of Area Dependents	Coverage provided at the preferred and non-preferred benefit level of the plan.	
FAMILY PLANNING	PREFERRED CARE	NON-PREFERRED CARE
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	30% after deductible
Diagnosis and treatment of the underlying medical condition.		
Vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	30% after deductible
Tubal Ligation	Covered 100%; deductible waived	30% after deductible
PHARMACY	PREFERRED CARE	NON-PREFERRED CARE
Pharmacy Plan Type	N/A	N/A
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26, regardless of student status.	
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Waived	

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.

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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.