



**PLAN DESIGN AND BENEFITS
 PROVIDED BY AETNA HEALTH INC. - FULL RISK**

PLAN FEATURES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Deductible (per calendar year)	None Individual None Family	\$1,000 Individual \$2,000 Family
<p>Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Member cost sharing for certain services including member cost sharing for prescription drugs, as indicated in the plan, are excluded from charges to meet the Deductible. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.</p>		
Out-of-Pocket Maximum (per calendar year)	\$1,000 Individual \$2,000 Family	\$5,000 Individual \$10,000 Family
<p>Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. Only those participating providers and non-participating providers out of pocket expenses resulting from the application of coinsurance percentage and copays (except any penalty amounts and pharmacy cost sharing) may be used to satisfy the Out-of-Pocket Maximum. Once Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.</p>		
Lifetime Maximum	Unlimited unless otherwise indicated.	\$1,000,000
Primary Care Physician Selection	Not Required	Not Applicable
<p>Precertification Requirement Certain non-participating providers/participating provider self referred services require precertification or benefits will be reduced. Refer to your plan documents for a complete list of services that require precertification.</p>		
Referral Requirements	None	None
PREVENTIVE CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Routine Adult Physical Exams / Immunizations (Age and frequency schedules apply)	\$25 PCP copay /\$45 Specialist copay	20%
Well Child Exams / Immunizations (Age and frequency schedules apply)	\$25 PCP copay/\$45 Specialist copay. If part of office visit no separate copay for immunization	20% for children up to age 16. If part of office visit no separate copay for immunization
Routine Gynecological Care Exams Includes Pap smear and related lab fees. Ob/Gyn providers may be chosen as PCP's. One exam per calendar year.	\$25 PCP copay /\$45 Specialist copay	20%
Routine Mammograms One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over	Covered 100%	20%
Routine Digital Rectal Exams / Prostate Specific Antigen Test For males age 40 and over	Covered 100%	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Colorectal Cancer Screening For all members 50 and over. Frequency schedule applies	Member copay is based on where services are performed.	Member coinsurance is based on where services are performed.



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Routine Eye Exam Age/Frequency Schedule may apply.	\$25 PCP copay /\$45 Specialist copay	Not Covered
Routine Hearing Screening	Subject to Routine Physical Exam cost sharing	Not Covered
PHYSICIAN SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Primary Care Physician Visits	Office Hours: \$25 copay After Office Hours/Home: \$30 copay	20%
Specialist Office Visits	\$45 copay	20%
Maternity OB Visits	\$45 copay for initial visit only, thereafter covered 100%	20%
Allergy Treatment (Allergy serum in office no charge)	Same as applicable participating provider office visit member cost sharing	20%
Allergy Testing	Same as applicable participating provider office visit member cost sharing	20%
DIAGNOSTIC PROCEDURES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Diagnostic Laboratory If performed as a part of a physician's office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit cost sharing.	Covered 100%	20%
Diagnostic X-ray Outpatient hospital or other Outpatient facility (except for Complex Imaging Services)	Covered 100%	20%
Diagnostic X-ray for Complex Imaging Services	Covered 100%	20%
EMERGENCY MEDICAL CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Urgent Care	\$75 copay, waived if admitted	\$75 copay, waived if admitted
Non-Urgent use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	\$150 copay, waived if admitted	\$150 copay, waived if admitted
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Ambulance	Covered 100%	Covered 100%
HOSPITAL CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	\$250 per admission copay	20% per admission
Inpatient Maternity Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	\$250 per admission copay	20% per admission
Outpatient Surgery The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered 100% per visit	20% per visit
MENTAL HEALTH SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Inpatient Mental Illness The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	\$250 per admission copay Limited to 30 days per calendar year	Not Covered



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Outpatient Mental Illness	\$45 copay per visit Limited to 20 visits per calendar year	Not Covered
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		

ALCOHOL/DRUG ABUSE SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
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Inpatient Detoxification	\$250 per admission copay	Not covered
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		

Outpatient Detoxification	\$45 copay	Not covered
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		

Inpatient Rehabilitation	\$250 per admission copay Limited to 30 days per calendar year	Not Covered
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		

Outpatient Rehabilitation	\$45 copay	Not Covered
Limited to 30 visits per calendar year		
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		

OTHER SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
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Skilled Nursing Facility	Covered 100% Limited to 60 days per calendar year.	20% per admission Limited to 240 days per calendar year
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		

Home Health Care	Covered 100% Limited to 120 visits per calendar year.	20% per visit Limited to 120 visits per calendar year.
Each visit up to 4 hours by a home health care aide is one visit. Coverage includes nutritional counseling and services of a medical social worker.		

Hospice Care - Inpatient	Covered 100%	20% per admission
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		

Hospice Care - Outpatient	Covered 100%	20% per visit
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		

Private Duty Nursing	Not Covered unless pre-authorized	Not Covered unless pre-authorized
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Outpatient Rehabilitation Therapy)	\$45 copay (Usually Specialist, but if PCP then \$25) Treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment.	20% Treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment.
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Spinal Manipulation Therapy	\$45 copay Limited to 20 visits per calendar year	20% per visit Limited to 20 visits per calendar year
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Durable Medical Equipment	Covered 100% Limited to \$5,000 per calendar yr	Not Covered
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.	20%
Transplants	\$250 per admission copay Coverage is provided at an IOE contracted facility only	Not Covered
Bariatric Surgery The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Not Covered	Not Covered

FAMILY PLANNING	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Infertility Treatment Diagnosis and treatment of the underlying medical condition.	\$25 PCP copay /\$45 Specialist copay	20%
Comprehensive Infertility Services Coverage includes Artificial Insemination and Ovulation Induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART) ART coverage includes In-Vitro Fertilization (IVF), Zygote Intra-Fallopian Transfer (ZIFT), Gamete Intra-Fallopian Transfer (GIFT), cryopreserved embryo transfers, Intra-Cytoplasmic Sperm Injection (ICSI) or ovum microsurgery.	Not Covered	Not Covered
Voluntary Sterilization Including tubal ligation and vasectomy.	Subject to applicable service type member cost sharing	Subject to applicable service type member cost sharing

PHARMACY - PRESCRIPTION DRUG BENEFITS	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Retail	\$7 copay for formulary generic drugs, \$35 copay for formulary brand-name drugs, and \$60 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.	Not Covered
Mail Order	\$14 copay for formulary generic drugs, \$70 copay for formulary brand-name drugs, and \$120 copay for non-formulary brand-name and generic drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not Covered

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

No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only.

Plan Includes : Contraceptive drugs and devices obtainable from a pharmacy.

Precert included

Step Therapy included



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Spouse; dependent children covered from birth until the end of the calendar year in which they attain age 25, regardless of student status.

Exclusions and Limitations

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The Aetna companies that offer, underwrite or administer benefits include Aetna Health Inc. While this material is believed to be accurate as of the print date, it is subject to change

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.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates.
- Cosmetic surgery.
- Custodial care.
- Dental care and dental x-rays.
- Donor egg retrieval.
- 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
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- 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 except diabetic orthotics.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling.
- Therapy or rehabilitation other than those listed as covered in the plan documents.
- 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 any results or outcomes. Consult the plan document (i.e. Schedule of Benefits, Certificate of Coverage, Evidence of Coverage, Group Agreement, Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. The availability of a plan or program may vary by geographic service area. Some benefits are subject to limitations or visit maximums. With the exception of Aetna Rx Home Delivery, all participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.



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Aetna Pharmacy Management refers to an internal business unit of Aetna Health Management, LLC. If your plan covers outpatient prescription drugs, your plan may include a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally not limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step-therapy, please refer to Aetna's website at www.aetna.com, or the Aetna Medication Formulary Guide. Many drugs, including many of those listed on the formulary, are subject to rebate arrangements between Aetna and the manufacturer of the drugs. Rebates received by Aetna from drug manufacturers are not reflected in the cost paid by a member for a prescription drug.

In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage. Aetna Rx Home Delivery® refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna Inc., that is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated charge with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services.

Certain primary care providers are affiliated with integrated delivery systems or other provider groups (such as independent practice associations and physician-hospital organizations), and members who select these providers will generally be referred to specialists and hospitals within those systems or groups. However, if a system or group does not include a provider qualified to meet member's medical needs, member may request to have services provided by a non-system or non-group providers. Member's request will be reviewed and will require prior authorization from the system or group and/or Aetna to be a covered benefit.

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 obtains covered services from participating providers, the provider will obtain precertification. If the Member obtains covered services from a nonparticipating provider, the Member must obtain the precertification. Precertification requirements may vary. Members may refer to their plan documents for a complete list of medical services that require precertification. Certain benefits like comprehensive infertility and advanced reproductive technology (ART) services, if covered under your plan, are subject to a select network of participating providers, from which you will be required to seek care to receive covered benefits.