**PLAN DESIGN & BENEFITS**
**ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED**

| PLAN FEATURES | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Benefit Limitations** - For any service or supply that is subject to a maximum visit, day, or dollar limitation on a per year basis, the benefit year begins on January 1st unless otherwise mandated. Refer to your plan documents for more information. | | |
| **Deductible** (per year) | $5,000 Individual<br>$10,000 Family | $10,000 Individual<br>$20,000 Family |
| All covered expenses accumulate separately toward the preferred or non-preferred Deductible.<br>Unless otherwise indicated, the deductible must be met prior to benefits being payable.<br>Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses apply towards the Deductible.<br>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**<br>Applies to all expenses unless otherwise stated. | Covered 100% | 30% |
| **Payment Limit** (per year) | $5,000 Individual<br>$10,000 Family | $15,000 Individual<br>$30,000 Family |
| All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit.<br>Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit.<br>Pharmacy expenses apply towards the Payment Limit.<br>The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment 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 Payment Limit amount. | | |
| **Lifetime Maximum**<br>Unlimited except where otherwise indicated. | | |
| **Primary Care Physician Selection** | Optional | Not Applicable |
| **Certification Requirements -**<br>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 |
| **PREVENTIVE CARE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Routine Adult Physical Exams/ Immunizations** | Covered 100%; deductible waived | 30%; after deductible |
| 1 exam per 12 months for members age 22 to age 65; 1 exam per 12 months for adults age 65 and older. | | |
| **Routine Well Child Exams/Immunizations** | Covered 100%; deductible waived | 30%; after deductible |
| 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 year thereafter to age 22. | | |
| **Routine Gynecological Care Exams** | Covered 100%; deductible waived | 30%; after deductible |

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|---|---|---|
| 1 exam and pap smear per calendar year, includes related fees. | | |
| **Routine Mammograms** | Covered 100%; deductible waived | 30%; after deductible |
| **Women's Health** | Covered 100%; deductible waived | 30%; after deductible |
| 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.<br>Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply. | | |
| **Routine Digital Rectal Exam** | Covered 100%; deductible waived | 30%; after deductible |
| Recommended: For covered males age 40 and over. | | |
| **Prostate-specific Antigen Test** | Covered 100%; deductible waived | 30%; after deductible |
| Recommended: For covered males age 40 and over. | | |
| **Colorectal Cancer Screening** | Covered 100%; deductible waived | Covered under Routine Adult Exams |
| Recommended: For all members age 50 and over. | | |
| **Routine Eye Exams** | Covered 100%; deductible waived | 30%; after deductible |
| 1 routine exam per 24 months. | | |
| **Routine Hearing Screening** | Covered 100%; deductible waived | 30%; after deductible |
| **PHYSICIAN SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Office Visits to Non-Specialist** | Covered 100%; after deductible | 30%; after deductible |
| Includes services of an internist, general physician, family practitioner or pediatrician. | | |
| **Specialist Office Visits** | Covered 100%; after deductible | 30%; after deductible |
| **Hearing Exams** | Not Covered | Not Covered |
| **Pre-Natal Maternity** | Covered 100%; deductible waived | Covered according to standard claim practice. |
| **Walk-in Clinics** | Covered 100%; after deductible | 30%; after deductible |
| Walk-in Clinics are network, 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 the outpatient department of a hospital, shall be considered a Walk-in Clinic. | | |
| **Allergy Testing** | Your cost sharing is based on the type of service and where it is performed | Your cost sharing is based on the type of service and where it is performed |
| **Allergy Injections** | Your cost sharing is based on the type of service and where it is performed. Covered 100% when an office visit charge is not applicable. | Your cost sharing is based on the type of service and where it is performed |
| **DIAGNOSTIC PROCEDURES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Diagnostic X-ray** | Covered 100%; after deductible | 30%; after deductible |
| (other than Complex Imaging Services)<br>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 Laboratory** | Covered 100%; after deductible | 30%; 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. | | |
| **Diagnostic Complex Imaging** | Covered 100%; after deductible | 30%; after deductible |

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| EMERGENCY MEDICAL CARE | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Urgent Care Provider** | Covered 100%; after deductible | 30%; after deductible |
| **Non-Urgent Use of Urgent Care Provider** | Not Covered | Not Covered |
| **Emergency Room** | Covered 100%; after deductible | Same as in-network care |
| **Non-Emergency Care in an Emergency Room** | Not Covered | Not Covered |
| **Emergency Use of Ambulance** | Covered 100%; after deductible | Same as in-network care |
| **Non-Emergency Use of Ambulance** | Not Covered | Not Covered |
| **HOSPITAL CARE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient Coverage** | Covered 100%; after deductible | 30%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Inpatient Maternity Coverage** (includes delivery and postpartum care) | Covered 100%; after deductible | 30%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Outpatient Hospital Expenses** | Covered 100%; after deductible | 30%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **Outpatient Surgery - Hospital** | Covered 100%; after deductible | 30%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **Outpatient Surgery - Freestanding Facility** | Covered 100%; after deductible | 30%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **MENTAL HEALTH SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient** | Covered 100%; after deductible | 30%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Mental Health Office Visits** | Covered 100%; after deductible | 30%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **Other Mental Health Services** | Covered 100%; after deductible | 30%; after deductible |
| **SUBSTANCE ABUSE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient** | Covered 100%; after deductible | 30%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Residential Treatment Facility** | Covered 100%; after deductible | 30%; after deductible |
| **Substance Abuse Office Visits** | Covered 100%; after deductible | 30%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **Other Substance Abuse Services** | Covered 100%; after deductible | 30%; after deductible |
| **OTHER SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Skilled Nursing Facility** | Covered 100%; after deductible | 30%; after deductible |
| Limited to 60 days per year<br>Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |

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| **Home Health Care**<br>Limited to 60 visits per year.<br>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**<br>Your cost sharing applies to all covered benefits incurred during your inpatient stay. | Covered 100%; after deductible | 30%; after deductible |
| **Hospice Care - Outpatient**<br>Your cost sharing applies to all covered benefits incurred during your outpatient visit. | Covered 100%; after deductible | 30%; after deductible |
| **Private Duty Nursing** | Not Covered | Not Covered |
| **Outpatient Short-Term Rehabilitation**<br>Includes speech, physical, occupational therapy; limited to 60 visits per year | Covered 100%; after deductible | 30%; after deductible |
| **Spinal Manipulation Therapy**<br>Limited to 20 visits per year | Covered 100%; after deductible | 30%; after deductible |
| **Autism Behavioral Therapy**<br>Combined with outpatient mental health visits | Covered 100%; after deductible | 30%; after deductible |
| **Autism Applied Behavior Analysis** | Covered 100%; after deductible | 30%; after deductible |
| **Autism Physical Therapy**<br>Visits combined with Short Term Rehabilitation. | Covered 100%; after deductible | 30%; after deductible |
| **Autism Occupational Therapy**<br>Visits combined with Short Term Rehabilitation. | Covered 100%; after deductible | 30%; after deductible |
| **Autism Speech Therapy**<br>Visits combined with Short Term Rehabilitation. | Covered 100%; after deductible | 30%; after deductible |
| **Durable Medical Equipment** | Covered 100%; after deductible | 30%; after deductible |
| **Diabetic Supplies** | Covered same as any other medical expense. | Covered same as any other medical expense. |
| **Affordable Care Act mandated Women's Contraceptives** | Covered 100%; deductible waived | Covered same as any other expense. |
| **Women's Contraceptive drugs and devices not obtainable at a pharmacy** | Covered 100%; deductible waived | Covered same as any other medical expense. |
| **Infusion Therapy**<br>Administered in the home or physician's office | Covered 100%; after deductible | 30%; after deductible |
| **Infusion Therapy**<br>Administered in an outpatient hospital department or freestanding facility | Covered 100%; after deductible | 30%; after deductible |
| **Vision Eyewear** | Not Covered | Not Covered |
| **Transplants** | Covered 100%; after deductible<br>Preferred coverage is provided at an IOE contracted facility only. | 30%; after deductible<br>Non-Preferred coverage is provided at a Non-IOE facility. |
| **Bariatric Surgery** | Not Covered | Not Covered |

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| FAMILY PLANNING | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Infertility Treatment**<br>Diagnosis and treatment of the underlying medical condition only. | Your cost sharing is based on the type of service and where it is performed | Your cost sharing is based on the type of service and where it is performed |
| **Comprehensive Infertility Services**<br>Artificial insemination and ovulation induction | Not Covered | Not Covered |
| **Advanced Reproductive Technology (ART)** | Not Covered | Not Covered |
| **Vasectomy** | Your cost sharing is based on the type of service and where it is performed | 30%; after deductible |
| **Tubal Ligation** | Covered 100%; deductible waived | Your cost sharing is based on the type of service and where it is performed |

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| PHARMACY | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan. | | |
| **Pharmacy Plan Type** | Aetna Value Plus Open Formulary | |
| **Value Drugs Tier 1A** | | |
| **Retail** | Covered 100% | 30% of submitted cost; after applicable copay |
| **Mail Order** | Covered 100% | Not Applicable |
| **Preferred Generic Drugs** | | |
| **Retail** | Covered 100% | 30% of submitted cost; after applicable copay |
| **Mail Order** | Covered 100% | Not Applicable |
| **Preferred Brand-Name Drugs** | | |
| **Retail** | Covered 100% | 30% of submitted cost; after applicable copay |
| **Mail Order** | Covered 100% | Not Applicable |
| **Non-Preferred Generic and Brand-Name Drugs** | | |
| **Retail** | Covered 100% | 30% of submitted cost; after applicable copay |
| **Mail Order** | Covered 100% | Not Applicable |
| **Value Plus Specialty Drugs** | | |
| **Preferred Specialty** | Covered 100% | Not Covered |
| **Non-Preferred Specialty** | Covered 100% | Not Covered |
| **Pharmacy Day Supply and Requirements** | | |
| **Retail** | Up to a 30 day supply from Aetna National Network | |
| **Mail Order** | A 31-90 day supply from Aetna Rx Home Delivery®. | |
| **Value Plus Specialty** | Up to a 30 day supply<br>All prescription fills must be through our preferred specialty pharmacy network. | |
| **Choose Generics with Dispense as Written (DAW) override** - The member pays the applicable copay. If the physician requires brand-name, 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:** Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.<br>A limited list of over-the-counter medications are covered when filled with a prescription.<br>Performance Enhancing Drugs limited to 6 tablets per month.<br>Value Plus Pre-certification included<br>Value Plus Step Therapy included<br>Seasonal Vaccinations covered 100% in-network<br>Preventive Vaccinations covered 100% in-network<br>One transition fill allowed within 90 days of member's effective date<br>Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network. | | |
| **GENERAL PROVISIONS** | | |
| **Dependents Eligibility** | Spouse, children from birth to age 26 regardless of student status. | |

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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. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do 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 employer.
• 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
• 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 injectable drugs including injectable 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.
• 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/enhancement, including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• 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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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.
Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**
Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**
Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com.**