PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$3,500 Individual $7,000 Family	$5,500 Individual $11,000 Family
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. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the 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.	30%	50%
Payment Limit (per calendar year)	$6,000 Individual $12,000 Family	$10,000 Individual $20,000 Family
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. 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. 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 Unlimited except where otherwise indicated.		
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
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	50%; after deductible
1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	50%; 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	50%; after deductible
Recommended: One exam per calendar year. Includes routine tests and related lab fees.		
Routine Mammograms	Covered 100%; deductible waived	50%; after deductible
Women's Health	Covered 100%; deductible waived	50%; 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. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		
Routine Digital Rectal Exam	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males age 40 and over.		

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Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	50%; after deductible
Colorectal Cancer Screening Recommended: For all members age 50 and over.	Covered 100%; deductible waived	Your cost sharing is based on the type of service and where it is performed
Routine Eye Exams 1 routine exam per 24 months.	Covered 100%; deductible waived	50%; after deductible
Routine Hearing Screening 1 routine exam every 12 months	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician.	30%; after deductible	50%; after deductible
Specialist Office Visits	30%; after deductible	50%; after deductible
Walk-in Clinics 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.	30%; after deductible	50%; after deductible
Allergy Testing	30%; after deductible	50%; after deductible
Allergy Injections	30%; after deductible	50%; after deductible
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic 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.	30%; after deductible	50%; after deductible
Diagnostic Laboratory 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.	30%; after deductible	50%; after deductible
Diagnostic Outpatient Complex Imaging	30%; after deductible	50%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	30%; after deductible	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	30%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	30%; 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 Your cost sharing applies to all covered benefits incurred during your inpatient stay.	30%; after deductible	50%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	30%; after deductible	50%; after deductible
Outpatient Hospital Expenses Your cost sharing applies to all covered benefits incurred during your outpatient visit.	30%; after deductible	50%; after deductible
Outpatient Surgery - Hospital Your cost sharing applies to all covered benefits incurred during your outpatient visit.	30%; after deductible	50%; after deductible

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Outpatient Surgery - Freestanding Facility	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Mental Health Inpatient	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Substance Abuse Inpatient	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	30%; after deductible	50%; after deductible
Substance Abuse Rehabilitation Visits	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	30%; after deductible	50%; after deductible
Limited to 100 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	30%; after deductible	50%; after deductible
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.		
Hospice Care - Inpatient	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing	Not Covered	Not Covered
Outpatient Speech Therapy	30%; after deductible	50%; after deductible
Outpatient Physical and Occupational Therapy	30%; after deductible	50%; after deductible
Spinal Manipulation Therapy	30%; after deductible	50%; after deductible
Limited to 20 visits per calendar year.		
Autism Behavioral Therapy	30%; after deductible	50%; after deductible
Covered same as any other Outpatient Mental Health benefit		
Autism Applied Behavior Analysis	30%; after deductible	50%; after deductible
Covered same as any other Outpatient Mental Health Other Services benefit		
Autism Physical Therapy	30%; after deductible	50%; after deductible
Autism Occupational Therapy	30%; after deductible	50%; after deductible
Autism Speech Therapy	30%; after deductible	50%; after deductible
Durable Medical Equipment	30%; after deductible	50%; after deductible
Orthotics	30%; after deductible	50%; after deductible
Orthotics and special footwear covered for persons with foot disfigurement.		
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; after deductible	50%; after deductible
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; after deductible	50%; after deductible

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Vision Eyewear	Not Covered	Not Covered
Transplants	30%; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Acupuncture Limit of 20 visits per year	30%; after deductible	50%; after deductible
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment 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 Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered	Not Covered
Vasectomy	30%; after deductible	50%; after deductible
Tubal Ligation	100% No Deductible/No Copay applied including associated ancillary services	50%; after deductible

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PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type:	Advanced Control Pharmacy - Aetna	
Preferred Generic Drugs:		
Retail	$10 copay	$10 copay
Mail Order	$10 copay	Not Covered
Preferred Brand Name Drugs:		
Retail	$75 copay	$75 copay
Mail Order	$75 copay	Not Covered
Non-Preferred Generic and Brand Drugs:		
Retail	50% up to a max of $250	50% up to a max of $250
Mail Order	50% up to a max of $500	Not Covered
Specialty Drugs:		
Preferred Specialty	50% up to a max of $250	Not Covered
Non-Preferred Specialty	50% up to a max of $250	Not Covered

Pharmacy Day Supply and Requirements	
Retail	Up to a 30-day supply from Aetna National Network Percentage copays will not be doubled
Mail Order	A 31-90-day supply from CVS Caremark® Mail Service Pharmacy
Specialty	Up to a 30-day supply First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network. Advanced Control Formulary Aetna Insured List

Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.

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

Precert for growth hormones included

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GENERAL PROVISIONS

Dependents Eligibility Spouse, children from birth to age 26 regardless of student status.

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay 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.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your 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, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Navigator member site.

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

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.

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.

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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 our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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.

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.**