PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	$1,000 Employee $2,000 Family	$3,000 Employee $6,000 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, except for PCP office visits. Once family deductible is met, all family members will be considered as having met their deductible for the remainder of the calendar year.		
Member Coinsurance	20%	40%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$4,000 Employee $8,000 Family	$7,000 Employee $14,000 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 (except any deductibles, copays, and 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		
$5,000,000 per member's lifetime.		
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. Precertification for certain procedures/treatments - excluded amount is $200 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Routine Adult Physical Exams/ Immunizations	$20 office visit copay	40%
1 exam per 12 months for members age 18 to age 65; 1 exam per 12 months for adults age 65 and older.		
Routine Well Child Exams/Immunizations	$20 office visit copay	40%
6 exams in the first 12 months of life, 2 exams in the 13th-24th months of life; 1 exam per 12 months thereafter to age 18.		
Routine Gynecological Care Exams	$20 office visit copay	40%
Includes Pap smear and related lab fees		
Routine Mammograms For covered females age 35 and over.	Covered 100%; deductible waived	40%
Routine Digital Rectal Exam / Prostate-specific Antigen Test For covered males age 40 and over.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	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 age 50 and over.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Routine Eye Exams 1 routine exam per 24 months	$20 office visit copay	40%
Routine Hearing Exams 1 routine exam per 24 months	$20 office visit copay	40%
PHYSICIAN SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Office Visits (non surgical) to PCP	$20 office visit copay	40%

Includes services of an internist, general physician, family practitioner or pediatrician for routine care as well as diagnosis and treatment of an illness or injury.

Specialist Office Visits (non-surgical)	$30 office visit copay	40%
Outpatient Surgery	20%	40%
Maternity OB Visits	Covered same as Specialist Office Visit for initial visit only; thereafter covered 100%; deductible waived	40%
Allergy Testing	Covered as either PCP or specialist office visit; deductible waived	40%
Allergy Injections (Copay waived when an office visit charge is not made)	Covered as either PCP or specialist office visit	40%
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Diagnostic Laboratory and X-ray	100% deductible waived	40%
MRIs, CAT Scans & PET Scans are covered after the deductible at 80% coinsurance		
EMERGENCY MEDICAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Urgent Care Provider (benefit availability may vary by location)	$50 copay	40%
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	$100 copay; deductible waived then 80%	$100 copay; deductible waived then 80%
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	20%	20%
HOSPITAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Coverage	20%	40% after $500 per confinement deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Inpatient Maternity Coverage	20%	40% after $500 per confinement
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Hospital Expenses (including surgery)	20%	40%
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%	40% after $500 per confinement deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	$30 copay	40%
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit Combined Mental Health and Alcohol/Drug maximum for preferred and non-preferred services		
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	20%	40% after $500 per confinement deductible
Limited to 90 visits per lifetime. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	$30 copay	40%
Limited to 30 visits per calendar year. The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit Combined Mental Health and Alcohol/Drug maximum for preferred and non-preferred services		

OTHER SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Convalescent Facility Limited to 100 days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay	20%	40%
Home Health Care Limited to 120 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%	40%
Hospice Care - Inpatient Up to a maximum lifetime benefit of $10,000 combined inpatient/outpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	20%	40% after $500 per confinement deductible
Hospice Care - Outpatient Up to a maximum lifetime benefit of $10,000 combined inpatient/outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	20%	40%
Outpatient Speech Therapy Limited to 20 visits per calendar year	$30 copay	40%
Outpatient Physical and Occupational Therapy *Limited to 60 visits per cal yr	$30 copay	40%
Spinal Manipulation Therapy Limited to 24 visits per calendar year	$30 copay	40%
Durable Medical Equipment Maximum annual benefit of $10,000 per member per calendar year	20%	40%
Diabetic Supplies	Covered same as any other medical expense.	Covered same as any other medical expense.
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	Not Covered	Not Covered
Transplants	20% Preferred coverage is provided at an IOE contracted facility only	40% Non-Preferred coverage is provided at a Non-IOE facility.
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	40%
Out of Area Employees & Dependents	Coverage provided at the non-preferred benefit level of the plan.	
FAMILY PLANNING	**PREFERRED CARE**	**NON-PREFERRED CARE**
Infertility Treatment Covers Basic Diagnosis and Treatment ONLY	Member cost sharing is based on the type of service performed and the place of service where it is rendered	40%
Voluntary Sterilization Including tubal ligation and vasectomy.	Not Covered	Not Covered
PHARMACY	**PREFERRED CARE**	**NON-PREFERRED CARE**
Retail	$10 copay for generic drugs, $20 copay for formulary brand-name drugs, and $35 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	40% of submitted cost after $10 copay for generic drugs, $20 copay for formulary brand-name drugs, and $35 copay for non-formulary brand-name drugs up to a 30 day supply.

Mail Order	$20 copay for generic drugs, $40 copay for formulary brand-name drugs, and $70 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not applicable

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

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

Plan Includes: Diabetic supplies.

Precert for growth hormones included

GENERAL PROVISIONS

Dependents Eligibility	Spouse, children & grandchildren from birth to age 25.
Pre-existing Conditions Rule	On effective date: Waived After effective date: Full Postponement

This plan imposes a pre-existing condition exclusion, which may be waived in some circumstances and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to this plan, you may have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received or for which the individual took prescribed drugs within 90 days.Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, 90 days ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. If you had prior creditable coverage within 90 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.

If you had no prior creditable coverage within the 90 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 90 day gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion. In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any certificates of creditable coverage you have.Please contact Aetna Member Services at 1-888-982-3862 if you need assistance in obtaining a certificate of creditable coverage from your prior carrier or if you have any questions on the information noted above. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days of birth, adoption, or placement for adoption. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment, and the pre-existing condition exclusion will be applied from the individual's effective date of coverage.

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.

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 limitation 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.