



PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE		NON-PREFERRED CARE	
Deductible (per calendar year)	\$500	Individual	\$1,000	Individual
	\$1,500	Family	\$3,000	Family

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.

Member Coinsurance	10%	50%
Applies to all expenses unless otherwise stated.		

Payment Limit (per calendar year)	\$2,000	Individual	Unlimited	Individual
	\$6,000	Family	Unlimited	Family

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	\$2,000,000 per member's lifetime.			
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Primary Care Physician Selection	Optional	Not applicable
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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
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PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE
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Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	50% after deductible
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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	Covered; 100%; deductible waived	50% after deductible
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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 of life; 1 exam per 12 months thereafter to age 18.

Routine Gynecological Care Exams	Covered 100%; deductible waived	50% after deductible
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Includes pap smear and related lab fees.

Routine Mammograms	Covered 100%; deductible waived	50% after deductible
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For covered females age 40 and over.

Routine Digital Rectal Exam / Prostate-specific Antigen Test	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
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For covered males age 40 and over.

Colorectal Cancer Screening	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
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For all members age 50 and over.

Routine Eye Exams	Covered 100%; deductible waived	Not Covered
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Limited to 1 routine eye exam every 24 months.

Routine Hearing Exams	Covered 100%; deductible waived	Not Covered
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Limited to 1 routine hearing exam every 24 months.

PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE
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Office Visits (non-surgical) to PCP	\$20 office visit copay; deductible waived	50% after deductible
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Includes services of an internist, general physician, family practitioner or pediatrician.



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Specialist Office Visits (non-surgical)	\$40 office visit copay; deductible waived	50% after deductible
Office Visits for Surgery	10% after deductible	50% after deductible
Maternity OB Visits	Covered same as Specialist Office Visit for initial visit only; thereafter covered 100%; deductible waived	50% after deductible
Allergy Testing	Covered same as Primary Care or Specialist office visit; deductible waived	50% after deductible
Allergy Injections (Copay waived when an office visit charge is not made)	Covered same as Primary Care or Specialist office visit; deductible waived when billed with an office visit. Copay waived when an office visit charge is not made.	50% after deductible

DIAGNOSTIC PROCEDURES	PREFERRED CARE	NON-PREFERRED CARE
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Diagnostic Laboratory and X-ray	Covered 100%; deductible waived	50% 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.

EMERGENCY MEDICAL CARE	PREFERRED CARE	NON-PREFERRED CARE
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Urgent Care Provider (benefit availability may vary by location)	\$50 copay then 10%; deductible waived	50% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room (copay waived if admitted to hospital)	\$100 copay then 10%; deductible waived. Includes charges billed separately by ER physician, ER surgeon, ER Anesthesiologies, ER Xray/Lab.	Same as preferred care.

Non-Emergency care in an Emergency Room	Not Covered	Not Covered
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Ambulance	10% after deductible	50% after deductible
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HOSPITAL CARE	PREFERRED CARE	NON-PREFERRED CARE
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Inpatient Coverage	\$250 per confinement copay, then 10% after deductible	\$500 per confinement deductible, then 50% 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	\$250 per confinement copay, then 10% after deductible	\$500 per confinement deductible, then 50% after deductible
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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.

Outpatient Surgery	10% after deductible	50% after deductible
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Outpatient Hospital Expenses (excluding surgery)	10% after deductible	50% 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	\$250 per confinement copay, then 10% after deductible	\$500 per confinement deductible, then 50% after deductible
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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.

Outpatient	\$40 office visit copay; deductible waived	50% after deductible
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The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.

ALCOHOL/DRUG ABUSE SERVICES	PREFERRED CARE	NON-PREFERRED CARE
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Inpatient	\$250 per confinement copay, then 10% after deductible	\$500 per confinement deductible, then 50% after deductible
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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.



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Outpatient	\$40 office visit copay; deductible waived	50% after deductible
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit.		
OTHER SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Convalescent Facility	10% after deductible	50% after deductible
Limited to 120 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Home Health Care	10% after deductible	50% after deductible
Limited to 75 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.		
Hospice Care - Inpatient	10% after deductible	50% after deductible
Limited to 30 days per lifetime. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	10% after deductible	50% after deductible
Up to a maximum benefit of \$7,500. The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Private Duty Nursing - Outpatient (Limited to 70 eight hour shifts per calendar year)	10% after deductible	50% after deductible
Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift. Each visiting nurse care or private duty nursing care shift of 4 hours or less counts as one home health visit. Each such shift of over 4 hours and up to 8 hours counts as two home health care visits.		
Outpatient Short-Term Rehabilitation	10% after deductible	50% after deductible
Include Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year.		
Spinal Manipulation Therapy	20%; deductible waived	20%; deductible waived
Limited to 20 visits per calendar year.		
Durable Medical Equipment	10% after deductible	50% after deductible
Maximum annual benefit of \$5,000 per member per calendar year.		
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)	10% (payable as any other covered expense)	50% (payable as any other covered expense)
Transplants	\$250 per confinement copay, then 10% after deductible. Preferred coverage is provided at an IOE contracted facility only	Not covered
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	50% after deductible
Out of Area Dependents	Coverage provided at 20%, all non-preferred benefits and limitations apply.	
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	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Diagnosis and treatment of the underlying medical condition.		
Voluntary Sterilization Including tubal ligation and vasectomy.	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered



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GENERAL PROVISIONS

Dependents Eligibility	Spouse, children from birth to age 19 or to age 25 if in school.
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Excluded amount is \$4,000

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. 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 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. All preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates.



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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.

Plans are provided by Aetna Life Insurance Company.