



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

<b>PLAN FEATURES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Deductible</b> (per contract year)	\$900 Individual \$1,800 Family	\$1,800 Individual \$3,600 Family
<p>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.</p>		
<b>Member Coinsurance</b>	20%	40%
<p>Applies to all expenses unless otherwise stated.</p>		
<b>Payment Limit</b> (per plan year)	\$4,650 Individual \$9,300 Family	\$9,300 Individual \$18,600 Family
<p>All covered expenses accumulate simultaneously toward both the preferred and non-preferred 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. Pharmacy expenses apply towards 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.</p>		
<b>Lifetime Maximum</b>	Unlimited except where otherwise indicated.	
<b>Primary Care Physician Selection</b>	Optional	Not Applicable
<b>Certification Requirements -</b>	<p>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 is required - excluded amount applied separately to each type of expense is \$400 per occurrence.</p>	
<b>Referral Requirement</b>	None	None
<b>PREVENTIVE CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Routine Adult Physical Exams/ Immunizations</b>	Covered 100%; deductible waived	40%; after deductible
<p>1 exam per calendar year up to age 65, 1 exam per calendar year age 65 and older</p>		
<b>Routine Well Child Exams/Immunizations</b>	Covered 100%; deductible waived	40%; after deductible
<p>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 calendar year thereafter to age 22.</p>		
<b>Routine Gynecological Care Exams</b>	Covered 100%; deductible waived	40%; after deductible
<p>Recommended: One exam per calendar year. Includes routine tests and related lab fees.</p>		
<b>Routine Mammograms</b>	Covered 100%; deductible waived	40%; after deductible
<p>Recommended: One per calendar year for covered females age 40 and over.</p>		
<b>Women's Health</b>	Covered 100%; deductible waived	40%; after deductible
<p>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.</p>		
<b>Routine Digital Rectal Exam</b>	Covered 100%; deductible waived	40%; after deductible
<p>Recommended: For covered males age 40 and over.</p>		



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<b>Prostate-specific Antigen Test</b> Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	40%; after deductible
<b>Colorectal Cancer Screening</b> Recommended: For all members age 50 and over.	Covered 100%; deductible waived	Covered under Routine Adult Exams
<b>Routine Hearing Screening</b>	Covered 100%; deductible waived	40%; after deductible
<b>PHYSICIAN SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Office Visits to Non-Specialist</b> Includes services of an internist, general physician, family practitioner or pediatrician.	20%; after deductible	40%; after deductible
<b>Specialist Office Visits</b>	20%; after deductible	40%; after deductible
<b>Pre-Natal Maternity</b>	Covered 100%; deductible waived	Covered according to standard claim practice.
<b>Walk-in Clinics</b> 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.	20%; after deductible	Not Covered
<b>Allergy Testing</b>	20%; after deductible	40%; after deductible
<b>Allergy Injections</b>	20%; after deductible	40%; after deductible
<b>DIAGNOSTIC PROCEDURES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Diagnostic X-ray</b> (other than Complex Imaging Services) 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.	20%; after deductible	40%; after deductible
<b>Diagnostic Laboratory</b> 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.	20%; after deductible	40%; after deductible
<b>Diagnostic Complex Imaging</b>	20%; after deductible	40%; after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Urgent Care Provider</b>	20%; after deductible	40%; after deductible
<b>Emergency Room</b> Copoly waived if admitted	20% after \$100 copay; after deductible	Same as in-network care
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered	Not Covered
<b>Emergency Use of Ambulance</b>	20%; deductible waived	Same as in-network care
<b>Non-Emergency Use of Ambulance</b>	20%; deductible waived	Same as in-network care
<b>HOSPITAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient Coverage</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible	40%; after deductible
<b>Inpatient Maternity Coverage</b> (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible	40%; after deductible
<b>Outpatient Hospital Expenses</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	40%; after deductible
<b>Outpatient Surgery</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	40%; after deductible



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<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible	40%; after deductible
<b>Outpatient</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	40%; after deductible
<b>SUBSTANCE ABUSE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible	40%; after deductible
<b>Residential Treatment Facility</b>	20%; after deductible	40%; after deductible
<b>Outpatient</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	40%; after deductible
<b>OTHER SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Skilled Nursing Facility</b> Limited to 120 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible	40%; after deductible
<b>Home Health Care</b> Limited to 60 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.	20%; after deductible	40%; after deductible
<b>Hospice Care - Inpatient</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible	40%; after deductible
<b>Hospice Care - Outpatient</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	40%; after deductible
<b>Private Duty Nursing</b>	Not Covered	Not Covered
<b>Outpatient Short-Term Rehabilitation</b> Includes speech, physical, occupational therapy; limited to 60 visits per calendar year	20%; after deductible	40%; after deductible
<b>Spinal Manipulation Therapy</b> Limited to 36 visits per calendar year.	20%; after deductible	40%; after deductible
<b>Durable Medical Equipment</b>	20%; after deductible	40%; after deductible
<b>Diabetic Supplies</b>	Covered same as any other medical expense.	Covered same as any other medical expense.
<b>Generic FDA-approved Women's Contraceptives</b>	Covered 100%; deductible waived	40%; after deductible
<b>Contraceptive drugs and devices not obtainable at a pharmacy</b>	Covered 100%; deductible waived	Covered same as any other medical expense.
<b>Transplants</b>	20%; after deductible Preferred coverage is provided at an IOE contracted facility only.	Not Covered
<b>Bariatric Surgery</b>	Not Covered	Not Covered
<b>Temporomandibular Joint Disorder (medical in nature only)</b>	20%; after deductible	40%; after deductible
<b>Mouth, Jaws and Teeth</b> (oral surgery procedures, whether medical or dental in nature)	20%; after deductible	40%; after deductible
<b>FAMILY PLANNING</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Infertility Treatment</b> Diagnosis and treatment of the underlying medical condition only.	20%; after deductible	40%; after deductible



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<b>Comprehensive Infertility Services</b>	Not Covered	Not Covered
<b>Advanced Reproductive Technology (ART)</b>	Not Covered	Not Covered
<b>Vasectomy</b>	20%; after deductible	40%; after deductible
<b>Tubal Ligation</b>	Covered 100%; deductible waived	40%; after deductible
<b>PHARMACY</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Pharmacy Plan Type</b>	Aetna Premier Plus Open Formulary	
<b>Generic Drugs</b>		
	<b>Retail</b> \$10 copay	20% of submitted cost; after applicable copay
	<b>Mail Order</b> \$25 copay	Not Applicable
<b>Preferred Brand-Name Drugs</b>		
	<b>Retail</b> \$45 copay	20% of submitted cost; after applicable copay
	<b>Mail Order</b> \$112.50 copay	Not Applicable
<b>Non-Preferred Brand-Name Drugs</b>		
	<b>Retail</b> \$75 copay	20% of submitted cost; after applicable copay
	<b>Mail Order</b> \$187.50 copay	Not Applicable
<b>Pharmacy Day Supply and Requirements</b>		
	<b>Retail</b> Up to a 30 day supply	
	<b>Mail Order</b> Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
	<b>Premier Plus Specialty</b> Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred Aetna Specialty Pharmacy network.	

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

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

A limited list of over-the-counter medications are covered when filled with a prescription.

Performance Enhancing Drugs limited to 6 tablets per month.

Oral Fertility drugs included

Premier Plus Pre-certification included

Premier Plus Step Therapy included

One transition fill allowed within 90 days of member's effective date

Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.

Attachment E drugs covered

**GENERAL PROVISIONS**

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

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.



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- 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.

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 traducción 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**.

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