



PLAN DESIGN & BENEFITS
ADMINISTERED BY AENTA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE
Deductible (per calendar year)	None
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%
Payment Limit (per calendar year)	None
Lifetime Maximum	Unlimited
Primary Care Physician Selection	Optional; if selected must be a Preferred Provider
Referral Requirement	None
PREVENTATIVE CARE	PREFERRED CARE
Routine Adult Physical Exams/Immunizations 1 exam per 12 months for members age 22 and older.	Covered 100%
Routine Well Child Exams/Immunizations 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.	Covered 100%
Routine Gynecological Care Exams Includes routine tests and related lab fees	Covered 100%
Routine Mammograms For covered females age 40 and over.	Covered 100%
Routine Digital Rectal Exam/Prostate-specific Antigen Test For covered males age 40 and over.	Covered 100%
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%
Routine Eye Exams 1 routine exam per 24 months	\$20 office visit copay
Routine Hearing Exams 1 routine exam per 24 months	\$20 office visit copay
PHYSICIAN SERVICES	PREFERRED CARE
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	\$10 office visit copay
Specialist Office Visits	\$20 office visit copay
Allergy Testing	\$10 office visit copay
Allergy Injections	\$10 office visit copay
DIAGNOSTIC PROCEDURES	PREFERRED CARE
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	Covered 100%
Diagnostic X-ray and Complex Imaging Services	\$10 copay
EMERGENCY MEDICAL CARE	PREFERRED CARE
Urgent Care Provider (benefit availability may vary by location)	\$25 copay
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	\$50 copay; waived if admitted
Ambulance	Covered 100%
HOSPITAL CARE	PREFERRED CARE
Inpatient Coverage	Covered 100%
Inpatient Maternity Coverage	Covered 100%
Outpatient Surgery	Covered 100%
Outpatient Hospital Expenses (excluding surgery)	Covered 100%

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MENTAL HEALTH SERVICES		PREFERRED CARE
Inpatient		Covered 100%
Outpatient		\$20 copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
ALCOHOL/DRUG ABUSE SERVICES		PREFERRED CARE
Inpatient		Covered 100%
Outpatient		\$20 copay
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
OTHER SERVICES		PREFERRED CARE
Convalescent Facility		Covered 100%
Limited to 120 days per calendar year.		
Home Health Care		Covered 100%
Limited to 100 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		Covered 100%
Hospice Care – Outpatient		Covered 100%
Private Duty Nursing – Outpatient (Limited to 70 eight hour shifts per calendar year)		Covered 100%
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 count as one home health visit. Each such shift of over 4 hours and up to 8 hours counts as two home health care visits.		
Private Duty Nursing – Inpatient		Not Covered
Outpatient Short-Term Rehabilitation		Covered 80%
Include Cognitive, Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year.		
Spinal Manipulation Therapy		Not Covered
Chemotherapy, Radiation Therapy, Dialysis, Cardiac Therapy and Respiratory Therapy		Member cost sharing is based on the type of service performed and the place of service where it is rendered
Durable Medical Equipment		Covered 80%
Diabetic Supplies		Covered same as any other medical expense.
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)		Covered 100% (payable as any other covered expense)
Transplants Coverage is only provided at an IOE contracted facility only.		Covered 100%
Bariatric		Covered 100%
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
Out of Area Dependents		No coverage for non-emergency care received outside the service area.
FAMILY PLANNING		PREFERRED CARE
Infertility Treatment		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		Covered 100%
Including tubal ligation and vasectomy		
GENERAL PROVISIONS		
Dependents Eligibility		Spouse, Domestic Partner, children from birth to age 26
Pre-existing Conditions Exclusion		On effective date: Waived After effective date: Waived

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For members age 19 or over 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.

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 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

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. They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are administered by Aetna Life Insurance Company.