PLAN DESIGN AND BENEFITS - CT HNOption 30/45 / 30/45 A 51+

PLAN FEATURES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Deductible (per calendar year)	Not Applicable	$3,000 Individual $6,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. All covered expenses accumulate separately toward the participating and non-participating Deductible. Member cost sharing for certain services including member cost sharing for prescription drugs, as indicated in the plan, are excluded from charges to meet the Deductible. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. No one family member may contribute more than the Individual Deductible amount to the Family Deductible.		
Member Coinsurance	Not Applicable	30% after deductible
Out-of-Pocket Maximum (per calendar year, includes deductible)	$2,500 Individual $5,000 Family	$6,000 Individual $12,000 Family
Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. All covered expenses accumulate separately toward the participating and non-participating Out-of-Pocket Maximum. Once the Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year. No one family member may contribute more than the Individual Out-of-Pocket Maximum amount to the Family Out-of-Pocket Maximum. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles and copays (not including any prescription drug copays or penalty amounts) may be used to satisfy the Out-of-Pocket Maximum. Members must continue to pay any prescription drug copays and penalty amounts after meeting their Out-of-Pocket Maximum.		
Health Incentive Credit Program	Incentive Rewards will be credited towards the deductible and Out-of-Pocket Maximum.	
Wellness Programs through Simple Steps Reward	Simple Steps Health Assessment and one Online Wellness Program $50.00 per employee and/or spouse with a family limit of $100.00 per year for completion of the Health Assessment and one Online Wellness Program.	
Lifetime Maximum	Unlimited	Unlimited
Payment for services from a Non-Participating Provider*	Not Applicable	Professional: 110% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Not Required	Not Applicable
Precertification Requirement Certain non-participating provider services require precertification or benefits will be reduced. Refer to your plan documents for a complete list of services that require precertification.		
Referral Requirement	None	None
PHYSICIAN SERVICES	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Primary Care Physician Visits	$30 copay	30% after deductible
Specialist Office Visits	$45 copay	30% after deductible
Pre-Natal Maternity	$0 copay	30% after deductible
Allergy Treatment	Same as applicable participating provider office visit member cost sharing	30% after deductible
Allergy Testing	Same as applicable participating provider office visit member cost sharing	30% after deductible

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PREVENTIVE CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Routine Adult Physical Exams / Immunizations 1 exam per 12 months Participating and Non-Participating combined	$0 copay	Not Covered / 30%; deductible waived
Well Child Exams / Immunizations 7 exams in the first 12 months of life; 3 visits in the second 12 months of life; 3 visits in the third 12 months of life; 1 exam per 12 months thereafter to age 18 Participating and Non-Participating combined	$0 copay	30% after deductible / 30%; deductible waived
Routine Gynecological Exams One routine exam per calendar year Participating and Non-Participating combined	$0 copay	30%; deductible waived
Routine Mammograms One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over Participating and Non-Participating combined	$0 copay	30% after deductible
Women's Health Includes: Pre-natal maternity, 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 and counseling; limited to 2 visits	$0 copay	30% after deductible
Routine Digital Rectal Exams / Prostate Specific Antigen Test One exam every 12 months for all males ages 50 and over and males under 50 who are symptomatic and/or whose biological father/brother has been diagnosed w/ prostate cancer Participating and Non-Participating combined	$0 copay	30% after deductible
Routine (or Preventive) Colorectal Cancer Screening For all members age 50 and over. Sigmoidoscopy and Double Contrast Barium Enema (DCBE) - 1 every 5 years for all members age 50 and over Colonoscopy - 1 every 10 years for all members age 50 and over Fecal Occult Blood Testing (FOBT) - 1 every year for all members age 50 and over Participating and Non-Participating combined	$0 copay	30% after deductible

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PREVENTIVE CARE, cont.	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Routine Eye Exams at Specialist One exam every 24 months Participating and Non-Participating combined	$0 copay	Not Covered
Routine Hearing Screening at PCP	Covered as part of a routine physical exam	Covered as part of a routine physical exam
DIAGNOSTIC PROCEDURES	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Diagnostic Laboratory If performed as a part of a physician's office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing	$0 copay	30% after deductible
Diagnostic X-ray except for Complex Imaging Services Outpatient hospital or other outpatient facility	$45 copay	30% after deductible
Diagnostic X-ray for Complex Imaging Services Including, but not limited to, MRI, MRA, PET and CT Scans	$75 copay per test up to a combined maximum of $375 per calendar year	30% after deductible
EMERGENCY MEDICAL CARE	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Urgent Care Provider	$75 copay	30% after deductible
Non-Urgent use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	$150 copay	Refer to participating provider benefit
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Emergency Ambulance	$0 copay	Refer to participating provider benefit
Non-Emergency Ambulance	$0 copay	30% after deductible
HOSPITAL CARE	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Inpatient Coverage Including maternity & transplants Coverage is provided at an IOE contracted facility only	$500 copay per day up to $2,000 per admission	30% after deductible
Outpatient Surgery Provided in an outpatient hospital department	$500 copay	30% after deductible
Outpatient Surgery Provided in a freestanding surgical facility	$250 copay	30% after deductible
MENTAL HEALTH SERVICES	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Inpatient	$500 copay per day up to $2,000 per admission	30% after deductible
Outpatient	$45 copay	30% after deductible
ALCOHOL/DRUG ABUSE SERVICES	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Inpatient Detoxification	$500 copay per day up to $2,000 per admission	30% after deductible
Outpatient Detoxification	$45 copay	30% after deductible
Inpatient Rehabilitation	$500 copay per day up to $2,000 per admission	30% after deductible
Outpatient Rehabilitation	$45 copay	30% after deductible

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OTHER SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Skilled Nursing Facility Limited to 30 days per member per calendar year Participating and Non-Participating combined	$500 copay per day up to $2,000 per admission	30% after deductible
Home Health Care Limited to 80 visits per member per calendar year; 1 visit equals a period of 4 hours or less Participating and Non-Participating combined	$25 copay	25%; deductible waived
Inpatient Hospice Care	$500 copay per day up to $2,000 per admission	30% after deductible
Outpatient Hospice Care	$45 copay	30% after deductible
Private Duty Nursing	Not Covered	Not Covered
Outpatient Rehabilitation Therapy Includes speech, physical and occupational therapy Limited to 20 combined visits per calendar year Participating and Non-Participating combined	$45 copay	30% after deductible
Chiropractic Limited to 20 visits per member per calendar year Participating and Non-Participating combined	$10 copay	25% after deductible
Durable Medical Equipment	50%	50% after deductible
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	Covered same as any other medical expense.	Covered same as any other medical expense.
Generic FDA-approved Women's Contraceptives: Female Condoms, Spermicides, Sponges and Emergency Contraception	$0 copay	30% after deductible
FAMILY PLANNING	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Infertility Treatment Coverage for only the diagnosis and surgical treatment of the underlying medical cause	Member cost sharing is based on the type of service performed and the place rendered	30% after deductible
Comprehensive Infertility Services For a covered person who is under age 40 and unable to conceive or produce conception, or sustain a successful pregnancy during a one year period. Coverage includes the following: • 3 courses of treatment for Artificial Insemination (AI) per lifetime • 4 courses of treatment of Ovulation Induction (OI) per lifetime	Member cost sharing is based on the type of service performed and the place rendered	30% after deductible

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FAMILY PLANNING, cont.	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Advanced Reproductive Technology (ART) For a covered person who is under age 40 and unable to conceive or produce conception, or sustain a successful pregnancy during a one year period. Coverage includes the following: • 2 cycles with not more than 2 embryos per cycle of ART treatments (IVF, GIFT, ZIFT, low tubal ovum transfer) combined per lifetime	Member cost sharing is based on the type of service performed and the place rendered	30% after deductible
Tubal ligation	$0 copay	30% after deductible
Vasectomy	Member cost sharing is based on the type of service performed and the place rendered	30% after deductible
PHARMACY-PRESCRIPTION DRUG BENEFITS	**PARTICIPATING PHARMACIES**	**NON-PARTICIPATING PHARMACIES**
Prescription Drugs: Up to a 30-day supply at participating pharmacies	$15 copay for generic formulary drugs, $25 copay for brand name formulary drugs, and $40 copay for generic and brand name non-formulary drugs	Not Covered
Retail or Mail Order: 31-90 day supply at participating pharmacies	$30 copay for generic formulary drugs, $50 copay for brand name formulary drugs, and $80 copay for generic and brand name non-formulary drugs	Not Covered
Specialty CareRx℠ Drugs	20% for generic formulary, brand name formulary and generic and brand name non-formulary drugs to a $250 per script maximum for up to a 30 day supply and $500 per script maximum for a 31-90 day supply	Not Covered
Mandatory Generic (MG) - If the member or the physician requests brand when generic is available, the member pays the applicable copay or coinsurance plus the difference between the generic price and the brand price.		
Plan Includes: Specialty CareRX Drugs and diabetic supplies obtainable from a pharmacy. Formulary generic FDA-approved Women's Contraceptives, certain brand formulary contraceptives when approved, female condoms, spermicides, sponges and emergency contraception covered 100% in network.		
Precertification and Step Therapy included and 90 day Transition of Care (TOC) for Precertification and Step Therapy included.		

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*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 Aetna pays 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 Aetna 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, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount. When you choose out-of-network care, Aetna "recognizes" an amount based on what Medicare pays for these services. The government sets the Medicare rate.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna plan "recognizes." Your doctor may bill you for the dollar amount that Aetna doesn'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 Aetna.com. Type "how Aetna pays" in the search box.

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 Aetna 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 and you should contact Aetna 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.

What's Not Covered

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**.

- All medical or hospital services not specifically covered in, or which are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates.
- Cosmetic surgery.
- Custodial care.
- Dental care and 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).
- Home births.
- Immunizations for travel or work.
- Implantable drugs and certain injectible drugs.
- Nonmedically necessary services or supplies.
- Orthotics.
- Over-the-counter medications and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.

- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered in the plan documents.
- 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, exercises 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 existence of comorbid conditions.

This material is for informational purposes only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Plan features and availability may vary by location and group size. Not all heath services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. With the exception of Aetna Rx Home Delivery, Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does 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.

If your plan covers outpatient prescription drugs, your plan may include a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally not limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step-therapy, please refer to Aetna's website at Aetna.com, or the Aetna Medication Formulary Guide. 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. In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage.

Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna, Inc., that is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated charge with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group subsidiary companies.

For more information about Aetna plans, refer to **www.aetna.com**.