PLAN DESIGN AND BENEFITS - CT Traditional Choice (TC) 1-10/10 HSA Compatible

PLAN FEATURES	MEMBER COST SHARE
Deductible (per calendar year)	$3,000 Individual $6,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. The Individual Deductible can only be met when a member is enrolled for self only coverage with no dependent coverage. The Family Deductible can be met by a combination of family members or by any single individual within the family. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.	
Member Coinsurance (applies to all expenses unless otherwise stated)	20% after deductible
Maximum Out-of-Pocket Limit (per calendar year, excludes deductible)	$2,950 Individual $5,900 Family
Only those expenses resulting from the application of coinsurance percentage, copays, including prescription drug copays, (except any penalty amounts) may be used to satisfy the Maximum Out-of-Pocket Limit. The Individual Maximum Out-of-Pocket Limit can only be met when a member is enrolled for self only coverage with no dependent coverage. The Family Maximum Out-of-Pocket Limit can be met by a combination of family members or by any single individual within the family. Once the Family Maximum Out-of-Pocket Limit is met, all family members will be considered as having met their Maximum Out-of-Pocket Limit for the remainder of the calendar year.	
Lifetime Maximum	Unlimited
Provider Payment	Usual & Customary*
Primary Care Physician Selection	Not Applicable
Certification Requirements Certification for certain types of 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, and Hospice Care is required. Benefits will be reduced by 50% up to a maximum of $400 per service or supply if Certification is not obtained.	
Referral Requirement	None
PHYSICIAN SERVICES	**MEMBER COST SHARE**
Office Visits to Non-Specialist 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	20% after deductible
Specialist Office Visits	20% after deductible
Maternity OB Visits	20% after deductible
Surgery (in office)	20% after deductible
Allergy Testing (given by a physician)	20% after deductible
Allergy Injections (not given by a physician)	20% after deductible
PREVENTIVE CARE	**MEMBER COST SHARE**
Routine Adult Physical Exams / Immunizations Ages 19-65: One exam every 24 months Ages 65 and over: One exam every 12 months	$0 copay; deductible waived
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 12 months thereafter to age 18	$0 copay; deductible waived

PLAN DESIGN AND BENEFITS - CT Traditional Choice (TC) 1-10/10 HSA Compatible

PREVENTIVE CARE, cont.	MEMBER COST SHARE
Routine Gynecological Care Exams One routine exam per calendar year	$0 copay; deductible waived
Routine Mammograms One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over	$0 copay; deductible waived
Routine Digital Rectal Exam / Prostate Specific Antigen Test One exam every 12 months for all males ages 50 and over & males under 50 who are symptomatic and/or whose biological father/brother has been diagnosed with prostate cancer	$0 copay; deductible waived
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	$0 copay; deductible waived
Routine Eye Exams at Specialist One routine exam every 24 months	$0 copay; deductible waived
Routine Hearing Exams at Specialist	Not Covered
DIAGNOSTIC PROCEDURES	**MEMBER COST SHARE**
Outpatient Diagnostic Laboratory and X-ray except for Complex Imaging Services 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.	20% after deductible
Outpatient Diagnostic X-ray for Complex Imaging Services Including, but not limited to, MRI, MRA, PET and CT Scans	20% after deductible
EMERGENCY MEDICAL CARE	**MEMBER COST SHARE**
Urgent Care Provider	20% after deductible
Non-Urgent use of Urgent Care Provider	Not Covered
Emergency Room	20% after deductible
Non-Emergency care in an Emergency Room	Not Covered
Emergency Ambulance	20% after deductible
Non-Emergency Ambulance	20% after deductible

PLAN DESIGN AND BENEFITS - CT Traditional Choice (TC) 1-10/10 HSA Compatible

HOSPITAL CARE	MEMBER COST SHARE
Inpatient Coverage Including maternity & transplants	20% after deductible
Outpatient Surgery Provided in an outpatient hospital department or a freestanding surgical facility	20% after deductible
Outpatient Hospital Services other than Surgery Including, but not limited to, physical therapy, speech therapy, occupational therapy, spinal manipulation, dialysis, radiation therapy and infusion therapy	20% after deductible
MENTAL HEALTH SERVICES	**MEMBER COST SHARE**
Inpatient	20% after deductible
Outpatient	20% after deductible
ALCOHOL/DRUG ABUSE SERVICES	**MEMBER COST SHARE**
Inpatient Detoxification	20% after deductible
Outpatient Detoxification	20% after deductible
Inpatient Rehabilitation	20% after deductible
Outpatient Rehabilitation	20% after deductible
OTHER SERVICES	**MEMBER COST SHARE**
Skilled Nursing Facility Limited to 30 days per member per calendar year	20% after deductible
Home Health Care Limited to 80 visits per member per calendar year	20% after deductible
Inpatient Hospice Care	20% after deductible
Outpatient Hospice Care	20% after deductible
Private Duty Nursing - Outpatient	Not Covered
Outpatient Short-Term Rehabilitation Includes speech, physical and occupational therapy (if provided in the outpatient hospital department, paid under outpatient hospital benefit) Limited to 20 combined visits per member per calendar year	20% after deductible
Spinal Manipulation Therapy (Chiropractic) (if provided in the outpatient hospital department, paid under outpatient hospital benefit) Limited to 20 visits per member per calendar year	20% after deductible
Durable Medical Equipment Maximum benefit of $1,000 per member per calendar year	50% after deductible

PLAN DESIGN AND BENEFITS - CT Traditional Choice (TC) 1-10/10 HSA Compatible

FAMILY PLANNING	MEMBER COST SHARE
Infertility Treatment Covered only for the diagnosis and treatment of the underlying medical condition	Member cost sharing is based on the type of service performed and the place rendered
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
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
Voluntary Sterilization Including tubal ligation and vasectomy	Member cost sharing is based on the type of service performed and the place rendered
PHARMACY-PRESCRIPTION DRUG BENEFITS	**MEMBER COST SHARE**
Prescription calendar year deductible Must be satisfied before any prescription drug benefits are paid	Integrated with Medical plan
Retail Up to a 30-day supply	After Integrated Medical/Pharmacy deductible is met, $10 copay for generic drugs, $25 copay for brand name formulary drugs, and $40 copay for brand name non-formulary drugs
Mail Order Delivery 31-90 day supply	After Integrated Medical/Pharmacy deductible is met, $20 copay for generic drugs, $50 copay for brand name formulary drugs, and $80 copay for brand name non-formulary drugs
Specialty CareRx^{SM} Drugs	After Integrated Medical/Pharmacy deductible is met, 20% for generic, brand name formulary and brand name non-formulary drugs
Mandatory Generic (MG) - If the member or the physician requests brand when generic is available, the member pays the applicable coinsurance plus the difference between the generic price and brand price.	
Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy and diabetic supplies obtainable from a pharmacy	
Precertification included and 90 day Transition of Care (TOC) for Precertification included.	

*Payment for care is determined based upon the lowest of: the provider's usual charge for furnishing it or the charge Aetna determines to be appropriate based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made. These charges are referred to in your plan as "reasonable" or "recognized" charges.

PLAN DESIGN AND BENEFITS - CT Traditional Choice (TC) 1-10/10 HSA Compatible

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;
- 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;
- Immunizations for travel or work;
- 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, counseling and prescription drugs;
- Special duty nursing; and
- Treatment of those services for or related to treatment of obesity or for diet or weight control.

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.

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). Member is responsible for obtaining precertification for certain services. Precertification requirements may vary.

PLAN DESIGN AND BENEFITS - CT Traditional Choice (TC) 1-10/10 HSA Compatible

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 manufactures 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.

Plans are provided by Aetna Life Insurance Company.

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