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PLAN FEATURES	NETWORK CARE	OUT-OF-NETWORK CARE
Deductible (per calendar year)	$3,000 Individual $6,000 Family	$5,000 Individual $10,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. All covered expenses accumulate separately toward the network and out-of-network 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	10% after deductible	30% after deductible
Maximum Out-of-Pocket Limit (per calendar year, includes deductible)	$4,500 Individual $9,000 Family	$10,000 Individual $20,000 Family
Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. All covered expenses accumulate separately toward the network and out-of-network Maximum Out-of-Pocket Limit. 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. No one family member may contribute more than the Individual Maximum Out-of-Pocket Limit amount to the Family Maximum Out-of-Pocket Limit. Only those out-of-network expenses resulting from the application of coinsurance percentage and deductibles (not including any copays, prescription drug copays or penalty amounts) may be used to satisfy the Maximum Out-of-Pocket Limit.		
Health Incentive Credit Program Wellness Programs through Simple Steps Reward	Incentive Rewards will be credited towards the deductible and Out-of-Pocket Limit. 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 Out-of-Network Care*	Not Applicable	Professional: 110% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Not Applicable	Not Applicable
Certification Requirements Certification for certain types of Out-of-Network 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	None

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PHYSICIAN SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
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	$25 copay; deductible waived	30% after deductible
Specialist Office Visits	$40 copay; deductible waived	30% after deductible
Pre-Natal Maternity	$0 copay; deductible waived	30% after deductible
Surgery (in office)	10% after deductible	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
PREVENTIVE CARE	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Routine Adult Physical Exams / Immunizations One exam every 12 months Network and Out-of-Network combined	$0 copay; deductible waived	30% after deductible / 30%; 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 Network and Out-of-Network combined	$0 copay; deductible waived	30% after deductible / 30%; deductible waived
Routine Gynecological Exams One routine exam per calendar year Network and Out-of-Network combined	$0 copay; deductible waived	30%; deductible waived
Routine Mammograms One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over Network and Out-of-Network combined	$0 copay; deductible waived	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; deductible waived	30% after deductible

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PREVENTIVE CARE, cont.	NETWORK CARE	OUT-OF-NETWORK CARE
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 Network and Out-of-Network combined	$0 copay; deductible waived	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 Network and Out-of-Network combined	$0 copay; deductible waived	30% after deductible
Routine Eye Exams at Specialist One routine exam per 24 months Network and Out-of-Network combined	$0 copay; deductible waived	30% after deductible
Routine Hearing Exams	Not Covered	Not Covered
DIAGNOSTIC PROCEDURES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
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. If performed in the outpatient hospital department, payable under outpatient hospital benefit.	10% after deductible	30% after deductible
Outpatient Diagnostic X-ray for Complex Imaging Services Including, but not limited to, MRI, MRA, PET and CT Scans	10% after deductible	30% after deductible
EMERGENCY MEDICAL CARE	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Urgent Care Provider	$75 copay; deductible waived	30% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	$150 copay; deductible waived	Paid as Network Care
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Emergency Ambulance	10% after deductible	Paid as Network Care
Non-Emergency Ambulance	10% after deductible	30% after deductible

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HOSPITAL CARE	NETWORK CARE	OUT-OF-NETWORK CARE
Inpatient Coverage Including maternity & transplants If transplant is performed through an Institute of Excellence™ facility, benefits would be paid at the network level. If procedure is not performed through an Institute of Excellence™ facility, benefits would be paid at the out-of-network level	10% after deductible	30% after deductible
Outpatient Surgery Provided in an outpatient hospital department or a freestanding surgical facility	10% after deductible	30% after deductible
MENTAL HEALTH SERVICES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Inpatient	10% after deductible	30% after deductible
Outpatient	$40 copay; deductible waived	30% after deductible
ALCOHOL/DRUG ABUSE SERVICES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Inpatient Detoxification	10% after deductible	30% after deductible
Outpatient Detoxification	$40 copay; deductible waived	30% after deductible
Inpatient Rehabilitation	10% after deductible	30% after deductible
Outpatient Rehabilitation	$40 copay; deductible waived	30% after deductible
OTHER SERVICES AND PLAN DETAILS	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Skilled Nursing Facility Limited to 30 days per member per calendar year Network and Out-of-Network combined	10% after deductible	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 Network and Out-of-Network combined	10%; deductible waived	25%; deductible waived
Inpatient Hospice Care	10% after deductible	30% after deductible
Outpatient Hospice Care	10% after deductible	30% after deductible
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Outpatient Short-Term Rehabilitation Includes speech, physical and occupational therapy Limited to 20 combined visits per member per calendar year Network and Out-of-Network combined	10% after deductible	30% after deductible
Outpatient Spinal Manipulation Therapy (Chiropractic) Limited to 20 visits per member per calendar year Network and Out-of-Network combined	$10 copay; deductible waived	25% after deductible
Durable Medical Equipment	50% after deductible	50% after deductible

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OTHER SERVICES AND PLAN DETAILS, cont.	NETWORK CARE	OUT-OF-NETWORK CARE
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; deductible waived	30% after deductible
FAMILY PLANNING	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
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	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
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; deductible waived	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	20% of submitted cost after $15 copay for generic formulary drugs, $25 copay for brand name formulary drugs, and $40 copay for generic and brand name non-formulary drugs
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

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PHARMACY-PRESCRIPTION DRUG BENEFITS. cont.	PARTICIPATING PHARMACIES	NON-PARTICIPATING PHARMACIES
Specialty CareRx[SM] 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	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
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.		

*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 no 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;
- 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.

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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. Precertification requirements may vary.

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.

Plans are provided by Aetna Life Insurance Company.

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

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