

PLAN DESIGN AND BENEFITS
PPO HDHP \$2,650 80/50
(HSA Compatible)

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	\$2,650 Individual, \$5,300 Family	\$2,650 Individual, \$5,300 Family
All covered expenses accumulate separately toward the preferred and non-preferred Deductible. Unless otherwise indicated, the Deductible must be met prior to benefits being payable (including prescription drugs). 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	20%	50%
Payment Limit (per calendar year) (includes deductible)	\$5,100 Individual, \$10,200 family	\$5,100 Individual, \$10,200 family
All covered expenses (including RX) accumulate separately toward the Preferred and Non-Preferred Payment Limit. Certain Member cost sharing elements may not apply towards the Payment Limit. Once the Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year.		
Lifetime Maximum	\$2,000,000 per member lifetime	
Payment for Non-Preferred Care	Not Applicable	Recognized Amount*
Primary Care Physician Selection	Not Applicable	Not Applicable
Referral Requirement	None	None
Precertification Requirements – Precertification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Precertification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care and Hospice Care is required. Benefits will be reduced by \$400 per occurrence if Precertification is not obtained.		
PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE
Routine Adult Physical Exams / Immunizations Age and Frequency schedules apply.	\$20 copay; deductible waived	50% after deductible per visit
Well Child Exams / Immunizations Age and Frequency schedules apply.	\$20 copay; deductible waived	50% after deductible per visit
Routine Gynecological Care Exams Includes Pap smear and related lab fees. One Routines exam per 365 days.	\$20 copay; deductible waived	50% after deductible per visit
Routine Mammograms One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over.	\$20 copay; deductible waived	50% after deductible per visit
Routine Digital Rectal Exam / Prostate Specific Antigen Test For covered males age 40 and over.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	50% after deductible per visit
Colorectal Cancer Screening For all members age 50 and over.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	50% after deductible per visit
Routine Eye Exams	Not covered (except as part of physical)	Not covered (except as part of physical)
Routine Hearing Exams	Not covered (except as part of physical)	Not covered (except as part of physical)
PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Office Visits to Non-Specialists 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 per visit	50% after deductible per visit
Specialist Office Visits	20% after deductible per visit	50% after deductible per visit
Maternity OB Visit	20% after deductible per visit	50% after deductible per visit
Allergy Testing (given by a physician)	20% after deductible per visit	50% after deductible per visit
Allergy Injections (not given by a physician)	20% after deductible per visit	50% after deductible per visit

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DIAGNOSTIC PROCEDURES	PREFERRED CARE	NON-PREFERRED CARE
Outpatient Diagnostic Laboratory and X-ray - (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 per visit	50% after deductible per visit
Outpatient Diagnostic X-ray for Complex Imaging Services (including, but not limited to, MRI, CAT, MI/MRS and PET Scans)	30% after deductible per visit	50% after deductible per visit
EMERGENCY MEDICAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Urgent Care Provider	20% after deductible per visit	20% after deductible per visit
Non-Urgent Use of Urgent Care Provider	Not covered	No benefit is provided
Emergency Room	20% after \$100 copay after deductible per visit	20% after \$100 copay after deductible per visit
Non-Emergency Care in an Emergency Room	Not covered	No benefit is provided
Ambulance	20% after deductible per visit	20% after deductible per visit
HOSPITAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Coverage (including maternity)	20% after deductible per admission	50% after deductible per admission
Outpatient Surgery Performed at a Hospital Outpatient Facility	30% after deductible per surgery	50% after deductible per surgery
Outpatient Surgery Performed at a Facility other than a Hospital Outpatient Facility	20% after deductible per surgery	50% after deductible per surgery
MENTAL HEALTH SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient – Limited to 15 days per calendar year. Preferred and Non-Preferred combined.	50% after deductible per admission	50% after deductible per admission
Outpatient – Limited to 20 visits per member per calendar year. Preferred and Non-Preferred combined.	50% after deductible per visit	50% after deductible per visit
ALCOHOL/DRUG ABUSE SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Detoxification - Limited to 3 days per admission, 2 admissions per Lifetime. Preferred and Non-Preferred combined.	50% after deductible per admission	No benefit is provided
Outpatient Detoxification	Not covered	No benefit is provided
OTHER SERVICES AND PLAN DETAILS	PREFERRED CARE	NON-PREFERRED CARE
Convalescent Facility Limited to 30-days per calendar year. Preferred and Non-Preferred combined.	20% after deductible per admission	50% after deductible per admission
Home Health Care	20% after deductible per visit	50% after deductible per visit
Hospice Care – Inpatient Limited to 30-days per member per calendar year. Preferred and Non-Preferred combined.	20% after deductible per admission	50% after deductible per admission
Hospice Care – Outpatient Limited to 60-visits per member per calendar year. Preferred and Non-Preferred combined.	20% after deductible per visit	50% after deductible per visit
Private Duty Nursing – Outpatient	Not covered	No benefit is provided
Outpatient Speech Therapy Limited to 20 visits per member per calendar year. Preferred and Non-Preferred combined.	20% after deductible per visit	50% after deductible per visit
Outpatient Physical and Occupational Therapy Limited to 20 visits per member per calendar year PT & OT combined. Preferred and Non-Preferred combined.	20% after deductible per visit	50% after deductible per visit
Spinal Manipulation Therapy	20% after deductible per visit	50% after deductible per visit
Durable Medical Equipment Maximum benefit of \$2,500 per member per calendar year. Preferred	20% after deductible per visit	50% after deductible per visit

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and Non-Preferred combined.

Transplants	20% after deductible per admission	50% after deductible
FAMILY PLANNING	PREFERRED CARE	NON-PREFERRED CARE
Infertility Treatment Coverage only for the diagnosis and treatment of the underlying medical condition.	20% after deductible	50% after deductible
Voluntary Sterilization Including tubal ligation and vasectomy.	20% after deductible	50% after deductible
PHARMACY – PRESCRIPTION DRUG BENEFITS	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
Retail Up to a 30 day supply	\$20 copay for generic formulary and non-formulary drugs, \$40 copay for brand formulary drugs, and \$60 copay for non-formulary drugs	\$20 copay for generic formulary and non-formulary drugs, \$40 copay for brand formulary drugs, and \$60 copay for non-formulary drugs plus 20%
Mail Order Delivery (MOD) Up to a 31 to 90 day supply	\$40 copay for generic formulary and non-formulary drugs, \$80 copay for brand formulary drugs, and \$120 copay for non-formulary drugs	No benefit is provided
No Mandatory Generics (NoMG) – Member is responsible to pay the applicable copay only. Plan includes: Lifestyle/performance prescription drugs - 6 pills per month, contraceptive drugs and devices obtainable from a pharmacy and diabetic supplies.		
Prescription drug calendar year deductible - Must be satisfied before any prescription drug benefits are paid.	Integrated Medical/Rx Deductible	Integrated Medical/Rx Deductible

SPECIAL PROGRAMS/SERVICES

Certain Special programs and Services may be included in your plan: Aetna Navigator™, Fitness, Healthy Outlook, Moms-to-Babies Maternity Management™, National Advantage, National Medical Excellence, Natural Alternatives, Natural Products, Vision One®, and Vitamin Advantage™.

*Non-Participating Provider payments are determined based upon the charge established in Aetna's Allowable Fee Schedule.

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.

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 documents; Treatment of those for or related to treatment of obesity or for diet or weight control; Medical expenses for a pre-existing condition are not covered (full postponement rule) for the first 12 months after the insured's enrollment date. Look back period for determining a pre-existing condition (conditions for which diagnosis, care or treatment was recommended or received) is 180 days prior to the enrollment date. The pre-existing condition limitation period will be reduced by the number of days of prior creditable coverage the member has as of the enrollment date; Nonmedically necessary services or supplies; Orthotics except as specified in the plan; 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.

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 any results or outcomes. Consult the plan documents (i.e. Booklet, Booklet-Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. The availability of a plan or program may vary by geographic service area. With the exception of Aetna Rx

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Home Delivery, LLC, participating 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, and 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 nonpreferred 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 at the highest copay 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 enrollment) are not covered, and medical exceptions are not available for them. Aetna Rx Home Delivery, LLC, is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated reimbursement rates 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 prescription plans with copayment or coinsurance tiers, use of formulary drugs generally will result in lower costs to members. However, where the prescription plan utilizes copayments or coinsurance calculated on a percentage basis, there could be some circumstances in which a formulary drug would cost the member more than a non-formulary drug because (i) the negotiated pharmacy payment rate for the formulary drug may be more than the negotiated pharmacy payment rate for the non-formulary drug, and (ii) rebates received by Aetna from drug manufacturers are not reflected in the cost of a prescription drug obtained by a member.

Plans are offered by: Aetna Life Insurance Company. While this material is believed to be accurate as of the print date, it is subject to change.