

PLAN DESIGN AND BENEFITS  
**PPO Basic**

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
<b>Deductible (per calendar year)</b>	\$2,000 Individual	\$2,000 Individual
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. 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.		
<b>Member Coinsurance</b>	20%	50%
<b>Payment Limit (per calendar year)</b>	\$5,000 per member	\$5,000 per member
All covered expenses accumulate separately toward the preferred and non-preferred Payment Limit. Certain member cost sharing elements may not apply towards the Payment Limit.		
<b>Lifetime Maximum</b>	\$2,000,000 per member lifetime	
<b>Payment for Non-Preferred Care</b>	Not Applicable	Recognized Amount*
<b>Primary Care Physician Selection</b>	Not Applicable	Not Applicable
<b>Referral Requirement</b>	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
<b>Routine Adult Physical Exams / Immunizations</b> Age and Frequency schedules apply. \$300 maximum benefit every 12 months, preferred and non-preferred combined.	See office visit benefit. If not received as one of three office visits, than 20% after deductible.	See office visit benefit. If not received as one of three office visits, than 50% after deductible.
<b>Well Child Exams / Immunizations</b> Age and Frequency schedules apply.	See office visit benefit. If not received as one of three office visits, than 20% after deductible.	See office visit benefit. If not received as one of three office visits, than 50% after deductible.
<b>Routine Gynecological Care Exams</b> Includes Pap smear and related lab fees. One Routines exam per 365 days.	See office visit benefit. If not received as one of three office visits, than 20% after deductible.	See office visit benefit. If not received as one of three office visits, than 50% after deductible.
<b>Routine Mammograms</b> One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over.	See office visit benefit. If not received as one of three office visits, than 20% after deductible.	See office visit benefit. If not received as one of three office visits, than 50% after deductible.
<b>Routine Digital Rectal Exam / Prostate Specific Antigen Test</b> 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. See office visit benefit. If not received as one of three office visits, than 20% after deductible.	See office visit benefit. If not received as one of three office visits, than 50% after deductible.
<b>Colorectal Cancer Screening</b> For all members age 50 and over.	Member cost sharing is based on the type of service performed and the place where it is rendered. See office visit benefit. If not received as one of three office visits, than 20% after deductible.	See office visit benefit. If not received as one of three office visits, than 50% after deductible.
<b>Routine Eye Exams</b>	Not covered (except as part of physical)	Not covered (except as part of physical)
<b>Routine Hearing Exams</b>	Not covered (except as part of physical)	Not covered (except as part of physical)

PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE
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<b>Office Visits to Non-Specialists</b>	\$25 copay; no deductible. 3 visits per member per calendar year, primary & specialist office visits combined. Any visits over this limit are not covered	50%; no deductible. 3 visits per member per calendar year, primary & specialist office visits combined. Any visits over this limit are not covered
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.		
<b>Specialist Office Visits</b>	\$25 copay; no deductible. 3 visits per member per calendar year, primary & specialist office visits combined. Any visits over this limit are not covered	50%; no deductible. 3 visits per member per calendar year, primary & specialist office visits combined. Any visits over this limit are not covered
<b>Maternity OB Visits</b>	20% after deductible	50% after deductible
<b>Allergy Testing</b> (given by a physician)	Not covered	No benefit is provided
<b>Allergy Injections</b> (not given by a physician)	Not covered	No benefit is provided
<b>DIAGNOSTIC PROCEDURES</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Outpatient Diagnostic Laboratory and X-ray</b> - (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)	Not covered	No benefit is provided
<b>Outpatient Diagnostic X-ray for Complex Imaging Services</b> (including, but not limited to, MRI, CAT, MI/MRS and PET Scans)	Not covered	No benefit is provided
<b>EMERGENCY MEDICAL CARE</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Urgent Care Provider</b>	Not covered	No benefit is provided
<b>Non-Urgent Use of Urgent Care Provider</b>	Not covered	No benefit is provided
<b>Emergency Room</b>	20% after deductible	20% after deductible
<b>Non-Emergency Care in an Emergency Room</b>	Not covered	No benefit is provided
<b>Ambulance</b>	20% after deductible	20% after deductible
<b>HOSPITAL CARE</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Inpatient Coverage</b> (including maternity)	20% after deductible	50% after deductible
<b>Outpatient Surgery</b> Performed in a Hospital Outpatient Facility	30% after deductible	50% after deductible
<b>Outpatient Surgery</b> Performed in a Facility other than a Hospital Outpatient Facility	20% after deductible	50% after deductible
<b>MENTAL HEALTH SERVICES</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Inpatient</b>	No benefit is provided	No benefit is provided
<b>Outpatient</b>	See office visit benefit.	No benefit is provided
<b>ALCOHOL/DRUG ABUSE SERVICES</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Inpatient Detoxification</b>	Not benefit is provided	No benefit is provided
<b>Outpatient Detoxification</b>	Not benefit is provided	No benefit is provided
<b>OTHER SERVICES AND PLAN DETAILS</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Convalescent Facility</b> Limited to 30-days per calendar year. Preferred and Non-Preferred combined.	20% after deductible	50% after deductible
<b>Home Health Care</b>	20% after deductible	50% after deductible
<b>Hospice Care – Inpatient</b> Limited to 30-days per member per calendar year. Preferred and Non-Preferred combined.	20% after deductible	50% after deductible
<b>Hospice Care - Outpatient</b>	No benefit is provided	No benefit is provided
<b>Private Duty Nursing – Outpatient</b>	Not benefits provided	No benefit is provided

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<b>Outpatient Speech Therapy</b>	See office visit benefit	50% after deductible (see office visit benefit)
<b>Outpatient Physical and Occupational Therapy</b>	See office visit benefit	50% after deductible (see office visit benefit)
<b>Spinal Manipulation Therapy</b>	See office visit benefit	50% after deductible (see office visit benefit)
<b>Durable Medical Equipment</b>	Not benefit is provided	No benefit is provided
<b>Transplants</b>	20% after deductible	50%; after deductible

<b>FAMILY PLANNING</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Infertility Treatment</b> Coverage 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 where it is rendered.	Member cost sharing is based on the type of service performed and the place where it is rendered.
<b>Voluntary Sterilization</b> Including tubal ligation and vasectomy.	Member cost sharing is based on the type of service performed and the place where it is rendered.	Member cost sharing is based on the type of service performed and the place where it is rendered.

<b>PHARMACY – PRESCRIPTION DRUG BENEFITS</b>	<b>PARTICIPATING PHARMACY</b>	<b>NON-PARTICIPATING PHARMACY</b>
<b>Retail</b> Up to a 30 day supply	Discount Card (Rx Discount Network)	No benefit is provided
<b>Mail Order Delivery (MOD)</b> Up to a 31 to 90 day supply	Discount Card (Rx Discount Network)	No benefit is provided

**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 provides limited benefits only and does not constitute a comprehensive health insurance plan. As such, it may not cover all the expenses associated with your health care needs.

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 Home Delivery, LLC, participating providers and vendors are independent contractors in private practice and are neither

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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.