PLAN DESIGN AND BENEFITS
AETNA LIFE INSURANCE COMPANY - Insured

PLAN FEATURES		
Deductible (per calendar year)	$1,500	Individual
	$3,000	Family

All covered expenses accumulate toward the Deductible.
Unless otherwise indicated, the Deductible must be met prior to benefits being payable.
Pharmacy expenses does not apply towards the Deductible.
The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Deductible amount.

Member Coinsurance	20%

Applies to all expenses unless otherwise stated.

Payment Limit (per calendar year)	$3,500	Individual
	$7,000	Family

Certain member cost sharing elements may not apply toward the Payment Limit.
Pharmacy expenses apply towards the Payment Limit.
Only those out-of-pocket expenses resulting from the application of coinsurance percentage and deductibles may be used to satisfy the Payment Limit.
The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Payment Limit amount.

Lifetime Maximum	Unlimited
Primary Care Physician Selection	Not applicable

Certification Requirements -
Certification for Hospital Admissions must be obtained to avoid a reduction in benefits paid. Excluded amount is $400 per occurrence.

Referral Requirement	None
PREVENTIVE CARE	
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived

1 exam every 12 months age 22 and over.

Routine Well Child Exams/ Immunizations	Covered 100%; deductible waived

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 year thereafter to age 22.

Routine Gynecological Care Exams	Covered 100%; deductible waived

Includes routine tests and related lab fees

Routine Mammograms	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived

Includes: 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, sterilization procedures, patient education and counseling. Limitations may apply.

Routine Digital Rectal Exam / Prostate-specific Antigen Test	Covered 100%; deductible waived

Recommended for covered males age 40 and over

Colorectal Cancer Screening	Covered 100%; deductible waived

For all members age 50 and over.

Routine Eye Exams	Covered 100%; deductible waived

1 routine eye exam per 24 months

Routine Hearing Screening	Covered 100%; deductible waived
PHYSICIAN SERVICES	
Office Visits to Non-Specialist	20% after deductible

Includes services of an internist, general physician, family practitioner or pediatrician.

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Specialist Office Visits	20% after deductible
Audiometric Hearing Exams	Covered 100%; deductible waived
One routine hearing exam per 24 months.	
Pre-Natal Maternity	Covered 100%; deductible waived
Allergy Testing	20% after deductible
Allergy Injections	20% after deductible
DIAGNOSTIC PROCEDURES	
Diagnostic Laboratory and X-ray	20% after deductible
EMERGENCY MEDICAL CARE	
Emergency Room	20% after deductible
Non-Emergency care in an Emergency Room	50% after deductible
Ambulance	20% after deductible
HOSPITAL CARE	
Inpatient Coverage	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	
Inpatient Maternity Coverage	20% after deductible
(includes delivery and postpartum care)	
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	
Outpatient Hospital Expenses (including surgery)	20% after deductible
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit	
MENTAL HEALTH SERVICES	
Inpatient	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	
Outpatient	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	
ALCOHOL/DRUG ABUSE SERVICES	
Inpatient	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	
Residential Treatment Facility	20% after deductible
Outpatient	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	
OTHER SERVICES	
Convalescent Facility	20% after deductible
Limited to 60 days per calendar year	
The member cost sharing applies to all covered benefits incurring during a member's inpatient stay	
Home Health Care	20% after deductible
Limited to 60 visits per calendar year	
Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit	
Hospice Care - Inpatient	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	
Hospice Care - Outpatient	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	
Aetna Compassionate Care Program (ACCP) Inpatient and Outpatient - Enrollment available to members with a 12 month terminal prognosis. Members would be able to continue receiving curative care.	
Autism Spectrum PT/OT/ST	Covered in accordance with standard claim practice
Covered same as any other Short Term Rehabilitation expense.	
Autism Spectrum Behavior Therapy	20% after deductible
Covered same as any other Outpatient Mental Health benefit.	
Autism Spectrum Applied Behavior Analysis	Not Covered
Outpatient Short-Term Rehabilitation	20% after deductible

Includes speech, physical, and occupational therapy. Limited to 60 combined visits per calendar year.	
Spinal Manipulation Therapy Limited to 12 visits per calendar year	20% after deductible
Hearing Aids	20%; after deductible
Limited to 1 hearing aid for each impaired ear per 48 month period for children under age 18. 4 additional ear molds per calendar year for children to age 2.	
Durable Medical Equipment	20%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived
Generic FDA-approved Women's Contraceptives	Covered 100%; deductible waived
Transplant	20%; after deductible
FAMILY PLANNING	
Infertility Treatment Diagnosis and treatment of the underlying medical condition.	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Tubal Ligation	Covered 100%; deductible waived
Voluntary Abortion	Not Covered
PHARMACY	
Pharmacy Plan Type	Aetna Value Plus Open Formulary
Retail	$15 copay for generic drugs, $35 copay for formulary brand-name drugs, and $60 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies. 20% after the above copays at non-participating pharmacies.
Mail Order	$30 copay for generic drugs, $70 copay for formulary brand-name drugs, and $120 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery® .
Aetna Value Plus Specialty Drugs Value Plus Specialty Drug List All prescription fills must be through our preferred Aetna Specialty Pharmacy network.	20% for formulary and non-formulary drugs
Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs, and Diabetic supplies.	
A limited list of over-the-counter medications are covered when filled with a prescription. Value Plus Pre-certification included Value Plus Step Therapy included	
Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.	
GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.

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

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

The following is a 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 by your employer.

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental X-rays.
• Donor egg retrieval.
• Durable medical Equipment
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Hearing aids
• Home births
• Immunizations for travel or work except where medically necessary or indicated.
• Implantable drugs and certain injectible drugs including injectible infertility drugs.
• Infertility services, including 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.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Orthotics except diabetic orthotics.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Treatment of behavioral disorders.

• 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, exercise 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 the existence of comorbid conditions.

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. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy’s cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

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

If you require language assistance from an Aetna representative, please call Member Services' multilingual hotline at **1-888-982-3862** (140 languages are available. You must ask for an interpreter). **TDD 1-800-628-3323** (hearing impaired only).

Si necesita asistencia lingüística de un representante de Aetna, contamos con una línea directa de Servicios a Miembros disponible en varios idiomas. Comuníquese al **1-888-982-3862** (140 idiomas disponibles. Debe solicitar un intérprete). **TDD 1-800-628-3323** (para personas con problemas de audición únicamente).

Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com.**