



PLAN DESIGN & BENEFITS
 PROVIDED BY AETNA LIFE INSURANCE COMPANY

| PLAN FEATURES | IN NETWORK CARE |
|--|---|
| Deductible | None |
| Member Coinsurance | None |
| Payment Limit | None |
| Lifetime Maximum | Unlimited except where otherwise indicated. |
| Primary Care Physician Selection (PCP) | Optional |
| Referral Requirement | None |
| PREVENTIVE CARE | IN NETWORK CARE |
| Routine Adult Physical Exams/ Immunizations | \$15 office visit copay 1 exam per 24 months for members age 18 to age 50; 1 exam per 12 months for adults age 50 and older. |
| Routine Well Child Exams/Immunizations | \$15 office visit copay 7 exams in the first 12 months of life, 2 exams in the 13th-24th months of life; 1 exam per 12 months thereafter to age 18. |
| Routine Gynecological Care Exams | \$15 office visit copay Includes Pap smear and related lab fees |
| Routine Mammograms | Covered 100% For covered females age 35 and over. |
| Routine Digital Rectal Exam / Prostate-specific Antigen Test | \$15 office visit copay For all members age 50 and over. |
| Routine Colorectal Cancer Screening | Covered 100% For all members age 50 and over. |
| Routine Vision Exam | \$15 office visit copay 1 exam every 12 months |
| PHYSICIAN SERVICES | IN NETWORK CARE |
| Office Visits to PCP | \$15 office visit copay Includes services of an internist, general physician, family practitioner or pediatrician. |
| Specialist Office Visits | \$15 office visit copay |
| Allergy Testing | \$15 office visit copay |
| Allergy Injections (Copay waived when an office visit charge is not made) | \$15 office visit copay |
| DIAGNOSTIC PROCEDURES | IN NETWORK CARE |
| Diagnostic Laboratory and X-ray | Covered 100% If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing |
| EMERGENCY MEDICAL CARE | IN NETWORK CARE |
| Urgent Care Provider | \$20 copay |
| Emergency Room | \$50 copay |
| Non-Emergency care in an Emergency Room | Not Covered |
| Ambulance (Covers Emergency Services only) | Covered 100% |
| HOSPITAL CARE | IN NETWORK CARE |
| Inpatient Coverage | Covered 100% |
| Inpatient Maternity Coverage | Covered 100% |
| Outpatient Surgery | Covered 100% |
| Outpatient Hospital Expenses (excluding surgery) | Covered 100% |
| MENTAL HEALTH SERVICES | IN NETWORK CARE |
| Inpatient | Covered 100% after \$100 copay per admission |
| Outpatient | 100% after \$15 copay |
| ALCOHOL/DRUG ABUSE SERVICES | IN NETWORK CARE |
| Inpatient | Covered 100% after \$100 copay per admission |
| Outpatient | Covered 100% after \$15 copay |



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| OTHER SERVICES | IN NETWORK CARE |
|--|---|
| Convalescent Facility Limited to 90 days per calendar year. | Covered 100% |
| Home Health Care Limited to 200 visits per calendar year. Includes Private Duty Nursing, nurse, therapist and home health care aide. | Covered 100% |
| Hospice Care - Inpatient Limited to 30 days per lifetime. | Covered 100% |
| Hospice Care - Outpatient Up to a maximum benefit of \$5,000 | Covered 100% |
| Outpatient Short-Term Rehabilitation Includes Speech, Physical, Occupational, and Spinal Manipulation Therapy, limited to 40 visits per calendar year. | Covered 100% after \$15 copay |
| Chiropractic Care Limited to 20 visits per calendar year. | Covered 100% after \$15 copay |
| Durable Medical Equipment Maximum annual benefit of \$5,000 per member per calendar year | Covered 80% |
| Diabetic Supplies | Covered 100% |
| Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits) | Covered 100% |
| Transplants/Institute of Excellence (IOE) | Covered 100% Coverage is provided at an IOE contracted facility only. |
| Mouth, Jaws and Teeth (oral surgery procedures medical in nature) | Covered 100% |
| FAMILY PLANNING | |
| Infertility Treatment Diagnosis and treatment of the underlying medical condition. | Covered 100% |
| Voluntary Sterilization Including tubal ligation and vasectomy. | Covered 100% |
| PHARMACY | |
| Retail | \$10 copay for generic drugs, \$20 copay for formulary brand-name drugs, and \$35 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies. |
| Mail Order | \$20 copay for generic drugs, \$40 copay for formulary brand-name drugs, and \$70 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®. |
| No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only. | |
| Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs. | |
| GENERAL PROVISIONS | |
| Dependents Eligibility | Spouse, children from birth to age 19 or to age 25 if a Full Time Student |
| Pre-existing Conditions Rule | Waived on or after effective date |

Plans are provided by Aetna Life Insurance Company.