



PLAN DESIGN & BENEFITS  
 PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN NETWORK CARE		OUT OF NETWORK CARE	
<b>Deductible</b> (per calendar year)	none	Individual	\$400	Individual
	none	Employee plus One	\$800	Employee plus One
	none	Family	\$1,200	Family

All covered expenses, excluding prescription drugs, accumulate toward both the In Network Care and Out of Network Care Deductible.

Unless otherwise indicated, the Deductible must be met prior to benefits being payable.

Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.

<b>Member Coinsurance</b>	N/A	30%
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Applies to all expenses unless otherwise stated.

<b>Payment Limit</b> (per calendar year)	N/A	Individual	\$2,600	Individual
	N/A	Employee plus One	\$5,200	Employee plus One
	N/A	Family	\$7,800	Family

All covered expenses, excluding prescription drugs, accumulate toward both the in network care and out of network care Payment Limit.

Certain member cost sharing elements may not apply toward the Payment Limit.

Only those out-of-pocket expenses resulting from the application of coinsurance percentage (except any deductibles, copays, and penalty amounts) may be used to satisfy the Payment Limit.

Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year.

<b>Lifetime Maximum</b>	Unlimited	\$2,000,000
<b>Primary Care Physician Selection (PCP)</b>	Optional	N/A

**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, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is \$400 per occurrence.

Precertification for certain procedures/treatments - excluded amount is \$200 per occurrence.

<b>Referral Requirement</b>	None	None
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PREVENTIVE CARE	IN NETWORK CARE	OUT OF NETWORK CARE
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<b>Routine Adult Physical Exams/ Immunizations</b>	\$20 office visit copay	30% after deductible
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**Immunizations**

1 exam per 24 months for members age 18 to age 50; 1 exam per 12 months for adults age 50 and older.

<b>Routine Well Child Exams/Immunizations</b>	\$20 office visit copay	30% after deductible
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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.

<b>Routine Gynecological Care Exams</b>	\$20 office visit copay	30% after deductible
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Includes Pap smear and related lab fees

<b>Routine Mammograms</b>	Covered 100%	30% after deductible
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For covered females age 35 and over.

<b>Routine Digital Rectal Exam / Prostate-specific Antigen Test</b>	\$20 office visit copay	30% after deductible
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For covered males age 40 and over.

<b>Routine Colorectal Cancer Screening</b>	Covered 100%	30% after deductible
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For all members age 50 and over.

<b>Routine Vision Exam</b>	\$20 office visit copay	30% after deductible
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1 exam every 12 months

PHYSICIAN SERVICES	IN NETWORK CARE	OUT OF NETWORK CARE
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<b>Office Visits to PCP</b>	\$20 office visit copay	30% after deductible
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Includes services of an internist, general physician, family practitioner or pediatrician.

<b>Specialist Office Visits</b>	\$20 office visit copay	30% after deductible
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<b>Allergy Testing</b>	\$20 office visit copay	30% after deductible
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<b>Allergy Injections</b> (Copay waived when an office visit charge is not made)	\$20 office visit copay	30% after deductible
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DIAGNOSTIC PROCEDURES	IN NETWORK CARE	OUT OF NETWORK CARE
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<b>Diagnostic Laboratory and X-ray</b>	Covered 100%	30% after deductible
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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



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<b>EMERGENCY MEDICAL CARE</b>	<b>IN NETWORK CARE</b>	<b>OUT OF NETWORK CARE</b>
<b>Urgent Care Provider</b>	\$25 copay	30% after deductible
<b>Emergency Room</b>	\$50 copay	\$50 copay
<b>Non-Emergency care in an Emergency Room</b>	Not Covered	Not Covered
<b>Ambulance</b>	Covered 100%	30% after deductible
<b>Out of Network Ambulance Services covered at 100% for Emergencies. Non Emergency Ambulance Services 30% after Deductible.</b>		
<b>HOSPITAL CARE</b>	<b>IN NETWORK CARE</b>	<b>OUT OF NETWORK CARE</b>
<b>Inpatient Coverage</b>	Covered 100% after \$100 copay per admission	30% after deductible
<b>Inpatient Maternity Coverage</b>	Covered 100% after \$100 copay per admission	30% after deductible
<b>Outpatient Surgery</b>	Covered 100% after \$75 outpatient surgery copay	30% after deductible
<b>Outpatient Hospital Expenses</b> (excluding surgery)	Covered 100%	30% after deductible
<b>MENTAL HEALTH SERVICES</b>	<b>IN NETWORK CARE</b>	<b>OUT OF NETWORK CARE</b>
<b>Inpatient</b>	Covered 100% after \$100 copay per admission	30% after deductible
<b>Outpatient</b>	100% after \$20 copay	30% after deductible
<b>ALCOHOL/DRUG ABUSE SERVICES</b>	<b>IN NETWORK CARE</b>	<b>OUT OF NETWORK CARE</b>
<b>Inpatient</b>	Covered 100% after \$100 copay per admission	30% after deductible
<b>Outpatient</b>	100% after \$20 copay	30% after deductible
<b>OTHER SERVICES</b>	<b>IN NETWORK CARE</b>	<b>OUT OF NETWORK CARE</b>
<b>Convalescent Facility/Skilled Nursing Facility</b> Limited to 90 days per calendar year.	Covered 100%	30% after deductible
<b>Home Health Care</b> Limited to 200 visits per calendar year. Includes Private Duty Nursing, nurse, therapist and home health care aide.	Covered 100%	30% after deductible
<b>Hospice Care - Inpatient</b> Limited to 30 days per lifetime.	Covered 100%	30% after deductible
<b>Hospice Care - Outpatient</b> Up to a maximum benefit of \$5,000	Covered 100%	30% after deductible
<b>Outpatient Short-Term Rehabilitation</b> Includes Speech, Physical, Occupational Therapy, limited to 40 visits per calendar year.	Covered 100% after \$20 copay	30% after deductible
<b>Chiropractic Care</b> Limited to 20 visits per calendar year.	Covered 100% after \$20 copay	30% after deductible
<b>Durable Medical Equipment</b> Maximum annual benefit of \$5,000 per member per calendar year	Covered 80%	30% after deductible
<b>Diabetic Supplies</b>	Covered 100%	30% after deductible
<b>Contraceptive drugs and devices not obtainable at a pharmacy</b> (includes coverage for contraceptive visits)	Covered 100%	30% after deductible
<b>Transplants/Institute of Excellence (IOE)</b>	Covered 100% In Network coverage is provided at an IOE contracted facility only	30% after deductible Out of Network coverage provided at a Non-IOE facility.
<b>Mouth, Jaws and Teeth</b> (oral surgery procedures medical in nature)	Covered 100%	30% after deductible
<b>FAMILY PLANNING</b>	<b>IN NETWORK CARE</b>	<b>OUT OF NETWORK CARE</b>
<b>Infertility Treatment</b> Diagnosis and treatment of the underlying medical condition.	Covered 100%	Not Covered
<b>Voluntary Sterilization</b> Including tubal ligation and vasectomy.	Covered 100%	Not Covered



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PHARMACY	IN NETWORK CARE	OUT OF NETWORK CARE
<b>Retail</b>	\$15 copay for generic drugs, \$25 copay for formulary brand-name drugs, and \$40 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	\$15 copay for generic drugs, \$25 copay for formulary brand-name drugs, and \$40 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.
<b>Mail Order</b>	\$30 copay for generic drugs, \$50 copay for formulary brand-name drugs, and \$80 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not Covered
<b>No Mandatory Generic (NO MG)</b> - Member is responsible to pay the applicable copay only.		
<b>Plan Includes:</b> Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs		
GENERAL PROVISIONS		
<b>Dependents Eligibility</b>	Spouse, children from birth to age 19 or to age 25 if a Full Time Student.	
<b>Pre-existing Conditions Rule</b>	Waived on or after effective date	

Plans are provided by Aetna Life Insurance Company.