



**PLAN DESIGN & BENEFITS  
PROVIDED BY AETNA LIFE INSURANCE COMPANY**

**FUND FEATURES**

<b>HealthFund Amount</b>	Individual	\$750
	Employee + 1	\$1,125
	Family	\$1,500

Employee contribution amounts shown are per calendar year. The fund received may be prorated based on your effective date of coverage.

<b>Fund Administration</b>	The fund will be used to pay for your member responsibility, including your <b>deductible</b> and coinsurance. Once the deductible is met, the underlying medical plan provides coverage and if a fund balance still exists, the fund will pay your member responsibility (i.e. your share of coinsurance) until the coinsurance limit has been reached or the fund has been exhausted, whichever comes first. Services covered at 100% with no deductible will be paid by the plan and not by the Fund. Any remaining health fund benefit amount at end of plan year is rolled over into next years health fund benefit amount. No maximum rollover applies.
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<b>Employee Termination from Aetna HealthFund</b>	Any remaining health fund benefit amount is forfeited (or terminated) when the employee's Aetna HealthFund coverage terminates.
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<b>Eligible Fund Expenses</b>	Fund covers same expenses as the medical and pharmacy plan. Expenses above the Reasonable & Customary limit, any plan limits, and any noncovered expenses are not eligible for reimbursement under the Fund.
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<b>Incentive Programs</b>	
Wellness Programs through Simple Steps	Employee and spouse can each earn \$25 for completing the Simple Steps health assessment
Member Advantage Program Incentives	Each member can earn \$100 for enrollment in an Aetna Health Connections <sup>SM</sup> disease management program. Each member can earn \$100 for enrollment in Beginning Right <sup>®</sup> Maternity Program.

<b>Prescription Drug Plan</b>	The full cost of the drug is applied to the Fund and Deductible before any benefits are considered for payment under the pharmacy plan.
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**PLAN FEATURES**

	<b>PREFERRED CARE</b>		<b>NONPREFERRED CARE</b>	
<b>Deductible</b> (per calendar year)	Individual	\$1,750	Individual	\$1,750
	Employee + 1	\$2,625	Employee + 1	\$2,625
	Family	\$3,500	Family	\$3,500

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

<b>Coinsurance</b>	80%	80%
Applies to all expenses unless otherwise stated.		

<b>Coinsurance Limit (per calendar year)</b>	Individual	\$3,000	Individual	\$3,000
	Employee + 1	\$4,500	Employee + 1	\$4,500
	Family	\$6,000	Family	\$6,000

Excludes deductible, copay, penalties, & expenses paid at 50%  
Once Family Coinsurance Limit is met, all family members will be considered as having met their Coinsurance Limit for the remainder of the calendar year.

<b>Lifetime Maximum</b>	Unlimited
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<b>Precertification</b>	<b>Provider Responsibility</b>	<b>Member Responsibility</b>
Precertification is required for certain services — excluded amount applied separately to each type of expense is \$400 per occurrence. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). For preferred care, provider is responsible for getting precertification from Aetna. For nonpreferred care, member is responsible for getting precertification to avoid a reduction in benefits paid for that care. Precertification requirements may vary.		
<b>PREVENTIVE CARE</b>	<b>PREFERRED CARE</b>	<b>NONPREFERRED CARE</b>
<b>Routine Adult Physical Exams/ Immunizations</b> 1 exam per 12 months for members age 22 age 65 & over.	100%	100%
<b>Routine Well-Child Exams/Immunizations</b> Children to age 22: 7 exams in the first 12 months of life, 3 exams between ages 13 and 24 months, 3 exams between age 25 and 36 months, 1 exam every 12 months until age 22. Includes Immunizations	100%	100%
<b>Routine Gynecological Care Exams</b> Includes Pap smear and related lab fees	100%	100%
<b>Routine Mammograms</b> Baseline mammogram for females age 35-40. Annual for covered females age 40 and over.	100%	100%
<b>Routine Digital Rectal Exam / Prostate-specific Antigen Test</b> For covered males age 40 and over.	100%	100%
<b>Colorectal Cancer Screening</b> For all members age 50 and over.	100%	100%
<b>Routine Vision Benefit</b>	100%	100%
<b>PHYSICIAN SERVICES</b>	<b>PREFERRED CARE</b>	<b>NONPREFERRED CARE</b>
<b>PCP Office Visits</b> 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.	80%	80%
<b>Specialist Office Visits</b>	80%	80%
<b>Outpatient Surgery</b>	80%	80%
<b>Maternity OB Visits</b>	80%	80%
<b>Allergy Testing</b>	80%	80%
<b>Allergy Injections</b>	80%	80%
<b>DIAGNOSTIC PROCEDURES</b>	<b>PREFERRED CARE</b>	<b>NONPREFERRED CARE</b>
<b>Diagnostic Laboratory and X-ray</b>	80%	80%
<b>EMERGENCY MEDICAL CARE</b>	<b>PREFERRED CARE</b>	<b>NONPREFERRED CARE</b>
<b>Urgent Care Provider</b> (Benefit availability may vary by location)	80%	80%
<b>Emergency Room</b>	100%	100%
<b>Non-Emergency Care in an Emergency Room</b>	80% after deductible	80% after deductible
<b>Ambulance</b>	80%	80%
<b>HOSPITAL CARE</b>	<b>PREFERRED CARE</b>	<b>NONPREFERRED CARE</b>
<b>Inpatient Coverage</b>	80%	80%
<b>Inpatient Maternity Coverage</b>	80%	80%
<b>Outpatient Hospital Expenses</b> (including surgery)	80%	80%
<b>MENTAL HEALTH BENEFIT</b>	<b>PREFERRED CARE</b>	<b>NONPREFERRED CARE</b>
<b>Inpatient</b>	80%	80%



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<b>Outpatient</b>	80%	80%
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ALCOHOL/DRUG ABUSE SERVICES	PREFERRED CARE	NONPREFERRED CARE
<b>Inpatient</b>	80%	80%
<b>Outpatient</b>	80%	80%
OTHER SERVICES	PREFERRED CARE	NONPREFERRED CARE
<b>Convalescent Facility</b> Limited to 60 days per calendar year.	80%	80%
<b>Home Health Care</b>	80%	80%
<b>Hospice Care - Inpatient</b>	80%	80%
<b>Hospice Care - Outpatient</b>	80%	80%
<b>Outpatient Short-Term Rehabilitation</b> Includes speech, physical, occupational, and spinal manipulation therapy	80%	80%
<b>Durable Medical Equipment</b>	80%	80%
<b>Diabetic Supplies</b>	80%	80%
<b>Contraceptive drugs and devices not obtainable at a pharmacy</b> (includes coverage for contraceptive visits)	80%	80%
<b>Transplants</b>	80% In-network coverage is provided at an IOE contracted facility only	
<b>Oral Surgery</b> Covered procedures include: gingivectomy or gingivoplasty, osseous surgery, removal of impacted tooth, surgical removal of residual tooth roots and ora-antral fistula closure.	80%	80%
<b>Mouth, Jaws and Teeth (TMJ)</b> Covers medical-in-nature treatment only, including exams, X-ray, injections, anesthetics, physical therapy, and oral surgery; excludes appliance therapy and tooth reconstruction. \$15,000 lifetime maximum benefit for surgical only.	80%	80%
FAMILY PLANNING	PREFERRED CARE	NONPREFERRED CARE
<b>Infertility Treatment</b> Diagnosis and treatment of the underlying medical condition.	80%	80%
<b>Voluntary Sterilization</b> Including tubal ligation and vasectomy.	80%	80%
PHARMACY	PREFERRED CARE	NONPREFERRED CARE
<b>Retail</b>	80%	80%
<b>Mail Order</b>	80%	Not Applicable

If the member's coinsurance limit has been reached, the plan benefit will pay the balance of the negotiated cost of the drug.

**Pharmacy Managed Self-Injectables (PMSI)**

First prescription fill at any retail or mail-order drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®

**No Mandatory Generic (NO MG)** - Member is responsible to pay the applicable coinsurance only.

**Plan Includes:** Contraceptive drugs and devices obtainable from a pharmacy, oral fertility drugs, diabetic supplies.

Precertification applies to growth hormones.



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**GENERAL PROVISIONS**

<b>Out-of-Area Dependents</b>	Covered in the same plan of benefits applicable to the covered employee
<b>Dependents Eligibility</b>	Spouse, children from birth to age 26. Same sex domestic partners.

**Pre-existing Conditions Rule**

This plan imposes a pre-existing condition exclusion, which may be waived in some circumstances and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to this plan, you may have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received or for which the individual took prescribed drugs within 90 days. Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, 90 days ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. If you had prior creditable coverage within 63 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.

If you had no prior creditable coverage within the 63 days before your enrollment date (either because you had no prior coverage or because there was more than a 63 day gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion. In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any certificates of creditable coverage you have. Please contact Aetna Member Services at 1-888-282-4172 if you need help getting a certificate of creditable coverage from your prior carrier or if you have any questions on the information noted above. The pre-existing condition exclusion does not apply to pregnancy nor to a dependent child under the age of 19.

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 or the plan design or rider(s) purchased by your employer.



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**What's Not Covered**

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; Nonmedically necessary services or supplies; Orthotics; 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. 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.

**Plans are administered by Aetna Life Insurance Company.**

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 results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred 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.

Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available 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. Nonprescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.