PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE
Deductible (per calendar year)	$100 Individual $200 Employee + 1 Dependent $300 Family
Unless otherwise indicated, the Deductible must be met before benefits are payable. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.	
Coinsurance Applies to all expenses unless otherwise stated.	90% of eligible charges, member pays 10%
Payment Limit (per calendar year)	$1,500 Individual $2,250 Employee + 1 Dependent $3,000 Family
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.	
Lifetime Maximum	Unlimited
Primary Care Physician Selection	Required
Referral Requirement	Required
PREVENTIVE CARE	**PREFERRED CARE**
Routine Adult Physical Exams/ Immunizations	$20 office visit copay; deductible waived
1 exam per 12 months for members age 22 to age 65; 1 exam per 12 months for adults age 65 and older.	
Routine Well-Child Exams/Immunizations	$20 office visit copay; deductible waived
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	
Routine Gynecological Care Exams Includes Pap smear and related lab fees	$35 office visit copay; deductible waived
Routine Mammograms Baseline mammogram for covered females age 35 to 40. Annual for covered females age 40 and over.	Covered 100%; deductible waived
Routine Digital Rectal Exam / Prostate-specific Antigen Test For covered males age 40 and over.	Covered 100%; $20 copay for associated wellness exam; deductible waived
Colorectal Cancer Screening Annual for all members age 50 and over.	Covered 100%; $20 copay for associated wellness exam; deductible waived
Routine Eye Exams	$35 office visit copay deductible waived
1 routine exam per 24 months (glasses and contacts not included). No referral required.	
PHYSICIAN SERVICES	**PREFERRED CARE**
Office Visits to PCP	$20 office visit copay; deductible waived
Includes services of an internist, general physician, family practitioner or pediatrician.	
Specialist Office Visits	$35 office visit copay; deductible waived
Outpatient Surgery During Office Visit	$35 office visit copay; deductible waived
Allergy Testing	Covered as either PCP or specialist office visit; deductible waived
Allergy Injections	Covered as either PCP or specialist office visit; copay waived for injections if no office visit is billed

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DIAGNOSTIC PROCEDURES	PREFERRED CARE
Diagnostic Laboratory	100% of eligible charges; deductible waived
X-ray Services	90% of eligible charges; after deductible
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	**PREFERRED CARE**
Urgent Care Provider (benefit availability may vary by location)	$50 copay, deductible waived
Emergency Room	$150 copay, waived if admitted; deductible waived
Ambulance	90% of eligible charges, after deductible
HOSPITAL CARE	**PREFERRED CARE**
Inpatient Coverage	$150 copay per day for up to 3 days after calendar-year deductible then plan pays 90%. Copayments waived if readmitted within 30 days.
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Inpatient Maternity Coverage	$150 copay per day for up to 3 days after calendar-year deductible then plan pays 90%. Copayments waived if readmitted within 30 days.
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Outpatient Hospital Expenses (excluding surgery)	Plan pays 90% of eligible charges after deductible.
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
Outpatient Hospital Surgical Expenses	$100 copay after calendar-year deductible then plan pays 90%.
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
MENTAL HEALTH SERVICES	**PREFERRED CARE**
Inpatient	$150 copay per day for up to 3 days after calendar-year deductible then plan pays 90%. Copayments waived if readmitted within 30 days.
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Outpatient	$20 per visit copay then plan pays 100%.
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. Maximums are combined for Mental Health and Alcohol/Drug services.	
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**
Inpatient	$150 copay per day for up to 3 days after calendar year deductible then plan pays 90%. Copayments waived if readmitted within 30 days.
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Outpatient	$20 per visit copay then plan pays 100%.
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. Maximums are combined for Mental Health and Alcohol/Drug services.	
OTHER SERVICES	**PREFERRED CARE**
Convalescent Facility	90% of eligible charges 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	Covered 100%; Deductible waived

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	Unlimited
Hospice Care - Inpatient	Covered 100%; Deductible waived
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Hospice Care - Outpatient	Covered 100%; Deductible waived
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
Outpatient Short-Term Rehabilitation	$35 per visit copay then plan pays 100%.
Includes speech, physical, occupational, and spinal manipulation therapy	
Durable Medical Equipment	90% after deductible
Diabetic Supplies	Covered same as any other medical expense.
Prescription Drugs	Covered through Express Scripts
Transplants Coverage is provided at an IOE contracted facility only.	90% of eligible charges after deductible
Bariatric	Bariatric surgery covered at 90% after deductible with a 10,000 lifetime max.
Mouth, Jaws and Teeth (TMJ) 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.	$35 per visit copay then plan pays 100%.
FAMILY PLANNING	**PREFERRED CARE**
Infertility Treatment	$35 per visit copay then plan pays 100%.
Diagnosis and treatment of the underlying medical condition.	
Family Planning Services	
Office Visits (tests, counseling)	$35 per visit copay then plan pays 100%.
Vasectomy/Tubal Ligation (excludes reversals)	
Outpatients Facility	$100 copay after calendar-year deductible then plan pays 90%.
Physicians Services	90% of eligible charges after deductible
GENERAL PROVISIONS	
Out of Area Dependents	**Covered in same plan of benefits applicable to employee**
Dependents Eligibility	Spouse, children from birth to age 26. Same sex domestic partners.

Pre-existing Conditions Exclusion

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.

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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.

Precertification

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). Preferred providers are responsible for getting precertification. Precertification requirements may vary.

What's Not Covered

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.

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 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.

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