PLAN DESIGN AND BENEFITS
AETNA LIFE INSURANCE COMPANY - ASC

PLAN FEATURES		
Deductible (per calendar year)	$200 $400	Individual 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%	
Payment Limit (per calendar year)	$2,000 $4,000	Individual 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	
Precertification Requirements - 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). Member is responsible for getting precertification to avoid a reduction in benefits paid for that care. Precertification requirements may vary.		
Referral Requirement	None	
PREVENTIVE CARE		
Routine Adult Physical Exams/Immunizations	90% not subject to deductible	
Children age 22 and over, and employee/spouse to age 65: 1 exam every 12 months. Employee and spouse age 65 and older: 1 exam every 12 months. Includes immunization.		
Routine Well-Child Exams/ Immunizations	90% not subject to deductible	
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 immunization		
Routine Gynecological Care Exams 1 routine Gynecological exam per calendar year with 1 Pap smear & related lab fees	90% not subject to deductible	
Routine Mammograms 1 baseline mammogram for females age 35 to 40; 1 annual mammogram for females age 40 & over	90% not subject to deductible	
Routine Digital Rectal Exam / Prostate-Specific Antigen Test 1 annual DRE/PSA for males age 40 and over	90% not subject to deductible	
Colorectal Cancer Screening 1 baseline at age 50 to 55; then 1 every 3 years	90% not subject to deductible	
Routine Eye Exams 1 exam every consecutive 24 months	90% not subject to deductible	
Routine Hearing Exams	Not Covered	
PHYSICIAN SERVICES		
Office Visits (non-surgical) to Nonspecialist	90%	
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 and in-office surgery.		
Specialist Office Visits	90%	
Office Visits for Surgery	90%	
Allergy Testing	90%	
Allergy Injections	90%	

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DIAGNOSTIC PROCEDURES		
Diagnostic Laboratory and X-ray	90%	
EMERGENCY MEDICAL CARE		
Emergency Room	100% after $20 copay (calendar-year deductible waived)	
Non-Emergency care in an Emergency Room	90%	
Ambulance	90%	
HOSPITAL CARE		
Inpatient Coverage	90% $35 copay (Calendar-year deductible waived)	
Includes inpatient surgery expenses, anesthesiologist, radiologist, room & board, physician expenses, routine nursery care, prescription drugs and all other inpatient care. IP hospital copay waived if readmitted within 30 days.		
Inpatient Maternity Coverage	90%	
Covers expenses for employee, spouse & unmarried female dependent same as any other expense		
Outpatient Hospital Expenses (including surgery)	90%	
Bariatric Surgery	90%	$10,000 lifetime maximum
MENTAL HEALTH SERVICES		
Inpatient	90%	
Outpatient	90%	
Combined Mental Health and Alcohol/Drug maximum		
ALCOHOL/DRUG ABUSE SERVICES		
Inpatient	90%	
Outpatient	90%	
Combined Mental Health and Alcohol/Drug maximum		
OTHER SERVICES		
Convalescent Facility	90%	
Limited to 60 days per calendar year		
Home Health Care	90%	
Limited to 60 visits per calendar year		
Hospice Care - Inpatient	90%	
Hospice Care - Outpatient	90%	
Inpatient/Outpatient combined hospice lifetime maximum – 180 days. $200 maximum for bereavement		
Private Duty Nursing	90%	
Unlimited		
Outpatient Short-Term Rehabilitation	90%	
Includes speech, physical, and occupational therapy.		
Spinal Manipulation Therapy	90%	
Unlimited		
Dental Services	90%	
Dental expenses resulting from injury to sound natural teeth or certain surgical procedures may be covered.		
TMJ	90% $15,000 Lifetime Maximum	
Covers medical-in-nature treatment only, including exams, X-rays, injections, anesthetics, physical therapy and oral surgery; surgery; excludes appliance therapy and tooth reconstruction		
Durable Medical Equipment	90%	
Transplant	90%	
Covered at 100% at an IOE facility		

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FAMILY PLANNING	
Infertility Treatment Covered same as any other expense	90%
Voluntary Sterilization Including tubal ligation and vasectomy; excludes reversals	90%
PHARMACY	
Retail	N/A
Mail Order	N/A
GENERAL PROVISIONS	
Dependents Eligibility	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 the number on your ID card if you need help getting a certificate of creditable coverage from your previous 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.

Exclusions and Limitations
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 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.
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