



PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	\$500 Employee \$1,500 Family	\$1,000 Employee \$3,000 Family
<p>All covered expenses accumulate toward both the preferred and non-preferred deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable, except for PCP office visits. Once family deductible is met, all family members will be considered as having met their deductible for the remainder of the calendar year.</p>		
Member Coinsurance	20%	40%
<p>Applies to all expenses unless otherwise stated.</p>		
Payment Limit (per calendar year)	\$2,000 Employee \$6,000 Family	\$5,000 Employee \$15,000 Family
<p>All covered expenses accumulate toward both the preferred and non-preferred 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.</p>		
Lifetime Maximum	\$5,000,000 per member's lifetime.	
Primary Care Physician Selection	Optional	Not applicable
Certification Requirements -	<p>Certification for certain types of Non-Preferred 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.</p>	
Referral Requirement	None	None
PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE
Routine Adult Physical Exams/ Immunizations	\$25 office visit copay	40%
<p>1 exam per 12 months for members age 18 to age 65; 1 exam per 12 months for adults age 65 and older.</p>		
Routine Well Child Exams/Immunizations	\$25 office visit copay	40%
<p>6 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.</p>		
Routine Gynecological Care Exams	\$25 office visit copay	40%
<p>Includes Pap smear and related lab fees</p>		
Routine Mammograms	Covered 100%; deductible waived	40%
<p>For covered females age 35 and over.</p>		
Routine Digital Rectal Exam / Prostate-specific Antigen Test	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
<p>For covered males age 40 and over.</p>		
Colorectal Cancer Screening	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
<p>For all members age 50 and over.</p>		

Routine Eye Exams 1 routine exam per 24 months	\$25 office visit copay	40%
Routine Hearing Exams 1 routine exam per 24 months	\$25 office visit copay	40%
PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Office Visits (non surgical) to PCP 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.	\$25 office visit copay	40%
Specialist Office Visits (non-surgical)	\$25 office visit copay	40%
Outpatient Surgery	20%	40%
Maternity OB Visits	Covered same as Specialist Office Visit for initial visit only; thereafter covered 100%; deductible waived	40%
Allergy Testing	Covered as either PCP or specialist office visit; deductible waived	40%
Allergy Injections (Copay waived when an office visit charge is not made)	Covered as either PCP or specialist office visit	40%
DIAGNOSTIC PROCEDURES	PREFERRED CARE	NON-PREFERRED CARE
Diagnostic Laboratory and X-ray	100% deductible waived	40%
MRIs, CAT Scans & PET Scans are covered after the deductible at 80% coinsurance		
EMERGENCY MEDICAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Urgent Care Provider (benefit availability may vary by location)	\$40 copay	40%
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	\$100 copay; deductible waived then 80%	\$100 copay; deductible waived then 80%
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	20%	20%
HOSPITAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Coverage	20%	40% after \$500 per confinement deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Inpatient Maternity Coverage	20%	40% after \$500 per confinement deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Hospital Expenses (including surgery)	20%	40%
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
MENTAL HEALTH SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient	20%	40% after \$500 per confinement deductible
Limited to 60 visits per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	\$25 copay	40%
Limited to 30 visits per calendar year. The member cost sharing applies to all covered benefits incurred during a member's outpatient visit Combined Mental Health and Alcohol/Drug maximum for preferred and non-preferred services		

ALCOHOL/DRUG ABUSE SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient	20%	40% after \$500 per confinement deductible
Limited to 90 visits per lifetime.		
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	\$25 copay	40%
Limited to 30 visits per calendar year.		
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
Combined Mental Health and Alcohol/Drug maximum for preferred and non-preferred services		
OTHER SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Convalescent Facility	20%	40%
Limited to 100 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%	40%
Limited to 120 visits per calendar year. Includes Private Duty Nursing limited to 70 eight hour shifts per calendar year.		
Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.		
Hospice Care - Inpatient	20%	40% after \$500 per confinement deductible
Up to a maximum lifetime benefit of \$10,000 combined inpatient/outpatient		
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Hospice Care - Outpatient	20%	40%
Up to a maximum lifetime benefit of \$10,000 combined inpatient/outpatient		
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
Outpatient Speech Therapy	\$25 copay	40%
Limited to 20 visits per calendar year		
Outpatient Physical and Occupational Therapy	\$25 copay	40%
Limited to 60 visits per cal year		
Spinal Manipulation Therapy	\$25 copay	40%
Limited to 24 visits per calendar year		
Durable Medical Equipment	20%	40%
Maximum annual benefit of \$10,000 per member per calendar year		
Diabetic Supplies	Covered same as any other medical expense.	Covered same as any other medical expense.
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	Not Covered	Not Covered
Transplants	20% Preferred coverage is provided at an IOE contracted facility only	40% Non-Preferred coverage is provided at a Non-IOE facility.
Mouth, Jaws and Teeth (oral surgery procedures, whether medical or dental in nature)	Member cost sharing is based on the type of service performed and the place of service where it is rendered	40%
Out of Area Employees & Dependents	Coverage provided at the non-preferred benefit level of the plan.	
FAMILY PLANNING	PREFERRED CARE	NON-PREFERRED CARE
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered	40%
Covers Basic Diagnosis and Treatment ONLY		
Voluntary Sterilization Including tubal ligation and vasectomy.	Not Covered	Not Covered

GENERAL PROVISIONS

Dependents Eligibility Spouse, children & grandchildren from birth to age 25.

Pre-existing Conditions Rule Full Postponement

A "preexisting condition" is an injury or disease for which a person: received treatment or services; or took prescribed drugs or medicines; prior to the person's effective date of coverage. Genetic information will not be treated as a preexisting condition in the absence of a diagnosis of the condition related to that information. Pregnancy will not be treated as a preexisting condition.

Covered Medical Expenses do not include expenses incurred: during the 365 days following your Enrollment Date; and after the Effective Date of Coverage under this Plan in connection with a "preexisting condition" that manifested itself during the 90 day period preceding your Enrollment Date.

Enrollment Date means the earlier of: your Effective Date of Coverage under this Plan (or, if applicable, a prior plan of your employer that has been replaced by this Plan); or the first day of your probationary period, if applicable. Any limitation as to a preexisting condition will not apply to: A newborn enrolled within 31 days of birth. A child who is adopted or placed for adoption before attaining 18 years of age and enrolled within 31 days of the adoption or placement for adoption.

Special Rules As To A Preexisting Condition

If a person had creditable coverage which terminated within 90 days prior to his or her Enrollment Date, any limitation as to a preexisting condition under this Plan will not apply for that person.

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.

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. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. 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). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. 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.