



PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY - INSURED

PLAN FEATURES	PREFERRED CARE
Deductible (per calendar year)	None
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%
Payment Limit (per calendar year)	None Individual None Family
Lifetime Maximum Unlimited except where otherwise indicated.	
Primary Care Physician Selection	Optional
Referral Requirement	None
PREVENTIVE CARE	PREFERRED CARE
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months age 19 and over.	Covered 100%
Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 19. Includes coverage for blood lead level screenings.	Covered 100%
Routine Gynecological Care Exams Includes routine tests and related lab fees. 2 exams per	Covered 100%
Routine Mammograms	Covered 100%
Routine Digital Rectal Exam / Prostate-specific Antigen Test	Covered 100%
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%
Routine Eye Exams 1 routine exam per 24 months	Covered 100%
Routine Hearing Screening	Covered 100%
PHYSICIAN SERVICES	PREFERRED CARE
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	\$25 office visit copay
Specialist Office Visits	\$30 office visit copay
Allergy Testing	Covered as either PCP or specialist office visit
Allergy Injections	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Hearing Exams 1 routine exam per 24 months. Includes exams relating to employment.	\$30 copay
DIAGNOSTIC PROCEDURES	PREFERRED CARE
Diagnostic Laboratory and X-ray 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	Covered 100%
EMERGENCY MEDICAL CARE	PREFERRED CARE
Emergency Room	\$100 copay; waived if admitted
Non-Emergency care in an Emergency Room	Not Covered
Ambulance	Covered 100%
HOSPITAL CARE	PREFERRED CARE
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered 100% after \$300 per confinement copay
Inpatient Maternity Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered 100% after \$300 per confinement copay
Outpatient Hospital Expenses (including surgery)	Covered 100%



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The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit

MENTAL HEALTH SERVICES	PREFERRED CARE
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Inpatient Non-Biologically Based	Covered 100% after \$300 per confinement copay
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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay

Outpatient Non-Biologically Based	\$30 copay
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Inpatient Biologically Based	Covered 100% after \$300 per confinement copay
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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay

Outpatient Biologically Based	\$30 copay
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The member cost sharing applies to all covered benefits incurred during a member's outpatient visit

Crisis Intervention Services	\$30 office visit copay
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ALCOHOL/DRUG ABUSE SERVICES	PREFERRED CARE
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Inpatient	Covered 100% after \$300 per confinement copay
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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay

Outpatient	\$30 copay
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The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit

OTHER SERVICES	PREFERRED CARE
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Convalescent Facility	Covered 100%
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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%
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Limited to 120 visits per calendar year.

For the first 40 visits, each 4 hours of home health aide services equals one visit; after the first 40 visits, each visit of up to 4 hours is equal to one visit. Each visit by a nurse or therapist is one visit.

In the event of early discharge for maternity confinement, i.e. prior to 48 hours for normal delivery, 96 hours for cesarean section, one Home Health Care visit will be covered. This visit is not subject to copays, deductibles, or coinsurance and does not reduce the Home Health Care maximum.

Hospice Care - Inpatient	Covered 100%
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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay

Hospice Care - Outpatient	Covered 100%
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The member cost sharing applies to all covered benefits incurred during a member's outpatient visit

Private Duty Nursing - Outpatient (Limited to 70 eight hour shifts per calendar year)	Covered 100%
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Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

Outpatient Short-Term Rehabilitation	Covered 100%
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Include Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year.

Spinal Manipulation Therapy	Covered 100%
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Durable Medical Equipment	Covered 100%
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Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as PCP office visit cost sharing.
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Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	Covered 100% (payable as any other covered expense)
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Transplants Coverage is provided at an IOE contracted facility only.	Covered 100% after \$300 per confinement copay
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Bariatric	Covered 100% after \$300 per confinement copay
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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.

Out of Area Dependents	No coverage for non-emergency care received outside the service area.
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FAMILY PLANNING	PREFERRED CARE
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Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered
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Diagnosis and treatment of the underlying medical condition.



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Comprehensive Infertility Services	Covered 100%
Voluntary Sterilization Including tubal ligation and vasectomy.	Member cost sharing is based on the type of service performed and the place of service where it is rendered
PHARMACY	PREFERRED CARE
Retail	\$15 copay for generic drugs, \$35 copay for formulary brand-name drugs, and \$50 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.
Mail Order	\$30 copay for generic drugs, \$70 copay for formulary brand-name drugs, and \$100 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.
No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only.	
Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy, Oral and Injectable fertility drugs (injectable, physician charges for injections are not covered under RX, medical coverage may be limited), Diabetic supplies and medication covered at PCP cost sharing. Performance Enhancing Drugs included.	
Precert for growth hormones included. Precert included with 90 day Transition of Care.	
GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26
Pre-existing Conditions Exclusion	Does not apply

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services.

The following is a 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 and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval.
- Durable medical Equipment
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids
- Home births
- Immunizations for travel or work except where medically necessary or indicated.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services, including 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.
- Long-term rehabilitation therapy.



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- Non-medically necessary services or supplies.
- Orthotics except diabetic orthotics.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Treatment of behavioral disorders.
- 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.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. . Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

If you require language assistance from an Aetna representative, please call Member Services' multilingual hotline at **1-888-982-3862** (140 languages are available. You must ask for an interpreter). **TDD 1-800-628-3323** (hearing impaired only).

Si necesita asistencia lingüística de un representante de Aetna, contamos con una línea directa de Servicios a Miembros disponible en varios idiomas. Comuníquese al **1-888-982-3862** (140 idiomas disponibles. Debe solicitar un intérprete). **TDD 1-800-628-3323** (para personas con problemas de audición únicamente).

Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com**.

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