



**PLAN DESIGN & BENEFITS
 PROVIDED BY AETNA HEALTH INC. - FULL RISK**

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	\$1,500 Individual \$3,000 Family	\$3,000 Individual \$6,000 Family
<p>Unless otherwise indicated, the deductible must be met prior to benefits being payable. Applicable covered expenses accumulate separately toward the in-network and out-of-network providers Deductible. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses apply towards the Deductible. Once Family Deductible is met, all family members will be considered as having met their Deductible. There is no Individual Deductible to satisfy within the Family Deductible.</p>		
Out-of-Pocket Maximum (per calendar year)	\$3,000 Individual \$6,000 Family	\$6,000 Individual \$12,000 Family
<p>All applicable covered expenses accumulate separately toward the in-network and out-of-network Out-of-Pocket-Maximum. In-network expenses include coinsurance/copays and deductibles. Out-of-network expenses include coinsurance and deductible. Penalty amounts do not apply. Pharmacy expenses apply towards the Out-of-Pocket-Maximum. Once Family Out-of-Pocket-Maximum is met, all family members will be considered as having met their Out-of-Pocket-Maximum. There is no Individual Out-of-Pocket-Maximum to satisfy within the Family Out-of-Pocket-Maximum.</p>		
Lifetime Maximum	Unlimited except where otherwise indicated.	Unlimited except where otherwise indicated.
<p>Benefit Limitations -- For any service or supply that is subject to a maximum visit, day, or dollar limitation, such services or supplies accumulate toward both the participating provider and non-participating provider benefit limits under this plan.</p>		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
<p>Precertification Requirement Certain non-participating providers/participating provider self referred services require precertification or benefits will be reduced. Refer to your plan documents for a complete list of services that require precertification.</p>		
Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/Immunizations 1 exam every 12 months for members age 22 and older.	Covered 100%; deductible waived	40%; deductible waived
Routine Well Child Exams/Immunizations (Age and frequency schedules apply)	Covered 100%; deductible waived	40%; deductible waived
Routine Gynecological Care Exams 1 exam per 12 months Includes routine tests and related lab fees.	Covered 100%; deductible waived	40%; deductible waived
Routine Mammograms Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	Covered 100%; deductible waived	Covered 100%; deductible waived



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Women's Health	Covered 100%; deductible waived	Covered according to standard claim practice.
Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		
Routine Digital Rectal Exams / Prostate Specific Antigen Test	Covered 100%; deductible waived	40%; deductible waived
Recommended for males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age 50 and over. Frequency schedule applies.		
Routine Eye Exams	Covered 100%; deductible waived 1 routine exam per 24 months.	40%; after deductible 1 routine exam per 24 months.
Routine Hearing Screening	Covered 100%; deductible waived	40%; deductible waived
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Primary Care Physician Visits	10%; after deductible	40%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	10%; after deductible	40%; after deductible
Teladoc	10% after deductible	N/A
Pre-Natal Maternity	Covered 100%; deductible waived	40%; after deductible
Walk-in Clinics	10%; after deductible	40%; after deductible
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.		
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic Laboratory	10%; after deductible	40%; 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.		
Diagnostic X-ray	10%; after deductible	40%; 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.		
Diagnostic X-ray for Complex Imaging Services	10%; after deductible	40%; after deductible
EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Provider	10%; after deductible	10%; after deductible
Emergency Room	10%; after deductible	Refer to participating provider benefit.
Emergency Use of Ambulance	10%; after deductible	Refer to participating provider benefit.
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	10%; after deductible	40% per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		



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Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10% after deductible for Physician maternity services; 10% for Facility Services; after deductible	40% for Physician Maternity Services; after deductible; 40% for Facility Services; after deductible
Outpatient Hospital Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	40%; after deductible
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	40% per admission; after deductible
Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	40% per visit; after deductible
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Detoxification Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	40% per admission; after deductible
Outpatient Detoxification Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	40% per visit; after deductible
Inpatient Rehabilitation Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	40% per admission; after deductible
Residential Treatment Facility Outpatient Rehabilitation Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	40% per admission; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible Limited to 60 days; per calendar year	40% per admission; after deductible Limited to 60 days; per calendar year
Home Health Care Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	10%; after deductible Limited to 20 visits; per calendar year	40%; after deductible Limited to 20 visits; per calendar year
Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	40% per admission; after deductible
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10% per visit; after deductible	40% per visit; after deductible
Outpatient Short-Term Rehabilitation Includes speech, physical, occupational, and spinal manipulation therapy.	10%; after deductible Limited to 35 visits; per calendar year	40% per visit; after deductible Limited to 35 visits; per calendar year
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health benefit with no age or visit limitations.	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Physical Therapy To age 22. Unlimited visits.	10%; after deductible	40%; after deductible
Autism Occupational Therapy To age 22. Unlimited visits.	10%; after deductible	40%; after deductible



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Autism Speech Therapy To age 22. Unlimited visits.	10%; after deductible	40%; after deductible
Durable Medical Equipment	10%; after deductible	40%; after deductible (must precertify if over \$1,500)
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Transplants	10%; after deductible Preferred coverage is provided at an IOE contracted facility only.	40% per admission; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Diagnosis and treatment of the underlying medical condition only.		
Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered	Not Covered



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Vasectomy	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Tubal Ligation	Covered 100%; deductible waived	Your cost sharing is based on the type of service and where it is performed
Medical Pharmacy	Covered 100% ; after deductible	40% after deductible

PRESCRIPTION DRUG BENEFITS	IN-NETWORK	OUT-OF-NETWORK
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The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.

Pharmacy Plan Type Aetna Premier Plus Open Formulary

Generic Drugs		
Retail	\$10 copay; after deductible	50%; after In-Network Deductible
Mail Order	\$25 copay; after deductible	Not Applicable

Preferred Brand-Name Drugs		
Retail	\$50 copay; after deductible	50%; after In-Network Deductible
Mail Order	\$125 copay; after deductible	Not Applicable

Non-Preferred Brand-Name Drugs		
Retail	\$80 copay; after deductible	50%; after In-Network Deductible
Mail Order	\$200 copay; after deductible	Not Applicable

Pharmacy Day Supply and Requirements	
Retail	Up to a 30 day supply Percentage copays will not be doubled
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.
Premier Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.

Choose Generics - If the member or the physician requests brand-name when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
 Oral fertility drugs included.
 Oral chemotherapy drugs covered 100%
 Premier Plus Pre-certification for Specialty Drugs
 Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

GENERAL PROVISIONS

Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status. Dependents to age 30 in Florida if state mandated requirements met.
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**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.



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When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.

- For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

- For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Navigator member site.

This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.

Exclusions and Limitations

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. Each insurer has sole financial responsibility for its own products.

Investment services are independently offered through JPMorgan Institutional Investors, Inc., a subsidiary of JPMorgan Chase Bank.

This material is for information only. 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 our agents. Provider participation may change without notice. We do 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.



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- Custodial care.
- Dental care and dental x-rays.
- Donor egg retrieval.
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- 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.
- 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.
- 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 and Aetna Specialty Pharmacy refer to Aetna Rx Home Delivery, LLC and Aetna Specialty Pharmacy, LLC, respectively. Aetna Rx Home Delivery and Aetna Specialty Pharmacy are licensed pharmacy subsidiaries of Aetna Inc. that operate through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery and Aetna Specialty Pharmacy 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 pharmacies' 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, please call the Member Services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).

Si requiere la asistencia de un representante que hable su idioma, por favor llame al número de Servicios al Miembro que aparece en su tarjeta de identificación y se le comunicará con la línea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intérprete). TDD-1-800-628-3323 (sólo para las personas con impedimentos auditivos).

Plan features and availability may vary by location and group size.



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For more information about Aetna plans, refer to www.aetna.com. While this material is believed to be accurate as of the production date, it is subject to change.

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