



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

| <b>PLAN FEATURES</b>  | <b>PARTICIPATING PROVIDERS / REFERRED</b>   |
|---|---|
| <b>Deductible</b> (per calendar year)   | None Individual<br>None Family  |
| <b>Out-of-Pocket Maximum</b><br>(per calendar year)<br>Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum.<br>Only those participating providers/referred out of pocket expenses resulting from the application of coinsurance percentage and copays (except any penalty amounts and pharmacy cost sharing) may be used to satisfy the Out-of-Pocket Maximum.<br>Once Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year. | \$1,500 Individual<br>\$3,000 Family  |
| <b>Lifetime Maximum</b>   | Unlimited unless otherwise indicated.   |
| <b>Primary Care Physician Selection</b>   | Required  |
| <b>Referral Requirements</b>  | Required for all non-emergency, non-urgent and non-Primary Care Physician services, except direct access services |
| <b>PREVENTIVE CARE</b>  | <b>PARTICIPATING PROVIDERS / REFERRED</b>   |
| <b>Routine Adult Physical Exams / Immunizations</b><br>(Age and frequency schedules apply)  | \$10 copay  |
| <b>Well Child Exams / Immunizations</b><br>(Age and frequency schedules apply)  | \$10 copay  |
| <b>Routine Gynecological Care Exams</b><br>Includes Pap smear and related lab fees.<br>Two exams per calendar year.   | \$10 copay  |
| <b>Routine Mammograms</b><br>One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over   | Covered 100%  |
| <b>Routine Digital Rectal Exams / Prostate Specific Antigen Test</b><br>For males age 40 and over   | Member cost sharing is based on the type of service performed and the place of service where it is rendered.      |
| <b>Colorectal Cancer Screening</b><br>For all members 50 and over.<br>Frequency schedule applies  | Member cost sharing is based on the type of service performed and the place of service where it is rendered.      |
| <b>Routine Eye Exam</b><br>Age/Frequency Schedule may apply.  | \$10 copay  |
| <b>Routine Hearing Screening</b>  | Subject to Routine Physical Exam cost sharing   |
| <b>PHYSICIAN SERVICES</b>   | <b>PARTICIPATING PROVIDERS / REFERRED</b>   |
| <b>Primary Care Physician Visits</b>  | Office Hours: \$10 copay<br>After Office Hours/Home: \$15 copay   |
| <b>Specialist Office Visits</b>   | \$10 copay  |
| <b>Maternity OB Visits</b>  | \$10 copay  |
| <b>Allergy Treatment</b>  | Same as applicable participating provider office visit member cost sharing  |
| <b>Allergy Testing</b>  | Same as applicable participating provider office visit member cost sharing  |
| <b>DIAGNOSTIC PROCEDURES</b>  | <b>PARTICIPATING PROVIDERS / REFERRED</b>   |
| <b>Diagnostic Laboratory</b><br>If performed as a part of a physician's office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit cost sharing.   | Covered 100%  |
| <b>Diagnostic X-ray</b><br>Outpatient hospital or other Outpatient facility (except for Complex Imaging Services)   | Covered 100%  |



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| <b>Diagnostic X-ray for Complex Imaging Services</b>  | \$10 copay   |
| <b>EMERGENCY MEDICAL CARE</b>   | <b>PARTICIPATING PROVIDERS / REFERRED</b>  |
| <b>Urgent Care</b>  | \$50 copay   |
| <b>Non-Urgent use of Urgent Care Provider</b>   | Not Covered  |
| <b>Emergency Room</b>   | \$50 copay   |
| <b>Non-Emergency Care in an Emergency Room</b>  | Not Covered  |
| <b>Ambulance</b>  | Covered 100%   |
| <b>HOSPITAL CARE</b>  | <b>PARTICIPATING PROVIDERS / REFERRED</b>  |
| <b>Inpatient Coverage</b>   | Covered 100% per admission   |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.                      |  |
| <b>Inpatient Maternity Coverage</b>   | Covered 100% per admission   |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.                      |  |
| <b>Outpatient Surgery</b>   | Covered 100% per visit   |
| The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.                    |  |
| <b>MENTAL HEALTH SERVICES</b>   | <b>PARTICIPATING PROVIDERS / REFERRED</b>  |
| <b>Inpatient Mental Illness</b>   | Covered 100% per admission   |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.                      |  |
| <b>Outpatient Mental Illness</b>  | \$10 copay per visit   |
| The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.                    |  |
| <b>ALCOHOL/DRUG ABUSE SERVICES</b>  | <b>PARTICIPATING PROVIDERS / REFERRED</b>  |
| <b>Inpatient Detoxification</b>   | Covered 100% per admission   |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.                      |  |
| <b>Outpatient Detoxification</b>  | \$10 copay   |
| The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.                    |  |
| <b>Inpatient Rehabilitation</b>   | Covered 100% per admission   |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.                      |  |
| <b>Outpatient Rehabilitation</b>  | \$10 copay   |
| The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.                    |  |
| <b>OTHER SERVICES</b>   | <b>PARTICIPATING PROVIDERS / REFERRED</b>  |
| <b>Early Intervention Services</b>  | Member cost sharing is based on the type of service performed and the place of service where it is rendered.     |
| Children from birth to age 3; maximum of \$5,000 per child per calendar year  |  |
| <b>Skilled Nursing Facility</b>   | Covered 100% per admission   |
| <b>Home Health Care</b>   | Covered 100%   |
| <b>Hospice Care - Inpatient</b>   | Covered 100% per admission   |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.                      |  |
| <b>Hospice Care - Outpatient</b>  | Covered 100%   |
| The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.                    |  |
| <b>Private Duty Nursing</b>   | Not Covered unless pre-authorized  |
| <b>Outpatient Rehabilitation Therapy</b> (Includes speech, physical and occupational therapy)                           | \$10 copay   |
| Treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment. |  |
| <b>Subluxation</b>  | \$10 copay   |
| <b>Durable Medical Equipment</b>  | 100%   |
| <b>Diabetic Supplies</b>  | Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies. |
| <b>Hearing Aids</b>   | \$1,000 every 24 months, Children 12 and under   |
| <b>Vision Eyewear</b>   | Not Covered  |
| <b>Transplants</b>  | Covered 100% per admission   |
| Coverage is provided at an IOE contracted facility only   |  |
| <b>Bariatric Surgery</b>  | Covered 100% per admission   |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.                      |  |



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| <b>FAMILY PLANNING</b>  | <b>PARTICIPATING PROVIDERS / REFERRED</b>   |
|---|---|
| <b>Infertility Treatment</b><br>Diagnosis and treatment of the underlying medical condition.  | Member cost sharing is based on the type of service performed and the place of service where it is rendered.  |
| <b>Comprehensive Infertility Services</b><br>Coverage includes Artificial Insemination, limited to 3 courses per lifetime, and Ovulation Induction, limited to 4 courses per lifetime. For covered females under age 40 only.   | Applicable copay applies  |
| <b>Advanced Reproductive Technology (ART)</b><br>ART coverage includes 2 cycles with not more than 2 embryos per cycle of In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), and gamete intrafallopian transfer (GIFT), combined, per lifetime. For covered females under age 40 only. | Not Covered   |
| <b>Voluntary Sterilization</b><br>Including tubal ligation and vasectomy.   | Subject to applicable service type member cost sharing  |
| <b>PHARMACY - PRESCRIPTION DRUG BENEFITS</b>  | <b>PARTICIPATING PROVIDERS / REFERRED</b>   |
| <b>Retail</b>   | \$5 copay for formulary generic drugs, \$15 copay for formulary brand-name drugs, and \$30 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.      |
| <b>Mail Order</b>   | \$10 copay for formulary generic drugs, \$30 copay for formulary brand-name drugs, and \$60 copay for non-formulary brand-name and generic drugs up to a 31-90 day supply from Aetna Rx Home Delivery®. |
| <b>No Mandatory Generic (NO MG)</b> - Member is responsible to pay the applicable copay only.   |   |
| <b>Plan Includes</b> : Contraceptive drugs and devices obtainable from a pharmacy.<br>Precept included<br>Step Therapy included with 90 day Transition of Care  |   |

**Exclusions and Limitations**

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The Aetna companies that offer, underwrite or administer benefits include Aetna Health Inc.. While this material is believed to be accurate as of the print date, it is subject to change.

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.



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- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates.
- Cosmetic surgery.
- 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
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Nonmedically 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.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered in the plan documents.
- 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.

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 any results or outcomes. Consult the plan document (i.e. Schedule of Benefits, Certificate of Coverage, Evidence of Coverage, Group Agreement, Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. The availability of a plan or program may vary by geographic service area. Some benefits are subject to limitations or visit maximums. With the exception of Aetna Rx Home Delivery, all participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.

Aetna Pharmacy Management refers to an internal business unit of Aetna Health Management, LLC. If your plan covers outpatient prescription drugs, your plan may include a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally not limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step-therapy, please refer to Aetna's website at [www.aetna.com](http://www.aetna.com), or the Aetna Medication Formulary Guide. Many drugs, including many of those listed on the formulary, are subject to rebate arrangements between Aetna and the manufacturer of the drugs. Rebates received by Aetna from drug manufacturers are not reflected in the cost paid by a member for a prescription drug.



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In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage. Aetna Rx Home Delivery® refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna Inc., that is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated charge with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services.

Certain primary care providers are affiliated with integrated delivery systems or other provider groups (such as independent practice associations and physician-hospital organizations), and members who select these providers will generally be referred to specialists and hospitals within those systems or groups. However, if a system or group does not include a provider qualified to meet member's medical needs, member may request to have services provided by a non-system or non-group providers. Member's request will be reviewed and will require prior authorization from the system or group and/or Aetna to be a covered benefit.

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 obtains covered services from participating providers, the provider will obtain precertification. If the Member obtains covered services from a nonparticipating provider, the Member must obtain the precertification. Precertification requirements may vary. Members may refer to their plan documents for a complete list of medical services that require precertification. Certain benefits like comprehensive infertility and advanced reproductive technology (ART) services, if covered under your plan, are subject to a select network of participating providers, from which you will be required to seek care to receive covered benefits.

Members or providers may be required to precertify, or obtain prior approval of coverage for certain services such as non-emergency inpatient hospital care. Certain benefits like comprehensive infertility and advanced reproduction technology (ART) services, if covered under your plan, are subject to a select network of participating providers, from which you will be required to seek care to receive covered benefits.

