# PLAN DESIGN & BENEFITS
PROVIDED BY AETNA

## PLAN FEATURES

<table>
<thead>
<tr>
<th></th>
<th>MAXIMUM SAVINGS</th>
<th>STANDARD SAVINGS</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible (per calendar year)</td>
<td>$500 Individual</td>
<td>$1,500 Individual</td>
<td>$1,500 Individual</td>
</tr>
<tr>
<td></td>
<td>$1,000 Family</td>
<td>$3,000 Family</td>
<td>$3,000 Family</td>
</tr>
</tbody>
</table>


Unless otherwise indicated, the deductible must be met prior to benefits being payable.

Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible.

The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Deductible amount.

### Member Coinsurance

<table>
<thead>
<tr>
<th></th>
<th>10%</th>
<th>30%</th>
</tr>
</thead>
</table>

 Applies to all expenses unless otherwise stated.

### Payment Limit (per calendar year)

<table>
<thead>
<tr>
<th></th>
<th>$2,500 Individual</th>
<th>$5,500 Individual</th>
<th>$5,500 Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$5,000 Family</td>
<td>$11,000 Family</td>
<td>$11,000 Family</td>
</tr>
</tbody>
</table>


Certain member cost sharing elements may not apply toward the Payment Limit.

Pharmacy expenses apply towards the Payment Limit.

Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit.

The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Payment Limit amount.

### Lifetime Maximum

Unlimited except where otherwise indicated.

### Payment for Non-Preferred Care**

<table>
<thead>
<tr>
<th></th>
<th>Not Applicable</th>
<th>Not Applicable</th>
<th>Professional: 105% of Medicare Facility: 140% of Medicare</th>
</tr>
</thead>
</table>

### Primary Care Physician Selection

<table>
<thead>
<tr>
<th></th>
<th>Not Applicable</th>
<th>Not Applicable</th>
<th>Not Applicable</th>
</tr>
</thead>
</table>

### Certification Requirements -

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.

### Referral Requirement

None

### Network Designations -

In order to be covered at the preferred in-network benefit level; you must use a designated provider for care. If you receive care from a non-designated provider, your care may be paid at the out-of-network benefit level or may not be covered at all.

### PREVENTIVE CARE

<table>
<thead>
<tr>
<th></th>
<th>MAXIMUM SAVINGS</th>
<th>STANDARD SAVINGS</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Adult Physical Exams/ Immunizations</td>
<td>Covered 100%; deductible waived</td>
<td>Covered 100%; deductible waived</td>
<td>30%; after deductible waived</td>
</tr>
</tbody>
</table>

1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.
## Routine Well Child Exams/Immunizations

- **Covered 100%; deductible waived**

Routine Well Child Exams/Immunizations includes routine tests and related lab fees. 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 22.

## Routine Gynecological Care Exams

- **Covered 100%; deductible waived**

Includes routine tests and related lab fees.

## Routine Mammograms

- **Covered 100%; deductible waived**

Includes mammograms for women of all ages. 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.

## Women’s Health

- **Covered 100%; deductible waived**

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 Exam

- **Covered 100%; deductible waived**

Recommended: For covered males age 40 and over.

## Prostate-specific Antigen Test

- **Covered 100%; deductible waived**

Recommended: For covered males age 40 and over.

## Colorectal Cancer Screening

- **Covered 100%; deductible waived**

Recommended: For all members age 50 and over.

## Routine Eye Exams

- **Covered 100%; deductible waived**

1 routine exam per 24 months.

## Routine Hearing Screening

- **Covered 100%; deductible waived**

Includes services of an internist, general physician, family practitioner or pediatrician.

## PHYSICIAN SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Maximum Savings</th>
<th>Standard Savings</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office Visits to non-Specialist</strong></td>
<td>$20 copay; deductible waived</td>
<td>30%; after deductible</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td>Includes services of an internist, general physician, family practitioner or pediatrician.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialist Office Visits</strong></td>
<td>$30 copay; deductible waived</td>
<td>30%; after deductible</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td><strong>Audiometric Hearing Exam</strong></td>
<td>$30 copay; deductible waived</td>
<td>30%; after deductible</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td>1 routine exam per 24 months.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pre-Natal Maternity</strong></td>
<td>Covered 100%; deductible waived</td>
<td>Covered 100%; deductible waived</td>
<td>Covered according to standard claim practice.</td>
</tr>
<tr>
<td><strong>Walk-in Clinics</strong></td>
<td>$20 copay; deductible waived</td>
<td>30%; after deductible</td>
<td>30%; after deductible</td>
</tr>
</tbody>
</table>

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.
### PLAN DESIGN & BENEFITS
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#### Allergy Testing
Member cost sharing is based on the type of service performed and the place of service where it is rendered.

#### Allergy Injections
Member cost sharing is based on the type of service performed and the place of service where it is rendered.

<table>
<thead>
<tr>
<th>DIAGNOSTIC PROCEDURES</th>
<th>MAXIMUM SAVINGS</th>
<th>STANDARD SAVINGS</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic X-ray</td>
<td>10%; after deductible</td>
<td>30%; after deductible</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Laboratory</td>
<td>10%; after deductible</td>
<td>30%; after deductible</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Outpatient Complex Imaging</td>
<td>10%; after deductible</td>
<td>30%; after deductible</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td>EMERGENCY MEDICAL CARE</td>
<td>MAXIMUM SAVINGS</td>
<td>STANDARD SAVINGS</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>Urgent Care Provider</td>
<td>10%; after deductible</td>
<td>30%; after deductible</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td>$30 copay; deductible waived</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Urgent Use of Urgent Care Provider</td>
<td>50%; after deductible</td>
<td>50%; after deductible</td>
<td>50%; after deductible</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>10%; after deductible</td>
<td>10%; after deductible</td>
<td>Same as in-network care</td>
</tr>
<tr>
<td>$100 copay; deductible waived</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copay waived if admitted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Emergency Care in an Emergency Room</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Emergency Use of Ambulance</td>
<td>10%; after deductible</td>
<td>10%; after deductible</td>
<td>Same as in-network care</td>
</tr>
<tr>
<td>Non-Emergency Use of Ambulance</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>HOSPITAL CARE</td>
<td>MAXIMUM SAVINGS</td>
<td>STANDARD SAVINGS</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>Inpatient Coverage</td>
<td>10%; after deductible</td>
<td>30%; after deductible</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td>The member cost sharing applies to all covered benefits incurred during a member’s inpatient stay.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Maternity Coverage (includes delivery and postpartum care)</td>
<td>10%; after deductible</td>
<td>30%; after deductible</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td>The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital Expenses</td>
<td>10%; after deductible</td>
<td>30%; after deductible</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td>The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery - Hospital</td>
<td>10%; after deductible</td>
<td>30%; after deductible</td>
<td>30%; after deductible</td>
</tr>
</tbody>
</table>
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.

### Outpatient Surgery - Freestanding Facility

<table>
<thead>
<tr>
<th>MENTAL HEALTH SERVICES</th>
<th>MAXIMUM SAVINGS</th>
<th>STANDARD SAVINGS</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>10%; after deductible</td>
<td>30%; after deductible</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$30 copay; deductible waived</td>
<td>30%; after deductible</td>
<td>30%; after deductible</td>
</tr>
</tbody>
</table>

The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.

### Inpatient MENTAL HEALTH SERVICES

<table>
<thead>
<tr>
<th>MENTAL HEALTH SERVICES</th>
<th>MAXIMUM SAVINGS</th>
<th>STANDARD SAVINGS</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>10%; after deductible</td>
<td>30%; after deductible</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td>Residential Treatment Facility</td>
<td>10%; after deductible</td>
<td>30%; after deductible</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$30 copay; deductible waived</td>
<td>30%; after deductible</td>
<td>30%; after deductible</td>
</tr>
</tbody>
</table>

### Residential Treatment Facility

Limited to 100 days per calendar year.

### Home Health Care

Limited to 90 visits 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

The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.

### Hospice Care - Outpatient

The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.

### Private Duty Nursing

Limited to 30 eight-hour shifts per calendar year.

Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

### Outpatient Physical Therapy

Limited to 12 visits per calendar year combined.

### Outpatient Speech and Occupational Therapy

Limited to 12 visits per calendar year combined.

### Spinal Manipulation Therapy

Limited to 12 visits per calendar year combined.

### Autism Behavioral Therapy

Covered same as any other Outpatient Mental Health benefit.

### Autism Applied Behavior Analysis

Covered same as any other Outpatient Mental Health benefit with no age or visit limitations.
## PLAN DESIGN & BENEFITS

**Provided by Aetna**

### Autism Physical Therapy
- $30 copay; deductible waived
- 30%; after deductible
- 30%; after deductible

### Autism Occupational Therapy
- $30 copay; deductible waived
- 30%; after deductible
- 30%; after deductible

### Autism Speech Therapy
- $30 copay; deductible waived
- 30%; after deductible
- 30%; after deductible

### Durable Medical Equipment
- 10%; after deductible
- 30%; after deductible
- 30%; after deductible

### Diabetic Supplies -- (if not covered under Pharmacy benefit)
- Covered same as any other medical expense.
- Covered same as any other medical expense.
- Covered same as any other medical expense.

### Generic FDA-approved Women's Contraceptives
- Covered 100%; deductible waived
- Covered 100%; deductible waived
- Covered same as any other expense.

### Contraceptive drugs and devices not obtainable at a pharmacy
- Covered 100%; deductible waived
- Covered 100%; deductible waived
- Covered same as any other medical expense.

### Hearing Aids
- $1,000 per 36 months
- 10%; after deductible
- 30%; after deductible
- 30%; after deductible

### Transplants
- Preferred coverage is provided at an IOE contracted facility only.
- 10%; after deductible
- 30%; after deductible
- 30%; after deductible
- Non-Preferred coverage is provided at a Non-IOE facility.

### Bariatric Surgery
- 10%; after deductible
- 30%; after deductible
- 30%; after deductible

The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.

### "Other" Health Care -- 20% member coinsurance after the preferred (per calendar year) deductible for services that are neither "preferred" nor "non-preferred".

### FAMILY PLANNING

<table>
<thead>
<tr>
<th>Maximum Savings</th>
<th>Standard Savings</th>
<th>Out-of-Network</th>
</tr>
</thead>
</table>

### Infertility Treatment
- Member cost sharing is based on the type of service performed and the place of service where it is rendered
- Member cost sharing is based on the type of service performed and the place of service where it is rendered
- Member cost sharing is based on the type of service performed and the place of service where it is rendered

Diagnosis and treatment of the underlying medical condition.

### Vasectomy
- Member cost sharing is based on the type of service performed and the place of service where it is rendered
- Member cost sharing is based on the type of service performed and the place of service where it is rendered
- Member cost sharing is based on the type of service performed and the place of service where it is rendered

### Tubal Ligation
- Covered 100%; deductible waived
- Covered 100%; deductible waived
- 30%; after deductible

### PHARMACY

#### IN-NETWORK

In-network pharmacy expenses apply towards the Maximum Savings tier only. Out-of-network pharmacy expenses apply towards the out-of-network tier.

#### OUT-OF-NETWORK

- Aetna Value Plus Open Formulary

### Preferred Generic Drugs

<table>
<thead>
<tr>
<th></th>
<th>Retail</th>
<th>Mail Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10 copay</td>
<td>30% of submitted cost; after applicable copay</td>
<td></td>
</tr>
<tr>
<td>$20 copay</td>
<td>Not Applicable</td>
<td></td>
</tr>
</tbody>
</table>

Page 5
**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.

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.

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

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.
PLAN DESIGN & BENEFITS
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• 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.
• 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.

This managed care plan may not cover all of your health care expenses. Read your contract carefully to determine which health care services are covered. To contact the plan if you are a member, call the number on your ID card; all others, call 1-888-982-3862.

Translation of the material into another language may be available. Please call Member Services at 1-888-982-3862.
Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al 1-888-982-3862.

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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