PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	
Benefit Limitations - For any service or supply that is subject to a maximum visit, day, or dollar limitation on a per year basis, the benefit year begins on January 1st unless otherwise mandated. The plan pays secondary to Medicare. Refer to your plan documents for more information.	
Deductible	$300 Individual $600 Family
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	10%
Applies to all expenses unless otherwise stated.	
Payment Limit	$1,750 Individual $3,500 Family
Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses do not 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.
Primary Care Physician Selection	Optional
Certification Requirements -	Certification for Hospital Admissions must be obtained to avoid a reduction in benefits paid. Excluded amount applied separately to each type of expense is $400 per occurrence.
Referral Requirement	None
PREVENTIVE CARE	
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived
1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived
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 12 months thereafter to age 22.	
Routine Gynecological Care Exams	Covered 100%; deductible waived
1 obgyn exam and pap smear per year	
Routine Mammograms	Covered 100%; deductible waived
Recommended: One per year for covered females age 40 and over.	
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.	

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Colorectal Cancer Screening	Covered 100%; deductible waived
Recommended: For all members age 45 and over.	
Routine Eye Exams	Covered 100%; deductible waived
1 routine exam per 12 months.	
Routine Hearing Screening	Covered 100%; deductible waived
PHYSICIAN SERVICES	
Office Visits to non-Specialist	10%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.	
Specialist Office Visits	10%; after deductible
Hearing Exams	10%; after deductible
Pre-Natal Maternity	Covered 100%; deductible waived
Walk-in Clinics	10%; after deductible
Walk-in Clinics are free-standing health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be Walk-in Clinics.	
Allergy Testing	10%; after deductible
Allergy Injections	10%; after deductible
DIAGNOSTIC PROCEDURES	
Diagnostic X-ray	10%; after deductible
(other than Complex Imaging Services)	
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 Laboratory	10%; 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 Complex Imaging	10%; 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.	
EMERGENCY MEDICAL CARE	
Urgent Care Provider	10%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	10%; after deductible
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	10%; after deductible
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	
Inpatient Coverage	10% after $250 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Inpatient Maternity Coverage (includes delivery and postpartum care)	10% after $250 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Outpatient Hospital Expenses	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	

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MENTAL HEALTH SERVICES	
Inpatient	10% after $250 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Mental Health Office Visits	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Mental Health Services	10%; after deductible
SUBSTANCE ABUSE	
Inpatient	10% after $250 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Residential Treatment Facility	10% after $250 copay; after deductible
Substance Abuse Office Visits	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Substance Abuse Services	10%; after deductible
OTHER SERVICES	
Skilled Nursing Facility	10%; after deductible
Limited to 100 days per year	
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Home Health Care	10%; after deductible
Private Duty Nursing not covered	
Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	
Hospice Care - Inpatient	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Hospice Care - Outpatient	10%; after deductible
Your cost sharing is based on the type of service and where it is performed	
Autism Behavioral Therapy	10%; after deductible
Covered same as any other Outpatient Mental Health benefit	
Autism Applied Behavior Analysis	10%; after deductible
Covered same as any other Outpatient Mental Health Other Services benefit	
Autism Physical Therapy	10%; after deductible
Autism Occupational Therapy	10%; after deductible
Autism Speech Therapy	10%; after deductible
Habilitative Physical Therapy	10%; after deductible
Habilitative Occupational Therapy	10%; after deductible
Habilitative Speech Therapy	10%; after deductible
Outpatient Rehabilitative Speech Therapy	10%; after deductible
Outpatient Physical and Occupational Therapy	10%; after deductible
Early Intervention Services	N/A
Spinal Manipulation Therapy	10%; after deductible
Acupuncture	Not Covered
Hearing Aids	10%; after deductible
Limited to $2,000 once every 24 months for all covered members	
Durable Medical Equipment	10%; after deductible
Diabetic Supplies	Covered same as any other medical expense.
Prosthetics	10%; after deductible

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Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived
Infusion Therapy Administered in the home or physician's office	10%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	10%; after deductible
Transplants	10%; after deductible
Bariatric Surgery	Not Covered
FAMILY PLANNING	
Infertility Treatment	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	Not Covered
Artificial insemination and ovulation induction	
Advanced Reproductive Technology (ART)	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	
Tubal Ligation	Covered 100%; deductible waived
Vasectomy	Your cost sharing is based on the type of service and where it is performed; after deductible
PHARMACY	
Pharmacy Plan Type	Benefit offered through SilverScripts
GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth, regardless of student status. Dependent children terminate coverage effective on the 1st of the month following the date they reach the limiting age. Limiting age can be any qualifying age up to age 26.

Plans are provided by: Aetna Health Inc. 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 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.

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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
• 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.
• 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/enhancement, 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.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.
Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**
Puede estar disponible la traduccion 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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