PLAN DESIGN AND BENEFITS - Tx OAMC Basic 2500-10

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	$2,500 Individual $7,500 Family	$4,000 Individual $12,000 Family
	3 Individuals per Family	3 Individuals per Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Member cost sharing for certain services including member cost sharing for prescription drugs, as indicated in the plan, are excluded from charges to meet the Deductible. All covered expenses accumulate separately toward the preferred and non-preferred Deductible. Once 3 individual members of a family each satisfy their Deductible amount separately, all family members will be considered as having met their Deductible for the remainder of the calendar year.		
Member Coinsurance (applies to all expenses unless otherwise stated)	50%	50%
Payment Limit (per calendar year, excludes deductible)	$6,000 Individual $18,000 Family 3 Individuals per Family	$10,000 Individual Family $30,000 3 Individuals per Family
All covered expenses accumulate separately toward the preferred and non-preferred Payment Limit. Once 3 individual members of a family each satisfy their Payment Limit separately, all family members will be considered as having met their Payment Limit for the remainder of the calendar year. Certain member cost sharing elements may not apply toward the Payment Limit including deductible, copays and pharmacy. Only those preferred & non-preferred expenses resulting from the application of coinsurance percentage (except any penalty amounts) may be used to satisfy the Payment Limit. Once 3 individual members of a family each satisfy their Payment Limit separately, all family members will be considered as having met their Payment Limit for the remainder of the calendar year.		
Lifetime Maximum (per member lifetime, Preferred and Non-Preferred combined)	Unlimited	
Payment for Non-Preferred	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare*
Primary Care Physician Selection	Not Applicable	Not Applicable
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, and Hospice Care is required. Benefits will be reduced by $400 per occurrence if Certification is not obtained.		
Referral Requirement	None	None
PHYSICIAN SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Office Visits to Non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery	$35 copay, deductible waived for first 3 visits (Specialist & non-Specialist combined), additional visits subject to deductible and coinsurance	50% after deductible
Specialist Office Visits	$35 copay, deductible waived for first 3 visits (Specialist & non-Specialist combined), additional visits subject to deductible and coinsurance	50% after deductible

PLAN DESIGN AND BENEFITS - Tx OAMC Basic 2500-10

Walk-in Clinics 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 an outpatient department of a hospital, shall be considered a Walk-in Clinic.	$35 copay, deductible waived for first 3 visits (Specialist & non-Specialist combined), additional visits subject to deductible and coinsurance	50% after deductible
Maternity OB Visits	50% after deductible	50% after deductible
Surgery (in office)	See office visits	50% after deductible
Allergy Testing (given by a physician)	See office visits	50% after deductible
Allergy Injections (not given by a physician)	See office visits	50% after deductible
PREVENTIVE CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Routine Adult Physical Exams / Immunizations 1 exam every 12 months to age 65; 1 exam every 12 months after age 65	$0 copay; deductible waived Preventive care visits do not accumulate toward the 3 visit limit	30% after deductible
Well Child Exams / Immunizations 7 exams in first 12 months; 2 exams in months 13-24; 1 exam every 12 months to age 18	$0 copay; deductible waived Preventive care visits do not accumulate toward the 3 visit limit	30% after deductible
Routine Gynecological Exams Includes annual exam, Pap smear and related lab fees	$0 copay; deductible waived Preventive care visits do not accumulate toward the 3 visit limit	30% after deductible
Routine Mammograms **Annual exam f**or covered females age 35 and over	$0 copay; deductible waived Preventive care visits do not accumulate toward the 3 visit limit	30% after deductible
Routine Digital Rectal Exam / Prostate-Specific Antigen Test For covered males age 40 and over. Frequency schedule applies.	$0 copay; deductible waived Preventive care visits do not accumulate toward the 3 visit limit	30% after deductible

PLAN DESIGN AND BENEFITS - Tx OAMC Basic 2500-10

Routine (or Preventive) Colorectal Cancer Screening For all members age 50 and over. Frequency schedule applies. Sigmoidoscopy and Double Contrast Barium Enema (DCBE) - 1 every 5 years for all members age 50 and over. Colonoscopy - 1 every 10 years for all members age 50 and over. Fecal Occult Blood Testing (FOBT) - 1 every year for all members age 50 and over	$0 copay; deductible waived Preventive care visits do not accumulate toward the 3 visit limit	30% after deductible
Routine Eye Exams at Specialist	Not Covered	Not Covered
Routine Hearing Exams	Not Covered	Not Covered
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Outpatient Diagnostic Laboratory 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 member cost sharing.	50% after deductible	50% after deductible
Outpatient Diagnostic X-ray (except for Complex Imaging Services] 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 member cost sharing.	50% after deductible	50% after deductible
Outpatient Diagnostic X-ray for Complex Imaging Services Including, but not limited to, MRI, MRA, PET and CT Scans	50% after deductible	50% after deductible
EMERGENCY MEDICAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Urgent Care Provider	50% after deductible	50% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	50% after deductible	Paid as Preferred Care
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Emergency Ambulance	50% after deductible	Paid as Preferred Care
Non-Emergency Ambulance	50% after deductible	50% after deductible

PLAN DESIGN AND BENEFITS - Tx OAMC Basic 2500-10

HOSPITAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Coverage Including maternity prenatal, delivery and postpartum & transplants. If transplant is performed through an Institute of Excellence® facility, benefits would be paid at the preferred level. If procedure is not performed through Institutes of Excellence®] facility, benefits would be paid at the non-preferred level.	50% after deductible	50% after deductible
Outpatient Surgery Provided in an outpatient hospital department or a freestanding surgical facility	50% after deductible	50% after deductible
MENTAL HEALTH SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	Not Covered	Not Covered
Outpatient	Not Covered	Not Covered
ALCOHOL / DRUG ABUSE SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	Not Covered	Not Covered
Outpatient	Not Covered	Not Covered
OTHER SERVICES AND PLAN DETAILS	**PREFERRED CARE**	**NON-PREFERRED CARE**
Skilled Nursing Facility Limited to 30 days per member per calendar year; Preferred and Non-Preferred combined	50% after deductible	50% after deductible
Home Health Care Limited to 60 visits per member per calendar year; Preferred and Non-Preferred combined; 1 visit equals a period of 4 hours or less	50% after deductible	50% after deductible
Infusion Therapy	50% after deductible	50% after deductible
Inpatient Hospice Care	50% after deductible	50% after deductible
Outpatient Hospice Care	50% after deductible	50% after deductible
Private Duty Nursing	Not Covered	Not Covered

PLAN DESIGN AND BENEFITS - Tx OAMC Basic 2500-10

Outpatient Speech Therapy (if provided in the outpatient hospital department, paid under outpatient hospital benefit) Limited to 20 visits per member per calendar year; Preferred and Non-Preferred combined	See office visits	50% after deductible
Outpatient Physical, Occupational and Spinal ManipulationTherapy Limited to 20 visits per member per calendar year; Preferred and Non-Preferred combined	See office visits	50% after deductible
Durable Medical Equipment	Not Covered	Not Covered
Diabetic Supplies not obtainable at a pharmacy	Covered same as any other medical expense	Covered same as any other medical expense
Contraceptive drugs and devices not obtainable at a pharmacy Includes coverage for contraceptive visits	Covered at applicable office visit copay; deductible waived	50% after deductible
FAMILY PLANNING	**PREFERRED CARE**	**NON-PREFERRED CARE**
Infertility Treatment Covered only for the diagnosis and treatment of the underlying medical condition	Not Covered	Not Covered
Advanced Reproductive Technology (ART) ART including but not limited to: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery	Not covered	Not covered
Voluntary Sterilization Including tubal ligation and vasectomy	Member cost sharing is based on the type of service performed and the place rendered	Member cost sharing is based on the type of service performed and the place rendered
PHARMACY - PRESCRIPTION DRUG BENEFITS	**PARTICIPATING PHARMACIES**	**NON-PARTICIPATING PHARMACIES**
Retail Up to a 30-day supply	$15 copay for generic drugs. Member pays 100% for brand name drugs	30% after $15 copay for generic drugs. Member pays 100% for brand name drugs
Mail Order Delivery 90 day supply	$45 copay for generic drugs. Member pays 100% for brand name drugs	Same as non-preferred retail
Specialty Care Rx - prescriptions for specialty care drugs may be filled at a participating retail pharmacy or Aetna Specialty Pharmacy®.		
Plan includes: Contraceptive drugs and devices obtainable from a pharmacy and diabetic supplies obtainable from a pharmacy.		
Plan excludes: Lifestyle/performance drugs		
Precertification and Step Therapy included with 90 day Transition of Care (TOC) for Precertification and Step Therapy included		

PLAN DESIGN AND BENEFITS - Tx OAMC Basic 2500-10

*You may choose providers in our network (physicians and facilities) or may visit an out-of-network provider. Typically, you will pay substantially more money out of your own pocket if you choose to use an out-of-network doctor or hospital. The out-of-network provider will be paid based on Aetna's "recognized charge." This is not the same as the billed charge from the doctor.

Aetna pays a percentage of the recognized charge, as defined in your plan. The recognized charge for out-of-network hospitals, doctors and other out-of-network health care providers is a percentage (100 percent or above) of the rate that Medicare pays them.

You may have to pay the difference between the out-of-network provider's billed charge and Aetna's recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the doctor or hospital bills you above Aetna's recognized charge does not count toward your deductible or out-of-pocket maximums.

This benefit applies when you choose to get care out of network. When you have no choice in the doctors you see (for example, an emergency room visit after a car accident), your deductible and coinsurance for the in-network level of benefits will be applied, and you should contact Aetna if your doctor asks you to pay more. Generally, you are not responsible for any outstanding balance billed by your doctors in an emergency situation.

What's Not Covered

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.

- All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents;
- Charges related to any eye surgery mainly to correct refractive errors;
- Cosmetic surgery, including breast reduction;
- Custodial care;
- Dental care and X-rays;
- Donor egg retrieval;
- Experimental and investigational procedures;
- Hearing aids;
- Immunizations for travel or work;
- Infertility services, including, but not limited to, 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;
- Medical expenses for a pre-existing condition are not covered (full postponement rule) for the first 365 days after the insured's enrollment date. Lookback period for determining a pre-existing condition (conditions for which diagnosis, care or treatment was recommended or received) is 90 days prior to the enrollment date. The pre-existing condition limitation period will be reduced by the number of days of prior creditable coverage the member has as of the enrollment date.
- Nonmedically necessary services or supplies;
- Orthotics;
- Over-the-counter medications and supplies;
- Reversal of sterilization;
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and
- Special duty nursing.
- 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.

Pre-existing Conditions Exclusion Provision

This plan imposes a pre-existing conditions exclusion, which may be waived in some circumstances (that is, creditable coverage) and may not be applicable to you. A pre-existing conditions exclusion means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis or treatment was recommended or received or for which the individual took prescribed drugs within 3 months.

PLAN DESIGN AND BENEFITS - Tx OAMC Basic 2500-10

Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 3 month period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 12 months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period.

If you had prior credible coverage within 63 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.

If you had no prior creditable coverage within the 63 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 63 day gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion.

In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any Certificates of Creditable Coverage you have. Please contact your Aetna Member Services representative at (888) 802-3862 if you need assistance in obtaining a Certificate of Creditable Coverage from your prior carrier or if you have any questions on the information noted above.

The pre-existing condition exclusion does not apply to pregnancy nor to a child under the age of 19. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment; the pre-existing exclusion will be applied from the individual's effective date of coverage.

This material is for informational purposes only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Plan features and availability may vary by location and group size. Not all heath services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. With the exception of Aetna Rx Home Delivery, 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.

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’s preferred provider is coordinating care, the preferred provider will obtain the precertification. Precertification requirements may vary.

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 Aetna.com, or the Aetna Medication Formulary Guide. 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. 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.

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

Plans are provided by Aetna Life Insurance Company.

For more information about Aetna plans, refer to www.aetna.com.