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PLAN FEATURES	PARTICIPATING PROVIDER REFERRED*	PARTICIPATING PROVIDER SELF-REFERRED
Deductible (per calendar year)	Not Applicable	$5,000 Individual $15,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. All covered expenses accumulate separately toward the participating referred and participating self-referred Deductible. 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. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.		
Member Coinsurance	Not Applicable	30% after deductible
Out-of-Pocket Maximum (per calendar year, not including deductible)	Not Applicable	$20,000 Individual $60,000 Family
Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. All covered expenses accumulate separately toward the participating referred and participating self- referred Out-of-Pocket Maximum. Once the 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. Members must continue to pay any prescription drug copays after meeting their Out-of-Pocket Maximum. Only those self-referred out-of-pocket expenses resulting from the application of coinsurance percentage may be used to satisfy the Out-of-Pocket Maximum.		
Lifetime Maximum	Unlimited	Unlimited
Primary Care Physician Selection	Required	Not Applicable
Referral Requirement	Required for all non-emergency, non-urgent and non-Primary Care Physician services, except direct access services	None
PHYSICIAN SERVICES	**PARTICIPATING PROVIDER REFERRED***	**PARTICIPATING PROVIDER SELF-REFERRED**
Primary Care Physician Visits	$30 copay	30% after deductible
Specialist Office Visits	$50 copay	30% after deductible
Maternity OB Visits	$30 copay for initial visit only, thereafter covered 100%	30% after deductible
Allergy Treatment	Applicable office visit copay	30% after deductible
Allergy Testing	$50 copay	30% after deductible
PREVENTIVE CARE	**PARTICIPATING PROVIDER REFERRED***	**PARTICIPATING PROVIDER SELF-REFERRED**
Routine Adult Physical Exams / Immunizations Ages 19 and over -One exam every 12 months Referred and Self-Referred combined	$0 copay / $0 copay	30% after deductible / 0%; deductible waived
Well Child Exams / Immunizations Ages 0 - 12 months - 6 exams Ages 1 - 2 - 2 exams Ages 2 - 19 - One exam every 12 months Referred and Self-Referred combined	$0 copay / $0 copay	0%; deductible waived / 0%; deductible waived

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PREVENTIVE CARE, cont.	PARTICIPATING PROVIDER REFERRED*	PARTICIPATING PROVIDER SELF-REFERRED
Routine Gynecological Exams Includes Pap smear and related lab fees Two routine exams per calendar year Referred and Self-Referred combined	$0 copay	30% after deductible
Routine Mammograms One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over Referred and Self-Referred combined	$0 copay	30% after deductible
Routine Digital Rectal Exams / Prostate Specific Antigen Test One exam per calendar year for any age for men with prior history; One exam per calendar year ages 50 and over if asymptomatic; One exam per calendar year ages 40 and over if family history or other risk factors Referred and Self-Referred combined	$0 copay	30% after deductible
Colorectal Cancer Screening For all members age 50 and over. Frequency schedule applies. Referred and Self-Referred combined	$0 copay	30% after deductible
Routine Eye Exams at Specialist One exam every 24 months Referred and Self-Referred combined	$0 copay	30% after deductible
Routine Hearing Screening at PCP	Covered as part of a routine physical exam	30% after deductible
DIAGNOSTIC PROCEDURES	**PARTICIPATING PROVIDER REFERRED***	**PARTICIPATING PROVIDER SELF-REFERRED**
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	$0 copay	30% after deductible
Diagnostic X-Ray 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 copay	30% after deductible

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EMERGENCY MEDICAL CARE	PARTICIPATING PROVIDER REFERRED*	PARTICIPATING PROVIDER SELF-REFERRED
Urgent Care Provider	$35 copay	30% after deductible
Non-Urgent use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	$150 copay	Refer to Referred benefit
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Emergency Ambulance	$100 copay	Refer to Referred benefit
Non-Emergency Ambulance Non-emergency ambulance only covered if ordered and authorized by plan	$100 copay	30% after deductible
HOSPITAL CARE	**PARTICIPATING PROVIDER REFERRED***	**PARTICIPATING PROVIDER SELF-REFERRED**
Inpatient Coverage Including maternity & transplants Transplant coverage is provided at an Institute of Excellence™ contracted facility only	$300 copay per day up to 3 days per admission	30% after deductible
Outpatient Surgery Provided in an outpatient hospital department or a freestanding surgical facility	$150 copay	30% after deductible
MENTAL HEALTH SERVICES	**PARTICIPATING PROVIDER REFERRED***	**PARTICIPATING PROVIDER SELF-REFERRED**
Inpatient Biologically Based Mental Illness and Children with Serious Emotional Disturbances Unlimited days per member per calendar year	$300 copay per day up to 3 days per admission	30% after deductible
Inpatient Other than Biologically Based Mental Illness and Children with Serious Emotional Disturbances Limited to 30 days per member per calendar year Referred and Self-Referred combined	$300 copay per day up to 3 days per admission	30% after deductible
Outpatient Biologically Based Mental Illness and Children with Serious Emotional Disturbances Unlimited visits per member per calendar year	$50 copay	30% after deductible
Outpatient Other than Biologically Based Mental Illness and Children with Serious Emotional Disturbances Limited to 20 visits per member per calendar year Referred and Self-Referred combined	$50 copay	30% after deductible

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ALCOHOL/DRUG ABUSE SERVICES	PARTICIPATING PROVIDER REFERRED*	PARTICIPATING PROVIDER SELF-REFERRED
Inpatient Detoxification Limited to 7 days per calendar year Referred and Self-Referred combined	$300 copay per day up to 3 days per admission	30% after deductible
Outpatient Detoxification Limited to 60 visits per member per calendar year, 20 visits per calendar year for family counseling Referred and Self-Referred combined	$20 copay	30% after deductible
Inpatient Rehabilitation Limited to 30 days per member per calendar year Referred and Self-Referred combined	$300 copay per day up to 3 days per admission	30% after deductible
Outpatient Rehabilitation Limited to 60 visits per member per calendar year, 20 visits per calendar year for family counseling Referred and Self-Referred combined	$20 copay	30% after deductible
OTHER SERVICES	**PARTICIPATING PROVIDER REFERRED***	**PARTICIPATING PROVIDER SELF-REFERRED**
Skilled Nursing Facility Limited to 60 days per member per calendar year Referred and Self-Referred combined	$300 copay per day up to 3 days per admission	30% after deductible
Home Health Care Limited to 40 visits per member per calendar year; Limited to 3 intermittent visits per day by a participating Home Health Care agency, 1 visit equals a period of 4 hours or less Referred and Self-Referred combined	$30 copay	25%; deductible waived
Inpatient Hospice Care	$300 copay per day up to 3 days per admission	30% after deductible
Outpatient Hospice Care	$50 copay	30% after deductible
Private Duty Nursing	Not covered	Not covered
Outpatient Rehabilitation Therapy Includes speech, physical and occupational therapy Limited to 20 combined visits per calendar year Referred and Self-Referred combined	$50 copay	30% after deductible
Chiropractic	$50 copay	30% after deductible
Durable Medical Equipment Maximum benefit of $2,500 per member per calendar year Referred and Self-Referred combined	50%	50% after deductible

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OTHER SERVICES, cont.	PARTICIPATING PROVIDER REFERRED*	PARTICIPATING PROVIDER SELF-REFERRED
Diabetic Drugs and Supplies obtainable at a pharmacy Including, but not limited to, insulin, test strips, lancets and syringes	$30 copay	30% after deductible
Diabetic Supplies not obtainable at a pharmacy Including, but not limited to, insulin pumps and insulin pump supplies	Covered same as any other medical expense	Covered same as any other medical expense
Glasses and Contact Lens Reimbursement	Not Covered	Not Covered
FAMILY PLANNING	**PARTICIPATING PROVIDER REFERRED***	**PARTICIPATING PROVIDER SELF-REFERRED**
Infertility Treatment Coverage for only the diagnosis and surgical treatment of the underlying medical cause	Member cost sharing is based on the type of service performed and the place rendered	30% after deductible
Comprehensive Infertility Services	Member cost sharing is based on the type of service performed and the place rendered	30% after deductible
Voluntary Sterilization Including tubal ligation and vasectomy	Member cost sharing is based on the type of service performed and the place rendered	30% after deductible
PHARMACY - PRESCRIPTION DRUG BENEFITS	**PARTICIPATING PHARMACIES**	**NON-PARTICIPATING PHARMACIES**
Retail Up to a 30-day supply at participating pharmacies	$15 copay for generic drugs and 50% for brand name drugs	Not Covered
Mail Order 31-90 day supply at participating pharmacies	$30 copay for generic drugs and 50% for brand name drugs	Not Covered
Specialty CareRx - First Prescription for a specialty drug must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy®. Subsequent fills must be through Aetna Specialty Pharmacy®.		
No Mandatory Generic (No MG) - Member is responsible to pay the applicable copay or coinsurance only		
Plan includes: Contraceptive drugs and devices obtainable from a pharmacy and diabetic supplies obtainable from a pharmacy		
Precertification and Step Therapy included and 90 day Transition of Care (TOC) for Precertification and Step Therapy included		

***Members may directly access participating providers for certain services as outlined in the plan documents.**

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, other than reconstructive surgery following a mastectomy;
- Custodial care;
- Dental care and x-rays, other than treatment of sound natural teeth due to an accidental injury within 12 months following the injury or care needed to repair congenital defects or anomalies;
- Donor egg retrieval;
- Experimental and investigational procedures, except in connection with certain types of clinical trials;
- Hearing aids;
- 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, counseling and prescription drugs, unless medically necessary; and
- Treatment of those services for or related to treatment of obesity or for diet or weight control, unless medically necessary.

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 6 months.

Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, 6 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 1-800-70-AETNA 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.

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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. If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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.

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group subsidiary companies.

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