PLAN DESIGN & BENEFITS - **HDHP Standard**
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	$1,750 Individual $3,500 Family	$3,500 Individual $7,000 Family
All covered expenses, including prescription drugs, accumulate toward both the preferred and non-preferred Deductible. Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. There is no Individual Deductible to satisfy within the Family Deductible.		
Member Coinsurance Applies to all expenses unless otherwise stated.	10%	30%
Member Payment Limit (per calendar year)	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family
All covered expenses, including prescription drugs, accumulate toward both the preferred and non-preferred Member Payment Limit. Certain member cost sharing elements may not apply toward the Member Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and copays (except any penalty amounts) may be used to satisfy the Member Payment Limit. Once Member Family Payment Limit is met, all family members will be considered as having met their Member Payment Limit for the remainder of the calendar year. There is no Individual Member Payment to satisfy within the Family Member Payment Limit.		
Lifetime Maximum	Unlimited	Unlimited
Primary Care Physician Selection	Optional	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, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Routine Adult Physical Exams/ Immunizations 1 exam per 12 months for members age 22 and older	Covered 100%; deductible waived	30% after deductible
Routine Well Child Exams/Immunizations 7 exams in the 1st 12 months of life, 3 exams in the 2nd 12 months of life, 3 exams in the 3rd 12 months of life, 1 exam per 12 months thereafter to age 22; age 22 to 65+, 1 exam every 12 months.	Covered 100%; deductible waived	30% after deductible
Routine Gynecological Care Exams Includes routine tests and related lab fees, limited to 1 exam per calendar year.	Covered 100%; deductible waived	30% after deductible
Routine Mammograms	Covered 100%; deductible waived	30% after deductible
Women's Health 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.	Covered 100%; deductible waived	30% after deductible
Routine Digital Rectal Exam / Prostate-specific Antigen Test	Covered 100%; deductible waived	30% after deductible
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%; deductible waived	30% after deductible
Routine Hearing Screenings	Covered 100%; deductible waived	30% after deductible

PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	10% after deductible	30% after deductible
Specialist Office Visits	10% after deductible	30% after deductible
Pre-Natal Maternity Office Visits	Covered 100%; deductible waived	30% after deductible
Maternity Care	10% after deductible	30% after deductible
E-Visit (Teladoc)	$40 consult fee (Until deductible is met, then subject to coinsurance)	
Walk -In Clinic	10% after deductible	30% after deductible
Allergy Testing	10% after deductible	30% after deductible
Allergy Injections	10% after deductible	30% after deductible
Audiometric Hearing Exams 1 routine exam per 24 months.	Covered 100%; deductible waived	30% after deductible
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Diagnostic Laboratory and X-ray except for 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	10% after deductible	30% after deductible
Diagnostic X-ray for Complex Imaging Services	10% after deductible	30% after deductible
EMERGENCY MEDICAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Emergency Room	10% after deductible	Same as preferred care.
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	10% after deductible	10% after deductible
HOSPITAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	10% after deductible	30% after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care) The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	10% after deductible	30% after deductible
Outpatient Surgery	10% after deductible	30% after deductible
Outpatient Hospital Expenses (excluding surgery) The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit	10% after deductible	30% after deductible
MENTAL HEALTH SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	10% after deductible	30% after deductible
Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	10% after deductible	30% after deductible
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	10% after deductible	30% after deductible
Outpatient The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit	10% after deductible	30% after deductible

OTHER SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Convalescent Facility	10% after deductible	30% after deductible
Limited to 60 days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay		
Home Health Care	10% after deductible	30% after deductible
Limited to 120 visits per calendar year. Includes Private Duty Nursing limited to 70 eight hour shifts 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	10% after deductible	30% after deductible
Aetna Compassionate Care Program (ACCP) - Enrollment available to members with a 12 month terminal prognosis. Members may be eligible to continue receiving curative care. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	10% after deductible	30% after deductible
Aetna Compassionate Care Program (ACCP) - Enrollment available to members with a 12 month terminal prognosis. Members may be eligible to continue receiving curative care. The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Short-Term Rehabilitation Include Speech, Physical, and Occupational Therapy.	10% after deductible	30% after deductible
Spinal Manipulation Therapy	10% after deductible	30% after deductible
Acupuncture	10% after deductible	30% after deductible
Durable Medical Equipment	10% after deductible	30% after deductible
Diabetic Supplies	Covered same as any other medical expense; after deductible	Covered same as any other medical expense; after deductible
Autism	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
Covered the same as any other expense. Applied Behavioral Analysis, Behavorial Therapy, Physical, Occupational and Speech Therapy for the treatment of Autism covered with no visit limits or age restrictions.		
Hearing Aids (Limited to $5,000 per calendar year.)	10% after deductible	30% after deductible
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	Covered 100%; deductible waived	30% after deductible
Generic FDA-approved Women's Contraceptives	Covered 100%; deductible waived	30% after deductible
Transplants	10%; after deductible. Preferred coverage is provided at an Institute of Excellence (IOE) contracted facility only.	30%; after deductible. Non-Preferred coverage is provided at a Non-IOE facility; after deductible.
Bariatric Surgery	10% after deductible	Not Covered
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Gender Reassignment Surgery	10% after deductible	30% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Mouth, Jaws and Teeth	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	30% after deductible
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan; after deductible	

FAMILY PLANNING	PREFERRED CARE	NON-PREFERRED CARE
Infertility Treatment 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; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Tubal Ligation	Covered 100%; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
PHARMACY	**PREFERRED CARE**	**NON-PREFERRED CARE**
The full cost of the drug is applied to the deductible before benefits are considered for payment under the pharmacy plan.		
Retail	$10 copay for generic drugs, $25 copay for formulary brand-name drugs, and $40 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	Not Covered
Mail Order	$20 copay for generic drugs, $50 copay for formulary brand-name drugs, and $80 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not Covered
Preventive Medications - Deductible is waived for certain preventive medications. A full list of these drugs is available on Aetna Navigator™ or Aetna Member Services.		
Generic maintenance drugs covered at 100% for asthma, diabetes, hyperlipidemia, hypertension, and heart disease.		
Plan Includes: Oral Contraceptives covered 100% for Generic, Brand, and All Prescribed forms of birth control. Oral and injectable fertility drugs, and Diabetic supplies.		
Performance Enhancement Medication (8 tablets/month).		
Precert for growth hormones included		
Formulary generic FDA-approved Women's Contraceptives covered 100% in network.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26	

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 by your employer.

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;

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.

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 results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Some benefits are subject to limitations or visit maximums. 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. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary.

They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are administered by Aetna Life Insurance Company.