



**PLAN DESIGN & BENEFITS**  
**ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED**

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
<b>Benefit Limitations</b> – 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 1 <sup>st</sup> unless otherwise mandated. Refer to your plan documents for more information.		
<b>Deductible</b> (per calendar year)	\$3,100 Individual \$6,200 Family	\$6,200 Individual \$12,400 Family
All covered expenses accumulate simultaneously toward both the preferred and non-preferred Deductible. 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 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.		
<b>Member Coinsurance</b>	100%	20%
Applies to all expenses unless otherwise stated.		
<b>Payment Limit</b> (per calendar year)	\$3,100 Individual \$6,200 Family	\$11,200 Individual \$22,400 Family
All covered expenses accumulatesimultaneously toward both the preferred and non-preferred 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. Pharmacy expenses apply towards 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.		
<b>Lifetime Maximum</b> Unlimited except where otherwise indicated.		
<b>Primary Care Physician Selection</b>	Optional	Not Applicable
<b>Certification Requirements -</b> 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 is required - excluded amount applied separately to each type of expense is \$400 per occurrence.		
<b>Referral Requirement</b>	None	None
<b>PREVENTIVE CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Routine Adult Physical Exams/ Immunizations</b> 1 exam per year up to age 65, 1 exam per year age 65 and older	Covered 100%; deductible waived	20%; after deductible
<b>Routine Well Child Exams/Immunizations</b> 7 exams in the first 12 months, 3 exams 13 <sup>th</sup> – 24 <sup>th</sup> months, 3 exams 25 <sup>th</sup> - 36 <sup>th</sup> months, 1 exam per year thereafter to age 22.	Covered 100%; deductible waived	20%; after deductible
<b>Routine Gynecological Care Exams</b> 1 exam and pap smear per calendar year, includes related fees.	Covered 100%; deductible waived	20%; after deductible
<b>Routine Mammograms</b>	Covered 100%; deductible waived	20%; after deductible
<b>Women's Health</b> 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	20%; after deductible



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<b>Routine Digital Rectal Exam</b> Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	20%; after deductible
<b>Prostate-specific Antigen Test</b> Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	20%; after deductible
<b>Colorectal Cancer Screening</b> Recommended: For all members age 45 and over.	Covered 100%; deductible waived	Covered under Routine Adult Exams
<b>Routine Eye Exams</b>	Not Covered	Not Covered
<b>Routine Hearing Screening</b>	Covered 100%; deductible waived	20%; after deductible
<b>PHYSICIAN SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Office Visits to Non-Specialist</b> Includes services of an internist, general physician, family practitioner or pediatrician.	Covered 100%; after deductible	20%; after deductible
<b>Specialist Office Visits</b>	Covered 100%; after deductible	20%; after deductible
<b>Hearing Exams</b>	Not Covered	Not Covered
<b>Pre-Natal Maternity</b>	Covered 100%; deductible waived	Covered according to standard claim practice.
<b>Walk-in Clinics</b> 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.	Covered 100%; after deductible	Not Covered
<b>Allergy Testing</b>	Covered 100%; after deductible	20%; after deductible
<b>Allergy Injections</b>	Covered 100%; after deductible	20%; after deductible
<b>DIAGNOSTIC PROCEDURES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Diagnostic X-ray</b> (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.	Covered 100%; after deductible	20%; after deductible
<b>Diagnostic Laboratory</b> 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.	Covered 100%; after deductible	20%; after deductible
<b>Diagnostic Complex Imaging</b> 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.	Covered 100%; after deductible	20%; after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Urgent Care Provider</b>	Covered 100%; after deductible	20%; after deductible
<b>Emergency Room</b>	Covered 100%; after deductible	Same as in-network care
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered	Not Covered
<b>Emergency Use of Ambulance</b>	Covered 100%; after deductible	Same as in-network care
<b>Non-Emergency Use of Ambulance</b>	Covered 100%; after deductible	Same as in-network care
<b>HOSPITAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient Coverage</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible
<b>Inpatient Maternity Coverage</b> (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	20%; after deductible



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<b>Outpatient Hospital Expenses</b>	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
<b>Outpatient Surgery</b>	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient</b>	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
<b>Mental Health Office Visits</b>	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
<b>Other Mental Health Services</b>	Covered 100%; after deductible	20%; after deductible
<b>SUBSTANCE ABUSE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient</b>	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
<b>Residential Treatment Facility</b>	Covered 100%; after deductible	20%; after deductible
<b>Substance Abuse Office Visits</b>	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
<b>Other Substance Abuse Services</b>	Covered 100%; after deductible	20%; after deductible
<b>OTHER SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Skilled Nursing Facility</b>	Covered 100%; after deductible	20%; after deductible
Limited to 120 days per year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
<b>Home Health Care</b>	Covered 100%; after deductible	20%; after deductible
Limited to 60 visits per year. Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.		
<b>Hospice Care - Inpatient</b>	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
<b>Hospice Care - Outpatient</b>	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
<b>Private Duty Nursing</b>	Not Covered	Not Covered
<b>Outpatient Short-Term Rehabilitation</b>	Covered 100%; after deductible	20%; after deductible
Includes speech, physical, occupational therapy; limited to 60 visits per year		
<b>Spinal Manipulation Therapy</b>	Covered 100%; after deductible	20%; after deductible
Limited to 36 visits per year.		
<b>Habilitative Physical Therapy</b>	Covered 100%; after deductible	20%; after deductible
<b>Habilitative Occupational Therapy</b>	Covered 100%; after deductible	20%; after deductible
<b>Habilitative Speech Therapy</b>	Covered 100%; after deductible	20%; after deductible
<b>Autism Behavioral Therapy</b>	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Combined with outpatient mental health		
<b>Autism Applied Behavior Analysis</b>	Covered 100%; after deductible	20%; after deductible
<b>Autism Physical Therapy</b>	Covered 100%; after deductible	20%; after deductible
<b>Autism Occupational Therapy</b>	Covered 100%; after deductible	20%; after deductible
<b>Autism Speech Therapy</b>	Covered 100%; after deductible	20%; after deductible
<b>Durable Medical Equipment</b>	Covered 100%; after deductible	20%; after deductible
<b>Diabetic Supplies</b>	Covered same as any other medical expense.	Covered same as any other medical expense.



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<b>Affordable Care Act mandated Women's Contraceptives</b>	Covered 100%; deductible waived	20%; after deductible
<b>Women's Contraceptive drugs and devices not obtainable at a pharmacy</b>	Covered 100%; deductible waived	Covered same as any other medical expense.
<b>Infusion Therapy</b> Administered in the home or physician's office	Covered 100%; after deductible	20%; after deductible
<b>Infusion Therapy</b> Administered in an outpatient hospital department or freestanding facility	Covered 100%; after deductible	20%; after deductible
<b>Transplants</b>	Covered 100%; after deductible Preferred coverage is provided at an IOE contracted facility only.	Not Covered
<b>Bariatric Surgery</b>	Not Covered	Not Covered
<b>Temporomandibular Joint Disorder</b> (medical in nature only)	Covered 100%; after deductible	20%; after deductible
<b>Mouth, Jaws and Teeth</b> (oral surgery procedures, whether medical or dental in nature)	Covered 100%; after deductible	20%; after deductible
<b>FAMILY PLANNING</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Infertility Treatment</b> Diagnosis and treatment of the underlying medical condition only.	Covered 100%; after deductible	20%; after deductible
<b>Comprehensive Infertility Services</b>	Not Covered	Not Covered
<b>Advanced Reproductive Technology (ART)</b>	Not Covered	Not Covered
<b>Vasectomy</b>	Covered 100%; after deductible	20%; after deductible
<b>Tubal Ligation</b>	Covered 100%; deductible waived	20%; after deductible



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PHARMACY	IN-NETWORK	OUT-OF-NETWORK
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
<b>Pharmacy Plan Type</b>	Advanced Control Formulary	
<b>Generic Drugs</b>		
<b>Retail</b>	Covered 100%	20% of submitted cost; after applicable deductible
<b>Mail Order</b>	Covered 100%	Not Applicable
<b>Brand-Name Drugs</b>		
<b>Retail</b>	Covered 100%	20% of submitted cost; after applicable deductible
<b>Mail Order</b>	Covered 100%	Not Applicable
<b>Specialty Drugs</b>		
<b>Preferred Specialty</b>	Covered 100%	Not Applicable
<b>Non-Preferred Specialty</b>	Covered 100%	Not Applicable
<b>Pharmacy Day Supply and Requirements</b>		
<b>Retail</b>	Up to a 30 day supply from Aetna National Network Percentage copays will not be doubled	
<b>Voluntary Maintenance Choice</b>	No refill restrictions or penalties apply. Members save when they fill a 90-day supply of maintenance drugs at CVS Caremark mail service or CVS/pharmacy.	
<b>Mail Order</b>		
<b>Specialty</b>	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network. Aetna Specialty Performance Network Drug List	

**Preventive Medications** - Deductible is waived for certain preventive medications. A full list of these drugs is available on your secure member site or from your employer.

**Choose Generics** - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.

**Plan Includes:**  
 Diabetic supplies, blood glucose monitors, prescription weight loss drugs and contraceptive drugs and devices obtainable from a pharmacy.  
 Includes sexual dysfunction drugs for females and males, including daily dose, additional 6 tablets a month for males for erectile dysfunction.  
 Oral fertility drugs included.  
 Pre-certification for Specialty Drugs included  
 Seasonal Vaccinations covered 100% in-network  
 Preventive Vaccinations covered 100% in-network  
 Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

**GENERAL PROVISIONS**

**Dependents Eligibility** Spouse, children from birth to age 26 regardless of student status.

Plans are provided by: Aetna Life Insurance Company. 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.

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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. 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.

- 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.

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.

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](http://www.aetna.com)**.

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