



PLAN DESIGN AND BENEFITS
 PROVIDED BY AETNA LIFE INSURANCE COMPANY - INSURED

| PLAN FEATURES | PREFERRED CARE | | NON-PREFERRED CARE | |
|---------------------------------------|----------------|------------|--------------------|------------|
| Deductible (per calendar year) | \$500 | Individual | \$1,000 | Individual |
| | \$1,000 | Family | \$2,000 | Family |

All covered expenses accumulate separately toward the preferred or 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.

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| Member Coinsurance | 10% | 30% |
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Applies to all expenses unless otherwise stated.

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| Payment Limit (per calendar year) | \$2,000 | Individual | \$4,000 | Individual |
| | \$4,000 | Family | \$8,000 | Family |

All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit.

Certain member cost sharing elements may not apply toward the Payment Limit.

Only those out-of-pocket expenses resulting from the application of coinsurance percentage (except any deductibles, copays, and penalty amounts) may be used to satisfy the Payment Limit.

Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year.

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| Lifetime Maximum | \$2,000,000 per member's lifetime. |
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| Primary Care Physician Selection | Optional | Not applicable |
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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.

Precertification for certain procedures/treatments - excluded amount is \$200 per occurrence.

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| Referral Requirement | None | None |
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| PREVENTIVE CARE | PREFERRED CARE | NON-PREFERRED CARE |
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| Routine Adult Physical Exams/ Immunizations | \$25 office visit copay; deductible waived | 30% |
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1 exam every 24 months age 18 - 65 and 1 exam every 12 months age 65 and over.

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| Routine Well Child Exams/Immunizations | \$25 office visit copay; deductible waived | 30% |
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7 exams in the first 12 months of life, 2 exams in the 13th - 24th month of life, 1 exam every 12 months thereafter to age 18.

For Preferred Care the following immunizations will be covered at 100% when given to children through age 6: diphtheria; haemophilus influenza type b, hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus and varicella and any other immunization that is required by law for the child.

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| Routine Gynecological Care Exams | \$30 office visit copay; deductible waived | 30% |
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One exam per calendar year. Includes routine tests and related lab fees.

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| Routine Mammograms | Covered 100%; deductible waived | 30% |
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One mammogram per calendar year for covered females age 35 and above.

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| Routine Digital Rectal Exam / Prostate-specific Antigen Test | Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived | Member cost sharing is based on the type of service performed and the place of service where it is rendered |
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For covered males age 40 and over.

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| Colorectal Cancer Screening | Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived | Member cost sharing is based on the type of service performed and the place of service where it is rendered |
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For all members age 50 and over.



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Coverage includes the following: Annual fecal occult blood test, Digital rectal exam and a flexible sigmoidoscopy every 5 years, Digital rectal exam and a double contrast barium enema every 5 years, and Digital rectal exam and a colonoscopy every 10 years.

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| Newborn Hearing Screening 1 in the first 30 days of life and follow-up diagnostic care until the age of 24 months | \$30 office visit copay; deductible waived | 30% |
| Routine Eye Exams 1 routine exam per 24 months | \$30 office visit copay | 30% |
| Routine Hearing Exams 1 routine exam per 24 months | \$30 office visit copay | 30% |
| PHYSICIAN SERVICES | | |
| | PREFERRED CARE | NON-PREFERRED CARE |
| Office Visits to PCP | \$25 office visit copay; deductible waived | 30% |
| Includes services of an internist, general physician, family practitioner or pediatrician. | | |
| Specialist Office Visits | \$30 office visit copay; deductible waived | 30% |
| Allergy Testing | Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived | Member cost sharing is based on the type of service performed and the place of service where it is rendered |
| Allergy Injections | 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 |
| DIAGNOSTIC PROCEDURES | | |
| | PREFERRED CARE | NON-PREFERRED CARE |
| Diagnostic Laboratory and X-ray except for Complex Imaging Services | \$30 copay | 30% |
| Diagnostic X-ray for Complex Imaging Services | 10% | 30% |
| EMERGENCY MEDICAL CARE | | |
| | PREFERRED CARE | NON-PREFERRED CARE |
| Urgent Care Provider (benefit availability may vary by location) | \$75 copay; deductible waived | 30% |
| Non-Urgent Use of Urgent Care Provider | Not Covered | Not Covered |
| Emergency Room | \$150 copay; deductible waived | Same as preferred care. |
| Non-Emergency care in an Emergency Room | Not Covered | Not Covered |
| Ambulance | 10% | 30% |
| HOSPITAL CARE | | |
| | PREFERRED CARE | NON-PREFERRED CARE |
| Inpatient Coverage | 10% | 30% |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | | |
| Inpatient Maternity Coverage | 10% | 30% |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | | |
| Outpatient Hospital Expenses (including surgery) | 10% | 30% |
| The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit | | |
| MENTAL HEALTH SERVICES | | |
| | PREFERRED CARE | NON-PREFERRED CARE |
| Inpatient | 10% | 30% |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | | |
| Crisis Stabilization Units/Residential Treatment Centers (for children and adolescents) | 10% | 30% |



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| Partial Hospitalization (for day/night care treatment) The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | 10% | 30% |
| Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit | \$30 copay | 30% |
| 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 Alcohol/Drug services limited to 3 series of treatments per lifetime, combined for preferred and non-preferred services. | 10% | 30% |
| Outpatient The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit | \$30 copay | 30% |
| OTHER SERVICES | PREFERRED CARE | NON-PREFERRED CARE |
| Convalescent Facility Limited to 100 days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay | 10% | 30% |
| Home Health Care 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. | Covered 100% | 30% |
| Hospice Care - Inpatient Limited to 30 days per lifetime. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | 10% | 30% |
| Hospice Care - Outpatient Up to a maximum benefit of \$5,000 The member cost sharing applies to all covered benefits incurred during a member's outpatient visit | 10% | 30% |
| Private Duty Nursing - Outpatient (Limited to 70 eight hour shifts per calendar year) Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift. Each visiting nurse care or private duty nursing care shift of 4 hours or less counts as one home health visit. Each such shift of over 4 hours and up to 8 hours counts as two home health care visits. | 10% | 30% |
| Outpatient Short-Term Rehabilitation Includes Speech, Physical, Occupational, and Spinal Manipulation Therapy, limited to 60 visits per calendar year. | \$30 copay | 30% |
| Durable Medical Equipment Maximum annual benefit of \$10,000 per member per calendar year | 10% | 30% |
| Diabetic Supplies -- (if not covered under Pharmacy benefit) | 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) | 10% (payable as any other covered expense) | 30% (payable as any other covered expense) |
| Transplants | 10% Preferred coverage is provided at an IOE contracted facility only | 30% Non-Preferred coverage is provided at a Non-IOE facility. |
| Out of Area Dependents | Coverage provided at the non-preferred benefit level of the plan. | |
| 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 | Member cost sharing is based on the type of service performed and the place of service where it is rendered |
| Voluntary Sterilization Including tubal ligation and vasectomy. | 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 |
| PHARMACY | PREFERRED CARE | NON-PREFERRED CARE |



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| Retail | \$15 copay for generic drugs, \$30 copay for formulary brand-name drugs, and \$50 copay for non-formulary brand-name drugs up to a 30 day supply at participating | 30% of submitted cost after \$15 copay for generic drugs, \$30 copay for formulary brand-name drugs, and \$50 copay for non-formulary brand-name drugs up to a 30 day supply. |
| Mail Order | \$30 copay for generic drugs, \$60 copay for formulary brand-name drugs, and \$100 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®. | Not applicable |

No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only.

Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs, Diabetic supplies. Precert for growth hormones included.

GENERAL PROVISIONS

Dependents Eligibility Spouse, children from birth to age 25 regardless of student status

Pre-existing Conditions Exclusion On effective date: Waived
 After effective date: Full Postponement

This plan imposes a pre-existing condition exclusion, which may be waived in some circumstances and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to this plan, you may 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, care, or treatment was recommended or received or for which the individual took prescribed drugs within 90 days. Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, 90 days ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days 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 creditable coverage within 90 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 90 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 90 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 Aetna Member Services at 1-888-982-3862 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 who is enrolled in the plan within 31 days of birth, adoption, or placement for adoption. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment, and the pre-existing condition exclusion will be applied from the individual's effective date of coverage.

Members may choose from a network of available providers (physicians and facilities) or may visit a nonparticipating provider. The nonparticipating provider will be paid based on Aetna's Recognized Charge (Aetna Market Fee Schedule (AMFS) and Aetna Facility Fee Schedule), which is the charge Aetna determines to be the usual charge level for the geographic area where the covered service is furnished. The member may be balance billed for the difference between the nonparticipating provider's usual fee and the amount allowed by the plan, in addition to any coinsurance or co-payments due under the plan provisions.

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



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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 provided by Aetna Life Insurance Company.