PLAN DESIGN AND BENEFITS – HNOnly Plan L-101

PLAN FEATURES	PARTICIPATING PROVIDERS
Deductible (per calendar year)	$2,500 Individual $5,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Member cost sharing for certain services including copays and 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	40%
Out-of-Pocket Maximum (per calendar year, includes deductible)	$5,500 Individual $11,000 Family
Only those out-of-pocket expenses resulting from the application of copays, coinsurance percentage and deductibles (not including any Prescription Drug cost sharing and penalty amounts) may be used to satisfy the Out of Pocket Maximum. Members must continue to pay any Prescription Drug cost sharing and penalty amounts after meeting their 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.	
Health Incentive Credit Program $50.00 per employee and/or spouse with a family limit of $100.00 per year for completion of the Health Assessment and one Online Wellness Program. Incentive Rewards will be credited towards the deductible and Maximum Out-of-Pocket Limit.	
Lifetime Maximum	Unlmited
Primary Care Physician Selection	Not Required
Precertification Requirement - Certain non-participating provider services require precertification or benefits will be reduced. Refer to your plan documents for a complete list of services that require precertification.	
Referral Requirement	None
PHYSICIAN SERVICES	**PARTICIPATING PROVIDERS**
Primary Care Physician Visits	$30 copay; deductible waived
Specialist Office Visits	$60 copay; deductible waived
Primary Care Physician E-Visits An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor.	$60 copay; deductible waived
Specialist E-Visits An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor.	$60 copay; deductible waived

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.	$60 copay; deductible waived
Maternity Pre-Natal Care	0% after deductible
Maternity Delivery and Post-Partum Care	40% after deductible
Allergy Treatment	Member cost sharing is based on the type of service performed and the place rendered
Allergy Testing	Member cost sharing is based on the type of service performed and the place rendered
PREVENTIVE CARE (Wellness on Us)	**PARTICIPATING PROVIDERS**
Routine Adult Physical Exams / Immunizations 1 exam every 12 months	$0 copay; deductible waived
Well Child Exams / Immunizations Age and frequency schedules may apply	$0 copay; deductible waived
Routine Gynecological Exams Includes Pap smear and related lab fees Frequency schedule applies	$0 copay; deductible waived
Routine Mammograms For covered females age 35 and over, or as medically indicated	$0 copay; deductible waived
Women's Health Includes: Pre-natal maternity, 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 and counseling.	$0 copay; deductible waived
Routine Digital Rectal Exam / **Prostate-Specific Antigen Test** Frequency schedule applies	$0 copay; deductible waived
Routine (or Preventive) Colorectal Cancer Screening 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
Routine Eye Exams at Specialist One routine exam per 24 months No referral required	$0 copay; deductible waived
Routine Hearing Exams at PCP Covered only as part of a routine physical exam	Covered as part of a routine physical exam

Hearing Aids Initial hearing aid evaluation, fitting, adjustments and supplies, including ear molds. Limited to one (1) hearing aid per hearing-impaired ear up to $2,500 per hearing aid every 36 months for covered individuals under the age of 22.	50% after deductible
DIAGNOSTIC PROCEDURES	**PARTICIPATING PROVIDERS**
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; deductible waived
Diagnostic X-ray, except for Complex Imaging Services Outpatient hospital or other outpatient facility	40% after deductible
Diagnostic X-ray for Complex Imaging Services Including, but not limited to, MRI, MRA, PET and CT Scans	40% after deductible
EMERGENCY MEDICAL CARE	**PARTICIPATING PROVIDERS**
Urgent Care Provider	$75 copay, deductible waived
Non-Urgent use of Urgent Care Provider	Not Covered
Emergency Room Copay (if applicable) waived if admitted	40% after deductible
Non-Emergency care in an Emergency Room	Not Covered
Emergency Ambulance	40% after deductible
Non-Emergency Ambulance	40% after deductible
HOSPITAL CARE	**PARTICIPATING PROVIDERS**
Inpatient Coverage Including maternity & transplants. Coverage is provided at an NME contracted facility only.	$1,000 per admission then 40%, after deductible
Outpatient Surgery Provided in an outpatient hospital department or a freestanding surgical facility	$500 copay then 40%, after deductible
MENTAL HEALTH SERVICES	**PARTICIPATING PROVIDERS**
Inpatient Non-Serious and Serious/Biologically Based Mental Illness	$1,000 per admission then 40%, after deductible
Outpatient Non-Serious and Serious/Biologically Based Mental Illness	$60 copay; deductible waived
ALCOHOL/DRUG ABUSE SERVICES	**PARTICIPATING PROVIDERS**
Inpatient Detoxification	$1,000 per admission then 40%, after deductible
Outpatient Detoxification	$60 copay; deductible waived
Inpatient Rehabilitation	$1,000 per admission then 40%, after deductible
Outpatient Rehabilitation	$60 copay; deductible waived

OTHER SERVICES	PARTICIPATING PROVIDERS
Skilled Nursing Facility Limited to 60 days per member per calendar year	$1,000 per admission then 40%, after deductible
Home Health Care Limited to 60 visits per member per calendar year, 1 visit equals a period of 4 hours or less	40% after deductible
Infusion Therapy Provided in the home or physician's office	$30 copay; deductible waived
Infusion Therapy Provided in an outpatient hospital department or freestanding facility	40% after deductible
Inpatient Hospice Care	$1,000 per admission then 40%, after deductible
Outpatient Hospice Care	40% after deductible
Outpatient Short-Term Rehabilitation Includes speech, physical and occupational therapy. Limited to 30 visits per member per calendar year	$60 copay; deductible waived
Chiropractic/Subluxation Services Limited to 20 visits per member per calendar year	$60 copay; deductible waived
Durable Medical Equipment Maximum benefit of $5000 per member per calendar year	40% after deductible
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	Member cost sharing is based on the type of service performed and the place rendered
FAMILY PLANNING	**PARTICIPATING PROVIDERS**
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
Vasectomy	Member cost sharing is based on the type of service performed and the place rendered
Tubal Ligation	$0 copay; deductible waived
PHARMACY - PRESCRIPTION DRUG BENEFITS	**PARTICIPATING PHARMACIES**
Retail Up to a 30-day supply	$10 copay for generic drugs, 50% for brand name formulary drugs and brand name non-formulary drugs
Mail Order Delivery Up to a 90 day supply	$20 copay for generic drugs, 50% for brand name formulary drugs and brand name non-formulary drugs
Aetna Specialty CareRx	25% copay
Specialty CareRx[SM] - 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 only.	
Plan includes: Contraceptive drugs and devices obtainable from a pharmacy and diabetic supplies obtainable from a pharmacy. Formulary generic FDA-approved Women's Contraceptives covered 100% in network.	
Plan excludes: Lifestyle/performance enhancing drugs	
Precertification and Step Therapy and 90 day Transition of Care (TOC) for Precertification and Step Therapy included	

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
- 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, counseling and prescription drugs
- Special duty nursing
- Treatment of those services for or related to treatment of obesity or for diet or weight control

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, the 6 month lookback period 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 1-888-702-3862 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 an individual 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. 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

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 determing 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**.