PLAN DESIGN & BENEFITS - CONCENTRIC MODEL

PLAN FEATURES	MAXIMUM SAVINGS
Deductible (per plan year)	None Individual None Family
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%
Payment Limit (per plan year) All covered expenses accumulate toward both the Payment Limits. 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 and deductibles (except any 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 plan year.	$1,500 Individual $3,000 Family
Lifetime Maximum	Unlimited
Primary Care Physician Selection	Required
Referral Requirement	Required
PREVENTIVE CARE	**MAXIMUM SAVINGS**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members age 22 and older.	Covered 100%
Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 22.	Covered 100%
Routine Gynecological Care Exams 1 routine exam every twelve months. Includes related lab	Covered 100%
Routine Mammograms One baseline mammogram for covered females age 35-39, one mammogram every twelve months for covered females age 40 and over.	Covered 100%
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%
Routine Digital Rectal Exam / Prostate-specific Antigen Test	Covered 100%
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%
Routine Eye Exams 1 routine exam per 12 months	Covered 100%
Routine Hearing Screenings	Covered 100%
PHYSICIAN SERVICES	**MAXIMUM SAVINGS**
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	$25 copay
Specialist Office Visits	$35 copay
Pre-Natal Maternity	Covered 100%
Allergy Testing	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**MAXIMUM SAVINGS**
Diagnostic X-ray 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.	$35 copay
Diagnostic Laboratory 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%
Diagnostic X-ray for Complex Imaging Services	$35 copay

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EMERGENCY MEDICAL CARE	MAXIMUM SAVINGS
Urgent Care Provider (benefit availability may vary by location)	$50 copay
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	$200 copay, waived if admitted
Non-Emergency care in an Emergency Room	Not Covered
Ambulance Emergency Use	Covered 100%
HOSPITAL CARE	**MAXIMUM SAVINGS**
Inpatient Hospital Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	$250 per confinement copay
Inpatient Maternity Coverage (includes delivery and postpartum care) The member cost sharing applies to all covered benefits incurred during a member's inpatient stay, however specialist services performed in a hospital or other facility may be billed separately and covered as Physician Services for Non-Office Care.	$35 for Physician Services; $250 per confinement copay for Facility services
Outpatient Hospital Expenses (including surgery) The member cost sharing applies to all covered benefits incurred during a member's outpatient visit, however specialist services performed in a hospital or other facility may be billed separately and covered as Physician Services for Non-Office Care.	$100 copay
MENTAL HEALTH SERVICES	**MAXIMUM SAVINGS**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	$250 per confinement copay
Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	$35 copay
ALCOHOL/DRUG ABUSE SERVICES	**MAXIMUM SAVINGS**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	$250 per confinement copay
Residential Treatment Facility	$250 per confinement copay
Outpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	$35 copay
OTHER SERVICES	**MAXIMUM SAVINGS**
Convalescent Facility The member cost sharing applies to all covered benefits incurring during a member's inpatient stay	$250 per confinement copay
Home Health Care 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%
Hospice Care - Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered 100%
Hospice Care - Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	Covered 100%
Private Duty Nursing - Outpatient (Limited to 70 eight hour shifts per plan 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	Covered 100%
Outpatient Short-Term Rehabilitation Includes Speech, Physical, Occupational.	$35 copay
Autism Applied Behavioral Analysis	$35 copay
Autism Behavioral Therapy	$35 copay
Autism Physical Therapy	$35 copay
Autism Occupational Therapy	$35 copay
Autism Speech Therapy	$35 copay
Spinal Manipulation Therapy Limited to 20 visits per plan year	$35 copay
Durable Medical Equipment	Covered 100%
Diabetic Supplies	Covered same as any other medical expense.
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%
Transplants	$250 per confinement copay

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	Preferred coverage is provided at an Institute Of Excellence contracted facility only.
Mouth, Jaws, and Teeth (oral surgery procedures, medical in nature only)	Your cost sharing is based on the type of service and where it is performed
Out of Area Dependents	No coverage for non-emergency care received outside the service area.
FAMILY PLANNING	**MAXIMUM SAVINGS**
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed
Diagnosis and treatment of the underlying medical condition.	
Vasectomy	Your cost sharing is based on the type of service and where it is performed
Tubal Ligation	Covered 100%
PHARMACY	**MAXIMUM SAVINGS**
Pharmacy coverage is provided by Express Scripts, Inc.	
GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26, regardless of student status.
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Waived

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;

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.