AN FEATURES | IN-NETWORK | OUT-OF-NETWORK
--- | --- | ---
**Deductible** | $300 Individual | $800 Individual 
$900 Family | $2,400 Family
All covered expenses accumulate toward the preferred or non-preferred Deductible. 
Unless otherwise indicated, the deductible must be met prior to benefits being payable.

**Member Coinsurance** | 20% | 40%
Applies to all expenses unless otherwise stated.

**Payment Limit (per plan year)** | $1,200 Individual | $2,400 Individual 
$3,600 Family | $7,200 Family
All covered expenses accumulate toward the preferred or non-preferred Payment Limit.

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.

**Lifetime Maximum**
Unlimited except where otherwise indicated.

**Primary Care Physician Selection** | Optional | Not Applicable

**Referral Requirement** | None | None

**PREVENTIVE CARE** | IN-NETWORK | OUT-OF-NETWORK
--- | --- | ---
**Routine Adult Physical Exams/Immunizations** | Covered 100%; deductible waived | 40%; after deductible 
1 exam every 12 months for members age 22 and older.

**Routine Well Child Exams/Immunizations** | Covered 100%; deductible waived | 40%; after deductible 
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.

**Routine Gynecological Care Exams** | Covered 100%; deductible waived | 40%; after deductible
One exam per plan year. Includes routine tests and related lab fees.

**Routine Mammograms** | Covered 100%; deductible waived | 40%; after deductible 
One per plan year for covered females age 40 and over.

**Women’s Health** | Covered 100%; deductible waived | 40%; after deductible
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.

**Routine Digital Rectal Exam** | Covered 100%; deductible waived | 40%; after deductible 
For covered males age 40 and over.

**Prostate-specific Antigen Test** | Covered 100%; deductible waived | 40%; after deductible 
For covered males age 40 and over.

**Colorectal Cancer Screening** | Covered 100%; deductible waived | 40%; after deductible 
For all members age 50 and over.

**Routine Eye Exams** | Covered 100%; deductible waived | 40%; after deductible 
1 routine exam per 24 months.
# PLAN DESIGN & BENEFITS

**PROVIDED BY AETNA LIFE INSURANCE COMPANY**

<table>
<thead>
<tr>
<th>Routine Hearing Screening</th>
<th>Covered 100%; deductible waived</th>
<th>40%; after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medications</td>
<td>Certain over-the-counter preventive medications covered 100% in network.</td>
<td></td>
</tr>
</tbody>
</table>

## PHYSICIAN SERVICES

| Office Visits to Non-Specialist | $30 copay; deductible waived | 40%; after deductible |
| Includes services of an internist, general physician, family practitioner, OB/GYN or pediatrician. |
| Specialist Office Visits | $40 copay; deductible waived | 40%; after deductible |
| Pre-Natal Maternity | Covered 100%; deductible waived | 40%; after deductible |

## 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 the outpatient department of a hospital, shall be considered a Walk-in Clinic.

## Allergy Testing

Covered as either PCP or specialist office visit; deductible waived 40%; after deductible

## Allergy Injections

Covered 100%; deductible waived 40%; after deductible

## Diagnostic Procedures

| Diagnostic X-ray | $40 copay; deductible waived | 40%; after deductible |
| (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. |
| Diagnostic Laboratory | $30 copay; deductible waived | 40%; after deductible |
| Diagnostic Complex Imaging | $100 copay; deductible waived | 40%; after deductible |

## Emergency Medical Care

| Urgent Care Provider | $50 copay; deductible waived | Same as in-network care |
| Non-Urgent Use of Urgent Care Provider | Not Covered | Not Covered |

## Hospital Care

| Emergency Room | Copay waived if admitted | $150 copay; deductible waived | Same as in-network care |
| Non-Emergency Care in an Emergency Room | Not Covered | Not Covered |
| Emergency Use of Ambulance | 20%; after deductible | Same as in-network care |
| Non-Emergency Use of Ambulance | 20%; after deductible | 40%; after deductible |

## Inpatient Coverage

The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.

## Inpatient Maternity Coverage

(includes delivery and postpartum care)

The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.

## Outpatient Hospital Expenses

The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.

## Outpatient Surgery

The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.
# PLAN DESIGN & BENEFITS
**Provided by Aetna Life Insurance Company**

## Mental Health Services

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>IN-Network</th>
<th>OUT-OF-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>Administered by Penn Behavioral Health - 1.888.321.4433</td>
<td>Administered by Penn Behavioral Health - 1.888.321.4433</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Administered by Penn Behavioral Health - 1.888.321.4433</td>
<td>Administered by Penn Behavioral Health - 1.888.321.4433</td>
</tr>
</tbody>
</table>

Inpatient and Outpatient deductibles and cost sharing are combined with medical plan.

## Alcohol/Drug Abuse Services

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<tr>
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<tr>
<td>Residential Treatment Facility</td>
<td>Administered by Penn Behavioral Health - 1.888.321.4433</td>
<td>Administered by Penn Behavioral Health - 1.888.321.4433</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Administered by Penn Behavioral Health - 1.888.321.4433</td>
<td>Administered by Penn Behavioral Health - 1.888.321.4433</td>
</tr>
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</table>

Inpatient and Outpatient deductibles and cost sharing are combined with medical plan.

## Other Services

<table>
<thead>
<tr>
<th>Service</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convalescent Facility (Limited to 180 days per plan year)</td>
<td>20%; after deductible</td>
<td>40%; after deductible</td>
</tr>
<tr>
<td>Home Health Care (Limited to 240 visits per plan year)</td>
<td>20%; after deductible</td>
<td>40%; after deductible</td>
</tr>
<tr>
<td>Hospice Care - Inpatient (The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.)</td>
<td>20%; after deductible</td>
<td>40%; after deductible</td>
</tr>
<tr>
<td>Hospice Care - Outpatient (The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.)</td>
<td>20%; after deductible</td>
<td>40%; after deductible</td>
</tr>
<tr>
<td>Private Duty Nursing (Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.)</td>
<td>20%; after deductible</td>
<td>40%; after deductible</td>
</tr>
<tr>
<td>Outpatient Speech Therapy (Limited to 60 visits per plan year)</td>
<td>$40 copay; deductible waived</td>
<td>40%; after deductible</td>
</tr>
<tr>
<td>Outpatient Short-Term Rehabilitation (Includes Physical, and Occupational Therapy, limited to 60 visits per plan year.)</td>
<td>$40 copay; deductible waived</td>
<td>40%; after deductible</td>
</tr>
<tr>
<td>Spinal Manipulation Therapy (Limited to 60 visits per plan year.)</td>
<td>$40 copay; deductible waived</td>
<td>40%; after deductible</td>
</tr>
<tr>
<td>Autism Behavioral Therapy (Combined with outpatient mental health visits)</td>
<td>Refer to MBH Outpatient Mental Health</td>
<td>Refer to MBH Outpatient Mental Health</td>
</tr>
<tr>
<td>Autism Applied Behavior Analysis</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Autism Physical Therapy</td>
<td>Covered in accordance with standard claim practice</td>
<td>Covered in accordance with standard claim practice</td>
</tr>
<tr>
<td>Autism Occupational Therapy</td>
<td>Covered in accordance with standard claim practice</td>
<td>Covered in accordance with standard claim practice</td>
</tr>
<tr>
<td>Autism Speech Therapy</td>
<td>Covered in accordance with standard claim practice</td>
<td>Covered in accordance with standard claim practice</td>
</tr>
<tr>
<td>Durable Medical Equipment (Limited to 6 visits per plan year.)</td>
<td>20%; after deductible</td>
<td>40%; after deductible</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>Covered 100%</td>
<td>Covered 100%</td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td>Covered same as any other medical expense.</td>
<td>Covered same as any other medical expense.</td>
</tr>
</tbody>
</table>

Prepared: 04/08/2016
Generic FDA-approved Women's Contraceptives  Covered 100%  Covered 100%

Contraceptive drugs and devices not obtainable at a pharmacy  Covered 100%; deductible waived  Covered same as any other medical expense.

Vision Eyewear  Not Covered  Not Covered.

Transplants  20% Preferred coverage is provided at an IOE contracted facility only; after deductible  40% Non-Preferred coverage is provided at a Non-IOE facility; after deductible

Bariatric Surgery  The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.

FAMILY PLANNING  IN-NETWORK  OUT-OF-NETWORK

Infertility Treatment  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; after deductible

Diagnosis and treatment of the underlying medical condition.

Comprehensive Infertility Services  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; after deductible

Coverage includes Artificial Insemination (limited to six courses of treatment per member's lifetime) and Ovulation Induction (limited to six courses of treatment per member's lifetime). Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law.

Advanced Reproductive Technology (ART)  20%; after deductible  Not Covered

ART coverage includes: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Limited to 2 courses of treatment per member's lifetime. Maximum applies to all procedures covered by any Aetna plan except where prohibited by law. Covered at HUP only.

Vasectomy  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; 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.

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. 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.
PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

• 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.
• Durable medical Equipment
• 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.
• Orthotics except diabetic orthotics.
• 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 or inadequacies, including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Treatment of behavioral disorders.
• 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.

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 1-888-302-8742.
Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al 1-888-302-8742.

Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to www.aetna.com.
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