PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	$1,500 Individual $3,000 Family	$1,500 Individual $3,000 Family
All covered expenses, including nonpreventive prescription drugs, accumulate toward both the preferred and non-preferred deductible. Unless otherwise, indicated, the Deductible must be met prior to benefits being payable. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. There is not Individual Deductible to satisfy within the Family Deductible. Refer to CrewNet or CrewConnect for prescription plan coverage details.		
Member Coinsurance Applies to all expenses unless otherwise stated.	20% After deductible	40% After deductible
Payment Limit (per calendar year)	$3,500 Individual $7,000 Family	$3,500 Individual $7,000 Family
All covered expenses including Deductible and non preventive prescription drugs accumulate toward both the preferred and 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, deductibles, and non preventive prescription drug copays (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 calendar year. There is no Individual Payment Limit to satisfy within the Family Payment Limit.		
Lifetime Maximum	Unlimited	Unlimited
Primary Care Physician Selection	Optional	Not applicable
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.		
Referral Requirement	None	None
PREVENTIVE CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Routine Adult Physical Exams/ Immunizations 1 exam per calendar year for members age 18 and over	Covered 100%; deductible waived	40% after deductible
Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 6 exams in the 13th-36th months of life; 1 exam per calendar year thereafter to age 18.	Covered 100%; deductible waived	40% after deductible
Routine Gynecological Care Exams Includes routine tests and related lab fees; 1 exam per calendar year	Covered 100%; deductible waived	40% after deductible
Routine Mammograms One baseline for covered females age 35-39, one annual mammogram for females age 40 & over.	Covered 100%; deductible waived	40% after deductible
Routine Digital Rectal Exam / Prostate-specific Antigen Test 1 annual DRE & PSA for males age 40 and over	Covered 100%; deductible waived	40% after deductible
Colorectal Cancer Screening For all members age 50 and over. Covered for members under age 50 with family history	Covered 100%; deductible waived	40% after deductible
Routine Hearing Exams 1 routine exam per 24 months	Covered 100%; deductible waived	40% after deductible
Hearing Aids	$500 maximum in a 36 month period	$500 maximum in a 36 month period
Skin Cancer Screenings (DX Code V76.43 only)	100% no copay; deductible waived	40% after deductible

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PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Office Visits to PCP	20% after deductible	40% after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	20% after deductible	40% after deductible
Allergy Testing	20% after deductible	40% after deductible
Allergy Injections	100% after deductible	40% after deductible
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Diagnostic Laboratory and X-ray	20% after deductible	40% after deductible
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		
EMERGENCY MEDICAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Urgent Care Provider (benefit availability may vary by location)	20% after deductible	40% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	20% after deductible	Same as preferred care.
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	20% after deductible	20% after deductible
HOSPITAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Coverage	20% after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Inpatient Maternity Coverage	20% after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Surgery	20% after deductible	40% after deductible
Outpatient Hospital Expenses (excluding surgery)	20% after deductible	40% after deductible
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	20% after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	20% after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	20% after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	20% after deductible	40% after deductible
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		

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OTHER SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Convalescent Facility	20% after deductible	40% after deductible
Limited to 240 days per calendar year. 3 days prior hospital confinement required. Admission must begin 14 days following discharge. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay		
Home Health Care	20% after deductible	40% after deductible
Limited to 120 visits per calendar year. Includes Private Duty Nursing unlimited; 1 shift = up to 8 hours 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.		
Hospice Care - Inpatient	20% after deductible	40% after deductible
Unlimited The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Hospice Care - Outpatient	20% after deductible	40% after deductible
Unlimited The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. Includes respite care, maximum of 7 days every 6 months		
Outpatient Short-Term Rehabilitation	20% after deductible	40% after deductible
Includes Speech, Physical, Occupational Therapy limited to 60 visits per calendar year combined; Spinal Manipulation Therapy limited to 30 visits per calendar year.		
Durable Medical Equipment Unlimited	20% after deductible	40% after deductible
Diabetic Supplies	20% after deductible	40% after deductible
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	20% after deductible	40% after deductible
Transplants Institutes of Excellence (IOE) network	20% after deductible Preferred coverage is provided at an IOE	40% after deductible Non-Preferred coverage is provided at a Non-IOE
Bariatric Institutes of Quality (IOQ) network	20% after deductible Preferred coverage is provided at an IOQ	40% after deductible Non-Preferred coverage is provided at a Non-IOQ
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Mouth, Jaws and Teeth (oral surgery procedures, whether medical or dental in nature - excludes TMJ expenses)	Member cost sharing is based on the type of service performed and the place of service where it is rendered	40% after deductible
Habilitative Services / Autism / Pervasive Developmental Delays	10% after deductible; $36,000 annual max. (Applied Behavioral Analysis not subject to annual max)	30% after deductible; $36,000 annual max. (Applied Behavioral Analysis not subject to annual max)
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan.	
FAMILY PLANNING	**PREFERRED CARE**	**NON-PREFERRED CARE**
Basic Infertility Treatment Covers the Diagnosis and treatment of 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
Comprehensive Infertility Services	20% after deductible	40% 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 Aetna plan except where prohibited by law.		
Advanced Reproductive Technology (ART)	20% after deductible	40% after deductible
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.		

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Limited to $15,000 combined maximum in members lifetime for both ART and Comprehensive Infertility. Maximum applies to all procedures covered by any Aetna plan except where prohibited by law.

Voluntary Sterilization	20% after deductible	40% after deductible
Including tubal ligation and vasectomy.		

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26
Pre-existing Conditions Exclusion	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;

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.

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.