Health Plan Benefit Summary

aetna℠

Aetna PPO | Group 6356800

Effective Date: 8/1/2019

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage. In accordance with the Patient Protection and Affordable Care Act of 2010:

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan.
- Agency Providers only: Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan. You will be responsible for paying the full cost of the premium for your dependents. Contact your employer for premium rates.

Benefits	Preferred Provider Network	Non-Preferred Provider Network
Plan deductible	No annual deductible	Individual deductible: $500 per calendar year
Individual deductible carryover	Not applicable	4th quarter carryover applies
Plan coinsurance	No plan coinsurance	Plan pays 80%, you pay 20% of the Allowed Amount.
Out-of-pocket limit	Individual out-of-pocket limit: $1,200 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit. All cost shares for covered services	Shared with in-network
Pre-existing condition (PEC) waiting period	No PEC	Same as preferred provider network
Lifetime maximum	Unlimited	Same as preferred provider maximum
Outpatient services (Office visits)	$15 co-pay	$15 co-pay, deductible and coinsurance apply
Hospital services	**Inpatient services:** $100 co-pay, per day for up to 5 days per admit **Outpatient surgery:** $50 co-pay	**Inpatient services**: $100 co-pay, per day for up to 5 days per admit Deductible and coinsurance apply **Outpatient surgery:** $50 co-pay, deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic (Tier 1)/preferred brand(Tier 2)/nonpreferred (Tier 3) $4/$8/$25/$50 co-pay	Preferred generic/preferred brand/non-preferred $13/$30/$55 co-pay
Prescription mail order	2 x prescription cost share per 90 day supply	Not covered
Acupuncture	12 visits per calendar year $15 co-pay	Shared with preferred provider visit limit $15 co-pay, deductible and coinsurance apply
Ambulance services	Plan pays 80%, you pay 20%	Same as preferred provider benefit

Aetna Health Plan Benefit Summary, continued

Benefits	Preferred Provider Network	Non-Preferred Provider Network
Chemical dependency	**Inpatient**: $100 co-pay, per day for up to 5 days per admit **Outpatient**: $0 co-pay	**Inpatient**: $100 co-pay, per day for up to 5 days per admit Deductible and coinsurance apply **Outpatient**: $15 co-pay, deductible and coinsurance apply
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Covered at 50%	Covered at 50%, deductible applies
Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.	Insulin, needles, syringes and lancets-see Prescription drugs.External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugsare covered and have benefit limits, diabetic supplies are not subject to these limits.
Diagnostic lab and X-ray services	**Inpatient**: Covered under Hospital services **Outpatient**: Covered in full	**Inpatient**: Covered under Hospital services **Outpatient**: Deductible and coinsurance apply
Emergency services (co-pay waived if admitted)	$200 co-pay	$200 co-pay
Hearing exams (routine)	$15 co-pay	$15 co-pay, deductible and coinsurance apply
Hearing hardware	Not covered	Not covered
Home health services	Covered in full up to 130 visits total per calendar year	Shared with preferred provider visit limit Deductible and coinsurance apply
Hospice services	Covered in full	Deductible and coinsurance apply
Infertility services	Medical and surgical services for the treatment of sterility and infertility and all related services, including artificial insemination, in-vitro fertilization and drug therapy are covered subject to the applicable outpatient services cost shares, limited to $50,000 per lifetime maximum. Fertility drugs are covered subject to deductible and 20% plan coinsurance, limited to a lifetime maximum of $5,000	Not covered
Manipulative therapy	Covered up to 12 visits per calendar year without prior authorization $15 co-pay	Shared with preferred provider visit limit $15 co-pay, deductible and coinsurance apply
Massage services	12 visits per calendar year $15 co-pay	Shared with preferred provider visit limit $15 co-pay, deductible and coinsurance apply
Maternity services	**Inpatient**: $100 co-pay, per day for up to 5 days per admit **Outpatient**: $15 co-pay. Routine care not subject to outpatient services co-pay.	**Inpatient**: $100 co-pay, per day for up to 5 days per admit Deductible and coinsurance apply **Outpatient**: $15 co-pay, deductible and coinsurance apply. Routine care not subject to outpatient services co-pay.
Mental Health	**Inpatient**: $100 co-pay, per day for up to 5 days per admit **Outpatient**: $0 co-pay	**Inpatient**: $100 co-pay, per day for up to 5 days per admit Deductible and coinsurance apply **Outpatient**: $15 co-pay, deductible and coinsurance apply

Aetna Health Plan Benefit Summary, continued

Benefits	Preferred Provider Network	Non-Preferred Provider Network
Naturopathy	12 visits per calendar year $15 co-pay	Shared with preferred provider visit limit$15 co-pay, deductible and coinsurance apply
Newborn Services	**Initial hospital stay:** See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.	**Initial hospital stay:** See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Covered at cost shares when medical criteria is met	Covered at cost shares when medical criteria is met
Organ transplants	Unlimited, no waiting period **Inpatient**: $100 co-pay, per day for up to 5 days per admit **Outpatient**: $15 co-pay	Not covered
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women's preventive care services (including contraceptive drugs and devices and sterilization) are covered in full.	Not covered Women's preventive care services (including contraceptive drugs and devices and sterilization) are subject to the applicable Preventive Care cost share and benefit maximums. Routine mammograms: Deductible and coinsurance apply
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient**: 60 days per calendar year. Services with mental health diagnoses are covered with no limit. $100 co-pay, per day for up to 5 days per admit **Outpatient**: 60 visits per calendar year. Services with mental health diagnoses are covered with no limit. $15 co-pay	**Inpatient**: Day limits shared with preferred provider benefit limit $100 co-pay, per day for up to 5 days per admit Deductible and coinsurance apply **Outpatient**: Visit limits shared with preferred provider benefit limit $15 co-pay, deductible and coinsurance apply
Skilled nursing facility	Covered in full up to 60 days per calendar year	Day limits shared with preferred provider benefit, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	**Inpatient**: $100 co-pay, per day for up to 5 days per admit **Outpatient**: $15 co-pay Women's sterilization procedures are covered in full.	**Inpatient**: $100 co-pay, per day for up to 5 days per admit Deductible and coinsurance apply **Outpatient**: $15 co-pay, deductible and coinsurance apply Women's sterilization procedures are covered subject to the applicable Preventive Care cost share and benefit maximums.
Temporomandibular Joint (TMJ) services	**Inpatient**: $100 co-pay, per day for up to 5 days per admit **Outpatient**: $15 co-pay	**Inpatient**: $100 co-pay, per day for up to 5 days per admit Deductible and coinsurance apply **Outpatient**: $15 co-pay, deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program – covered in full	Applicable cost shares apply
Routine vision care (1 visit every 12 months)	$15 co-pay	$15 co-pay, deductible and coinsurance apply
Optical hardware Lenses, including contact lenses and frames	Members under 19: 1 pair of frames and lenses per year or contact lenses covered at 50% coinsurance Members age 19 and over: $200 per 24 months	Shared with preferred provider benefit