

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	\$100 Individual	\$500 Individual
	\$200 Family	\$1,000 Family
All covered expenses accumulate sep	arately toward the preferred or non-pa	referred Deductible.
Jnless otherwise indicated, the deduc	tible must be met prior to benefits bei	ing payable.
Member cost sharing for certain servic	ces, as indicated in the plan, are exclu	uded from charges to meet the Deductible
Pharmacy expenses do not apply towa		
The family Deductible is a cumulative	Deductible for all family members. The	he family Deductible can be met by a
combination of family members; howe	ver no single individual within the fam	nily will be subject to more than the
ndividual Deductible amount.		
Member Coinsurance	Covered 100%	20%
Applies to all expenses unless otherwi	ise stated.	
Payment Limit (per calendar year)	\$3,500 Individual	\$4,000 Individual
	\$7,000 Family	\$8,000 Family
All covered expenses accumulate sep	arately toward the preferred or non-p	
		ance percentage, copays, and deductibles
(except any penalty amounts) may be	used to satisfy the Payment Limit.	· •
Pharmacy expenses apply towards the	e Payment Limit.	
The family Payment Limit is a cumulat	tive Payment Limit for all family memb	pers. The family Payment Limit can be me
		e family will be subject to more than the
individual Payment Limit amount.	-	-
Lifetime Maximum		
CERTIFICATION CONTRACTOR AND A DESCRIPTION	· ·	
Jhiimited except where otherwise indi	cated.	
Primary Care Physician Selection	Not Applicable	Not Applicable
Unlimited except where otherwise indi Primary Care Physician Selection Certification Requirements - Certification for cortain types of Non R	Not Applicable	••
Primary Care Physician Selection Certification Requirements - Certification for certain types of Non-P	Not Applicable Preferred care must be obtained to ave	oid a reduction in benefits paid for that car
Primary Care Physician Selection Certification Requirements - Certification for certain types of Non-P Certification for Hospital Admissions,	Not Applicable Preferred care must be obtained to ave Treatment Facility Admissions, Conva	oid a reduction in benefits paid for that car alescent Facility Admissions, Home Health
Primary Care Physician Selection Certification Requirements - Certification for certain types of Non-P Certification for Hospital Admissions, Care, Hospice Care and Private Duty	Not Applicable Preferred care must be obtained to ave Treatment Facility Admissions, Conva	oid a reduction in benefits paid for that car alescent Facility Admissions, Home Health
Primary Care Physician Selection Certification Requirements - Certification for certain types of Non-P Certification for Hospital Admissions, Care, Hospice Care and Private Duty expense is \$400 per occurrence.	Not Applicable Preferred care must be obtained to ave Treatment Facility Admissions, Conva Nursing is required - excluded amour	oid a reduction in benefits paid for that car alescent Facility Admissions, Home Health an applied separately to each type of
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Primary Care Physician Selection Certification Requirements - Certification for certain types of Non-P Certification for Hospital Admissions, Care, Hospice Care and Private Duty expense is \$400 per occurrence. Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members	Not Applicable Preferred care must be obtained to ave Treatment Facility Admissions, Conva Nursing is required - excluded amour None IN-NETWORK Covered 100%; deductible waived age 22 to age 65; 1 exam every 12 r	oid a reduction in benefits paid for that car alescent Facility Admissions, Home Health applied separately to each type of <u>None</u> OUT-OF-NETWORK 20%; after deductible months for adults age 65 and older.
Primary Care Physician Selection Certification Requirements - Certification for certain types of Non-P Certification for Hospital Admissions, Care, Hospice Care and Private Duty expense is \$400 per occurrence. Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members Routine Well Child	Not Applicable Preferred care must be obtained to ave Treatment Facility Admissions, Conva Nursing is required - excluded amoun None IN-NETWORK Covered 100%; deductible waived	oid a reduction in benefits paid for that car alescent Facility Admissions, Home Health applied separately to each type of <u>None</u> OUT-OF-NETWORK 20%; after deductible months for adults age 65 and older.
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Primary Care Physician Selection Certification Requirements - Certification for certain types of Non-P Certification for Hospital Admissions, Care, Hospice Care and Private Duty expense is \$400 per occurrence. Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 3 exam per year thereafter to age 22. Routine Gynecological Care	Not Applicable Preferred care must be obtained to ave Treatment Facility Admissions, Conva Nursing is required - excluded amoun None IN-NETWORK Covered 100%; deductible waived age 22 to age 65; 1 exam every 12 r Covered 100%; deductible waived	oid a reduction in benefits paid for that car alescent Facility Admissions, Home Health an applied separately to each type of <u>None</u> <u>OUT-OF-NETWORK</u> 20%; after deductible <u>months for adults age 65 and older.</u> 20%; after deductible life, 3 exams in the third 12 months of life,
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Emergency Room         Emergency Use of Ambulance       Covered 100%; deductible waived       Same as in-network care         Non-Emergency Use of Ambulance       Not Covered       Not Covered         HOSPITAL CARE       IN-NETWORK       OUT-OF-NETWORK         Inpatient Coverage       \$75 copay; deductible waived       20%; after deductible         Your cost sharing applies to all covered benefits incurred during your inpatient stay.       Same as in-network care			-
Colorectal Cancer Screening         Covered 100%; deductible waived         Covered under Routine Adult Exams           Recommended: For all members age 50 and over.         Not Covered         Not Covered           Routine Eye Exams         Not Covered 100%; deductible waived         20%; after deductible           PHYSICIAN SERVICES         IN-NETWORK         00T-OF-NETWORK           Office Visits to Non-Specialist         \$15 copay; deductible waived         20%; after deductible           Specialist Office Visits         \$30 copay; deductible waived         20%; after deductible           Audiometric Hearing Exam         Not Covered         Not Covered           Walk-in Clinics         \$15 copay; deductible waived         20%; after deductible           Walk-in Clinics are network, free-standing health care facilities. They are an alternative to aphysician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative to remergency illnesses and injuries are provided by a physician. Neither an emergency room, nor the outpatient department of a haspital, shall be considered a Walk-in Clinic.           Allergy Injections         Covered 100%; deductible waived         Your cost sharing is based on the type of service and where it is performed           Diagnostic X-ray         Covered 100%; after deductible         20%; after deductible           Iperformed as a part of a physician office visit and billed by the physician, expenses are co			20%; after deductible
Recommended: For all members age 50 and over.       Not Covered       Not Covered         Routine Eye Exams       Not Covered       Not Covered         Routine Hearing Screening       Covered 100%; deductible waived       20%; after deductible         PHYSICIAN SERVICES       IN-NETWORK       OUT-OF-NETWORK         Office Visits to Non-Specialist       \$15 copay; deductible waived       20%; after deductible         Audiometric Hearing Exam       Not Covered       Not Covered         Not Covered       Not Covered       Not Covered         Walk-In Clinics       \$15 copay; deductible waived       20%; after deductible         Walk-in Clinics       \$15 copay; deductible waived       20%; after deductible         Walk-in Clinics       \$15 copay; deductible waived       20%; after deductible         Walk-in Clinics       \$15 copay; deductible waived       20%; after deductible         Walk-in Clinics       \$15 copay; deductible waived       20%; after deductible         Allergy Testing       Covered 100%; deductible waived       Your cost sharing is based on the type of service and where it is performed         Allergy Injections       Covered 100%; after deductible       20%; after deductible         DiAcNOSTIC PROCEDURES       IN-NETWORK       OUT-OF-NETWORK         Diagnostic Laboratory       Covered 100%; after deductible <td></td> <td></td> <td>On and an Douting Adult France</td>			On and an Douting Adult France
Routine Eye Exams         Not Covered           Routine Hearing Screening         Covered 100%; deductible waived         20%; after deductible           PhySicIAN SERVICES         IN-NETWORK         OUT-OF-NETWORK           Office Visits to Non-Specialist         \$15 copay; deductible waived         20%; after deductible           Includes services of an internist, general physician, family practitione or pediatrician.         Specialist Office Visits         \$30 copay; deductible waived         20%; after deductible           Audiometric Hearing Exam         Not Covered         Not Covered         Not Covered           Walk-in Clinics         \$15 copay; deductible waived         20%; after deductible           Walk-in Clinics         \$15 copay; deductible waived         20%; after deductible           Walk-in Clinics         \$15 copay; deductible waived         20%; after deductible           Walk-in Clinics         \$15 copay; deductible waived         You; cost sharing is based on the type of service and where it is performed           Allergy Testing         Covered 100%; deductible waived         Your cost sharing is based on the type of service and where it is performed           Allergy Injections         Covered 100%; after deductible         20%; after deductible           Diagnostic X-ray         Covered 100%; after deductible         20%; after deductible           Diagnostic Laboratory         Cove	-		Covered under Routine Adult Exams
Routine Hearing Screening         Covered 10%; deductible waived         20%; after deductible           PHYSICIAN SERVICES         IN-NETWORK         OUT-OF-NETWORK         OUT-OF-NETWORK           Office Visits         \$15 copay; deductible waived         20%; after deductible         20%; after deductible           Specialist Office Visits         \$30 copay; deductible waived         20%; after deductible         20%; after deductible           Audiometric Hearing Exam         Not Covered         Not Covered         Covered according to standard claim practice.           Walk-in Clinics         \$15 copay; deductible waived         20%; after deductible         Walk-in Clinics are network, free-standing health care facilities. They are an atternative 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 toom, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.           Allergy Testing         Covered 100%; deductible waived         Your cost sharing is based on the type of service and where it is performed.           DIAGNOSTIC PROCEDURES         IN-NETWORK         OUT-OF-NETWORK         DUT-OF-NETWORK           Diagnostic Laboratory         Covered 100%; after deductible         20%; after deductible         20%; after deductible           Iphysiclan's office visit member cost sharing.			Nat Oavana d
PHYSICIAN SERVICES         IN-NETWORK         OUT-OF-NETWORK           Office Visits to Non-Specialist         \$15 copay, deductible waived         20%; after deductible           Includes services of an internist, general physician, family practitioner or pediatrician.         Specialist Office Visits         \$30 copay; deductible waived         20%; after deductible           Audiometric Hearing Exam         Not Covered         Not Covered         Not Covered           Walk-in Clinics         \$15 copay; deductible waived         20%; after deductible           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, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.           Allergy Testing         Covered 100%; deductible waived         Your cost sharing is based on the type of service and where it is performed           DIAGNOSTIC PROCEDURES         IN-NETWORK         OUT-OF-NETWORK         Diagnostic X-ray           Covered 100%; after deductible         20%; after deductible         (bit reductible           I 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 and billed by the physician, expenses are covered subject to the applicable physician's office visit and billed by the physician, expenses are covered subject to the applicable ph			
Office Visits to Non-Specialist         \$15 copay; deductible waived         20%; after deductible           Includes services of an internist, general physician, family practitioner or pediatrician.         20%; after deductible           Specialist Office Visits         \$30 copay; deductible waived         20%; after deductible           Audiometric Hearing Exam         Not Covered         Not Covered           Walk-in Clinics         \$15 copay; deductible waived         20%; after deductible           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 Injections         Covered 100%; deductible waived         Your cost sharing is based on the type of service and where it is performed           DIAGNOSTIC PROCEDURES         IN-NETWORK         OUT-OF-NETWORK           Diagnostic X-ray         Covered 100%; after deductible         20%; after deductible           Idagnostic Laboratory         Covered 100%; after deductible         20%; after deductible           Ipagnostic Complex Imaging Services)         In-NETWORK         OUT-OF-NETWORK           Diagnostic Laboratory         Covered 100%; after deductible         2			
Includes services of an internist, general physician, family practitioner or pediatrician. Specialist Office Visits \$30 copay; deductible waived 20%; after deductible Audiometric Hearing Exam Not Covered Not Covered Not Covered Pre-Natal Maternity Covered 100%; deductible waived 20%; after deductible Walk-in Clinics \$15 copay; deductible waived 20%; after deductible 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 100%; deductible waived Your cost sharing is based on the type of service and where it is performed Allergy Injections Covered 100%; deductible waived Your cost sharing is based on the type of service and where it is performed DIAGNOSTIC PROCEDURES IN-NETWORK OUT-OF-NETWORK Diagnostic X-ray Covered 100%; after deductible 20%; 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 Covered 100%; after deductible 20%; after deductible If performed as a part of a physician office visit member cost sharing. Diagnostic Complex Imaging Covered 100%; after deductible 20%; after deductible Breegency MeDiCAL CARE IN-NETWORK OUT-OF-NETWORK Urgent Care Provider S30 copay; deductible waived Same as in-network care Non-Urgent Use of Urgent Care Provider Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered			
Specialist Office Visits         \$30 copay; deductible waived         20%; after deductible           Audiometric Hearing Exam         Not Covered         Covered according to standard claim practice.           Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician: 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.         Neither an emergency: room services or the ongoing care provided by a physician. Neither an 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 100%; deductible waived         Your cost sharing is based on the type of service and where it is performed           DlaGNOSTIC PROCEDURES         IN-NETWORK         OUT-Or-NETWORK         OUT-Or-NETWORK           Diagnostic X-ray         Covered 100%; after deductible         20%; after deductible         10%; after deductible           Ip 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 and billed by the physician, expenses are covered subject to the applicable physician's office visit an			
Audiometric Hearing Exam         Not Covered         Not Covered         Not Covered           Pre-Natal Maternity         Covered 100%; deductible waived         Covered according to standard claim practice.           Walk-in Clinics         \$15 copay; deductible waived         20%; after deductible           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 100%; deductible waived         Your cost sharing is based on the type of service and where it is performed           Allergy Injections         Covered 100%; after deductible         20%; after deductible           Diagnostic X-ray         Covered 100%; after deductible         20%; 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.         20%; after deductible           Diagnostic Laboratory         Covered 100%; after deductible         20%; after deductible         20%; 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.			
Pre-Natal Maternity       Covered 100%; deductible waived       Covered according to standard claim practice.         Walk-in Clinics       \$15 copay; deductible waived       20%; after deductible         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 100%; deductible waived       Your cost sharing is based on the type of service and where it is performed         Allergy Injections       Covered 100%; deductible waived       Your cost sharing is based on the type of service and where it is performed         DIAGNOSTIC PROCEDURES       IN-NETWORK       OUT-OF-NETWORK         Diagnostic X-ray       Covered 100%; after deductible       20%; after deductible         16 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 Complex Imaging Covered 100%; after deductible       20%; after deductible         I 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 Complex Imaging Covered 100%; after deductible       20%; after deductible	•		
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Copay waived if admitted       Not Covered       Not Covered         Non-Emergency Care in an Emergency Room       Not Covered       Not Covered         Emergency Use of Ambulance       Covered 100%; deductible waived       Same as in-network care         Non-Emergency Use of Ambulance       Not Covered       Not Covered         Non-Emergency Use of Ambulance       Not Covered       Not Covered         HOSPITAL CARE       IN-NETWORK       OUT-OF-NETWORK         Inpatient Coverage       \$75 copay; deductible waived       20%; after deductible         Your cost sharing applies to all covered benefits incurred during your inpatient stay.       Inpatient Maternity Coverage       \$75 copay; deductible waived       20%; after deductible         (includes delivery and postpartum       \$75 copay; deductible waived       20%; after deductible       20%; after deductible			
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utpatient Hospital Expenses	d benefits incurred during your inpatien Covered 100%; deductible waived	20%; after deductible
	d benefits incurred during your outpatie	
utpatient Surgery - Hospital	\$30 copay; deductible waived	20%; after deductible
	d benefits incurred during your outpatie	
utpatient Surgery - Freestanding	\$30 copay; deductible waived	20%; after deductible
acility	·····	
•	d benefits incurred during your outpatie	ent visit.
ENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
patient	\$75 copay; deductible waived	20%; after deductible
	d benefits incurred during your inpatien	
utpatient	\$15 copay; deductible waived	20%; after deductible
-	d benefits incurred during your outpatie	
	IN-NETWORK	OUT-OF-NETWORK
patient	\$75 copay; deductible waived	20%; after deductible
	d benefits incurred during your inpatien	
esidential Treatment Facility	\$75 copay; deductible waived	20%; after deductible
utpatient	\$15 copay; deductible waived	20%; after deductible
	d benefits incurred during your outpatie	
THER SERVICES	IN-NETWORK	OUT-OF-NETWORK
killed Nursing Facility	\$75 copay; deductible waived	20%; after deductible
mited to 90 days per calendar year.		
	d benefits incurred during your inpatien	t stav.
ome Health Care	Covered 100%; after deductible	20%; after deductible
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nneu iu izu visiis del calendal Veal.		
mited to 120 visits per calendar year. ach visit by a nurse or therapist is one		me health care aide is one visit.
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Autism Speech Therapy	\$15 copay; deductible waived	20%; after deductible
Visits combined with Speech Therapy.	Covered 100%; deductible waived	20%; after deductible
Durable Medical Equipment		· · · · · · · · · · · · · · · · · · ·
Hearing Aids	Covered 100%; deductible waived	20%; after deductible
Limited to a \$1,000 lifetime maximum	Covered some as any other medical	Covered same as any other medica
Diabetic Supplies	Covered same as any other medical expense.	expense.
Generic FDA-approved Women's	Covered 100%; deductible waived	Covered same as any other expens
Contraceptives		
Contraceptive drugs and devices	Covered 100%; deductible waived	Covered same as any other medica
not obtainable at a pharmacy		expense.
Vision Eyewear	Not Covered	Not Covered
Transplants	\$75 copay; deductible waived	20%; after deductible
	Preferred coverage is provided at an	Non-Preferred coverage is provided
	Institute Of Excellence contracted	at a Non- Institute Of Excellence
	facility only.	facility.
Bariatric Surgery	Not Covered	Not Covered
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
Diagnosis and treatment of the underlying		
Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation indu	uction	
Artificial insemination and ovulation indu Advanced Reproductive		Not Covered
Artificial insemination and ovulation indu Advanced Reproductive Technology (ART)	uction Not Covered	Not Covered
Artificial insemination and ovulation indu Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafall	uction Not Covered Iopian transfer (ZIFT), gamete intrafallor	Not Covered bian transfer (GIFT), cryopreserved
Artificial insemination and ovulation indu Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafall embryo transfers, intracytoplasmic sper	uction Not Covered lopian transfer (ZIFT), gamete intrafallop m injection (ICSI), or ovum microsurger	Not Covered bian transfer (GIFT), cryopreserved y
Artificial insemination and ovulation indu Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafall	uction Not Covered lopian transfer (ZIFT), gamete intrafallop <u>m injection (ICSI), or ovum microsurger</u> Your cost sharing is based on the	Not Covered bian transfer (GIFT), cryopreserved y Your cost sharing is based on the
Artificial insemination and ovulation indu Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafall embryo transfers, intracytoplasmic sper	Auction Not Covered Iopian transfer (ZIFT), gamete intrafallop m injection (ICSI), or ovum microsurger Your cost sharing is based on the type of service and where it is	Not Covered bian transfer (GIFT), cryopreserved y Your cost sharing is based on the type of service and where it is
Artificial insemination and ovulation indu Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafall embryo transfers, intracytoplasmic sper Vasectomy	Not Covered Not Covered lopian transfer (ZIFT), gamete intrafallop <u>m injection (ICSI), or ovum microsurger</u> Your cost sharing is based on the type of service and where it is performed	Not Covered bian transfer (GIFT), cryopreserved y Your cost sharing is based on the type of service and where it is performed
Artificial insemination and ovulation indu Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafall embryo transfers, intracytoplasmic sper	Auction Not Covered Iopian transfer (ZIFT), gamete intrafallop m injection (ICSI), or ovum microsurger Your cost sharing is based on the type of service and where it is	Not Covered bian transfer (GIFT), cryopreserved y Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the
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Artificial insemination and ovulation indu Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafall embryo transfers, intracytoplasmic sper Vasectomy Tubal Ligation PHARMACY Pharmacy Plan Type	Not Covered Not Covered lopian transfer (ZIFT), gamete intrafallop <u>m injection (ICSI), or ovum microsurger</u> Your cost sharing is based on the type of service and where it is <u>performed</u> Covered 100%; deductible waived	Not Covered bian transfer (GIFT), cryopreserved y Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed
Artificial insemination and ovulation indu Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafall embryo transfers, intracytoplasmic sper Vasectomy Tubal Ligation PHARMACY Pharmacy Plan Type Value Drugs Tier 1A	uction         Not Covered         lopian transfer (ZIFT), gamete intrafallop         m injection (ICSI), or ovum microsurger         Your cost sharing is based on the         type of service and where it is         performed         Covered 100%; deductible waived         IN-NETWORK         Aetna Premier Plus Open Formulary	Not Covered bian transfer (GIFT), cryopreserved y Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK
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Artificial insemination and ovulation indu Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafall embryo transfers, intracytoplasmic sper Vasectomy Tubal Ligation PHARMACY Pharmacy Plan Type Value Drugs Tier 1A Retail (31 days) Retail (32-60 days) Retail (61-90 days)	uction         Not Covered         lopian transfer (ZIFT), gamete intrafallop         m injection (ICSI), or ovum microsurger         Your cost sharing is based on the         type of service and where it is         performed         Covered 100%; deductible waived         IN-NETWORK         Aetna Premier Plus Open Formulary         \$3 copay         \$6 copay         \$9 copay	Not Covered bian transfer (GIFT), cryopreserved y Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed <b>OUT-OF-NETWORK</b> Not Covered Not Covered Not Covered Not Covered
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Artificial insemination and ovulation indu Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafall embryo transfers, intracytoplasmic sper Vasectomy Tubal Ligation PHARMACY Pharmacy Plan Type Value Drugs Tier 1A Retail (31 days) Retail (61-90 days) Mail Order Generic Drugs Retail (31 days)	uction         Not Covered         lopian transfer (ZIFT), gamete intrafallop         m injection (ICSI), or ovum microsurger         Your cost sharing is based on the         type of service and where it is         performed         Covered 100%; deductible waived         IN-NETWORK         Aetna Premier Plus Open Formulary         \$3 copay         \$6 copay         \$9 copay	Not Covered bian transfer (GIFT), cryopreserved y Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered
Artificial insemination and ovulation indu Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafall embryo transfers, intracytoplasmic sper Vasectomy Tubal Ligation PHARMACY Pharmacy Plan Type Value Drugs Tier 1A Retail (31 days) Retail (32-60 days) Retail (61-90 days) Mail Order Generic Drugs	uction         Not Covered         lopian transfer (ZIFT), gamete intrafallop         m injection (ICSI), or ovum microsurger         Your cost sharing is based on the         type of service and where it is         performed         Covered 100%; deductible waived         IN-NETWORK         Aetna Premier Plus Open Formulary         \$3 copay         \$6 copay         \$9 copay         \$6 copay	Not Covered bian transfer (GIFT), cryopreserved y Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed <b>OUT-OF-NETWORK</b> Not Covered Not Covered Not Covered Not Covered Not Covered Not Applicable



Mail Order	\$20 copay	Not Applicable			
Retail (31 days)	\$10 copay	Not Covered			
Preferred Brand-Name Drugs Retail (31 days)	10% \$20 Minimum, \$100 Maximum	Not Covered			
Retail (32-60 days)	10%	Not Covered			
Retail (61-90 days)	\$40 Minimum, \$200 Maximum 10% \$60 Minimum, \$300 Maximum	Not Covered			
Mail Order	\$40 copay	Not Applicable			
Non-Preferred Brand-Name Drugs					
Retail (31 days)	10%	Not Covered			
	\$40 Minimum, \$100 Maximum				
Retail (32-60 days)	10%	Not Covered			
	\$80 Minimum, \$400 Maximum				
Retail (61-90 days)	10%	Not Covered			
	\$120 Minimum, \$300 Maximum				
Mail Order	\$80 copay	Not Applicable			
Premier Plus Specialty Drugs	100/				
Preferred Specialty	10%	Not Applicable			
New Dreferred Creekelty	\$20 Minimum, \$100 Maximum 10%	Not Applicable			
Non-Preferred Specialty	\$40 Minimum, \$100 Maximum	Not Applicable			
Pharmacy Day Supply and Poquirom					
Retail	Pharmacy Day Supply and Requirements Retail Up to a 31 day supply;				
Retail	Up to a 32-60 day supply;				
	Up to a 61-90 day supply.				
	Percentage copays will not be doubled	1			
Mail Order	Up to a 31-90 day supply from Aetna F				
Premier Plus Specialty	Up to a 30 day supply from Aetna Spe				
		ecialty pharmacy. Subsequent fills must			
	be through our preferred Aetna Specia				
Deductible waived for generics					
Deductible waived for value drugs/tier 1A					
Deductible waived for mail order drugs					
Choose Generics with Dispense as Written (DAW) override - The member pays the applicable copay. If the					
physician requires brand-name, member would pay brand-name copay. If the member requests brand-name when a					
generic is available, the member pays t	he applicable copay plus the difference	between the generic price and the			
brand-name price.					
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.					
	ations are covered when filled with a pre	scription.			
Smoking Cessation included.					
Premier Plus Pre-certification for Specialty Drugs.					
Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications					
covered 100% in network.					
Prescription Drug Calendar Year	\$50 Individual	\$50 Individual			
Deductible(must be satisfied before					
any drug benefits are paid. For Retail					
Drugs only.)	¢150 Fomily	\$150 Family			
	\$150 Family	\$150 Family			



## PLAN DESIGN & BENEFITS ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

All covered pharmacy expenses accumulate toward both the preferred and non-preferred pharmacy deductible. Unless otherwise indicated, the pharmacy deductible must be met prior to pharmacy benefits being payable. Once family pharmacy deductible is met, all family members will be considered as having met their pharmacy deductible for the remainder of the calendar year

# **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.

• 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

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

- · 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.

• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-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/enhancement, including therapy, supplies or counseling or prescription drugs.

• Therapy or rehabilitation other than those listed as covered.

• 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.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

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 **1-888-982-3862**.



# PLAN DESIGN & BENEFITS ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.** 

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to <u>www.aetna.com</u>.

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