



Member Benefits	Basic HMO Copay Plan 1	Basic HMO Copay Plan 2	Basic HMO Coinsurance Plan 1	Basic HMO Coinsurance Plan 2
In-Network Coinsurance	N/A	N/A	40%	40%
Deductible Individual/Family	N/A	N/A	\$1,500/\$4,500	\$2,500/\$7,500
Out of Pocket Max Individual/Family	\$5,000/\$10,000	\$7,500/\$15,000	\$7,500/\$15,000	\$7,500/\$15,000
Hospital Inpatient Copay/Coinsurance	\$750 per Day	\$750 per Day	40% Member/60% Plan	40% member / 60% plan
PCP copay	\$25	\$25	\$25	\$25
Specialist copay	\$75	\$75	\$75	\$75
Maternity	\$75	\$75	\$75	\$75
X-ray and Lab	\$0	\$0	\$0	\$0
Imagery Service (CT Scan, Pet Scan, MRI)	\$200	\$200	\$200	\$200
Outpatient Surgery	\$500	\$500	40% member / 60% plan	40% member / 60% plan
Urgent Care	\$75	\$75	40% member / 60% plan	40% member / 60% plan
Ambulance	\$100	\$100	\$100	\$100
Emergency Room (waive if admitted)	\$250	\$250	40% member / 60% plan	40% member / 60% plan
Home Health Care	\$25 (60 visits per calendar yr.)	\$25 (60 visits per calendar yr.)	\$25 (60 visits per calendar yr.)	\$25 (60 visits per calendar yr.)
Hospice	\$0	\$0	\$0	\$0
Durable Medical Equipment	\$0	\$0	20% member / 80% plan	20% member / 80% plan
Mental Health – Inpatient	\$750 per Day (5 days per calendar yr.)	\$750 per Day (5 days per calendar yr.)	40% member / 60% plan (5 days per calendar yr.)	40% member / 60% plan (5 days per calendar yr.)
Mental Health - Outpatient	\$25 (10 visits per calendar yr.)	\$25 (10 visits per calendar yr.)	\$25 (10 visits per calendar yr.)	\$25 (10 visits per calendar yr.)
Substance Abuse Detoxification Inpatient	\$750 per Day	\$750 per Day	40% member / 60% plan	40% member / 60% plan
Substance Abuse Detoxification – Outpatient	\$25 – 44 visits per calendar yr. \$35 max per visit	\$25 – 44 visits per calendar yr. \$35 max per visit	\$25 – 44 visits per calendar yr. \$35 max per visit	\$25 – 44 visits per calendar yr. \$35 max per visit
Substance Abuse Lifetime maximum combined inpatient and outpatient	\$2,000.00	\$2,000.00	\$2,000.00	\$2,000.00
Outpatient Rehabilitative Services	\$25 (10 Visits per calendar yr.)	\$25 (10 Visits per calendar yr.)	\$25 (10 Visits per calendar yr.)	\$25 (10 Visits per calendar yr.)
Chiropractic Care	25 (10 Visits per calendar yr.)	25 (10 Visits per calendar yr.)	25 (10 Visits per calendar yr.)	25 (10 Visits per calendar yr.)
Skilled Nursing Facility (100 day Lifetime benefit max.)	\$0	\$0	\$0	\$0
Lifetime Maximums	\$2,000,000.00	\$2,000,000.00	\$2,000,000.00	\$2,000,000.00
Pharmacy	\$10 / \$50 /\$100	\$10 / \$50 /\$100	\$10 / \$50 /\$100	\$10 / \$50 /\$100
Contraceptives	included	included	included	included

HMO benefits are provided or administered by: Aetna Health Inc.

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Member Benefits	Standard HMO Copay Plan 1	Standard HMO Copay Plan 2	Standard HMO Coinsurance Plan 1	Standard HMO Coinsurance Plan 2
In-Network Coinsurance	N/A	N/A	20%	20%
Deductible Individual/Family	N/A	N/A	\$1,000/\$3,000	\$1,000/\$3,000
Out of Pocket Max Individual/Family	\$3,000/\$6,000	\$5,000/\$10,000	\$3,000/\$6,000	\$5,000/\$10,000
Hospital Inpatient Copay/Deductible	\$300/Day (5 day max)	\$300/Day (5 day max)	20% member / 80% plan	20% member / 80% plan
PCP copay	\$25	\$25	\$25	\$25
Specialist copay	\$50	\$50	\$50	\$50
Maternity	\$50	\$50	\$50	\$50
X-ray and Lab	\$0	\$0	\$0	\$0
Imagery Services (CT Scan, Pet Scan, MRI)	\$100	\$100	\$100	\$100
Outpatient Surgery	\$200	\$200	20% member / 80% plan	20% member / 80% plan
Urgent Care	\$75	\$75	20% member / 80% plan	20% member / 80% plan
Emergency Room (waive if admitted)	\$150	\$150	20% member / 80% plan	20% member / 80% plan
Ambulance	\$100	\$100	\$100	\$100
Home Health Care	\$25 (60 visits per calendar yr.)	\$25 (60 visits per calendar yr.)	\$25 (60 visits per calendar yr.)	\$25 (60 visits per calendar yr.)
Hospice	\$0	\$0	\$0	\$0
Durable Medical Equipment	\$0	\$0	20% member / 80% plan	20% member / 80% plan
Mental Illness – Inpatient	\$100 per day (10 days per calendar yr.)	\$100 per day (10 days per calendar yr.)	20% member / 80% plan (10 days per calendar yr.)	20% member / 80% plan (10 days per calendar yr.)
Mental Illness - Outpatient	\$25 (20 visit per calendar yr.)	\$25 (20 visit per calendar yr.)	\$25 (20 visit per calendar yr.)	\$25 (20 visit per calendar yr.)
Substance Abuse Detoxification Inpatient	\$100/Day	\$100/Day	20% member / 80% plan	20% member / 80% plan
Substance Abuse Detoxification – Outpatient	\$25 – 44 visits per calendar yr. \$35 max per visit	\$25 – 44 visits per calendar yr. \$35 max per visit	\$25 – 44 visits per calendar yr. \$35 max per visit	\$25 – 44 visits per calendar yr. \$35 max per visit
Substance Abuse Lifetime maximum combined inpatient and outpatient	\$2,000.00	\$2,000.00	\$2,000.00	\$2,000.00
Outpatient rehabilitative services	\$25 (20 visit per calendar yr.)	\$25 (20 visit per calendar yr.)	\$25 (20 visit per calendar yr.)	\$25 (20 visit per calendar yr.)
Chiropractic Care	\$25 (10 visits per calendar yr.)	\$25 (10 visits per calendar yr.)	\$25 (10 visits per calendar yr.)	\$25 (10 visits per calendar yr.)
Skilled Nursing Facility (100 days lifetime benefit max.)	\$0	\$0	\$0	\$0
Lifetime Maximums	\$5,000,000.00	\$5,000,000.00	\$5,000,000.00	\$5,000,000.00
Pharmacy	\$10 / \$30 / \$50	\$10 / \$30 / \$50	\$10 / \$30 / \$50	\$10 / \$30 / \$50
Contraceptives	included	included	included	included

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EXCLUSIONS AND LIMITATIONS

In the addition to Access Rule Conditions and the Pre-existing Condition limitations noted above, the following services and/or supplies are excluded from coverage, and are not Covered Services under this Group Plan:

Abortion, including any service or supply related to an elective abortion. However, spontaneous abortions are not excluded nor are abortions performed for reasons when Medically Necessary.

Alcoholism or substance abuse treatment, services and supplies except as specifically provided for in the Covered Services Section and the Schedule of Benefits.

Ambulance services other than those specifically provided for in the Covered Services section.

Arch supports, orthopedic shoes, sneakers, ready-made compression hose or support hose, or similar type devices/appliances regardless of intended use except for therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

Autopsy or postmortem examination services, unless specifically requested by Aetna.

Biofeedback services and other forms of self-care or self-help training and any related diagnostic testing, hypnosis, meditation, and pain control.

Blood, (if replaced) including whole blood, blood plasma, blood components, and blood derivatives which are not classified as drugs in Aetna formulary.

Complications of non-covered services, including the diagnosis or treatment of any Condition which arises as a complication of a non-covered services (e.g. services or supplies to treat complication of a pre-existing condition or cosmetic surgery are not covered under this Group Plan.

Contraceptive appliances, except as specifically provided for in the Preventive Medical Benefit or Prescription Drug Benefit.

Cosmetic surgery (plastic and reconstructive surgery) and other services and supplies to improve the Covered Person's appearance or self-perception (except as covered under the Breast Reconstructive Surgery category), including without limitation: procedures or supplies to correct baldness or the appearance of skin (wrinkling). The restoration of bodily function, or the correction of a deformity resulting from disease, injury, or congenital or developmental abnormalities, is covered.

Costs incurred by the Covered Person related to the following:

1. Health care services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent such services are payable under any medical expense provision of any automobile insurance policy.
2. Telephone consultations, failure to keep a scheduled appointment, or completion of any form and /or medical information.

Custodial care, including any service or supply of a custodial nature primarily intended to assist the Covered Person in the activities of daily living. This includes rest homes, home health aides (sitters), home parents, domestic maid services, and respite care.

Dental care; routine dental procedures including, but not limited to: extraction of teeth, restoration of teeth with fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment including palatal expansion devices, bruxism appliances, dental x-rays and routine intra-oral surgical procedures are not covered, except as otherwise specifically covered under the Accidental Dental Injury provision



or the Congenital or Developmental Abnormality provision. Dental treatment in a hospital or ambulatory surgical center; or dental treatment for children under age 18 due to cleft palate or cleft lip are covered only as specified in the Covered Services section.

Likewise, all procedures, expenses, services and supplies related to the treatment of malocclusion or malposition of the teeth or jaws (orthographic treatment), as well as temporomandibular joint (TMJ) syndrome or craniomandibular jaw disorders (CMJ) are excluded unless determined to be Medically Necessary by Aetna.

Dietary regimens or treatments for reducing or controlling weight.

Durable medical equipment other than the equipment specifically listed in the Covered Services section. This exclusion includes, but is not limited to items that are primarily for convenience and/or comfort; wheelchair lifts or ramps, modifications to motor vehicles and or homes such as wheelchair lifts or ramps; water therapy devices such as Jacuzzis, swimming pools, whirlpools or hot tubs; exercise and massage equipment, electric scooters, air conditioners and purifiers, humidifiers, water softeners and/or purifiers, pillows, mattresses or waterbeds, escalators, elevators, stair glides, emergency alert equipment, handrails and grab bars, heat appliances, dehumidifiers, and the replacement of Durable Medical Equipment solely because it is old or used.

Experimental and investigational treatment as defined in this Group Plan.

Eye care, including:

1. The purchase, examination, or fitting of eyeglasses or contact lenses, except as specifically provided for in the Covered Services section.
2. Radial keratotomy, myopic keratomileusis, and any surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.
3. Training or orthoptics, including eye exercises.

Unless otherwise covered by a rider or endorsement attached to this coverage document.

Family planning services, other than those services specifically described in the Covered Services section.

Foot care (routine), including any service or supply in connection with foot care in the absence of disease. This exclusion includes, but is not limited to, treatment of bunions, flat feet, fallen arches, and chronic foot strain, removal of warts, corns, or calluses, unless determined by Aetna to be Medically Necessary.

Hearing aids (external or implantable) and services related to the fitting or provision of hearing aids, including tinnitus maskers.

Home health care services, except as specifically set forth in the Covered Services section.

Home infusion therapy, except for prescription drugs.

Hospice services, except as specifically set forth in the Covered Services section.

Hypnotism or hypnotic anesthesia.

Immunizations and physical examinations, when required for travel, or when needed for school, employment, insurance or governmental licensing, except insofar as such examinations are within the scope of, and coincide with, the periodic health assessment examination and/or state law requirements.



Infertility treatment, services and supplies, including infertility testing, treatment of infertility, diagnostic procedures, and artificial insemination, to determine or correct the cause or reason for infertility or inability to achieve conception. This includes in-vitro fertilization, ovum or embryo placement or transfer, gamete intra-fallopian tube transfer, or cryogenic or other preservation techniques used in such or similar procedures.

Injectables, injectable medication, except as specifically provided for in the Covered Services section.

Mental health services and supplies which are

1. Rendered in connection with a Condition not classified in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association,
2. Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation;
3. For marriage and juvenile counseling,
4. Court ordered care or testing or required as a condition of parole or probation;
5. Testing for aptitude, ability, intelligence or interest, or
6. Cognitive remediation.

Military service-connected medical care for which the Covered Person is legally entitled to service from military or government facilities, and for which such facilities are reasonably accessible to the Covered Person.

Non-prescription drugs, including any non-prescription medicine, remedy, vaccine, biological product, pharmaceuticals or chemical compounds, vitamin, mineral supplements, fluoride products, or health foods.

Obesity treatment, including surgical operations and medical procedures for the treatment of morbid obesity, unless determined to be Medically Necessary.

Orthomolecular therapy, including nutrients, vitamins, and food supplements.

Personal comfort, hygiene or convenience items, including services and supplies deemed to be not Medically Necessary by Aetna and not directly related to the care of the Covered Person, including, but not limited to, beauty and barber services, radio and television, guest meals and accommodations, telephone charges, take-home supplies, massages, travel expenses other than Medically Necessary ambulance services or other transportation services that are specifically provided for in the Covered Services section, motel/hotel accommodations, air conditioning humidifiers or physical fitness equipment.

Private duty nursing care, except as related to and set forth in the covered home health care services provision.

Rehabilitative therapy services, including cardiac, speech, occupational and physical therapy, except as set forth in the Covered Services section. This exclusion includes any service or supply:

1. Provided to a Covered Person as an inpatient in a hospital or other facility, where the admission is primarily to provide rehabilitative services.
2. Services that maintain rather than improve a level of physical function, or where it has been determined that the service will not result in significant improvement in the Covered Person's Condition within a 60-day period.

Reversal of voluntary, surgically-induced sterility, including the reversal of tubal ligations and vasectomies.

Services or supplies that are:



1. Determined to be not Medically Necessary;
2. Not specifically listed in Covered Services section unless such services are specifically required to be covered by state or federal law this Group Plan will provide coverage on a primary or secondary basis as required by state or federal law.
3. Court ordered care or treatment, unless otherwise covered in this Group Plan.
4. For the treatment of a Condition resulting from:
5. War or an act of war, whether declared or not;
6. Participation in any act which would constitute a riot or rebellion, or a crime punishable as a felony;
7. Engaging in an illegal occupation;
8. Services in the armed forces;
9. Intentionally self-inflicted injuries, suicide or attempted suicide, without regard to the mental state of the Covered Person; or
10. Being under the influence of alcohol or any narcotic unless taken on the specific advice of a Physician.
11. Received prior to a Covered Person's effective date or received on or after the date a Covered Person's coverage terminates under this Group Plan, unless coverage is extended in accordance with the Extension of Benefits provision in the Administrative Provisions section.
12. Provided by a Physician or other Health Care Provider related to the Covered Person by blood or marriage.
13. Rendered from a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group.
14. Non-medical conditions related to hyperkinetic syndromes, learning disabilities, mental retardation, or inpatient confinement for environmental change.
15. Supplied at no charge when health coverage is not present, and if applicable, any charges associated with the [[Calendar] [Contract] Year Deductible] [and] [Coinsurance Percentage] [Copayment] requirements which are waived by a Health Care Provider.

Sexual reassignment or modification services, including any service or supply related to such treatment, including psychiatric services.

Skilled nursing facility services except for those services set forth in the Covered Services Section.

Smoking cessation programs, including any service or supply to eliminate or reduce the dependency on or addiction to tobacco, including but not limited to nicotine withdrawal programs and nicotine products (e.g., gum, transdermal patches, etc.).

Training and educational programs, including programs primarily for pain management or vocational rehabilitation.

Transplantation or implantation services and supplies, including the transplant or implant, other than those specifically listed in the Covered Services section. This exclusion includes:

1. Any service or supply in connection with the implant of an artificial organ, including the implant of the artificial organ.
2. Any organ which is sold rather than donated to the Covered Person.
3. Any service or supply relating to any evaluation, treatment, or therapy involving the use of high dose chemotherapy and autologous bone marrow transplantation, autologous peripheral stem cell rescue, or autologous stem rescue for the treatment of any condition other than acute lymphocytic leukemia, acute non-lymphocytic leukemia, Hodgkin's disease, non-Hodgkin's lymphoma, or Stage II, III, or IV breast cancer.
4. Any service or supply in connection with identification of a donor from a local, state or national listing, except as specifically set forth for bone marrow donors in the Covered Services section.

Transportation service that is non-emergency transportation between institutional care facilities, or to and from the Covered Person's residence.



Volunteer services or services which would normally be provided free of charge and any charges associated with Deductible, Coinsurance, or Copayment requirements (if applicable), which are waived by a health care provider.

Voluntary sterilization, including tubal ligations and vasectomies, unless Medically Necessary.

Weight control services, including any service to lose, gain, or maintain weight, including without limitation: any weight control/loss program; appetite suppressants; dietary regimens; food or food supplements; exercise program; equipment; whether or not it is part of a treatment plan for a Covered Condition.

Wigs or cranial prosthesis, except when related to restoration after cancer or brain tumor treatment.

Work related condition services to the extent the Covered Service is paid by Workers' Compensation.

PRE-EXISTING CONDITIONS EXCLUSION PERIOD: A Pre-existing Condition, for a Small Employer who has two or more employees or for a Small Employer who has fewer than two employees which have been continually covered by Creditable Coverage within 63 days before the Covered Person's Effective Date, is any Condition, regardless of the cause of the Condition, for which medical advice, diagnosis, care, or treatment was recommended or received during the six month period immediately preceding the earlier of:

1. The first day the Covered Person's Waiting Period, typically the date full-time employment begins, for individuals enrolling during their Initial Enrollment Period; or
2. The Effective Date of the Covered Person's coverage for individuals enrolling during a Special Enrollment or Annual Enrollment Period.

A Pre-existing Condition does not include: Pregnancy; Genetic information in the absence of a diagnosis of the Condition; Routine follow-up care of breast cancer after the person was determined to be free of breast cancer; or Conditions arising from domestic violence.



Member Benefits	Basic PPO Plan 1		Basic PPO Plan 2		Standard PPO Plan 1		Standard PPO Plan 2	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Coinsurance	60%	50%	60%	50%	80%	60%	80%	60%
Deductible Individual/Family	\$1,500/\$4,500	\$1,500/\$4,500	\$2,500/\$7,500	\$2,500/\$7,500	\$1,000/\$3,000	\$1,000/\$3,000	\$1,000/\$3,000	\$1,000/\$3,000
Out of Pocket Max Individual/Family	\$7,500/\$15,000	\$7,500/\$15,000	\$7,500/\$15,000	\$7,500/\$15,000	\$3,000/\$6,000	\$3,000/\$6,000	\$5,000/\$10,000	\$5,000/\$10,000
Hospital Inpatient	60%	50%	60%	50%	80%	60%	80%	60%
PCP copay/coinsurance	\$25	50%	\$25	50%	\$25	60%	\$25	60%
Specialist copay/coinsurance	\$75	50%	\$75	50%	\$50	60%	\$50	60%
X-ray and Lab	60%	50%	60%	50%	80%	60%	80%	60%
Imagery Services (including MRI, PET and CT Scans)	60%	50%	60%	50%	80%	60%	80%	60%
Outpatient Surgery	60%	50%	60%	50%	80%	60%	80%	60%
Emergency Room (waive if admitted)	60%	60%	60%	60%	80%	80%	80%	80%
Durable Medical Equipment	60%	50%	60%	50%	80%	60%	80%	60%
Mental Illness-Inpatient	60% - 5 days per calendar yr.	50% - 5 days per calendar yr.	60% - 5 days per calendar yr.	50% - 5 days per calendar yr.	80% - 5 days per calendar yr.	60% - 5 days per calendar yr.	80% - 10 days per calendar yr.	60% - 10 days per calendar yr.
Mental Illness-Outpatient	60% - 10 visits per calendar yr. \$50 max per visit	50% - 10 visits per calendar yr. \$50 max per visit	60% - 10 visits per calendar yr. \$50 max per visit	50% - 10 visits per calendar yr. \$50 max per visit	80% - 10 visits per calendar yr. \$50 max per visit	60% - 10 visits per calendar yr. \$50 max per visit	80% - 10 visits per calendar yr. \$50 max per visit	60% - 10 visits per calendar yr. \$50 max per visit
Substance Abuse Detoxification	60%	50%	60%	50%	80%	60%	80%	60%
Substance Abuse Detoxification 44 visits per calendar yr.)	60% - \$35 max per visit	50% - \$35 max per visit	60% - \$35 max per visit	50% - \$35 max per visit	80% - \$35 max per visit	60% - \$35 max per visit	80% - \$35 max per visit	60% - \$35 max per visit
Substance Abuse Lifetime maximum combined inpatient and outpatient	\$2,000.00		\$2,000.00		\$2,000.00		\$2,000.00	
Outpatient Rehabilitation Services	60% (10 visits per calendar yr.)	50% (10 visits per calendar yr.)	60% (10 visits per calendar yr.)	50% (10 visits per calendar yr.)	80% (20 visits per calendar yr.)	60% (20 visits per calendar yr.)	80% (20 visits per calendar yr.)	60% (20 visits per calendar yr.)
Home Health Care (60 visits per calendar yr.)	60%	50%	60%	50%	80%	60%	80%	60%
Lifetime Maximums	\$2,000,000 combined maximum		\$2,000,000 combined maximum		\$5,000,000 combined maximum		\$5,000,000 combined maximum	
Pharmacy	\$10 / \$50 / \$100	50% of allowance	\$10 / \$50 / \$100	50% of allowance	\$10 / \$30 / \$50	60% of allowance	\$10 / \$30 / \$50	60% of allowance

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Member Benefits	PPO HSA Compatible Plan	
	In network	Out of network
Coinsurance	80%	60%
Deductible Individual/Family	\$4000/\$8000	\$5000/\$10,000
Out of Pocket Max Individual/Family	\$5000/\$10,000	\$7,500/\$15,000
Hospital Inpatient	80%	60%
PCP copay/coinsurance	80%	60%
Specialist copay/coinsurance	80%	60%
X-ray and Lab	80%	60%
Imagery Services (including MRI, PET and CT Scans)	80%	60%
Outpatient Surgery	80%	60%
Emergency Room (waive if admitted)	80%	60%
Durable Medical Equipment	80%	60%
Mental Illness- Inpatient	80% 10 days per calendar yr	60% 10 days per calendar yr
Mental Illness-Outpatient	80% 20 visits per calendar yr. \$50 max per visit	60% 20 visits per calendar yr. \$50 max per visit
Substance Abuse Detoxification	80%	60%
Substance Abuse Detoxification (44 visits per calendar yr.)	80%	60%
Substance Abuse Lifetime maximum combined inpatient and outpatient	\$2,000.00	
Outpatient Rehabilitation Services (20 visits per calendar yr.)	80%	60%
Home Health Care (60 visits per calendar yr.)	80%	60%
Lifetime Maximums	\$5,000,000.00	
Pharmacy	80%	60%

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Member Benefits	Basic Indemnity Plan 1	Basic Indemnity Plan 2	Standard Indemnity Plan 1	Standard Indemnity Plan 2
Coinsurance	60%	60%	80%	80%
Deductible Individual/Family	\$1,500/\$4,500	\$2,500/\$7,500	\$1,000/\$3,000	\$1,000/\$3,000
Out of Pocket Max Individual/Family	\$7,500/\$15,000	\$7,500/\$15,000	\$3,000/\$6,000	\$5,000/\$10,000
Hospital Inpatient	60%	60%	80%	80%
Physician Office Visit	60%	60%	80%	80%
Specialist Office Visit	60%	60%	80%	80%
X-ray and Lab	60%	60%	80%	80%
Outpatient Surgery	60%	60%	80%	80%
Urgent Care	60%	60%	80%	80%
Emergency Room	60%	60%	80%	80%
Durable Medical Equipment	60%	60%	80%	80%
Mental Illness – Inpatient	60% - 5 days per calendar yr.	60% - 5 days per calendar yr.	80% - 10 days per calendar yr.	80% - 10 days per calendar yr.
Mental Illness - Outpatient	60% 10- visits per calendar yr. \$50 max per visit	60% 10- visits per calendar yr. \$50 max per visit	80% - 20 visits per calendar yr. \$50 max per visits	80% - 20 visits per calendar yr. \$50 max per visit
Substance Abuse Rehabilitation - Inpatient	60%	60%	80%	80%
Substance Abuse Rehabilitation – Outpatient	60% 44 visit per calendar yr. \$35 max per visit	60% 44 visit per calendar yr. \$35 max per visit	80% 44 visits per calendar yr. \$35 max per visit	80% 44 visits per calendar yr. \$35 max per visit
Substance Abuse Lifetime maximum combined inpatient and outpatient	\$2,000.00	\$2,000.00	\$2,000.00	\$2,000.00
Outpatient Rehabilitation Services	60% (10 visits per calendar yr.)	60% (10 visits per calendar yr.)	80% (20 visits per calendar yr.)	80% (20 visits per calendar yr.)
Chiropractic Care	60% (10 visits per calendar yr.)	60% (10 visits per calendar yr.)	80% (10 visits per calendar yr.)	80% (10 visits per calendar yr.)
Skilled Nursing Facility (100 day lifetime max.)	60%	60%	80%	80%
Lifetime Maximums	\$2,000,000.00	\$2,000,000.00	\$5,000,000.00	\$5,000,000.00
Pharmacy	60%	60%	80%	80%

Traditional Choice benefits are provided or administered by: Aetna Life Insurance Company.

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EXCLUSIONS AND LIMITATIONS

In addition to the Pre-existing Condition limitations noted above, the following services and/or supplies are excluded from coverage, and are not Covered Services under this Group Plan:

Abortion, including any service or supply related to an elective abortion. However, spontaneous abortions are not excluded nor are abortions performed for reasons when Medically Necessary.

Alcoholism or substance abuse treatment, services and supplies except as specifically provided for in the Covered Services Section and the Schedule of Benefits.

Ambulance services other than those specifically provided for in the Covered Services section.

Arch supports, orthopedic shoes, sneakers, ready-made compression hose or support hose, or similar type devices/appliances regardless of intended use except for therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

Autopsy or postmortem examination services, unless specifically requested by [\[Aetna\]](#).

Biofeedback services and other forms of self-care or self-help training and any related diagnostic testing, hypnosis, meditation, and pain control.

Blood, (if replaced) including whole blood, blood plasma, blood components, and blood derivatives which are not classified as drugs in [\[Aetna's\]](#) formulary.

Complications of non-covered services, including the diagnosis or treatment of any Condition which arises as a complication of a non-covered services (e.g. services or supplies to treat complication of a pre-existing condition or cosmetic surgery are not covered under this Group Plan.

Contraceptive appliances, except as specifically provided for in the Preventive Medical Services Benefit or Prescription Drug Benefit.

Cosmetic surgery (plastic and reconstructive surgery) and other service and supply to improve the Covered Person's appearance or self-perception, (except as covered under the Breast Reconstructive Surgery category), including without limitation, procedures or supplies to correct baldness or the appearance of skin (wrinkling). The restoration of bodily function, or the correction of a deformity resulting from disease, Injury, or congenital or developmental abnormalities, is covered.

Costs incurred by the Covered Person related to the following:

1. Health care services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent such services are payable under any medical expense provision of any automobile insurance policy.
2. Telephone consultations, failure to keep a scheduled appointment, or completion of any form and /or medical information.

Custodial care, including any service or supply of a custodial nature primarily intended to assist the Covered Person in the activities of daily living. This includes rest homes, home health aides (sitters), home parents, domestic maid services, and respite care.

Dental care; routine dental procedures including, but not limited to: extraction of teeth, restoration of teeth with fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment including palatal expansion devices, bruxism appliances, dental x-rays and routine intra-oral surgical procedures are not covered, except as otherwise specifically covered under the Accidental Dental Injury provision or the Congenital or Developmental Abnormality provision. Dental treatment in a hospital or ambulatory surgical center; or dental treatment for children under age 18 due to cleft palate or cleft lip are covered only as specified in the Covered Services section.

Likewise, all procedures, expenses, services and supplies related to the treatment of malocclusion or malposition of the teeth or jaws (orthographic treatment), as well as temporomandibular joint (TMJ) syndrome or craniomandibular jaw disorders (CMJ) are excluded unless determined to be Medically Necessary by [\[Aetna\]](#).



Dietary regimens or treatments for reducing or controlling weight.

Durable medical equipment other than the equipment specifically listed in the Covered Services section. This exclusion includes, but is not limited to items that are primarily for convenience and/or comfort; wheelchair lifts or ramps, modifications to motor vehicles and or homes such as wheelchair lifts or ramps; water therapy devices such as Jacuzzis, swimming pools, whirlpools or hot tubs; exercise and massage equipment, electric scooters, air conditioners and purifiers, humidifiers, water softeners and/or purifiers, pillows, mattresses or waterbeds, escalators, elevators, stair glides, emergency alert equipment, handrails and grab bars, heat appliances, dehumidifiers, and the replacement of Durable Medical Equipment solely because it is old or used.

Experimental and investigational treatment as defined in this Group Plan.

Eye care, including:

1. The purchase, examination, or fitting of eyeglasses or contact lenses, except as specifically provided for in the Covered Services section.
2. Radial keratotomy, myopic keratomileusis, and any surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.
3. Training or orthoptics, including eye exercises.

Family planning services, other than those services specifically described in the Covered Services section.

Foot care (routine), including any service or supply in connection with foot care in the absence of disease. This exclusion includes, but is not limited to, treatment of bunions, flat feet, fallen arches, and chronic foot strain, removal of warts, corns, or calluses, unless determined by [Aetna] to be Medically Necessary.

Hearing aids (external or implantable) and services related to the fitting or provision of hearing aids, including tinnitus maskers.

Home health care services, except as specifically set forth in the Covered Services section.

Home infusion therapy; except for prescription drugs.

Hospice services, except as specifically set forth in the Covered Services section.

Hypnotism or hypnotic anesthesia.

Immunizations and physical examinations, when required for travel, or when needed for school, employment, insurance, or governmental licensing, except insofar as such examinations are within the scope of, and coincide with, the periodic health assessment examination and/or state law requirements; or immunizations necessary in the course of other medical treatments of a Covered Sickness or Injury.

Infertility treatment, services and supplies, including infertility testing, treatment of infertility, diagnostic procedures, and artificial insemination, to determine or correct the cause or reason for infertility or inability to achieve conception. This includes in-vitro fertilization, ovum or embryo placement or transfer, gamete intra-fallopian tube transfer, or cryogenic or other preservation techniques used in such or similar procedures.

Injectables, injectable medication, except as specifically set forth in the Covered Services section.

Mental health services and supplies which are

7. Rendered in connection with a Condition not classified in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association,
8. Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation;
9. For marriage and juvenile counseling,
10. Court ordered care or testing or required as a condition of parole or probation;
11. Testing for aptitude, ability, intelligence or interest, or
12. Cognitive remediation.

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Military service-connected medical care for which the Covered Person is legally entitled to service from military or government facilities, and for which such facilities are reasonably accessible to the Covered Person.

Non-prescription drugs, including any non-prescription medicine, remedy, vaccine, biological product, pharmaceuticals or chemical compounds, vitamin, mineral supplements, fluoride products, or health foods.

Obesity treatment, including surgical operations and medical procedures for the treatment of morbid obesity, unless determined to be Medically Necessary.

Orthomolecular therapy, including nutrients, vitamins, and food supplements.

Personal comfort, hygiene or convenience items, including services and supplies deemed to be not Medically Necessary by [Aetna] and not directly related to the care of the Covered Person, including, but not limited to, beauty and barber services, radio and television, guest meals and accommodations, telephone charges, take-home supplies, massages, travel expenses other than Medically Necessary ambulance services or other transportation services that are specifically provided for in the Covered Services section, motel/hotel accommodations, air conditioning humidifiers or physical fitness equipment.

Private duty nursing care, except as related to and set forth in the covered home health care services provision.

Rehabilitative therapy services, including cardiac, speech, occupational and physical therapy, except as set forth in the Covered Services section. This exclusion includes any service or supply:

1. Provided to a Covered Person as an inpatient in a hospital or other facility, where the admission is primarily to provide rehabilitative services.
2. Services that maintain rather than improve a level of physical function, or where it has been determined that the service will not result in significant improvement in the Covered Person's Condition within a 60 day period.

Reversal of voluntary, surgically-induced sterility, including the reversal of tubal ligations and vasectomies.

Services or supplies that are:

1. Determined to be not Medically Necessary;
2. Not specifically listed in Covered Services section unless such services are specifically required to be covered by state or federal law. This Group Plan will provide coverage on a primary or secondary basis as required by state or federal law.
3. Court ordered care or treatment, unless otherwise covered in this Group Plan.
4. For the treatment of a Covered Condition resulting from:
5. War or an act of war, whether declared or not;
6. Participation in any act which would constitute a riot or rebellion, or a crime punishable as a felony;
7. Engaging in an illegal occupation;
8. Services in the armed forces;
9. Intentionally self-inflicted injuries, suicide or attempted suicide, without regard to the mental state of the Covered Person;
10. Being under the influence of alcohol or any narcotic unless taken on the specific advice of a Physician.
11. Received prior to a Covered Person's effective date or received on or after the date a Covered Person's coverage terminates under this Group Plan, unless coverage is extended in accordance with the Extension of Benefits provision in the Administrative Provisions section.
12. Provided by a Physician or other Health Care Provider related to the Covered Person by blood or marriage.
13. Rendered from a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group.
14. Non-medical Conditions related to hyperkinetic syndromes, learning disabilities, mental retardation, or inpatient confinement for environmental change.
15. Supplied at no charge when insurance coverage is not present, and if applicable, any charges associated with the [Calendar] [Contract] Year Deductible and Coinsurance Percentage or Copayment requirements which are waived by a Health Care Provider.

Sexual reassignment or modification services, including any service or supply related to such treatment, including psychiatric services.

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Skilled nursing facility services not provided in lieu of hospitalization.

Smoking cessation programs, including any service or supply to eliminate or reduce the dependency on or addiction to tobacco, including but not limited to nicotine withdrawal programs and nicotine products (e.g. gum, transdermal patches, etc.).

Training and educational programs, including programs primarily for pain management, the management of diabetes, or vocational rehabilitation.

Transplantation or implantation services and supplies, including the transplant or implant, other than those specifically listed in the Covered Services section. This exclusion includes:

1. Any service or supply in connection with the implant of an artificial organ, including the implant of the artificial organ.
2. Any organ which is sold rather than donated to the Covered Person.
3. Any service or supply relating to any evaluation, treatment, or therapy involving the use of high dose chemotherapy and autologous bone marrow transplantation, autologous peripheral stem cell rescue, or autologous stem rescue for the treatment of any Condition other than acute lymphocytic leukemia, acute non-lymphocytic leukemia, Hodgkin's disease, non-Hodgkin's lymphoma, or Stage II, III, or IV breast cancer.
4. Any service or supply in connection with identification of a donor from a local, state or national listing, except as specifically set forth for bone marrow donors in the Covered Services section.

Transportation service that is non-emergency transportation between institutional care facilities, or to and from the Covered Person's residence.

Volunteer services or services which would normally be provided free of charge and any charges associated with Deductible, Coinsurance, or Copayment requirements (if applicable), which are waived by a health care provider.

Voluntary sterilization, including tubal ligations and vasectomies, unless Medically Necessary.

Weight control services, including any service to lose, gain, or maintain weight, including without limitation: any weight control/loss program; appetite suppressants; dietary regimens; food or food supplements; exercise program; equipment; whether or not it is part of a treatment plan for a Covered Condition.

Wigs or cranial prosthesis, except when related to restoration after cancer or brain tumor treatment.

Work related condition services to the extent the Covered Service is paid by Workers' Compensation.

PRE-EXISTING CONDITIONS EXCLUSION PERIOD: A Pre-existing Condition, for a Small Employer who has two or more employees or for a Small Employer who has fewer than two employees which have been continually covered by Creditable Coverage within 63 days before the Covered Person's Effective Date, is any Condition, regardless of the cause of the Condition, for which medical advice, diagnosis, care, or treatment was recommended or received during the six month period immediately preceding the earlier of:

1. The first day the Covered Person's Waiting Period, typically the date full-time employment begins, for individuals enrolling during their Initial Enrollment Period; or
2. The Effective Date of the Covered Person's coverage for individuals enrolling during a Special Enrollment or Annual Enrollment Period.

A Pre-existing Condition does not include: Pregnancy; Genetic information in the absence of a diagnosis of the Condition; Routine follow-up care of breast cancer after the person was determined to be free of breast cancer; or Conditions arising from domestic violence.