		Aetna HD		Aetna Low	Aetna Mid	Aetna High
Premium						
Employee Only		**$389.80**		**$400.58**	**$511.07**	**$587.45**
Employee and Spouse		**$1,064.81**		**$1,044.97**	**$1,214.97**	**$1,228.48**
Employee and Children		**$681.32**		**$673.96**	**$832.05**	**$972.77**
Employee and Family		**$1,301.72**		**$1,303.86**	**$1,583.99**	**$1,810.17**
Plan Features						
Type of Coverage		**In-Network/Out of Network**		**In-Network Coverage Only**	**In-Network Coverage Only**	**In-Network Coverage Only**
Network		**Nationwide Network**		**Nationwide Network**	**Nationwide Network**	**Nationwide Network**
PCP Requirement		**No**		**No**	**No**	**No**
Schedule of Benefits The following is a summary of covered benefits, as well as the permitted interval and any requirements of such medical services. This plan utilizes the AETNA network for all services. Secondary coverage is provided to reduce the participants' out-of-pocket expenses subject to the AETNA plan deductible. Plan Participant is responsible for 100% of the cost for any services provided by an out-of-network provider or for the cost of specific services not covered by the plan.						
Deductible *						
Individual		$3000	$6000	$3,000	$1,000	$1,000
Family		$6000	$12000	$6,000	$2,000	$2,000
Coinsurance		20% after Deductible	40% after Deductible	20% after Deductible	20% after Deductible	20% after Deductible
Out of Pocket Maximum ***(includes deductible, coinsurance and copays)***						
Individual		$7,000	$15,000	$7,500	$7,500	$7,500
Family		$14,000	$30,000	$15,000	$15,000	$15,000
Plan Provisions	**Prior Auth Required**	**In-Network**	**Out of Network**	**In-Network**	**In-Network**	**In-Network**
PHYSICIAN SERVICES						
Primary Care Office Visit	**No**	20% after deductible	40% after Deductible	$30 Copay	$30 Copay	$0
Specialist Office Visit	**No**	20% after deductible	40% after Deductible	$70 Copay	$70 Copay	$0
Services provided in a Physicians Office	**No**	20% after deductible	40% after Deductible	20% after deductible	20% after deductible	20% after deductible
Urgent Care	**No**	20% after deductible	40% after Deductible	$50 Copay	$50 Copay	$50 Copay
Telemedicine Services	**No**	$0 Copay		$0 Copay	$0 Copay	$0 Copay
PREVENTIVE & WELLNESS SERVICES						
Preventive Health Services	**No**	$0 Copay		$0 Copay	$0 Copay	$0 Copay
HOSPITAL/FACILITY SERVICES						
Inpatient Hospitalization	**Yes**	20% after deductible	40% after Deductible	20% after deductible	20% after deductible	20% after deductible
Inpatient Visits - Physician	**No**	20% after deductible	40% after Deductible	20% after deductible	20% after deductible	20% after deductible
Inpatient Surgery (Second surgical opinion may be required)	**Yes**	20% after deductible	40% after Deductible	20% after deductible	20% after deductible	20% after deductible
Outpatient Hospital Pre Staffing Facility Services and Surgery	**Yes**	20% after deductible	40% after Deductible	20% after deductible	20% after deductible	20% after deductible
Anesthesia	**No**	20% after deductible	40% after Deductible	20% after deductible	20% after deductible	20% after deductible
Emergency Room Services (Life threatening Services)	**No**	20% after deductible		20% after deductible	20% after deductible	20% after deductible
Emergency Room Services (Non-Emergent Care)	**No**	Not Covered / 100% paid by Member		Not Covered / 100% paid by Member	Not Covered / 100% paid by Member	Not Covered / 100% paid by Member
DIAGNOSTIC SERVICES						
Laboratory Services	**No**	20% after deductible	40% after Deductible	20% after deductible	20% after deductible	$70 Copay
Radiology (x-ray, ultrasound)	**No**	20% after deductible	40% after Deductible	20% after deductible	20% after deductible	$70 Copay
CT / MRI / MRA / PET Scan	**Yes**	20% after deductible	40% after Deductible	20% after deductible	20% after deductible	$500 Copay
PREGNANCY BENEFITS						
Physician Visits	**No**	20% after deductible	40% after Deductible	$30 Copay	$30 Copay	$30 Copay
Childbirth/Delivery	**No**	$0 after deductible / coinsurance		20% after deductible	20% after deductible	20% after deductible
OTHER SERVICES						
Allergy Office visits (The copay applies for the office visit only)	**No**	20% after deductible	40% after Deductible	$100 Copay	$70 Copay	$70 Copay
Allergy Services Testing / injections	**Yes**	20% after deductible	40% after Deductible	20% after deductible	20% after deductible	20% after deductible
Second Surgical Opinion (may be required)	**No**	$0 Copay	40% after Deductible	$0 Copay	$0 Copay	$0 Copay
Home Health Care (Limited to 30 visits per plan year)	**Yes**	20% after deductible	40% after Deductible	$30 Copay	$30 Copay	$30 Copay
Hospice Care	**Yes**	20% after deductible	40% after Deductible	$30 copay	$30 copay	$30 copay
Treatment for Chemical Abuse & Dependency (In-Patient)	**Yes**	20% after deductible	40% after Deductible	20% after deductible	20% after deductible	20% after deductible
Treatment for Chemical Abuse & Dependency (Out-Patient)	**Yes**	20% after deductible	40% after Deductible	$30 Copay	20% after deductible	$30 Copay
Rehabilitation/Habilitation Services (limited to 30 visits per plan year)	**No**	20% after deductible	40% after Deductible	$30 Copay	20% after deductible	$30 Copay
Emergency Medical Transportation	**No**	20% after deductible	40% after Deductible	20% after deductible	20% after deductible	20% after deductible
PHARMACY BENEFITS						
Preventive Prescriptions						
Pharmacy Retail – up to a 30 day supply		Generic - $0 Copay (Limited to Preventive Generic)		Generic - $0 Copay (Limited to Preventive Generic)	Generic - $0 Copay (Limited to Preventive Generic)	Generic - $0 Copay (Limited to Preventive Generic)
Pharmacy Mail Order – up to a 90 day supply		Generic - $0 Copay (Limited to Preventive Generic)		Generic - $0 Copay (Limited to Preventive Generic)	Generic - $0 Copay (Limited to Preventive Generic)	Generic - $0 Copay (Limited to Preventive Generic)
Non-Preventive Prescriptions						
Pharmacy Retail – up to a 30 day supply		Generic – 20% after deductible		Generic – $10 Copay	Generic – $10 Copay	Generic – $10 Copay
Pharmacy Mail Order – 90 day supply		Generic – 20% after deductible		Generic – $25 Copay	Generic – $25 Copay	Generic – $25 Copay
Pharmacy Retail – up to a 30 day supply		Preferred Brand – 20% after deductible		Preferred Brand – $35 Copay	Preferred Brand – $35 Copay	Preferred Brand – $35 Copay
Pharmacy Mail Order – 90 day supply		Preferred Brand – 20% after deductible		Preferred Brand – $87.50 Copay	Preferred Brand – $87.50 Copay	Preferred Brand – $87.50 Copay
Non Preferred Brand		20% after deductible Max $125		20% coinsurance max $125	20% coinsurance max $125	20% coinsurance max $125
Specialty Drugs / Infusion Therapy (pre-certification required)		50% after deductible Max $500		50% coinsurance max $500	50% coinsurance max $500	50% coinsurance max $500

* Deductible represents Maximum out of pocket expense for members of Aetna Low, Mid, and High balance covered by embedded GAP coverage.