Take charge of your health. We're here to help.

AETNA ADVANTAGE PLANS FOR INDIVIDUALS, FAMILIES AND THE SELF-EMPLOYED IN LOUISIANA



Aetna Advantage plan choices

Our health insurance plans are designed to offer you quality coverage at an excellent value. Coverage can include prescription drugs, doctor visits, hospitalization and preventive care services.

Generally speaking, the lower your "premiums," or monthly payments, the higher your "deductible," which is the amount you pay out of pocket before the plan begins paying for expenses.

You'll pay less by using "in-network" doctors, hospitals, pharmacies and other health care providers who participate in Aetna's nationwide network than by using "out-of-network" doctors.

Visit **www.planforyourhealth.com** for an in-depth list of terms in this brochure and what they mean.

About HSAs

Many of our high-deductible plans are Health Savings Account (HSA) Compatible, offering you lower premiums and tax advantaged savings. An HSA is a personal account that lets you pay for qualified medical expenses with tax advantaged funds. You or an eligible family member make contributions to your HSA tax-free, and those dollars earn interest tax-free. Then, when you make withdrawals from your account to pay for qualified health care expenses, they're tax-free, too.

Aetna Advantage Plans for Individuals, Families and the Self-Employed are underwritten by Aetna Life Insurance Company (Aetna) directly and/or through an out-of-state blanket trust. In some states, individuals may qualify as a business group of one and may be eligible for guaranteed issue, small group health plans. These plans are medically underwritten and you may be declined coverage in accordance with your health condition.

It's easy to establish a Health Savings Account...

Simply enroll in an Aetna HSA Compatible High Deductible Health Plan and you will automatically have an HSA opened through Bank of America. You will also receive a debit card and a welcome package with additional information to get you started.

If you do not wish to set up an HSA, you can opt out by calling Bank of America – or the account will be automatically canceled after 90 days if the debit card is not activated or if you do not enroll online.

Why choose an Aetna HealthFund HSA?

- No set-up fees
- No monthly administration fee
- No withdrawal forms required
- Convenient access to HSA funds via debit card or online
- Track HSA activity through Aetna Navigator®

Is your doctor in the Aetna network?

Which local physicians, hospitals, pharmacies and eyewear providers participate in the nationwide Aetna Advantage Plan network? Visit www.aetna.com/docfind/custom/advplans. Or call 1-800-694-3258 and ask for a directory of providers.

Get more from your Aetna plan

Cover just your children

Aetna Advantage Plans are also available for children only, which means you can enroll your child even if no other family member enrolls. Coverage includes immunizations, well-child visits, emergency room and dental preventive services (if a dental plan is selected).

Note: when an HSA Compatible plan is selected for child only enrollment. an HSA account is not available for the child.

Add Dental PPO Max

With the Aetna Advantage Dental PPO Max insurance plan, you can obtain services from either a participating or non-participating dentist. Participating dentists have agreed to provide services at a negotiated rate for both covered services, as well as non-covered services such as cosmetic tooth whitening and orthodontic care, so you generally pay less out-of-pocket. You also have the flexibility to visit a dentist who does not participate in Aetna's network, though you will not have access to negotiated fees. Dental coverage is offered only if medical coverage is obtained.

Plan Details

First Dollar PPO plan options

Robust coverage and lower out-of-pocket expenses with no deductibles when you choose a network provider

Featuring:

- Lower copay for in-network provider visits
- No deductible for generic prescription drugs

PPO plan options

Robust coverage and lower monthly payments balanced with a deductible...where you don't want to pay a lot for frequent doctor visits

Featuring:

■ Health insurance coverage with lower monthly premiums and varying deductible levels

PPO High Deductible plan options

Lower premium costs...and an HSA-compatible plan that offers tax advantaged savings

Featuring:

- 0% coinsurance in network after your deductible is met
- Lower monthly premiums, higher annual deductibles (at least \$3,000 for individuals and \$6,000 for families)
- Can be paired with a tax-advantaged Health Savings Account (HSA)

PPO Value plan options

Affordability — a balance of lower monthly premiums and quality coverage...where you want to cap the amount you'll spend on total medical expenses each year

Featuring:

- Lower monthly premiums (that's the "Value" part)
- No deductible for generic prescription drugs

Preventive and Hospital Care plan options

Affordability is one of your top priorities and you use only basic health care services...and want to keep your monthly premiums lower

Featuring:

■ Health insurance coverage with lower monthly premiums and varying deductible levels



PPO 7500 with Unlimited Primary Care Visits plus Dental

Medical, dental and eye care savings bundled together...at a reasonable cost

Featuring:

- One monthly payment for medical, dental and eye care savings
- Lower monthly premiums, higher annual deductibles (at least \$7,500 for individuals and \$15,000 for families)
- 100% coverage for diagnostic and preventive dental services from a preferred provider

PLUS ... THESE BENEFITS ARE INCLUDED WITH MOST OF OUR PLANS.

- Coverage for office visits to your primary care physician and specialists
- No claim forms to fill out when you visit a network provider
- No referrals required to see a specialist*
- No waiting period for routine physical exams
- 100% annual routine GYN exam coverage no waiting period, no dollar maximum and no copay or deductible when you visit a network provider
- Coverage for prescription drugs*
- Coverage for routine physicals including lab work and X-rays
- 100% coverage for in-network childhood immunizations



AETNA'S LOUISIANA RATINGS AREAS*

Your rates will depend on the area in which your county is located.

For more information or a quote on what your rate would be, call your broker.

Area 1 Counties

Allen	East Baton Rouge	Pointe Coupee
Ascension	East Feliciana	Saint Helena
Beauregard	Iberville	Tangipahoa
Calcasieu	Jefferson Davis	West Baton Rouge
Cameron	Livingston	West Feliciana

Area 2 Counties

Assumption	Saint Bernard	Saint John	
Jefferson	Saint Charles	the Baptist	
Lafourche	Saint James	Terrebonne	
Orleans	Saint Tammany	Washington	
Plaguemines			

Area 3 Counties

Bienville	Franklin	Richland	
Bossier	Grant	Sabine	
Caddo	Jackson	Union	
Caldwell	Lincoln	Webster	
Catahoula	Natchitoches	West Carroll	
Claiborne	Ouachita	Winn	
De Soto	Red River		

Area 4 Counties

Acadia	Lafayette	Saint Mary
Evangeline	Saint Landry	Vermillion
Iberia	Saint Martin	

Area 5 Counties

Avoyelles	La Salle	Rapides	
Concordia	Madison	Tensas	
East Carroll	Morehouse	Vernon	

^{*} All products not available in all counties. Please refer to the county in which you reside for the available product.

^{*} These benefits are not applicable to Preventive and Hospital Care plans

First Dollar PPO 30

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible		
Individual	\$0	\$5,000
Family	\$0	\$10,000
Coinsurance	30% up to	50% up to
(Member's responsibility)	out-of-pocket max.	out-of-pocket max.
	\$0 once out-of-poo	ket max. is satisfied
Coinsurance Maximum		
Individual	\$7,500	\$7,500
Family Out-of-Pocket Maximum	\$15,000	\$15,000
Individual	\$7,500	\$12,500
Family	\$15,000	\$25,000
		deductible
Lifetime Maximum* per insured		0,000
Non-Specialist Office Visit	\$30 copay	50%
Unlimited visits	450 copuj	after deductible
General Physician, Family Practitioner,		
Pediatrician or Internist		
Specialist Visit	\$40 copay	50%
(Includes Chiropractic Care Visits)		after deductible
Hospital Admission	30%	50%
		after deductible
Outpatient Surgery	30%	50%
	tro.	after deductible
Urgent Care Facility	\$50 copay	50% after deductible
		arter deductible
Emergency Room	\$100 copay** (waived if admitte	
	30% coi	nsurance
Annual Routine Gyn Exam	\$0 copay	50%
No waiting period, no calendar		after deductible
year max. Annual Pap/Mammogram		
Maternity		overed ancy complications)
Preventive Health —	\$30 copay	50%
Routine Physical	450 сориу	after deductible
Aetna will pay up to \$200 per exam*	Includes lab w	ork and X-rays
No waiting period		
Lab/X-Ray	30%	50%
		after deductible
Skilled Nursing — in lieu of hospital	30%	50%
30 days per calendar year*		after deductible
Physical/Occupational Therapy	30%	50%
24 visits per calendar year*		after deductible
	Aetna wili pay a m	ax. of \$25 per visit*
Home Health Care —	30%	50%
in lieu of hospital		after deductible
30 visits per calendar year*		
Durable Medical Equipment	30%	50%
Aetna will pay up to \$2000 per calendar year*		after deductible
PHARMACY	1	
Pharmacy Deductible	\$500	\$500
per individual		\$500 ply to generic
Generic	\$15 copay	\$15 copay plus 50%
Oral Contraceptives Included	deductible waived	deductible waived
Preferred Brand	\$40 copay	\$40 copay plus 50%
Oral Contraceptives Included	after deductible	after deductible
Non-Preferred Brand Oral Contraceptives Included	\$60 copay after deductible	\$60 copay plus 50% after deductible
Calendar Year Maximum	Unlimited	Unlimited
per individual*	O. IIII I III CU	Gillitited
	<u> </u>	

*	Maximum	applies to	combined	in and	out-of-network	benefits.

^{**} Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

First Dollar PPO 40

	First Dollar I	PPO 40			
MEMBER BENEFITS	In-Network	Out-of-Network+			
Deductible	**	t 7.000			
Individual	\$0	\$7,000			
Family	\$0	\$14,000			
Coinsurance	40% up to	50% up to			
(Member's responsibility)	out-of-pocket max.	out-of-pocket max.			
	\$0 once out-of-poo	ket max. is satisfied			
Coinsurance Maximum					
Individual	\$12,500	\$5,500			
Family	\$25,000	\$11,000			
Out-of-Pocket Maximum					
Individual	\$12,500	\$12,500			
Family	\$25,000	\$25,000			
	Includes deductible				
Lifetime Maximum* per insured	\$5,00	00,000			
Non-Specialist Office Visit	\$40 copay	50%			
Unlimited visits		after deductible			
General Physician, Family Practitioner,					
Pediatrician or Internist	¢EO sensi	F00/			
Specialist Visit	\$50 copay	50% after deductible			
(Includes Chiropractic Care visits) Hospital Admission	40%	50%			
nospital Aumission	→U 70	after deductible			
Outpatient Surgery	40%	50%			
Outpatient Jurgery		after deductible			
Urgent Care Facility	\$50 copay	50%			
orgent care ruanty	\$50 copuy	after deductible			
Emergency Room	\$100 copav** (w	vaived if admitted)			
Linergency Room		insurance			
Annual Routine Gyn Exam	\$0 copay	50%			
No waiting period, no calendar	, ,	after deductible			
year max. Annual Pap/Mammogram					
Maternity	Not o	overed			
	(except for pregna	ncy complications)			
Preventive Health —	\$40 copay	50%			
Routine Physical		after deductible			
Aetna will pay up to \$200 per exam*	Includes lab w	ork and X-rays			
No waiting period	100/	500/			
Lab/X-Ray	40%	50%			
Chilled Numeiron in line of bossital	400/	after deductible 50%			
Skilled Nursing — in lieu of hospital 30 days per calendar year*	40%	after deductible			
Physical/Occupational Therapy	40%	50%			
24 visits per calendar year*	40 /0	after deductible			
	Aetna will pay a max. of \$25 per visit*				
Home Health Care —	40%	50%			
in lieu of hospital	-10 /0	after deductible			
30 visits per calendar year*		a.i.i. deddetible			
Durable Medical Equipment	40%	50%			
Aetna will pay up to \$2000 per	"	after deductible			
calendar year*					
PHARMACY					
Pharmacy Deductible	Not Applicable	Not Applicable			
per individual	1,				
Generic	\$20 copay	\$20 copay plus 50%			
Oral Contraceptives Included	' '				
Preferred Brand	Not covered	Not covered			
Oral Contraceptives Included	Aetna Discount	TVOI COVELEG			
2. 2. 25/10 deepares medded	Applies Applies				
Non-Preferred Brand	Not covered	Not covered			
Oral Contraceptives Included	Aetna Discount				
	Applies				
Calendar Year Maximum	Unlimited	Unlimited			

Payment for out-of-network facility covered expenses is determined based on Aetna's Market Fee Schedule. Payment for out-of-network non-facility covered expenses is determined based on the negotiated charge that would apply if such services were received from a Network Provider.

PPO 1000

	PPO 1000	
MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible		
Individual	\$1,000	\$2,000
Family	\$2,000	\$4,000
Coinsurance	20% after	50% after
(Member's responsibility)	deductible up to	deductible up to
	out-of-pocket max.	out-of-pocket max.
	\$0 once out-of-poo	ket max. is satisfied
Coinsurance Maximum	,	
Individual	\$1,500	\$1,500
Family	\$3,000	\$3,000
Out-of-Pocket Maximum	,	
Individual	\$2,500	\$3,500
Family	\$5,000	\$7,000
Lifetime Maximum* per insured		00,000
Non-Specialist Office Visit	\$20 copay	50%
Unlimited visits	deductible waived	after deductible
General Physician, Family Practitioner,	deddenoie waived	arter deddetable
Pediatrician or Internist		
Specialist Visit	\$30 copay	50%
(Includes Chiropractic Care visits)	deductible waived	after deductible
Hospital Admission	20%	50%
	after deductible	after deductible
Outpatient Surgery	20%	50%
outputient Jurgery	after deductible	after deductible
Urgent Care Facility	\$50 copay	50%
orgent care racinty	deductible waived	after deductible
Function and December		
Emergency Room		vaived if admitted) e after deductible
Annual Bautina Com Franc		50%
Annual Routine Gyn Exam No waiting period, no calendar	\$0 copay deductible waived	after deductible
year max. Annual Pap/Mammogram	deductible waived	arter deductible
	Not s	overed
Maternity	1111	ancy complications)
	1 1 1	
Preventive Health —	\$20 copay	50%
Routine Physical	deductible waived	after deductible
Aetna will pay up to \$200 per exam* No waiting period	Includes lab w	ork and X-rays
	20%	50%
Lab/X-Ray	after deductible	after deductible
all la		
Skilled Nursing — in lieu of hospital	20%	50%
30 days per calendar year*	after deductible	after deductible
Physical/Occupational Therapy	20%	50%
24 visits per calendar year*	after deductible	after deductible
	Aetna will pay a m	ax. of \$25 per visit*
Home Health Care —	20%	50%
in lieu of hospital	after deductible	after deductible
30 visits per calendar year*	academore	2.10. Geodelible
Durable Medical Equipment	20%	50%
Aetna will pay up to \$2000 per	after deductible	after deductible
calendar year*		is stated
PHARMACY	1	
	¢250	¢2E0
Pharmacy Deductible	\$250	\$250
per individual	Does not ap	ply to generic
Generic	\$15 copay	\$15 copay plus 50%
Oral Contraceptives Included	deductible waived	deductible waived
Preferred Brand	\$25 copay	\$25 copay plus 50%
Oral Contraceptives Included	after deductible	after deductible
Non-Preferred Brand	\$40 copay	\$40 copay plus 50%
Oral Contraceptives Included	after deductible	after deductible
Calandar Voor Marrisson	Unlimited	Unlimited
Calendar Year Maximum per individual*	Orillimited	Onlimited
Der malviauar"	T. Control of the Con	

*	Maximum	applies to	combined	in and	out-of-network	benefits.

^{**} Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

PPO 2500

In-Network \$2,500 \$5,000 \$5,000 \$20% after deductible up to out-of-pocket max. \$0 once out-of-poc \$5,000 \$10,000 Includes of \$5,000 \$10,000 Includes of \$5,000 \$40 copay deductible waived 20% after deductible 20% after deductible \$50 copay deductible waived \$100 copay** (w 20% coinsurance	\$2,500 \$5,000 \$7,500 \$15,000 \$deductible 0,000 50% after deductible 50% after deductible 50% after deductible 50% after deductible 50% after deductible		
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\$100 copay** (w			
	and the second second		
20% coinsurance	raived it admitted)		
	e after deductible		
\$0 copay	50%		
deductible waived	after deductible		
Not co	overed		
(except for pregna			
\$30 copay	50%		
deductible waived	after deductible		
Includes lab w	ork and X-rays		
20%	50%		
after deductible	after deductible		
20%	50%		
/-	after deductible		
	50%		
	after deductible		
	50%		
arter deductible	after deductible		
/	/		
	50%		
after deductible	after deductible		
\$500	\$500		
Does not app	oly to generic		
\$15 copay deductible waived	\$15 copay plus 50% deductible waived		
\$25 conav	\$25 copay plus 50%		
	after deductible		
\$40 copay after deductible	\$40 copay plus 50% after deductible		
	Unlimited		
Ormittiteu	Oriminated		
	(except for pregnal 530 copay deductible waived Includes lab w 20% after deductible 20% after deductible 20% after deductible 20% after deductible Aetna will pay a me 20% after deductible 20% after		

Payment for out-of-network facility covered expenses is determined based on Aetna's Market Fee Schedule. Payment for out-of-network non-facility covered expenses is determined based on the negotiated charge that would apply if such services were received from a Network Provider.

PPO 5000

	PPO 5000			
MEMBER BENEFITS	In-Network	Out-of-Network+		
Deductible Individual Family	\$5,000 \$10,000	\$10,000 \$20,000		
Coinsurance (Member's responsibility)	20% after deductible up to	50% after deductible up to		
	out-of-pocket max.	out-of-pocket max. cket max. is satisfied		
Coinsurance Maximum Individual Family	\$2,500 \$5,000	\$2,500 \$5,000		
Out-of-Pocket Maximum Individual	\$7,500	\$12,500		
Family	\$15,000	\$25,000 deductible		
Lifetime Maximum* per insured		00,000		
Non-Specialist Office Visit Unlimited visits General Physician, Family Practitioner, Pediatrician or Internist	\$40 copay deductible waived	50% after deductible		
Specialist Visit (Includes Chiropractic Care visits)	\$50 copay deductible waived	50% after deductible		
Hospital Admission	20% after deductible	50% after deductible		
Outpatient Surgery	20% after deductible	50% after deductible		
Urgent Care Facility	\$50 copay deductible waived	50% after deductible		
Emergency Room	\$100 copay** (waived if admitted) 20% coinsurance after deductible			
Annual Routine Gyn Exam No waiting period, no calendar year max. Annual Pap/Mammogram	\$0 copay deductible waived	50% after deductible		
Maternity	Not covered (except for pregnancy complication			
Preventive Health — Routine Physical Aetna will pay up to \$200 per exam*	\$40 copay deductible waived	50% after deductible		
No waiting period	Includes lab work and X-rays			
Lab/X-Ray	20% after deductible	50% after deductible		
Skilled Nursing — in lieu of hospital 30 days per calendar year*	20% after deductible	50% after deductible		
Physical/Occupational Therapy 24 visits per calendar year*	20% after deductible	50% after deductible		
	Aetna will pay a m	ax. of \$25 per visit*		
Home Health Care — in lieu of hospital 30 visits per calendar year*	20% after deductible	50% after deductible		
Durable Medical Equipment Aetna will pay up to \$2000 per calendar year*	20% after deductible	50% after deductible		
PHARMACY	1			
	\$500	\$500		
	Door not an			
per individual Generic	Does not ap \$15 copay deductible waived			
per individual Generic Oral Contraceptives Included Preferred Brand	\$15 copay	\$15 copay plus 50%		
Pharmacy Deductible per individual Generic Oral Contraceptives Included Preferred Brand Oral Contraceptives Included Non-Preferred Brand Oral Contraceptives Included	\$15 copay deductible waived \$25 copay	\$15 copay plus 50% deductible waived \$25 copay plus 50%		

- Maximum applies to combined in and out-of-network benefits. Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

PPO High Deductible

$\supset I$	2000 (USA C	
	3000 (HSA C	.ompatible)
MEMBER BENEFITS	In-Network	Out-of-Network ⁺
Deductible		
Individual	\$3,000	\$6,000
Family	\$6,000	\$12,000
Coinsurance	0% after	50% after
(Member's responsibility)	deductible up to out-of-pocket max.	deductible up to out-of-pocket max.
		ket max. is satisfied
Coinsurance Maximum	30 once out-or-poo	Ket max. is satisfied
Individual	\$0	\$6,500
Family	\$0	\$13,000
Out-of-Pocket Maximum		
Individual	\$3,000	\$12,500
Family	\$6,000	\$25,000
	Includes o	deductible
Lifetime Maximum* per insured	\$5.00	0,000
Non-Specialist Office Visit	0%	50%
Unlimited visits	after deductible	after deductible
General Physician, Family Practitioner,		
Pediatrician or Internist		
Specialist Visit	0%	50%
(Includes Chiropractic Care visits)	after deductible	after deductible
Hospital Admission	0% after deductible	50% after deductible
Outpotiont Surgan	0%	50%
Outpatient Surgery	after deductible	after deductible
Urgent Care Facility	0%	50%
organic care ruanity	after deductible	after deductible
Emergency Room	\$0 conay aft	er deductible
Annual Routine Gyn Exam	\$0 copay	50%
No waiting period, no calendar	deductible waived	after deductible
year max. Annual Pap/Mammogram	acadeable Walled	diter deddelible
Maternity	Not co	overed
·		ancy complications)
Preventive Health —	\$20 copay	50%
Routine Physical	deductible waived	after deductible
Aetna will pay up to \$200 per exam*	Includes lab w	ork and X-rays
No waiting period		
Lab/X-Ray	0% after deductible	50% after deductible
Skilled Nursing — in lieu of hospital	0%	50%
30 days per calendar year*	after deductible	after deductible
Physical/Occupational Therapy	0%	50%
24 visits per calendar year*	after deductible	after deductible
	Aotna will nav a m	ax. of \$25 per visit*
Home Health Care —	0%	50%
in lieu of hospital	after deductible	after deductible
30 visits per calendar year*	arter deddeable	anter deddetable
Durable Medical Equipment	0%	50%
Aetna will pay up to \$2000 per	after deductible	after deductible
calendar year*		
PHARMACY	1	
Pharmacy Deductible	Integrated Medi	cal/Rx Deductible
per individual Generic	0% after Medical/	50% after Medical/
Oral Contraceptives Included	Rx deductible	Rx deductible
Preferred Brand	-	50% after Medical/
Oral Contraceptives Included	0% after Medical/ Rx deductible	Rx deductible
Non-Preferred Brand	0% after Medical/	50% after Medical/
Oral Contraceptives Included	Rx deductible	Rx deductible
Calendar Year Maximum per individual*	Unlimited	Unlimited
per maividual		

Payment for out-of-network facility covered expenses is determined based on Aetna's Market Fee Schedule. Payment for out-of-network non-facility covered expenses is determined based on the negotiated charge that would apply if such services were received from a Network Provider.

PPO High Deductible 5000 (HSA Compatible)

	3000 (H3A C	отпрацые)
MEMBER BENEFITS	In-Network	Out-of-Network*
Deductible Individual Family	\$5,000 \$10,000	\$10,000 \$20,000
Coinsurance (Member's responsibility)	0% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max. is satisfied
Coinsurance Maximum Individual Family	\$0 \$0	\$2,500 \$5,000
Out-of-Pocket Maximum Individual Family	\$5,000 \$10,000	\$12,500 \$25,000
Lifetime Maximum* per insured		deductible 00,000
Non-Specialist Office Visit Unlimited visits General Physician, Family Practitioner, Pediatrician or Internist	0% after deductible	50% after deductible
Specialist Visit (Includes Chiropractic Care visits)	0% after deductible	50% after deductible
Hospital Admission	0% after deductible	50% after deductible
Outpatient Surgery Urgent Care Facility	0% after deductible	after deductible
orgent care raciity	after deductible	after deductible
Emergency Room		er deductible
Annual Routine Gyn Exam No waiting period, no calendar year max. Annual Pap/Mammogram	\$0 copay deductible waived	50% after deductible
Maternity		overed ancy complications)
Preventive Health — Routine Physical Aetna will pay up to \$200 per exam*	\$25 copay deductible waived	50% after deductible
No waiting period		ork and X-rays
Lab/X-Ray	0% after deductible	50% after deductible
Skilled Nursing — in lieu of hospital 30 days per calendar year*	0% after deductible	50% after deductible
Physical/Occupational Therapy 24 visits per calendar year*	0% after deductible	50% after deductible
	Aetna will pay a m	ax. of \$25 per visit*
Home Health Care — in lieu of hospital 30 visits per calendar year*	0% after deductible	50% after deductible
Durable Medical Equipment Aetna will pay up to \$2000 per calendar year*	0% after deductible	50% after deductible
PHARMACY	1 .	
Pharmacy Deductible per individual		cal/Rx Deductible
Generic Oral Contraceptives Included	0% after Medical/ Rx deductible	50% after Medical/ Rx deductible
Preferred Brand Oral Contraceptives Included	0% after Medical/ Rx deductible	50% after Medical/ Rx deductible
Non-Preferred Brand Oral Contraceptives Included	0% after Medical/ Rx deductible	50% after Medical/ Rx deductible
Calendar Year Maximum per individual*	Unlimited	Unlimited

* Maximum applies to combined in and out-of-network benefits.

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- ** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.
- *** Brokers: please see broker information about commissions for these plans.



PPO Value 2500***

In-Network Out-of-Network Deductible Individual \$2,500 \$5,000 \$10,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000
Individual Family Sp.000 Sp.00
South of the composition of th
Coinsurance (Member's responsibility) deductible up to out-of-pocket max. \$0 once out-of-pocket max. \$0 once out-of-pocket max. \$0 once out-of-pocket max. \$5 satisfies Coinsurance Maximum Individual \$2,500 \$5,000 \$10,000 Out-of-Pocket Maximum Individual \$5,000 \$10,000 \$20,000 Includes deductible Lifetime Maximum* per insured Non-Specialist Office Visit Unlimited visits General Physician, Family Practitioner, Pediatrician or Internist Specialist and Non Specialist and Non Specialist share visit max. Specialist and Non Specialist and Non Specialist share visit max. Hospital Admission Hospital Admission Tight of the deductible after deductible Urgent Care Facility Soopay deductible waived. Visit 3+30% after deductible after deductible after deductible Specialist and Non Specialist share visit max. Foodate the deductible after deducti
deductible up to out-of-pocket max. \$0 once out-of-pocket max. \$0 once out-of-pocket max. \$5,000 \$5,000 \$5,000 \$5,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$10,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$20,000 \$2
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\$0 once out-of-pocket max. is satisfie
Coinsurance Maximum Individual \$2,500 \$5,000 \$10,000
Specialist Visit (Includes Chiropractic Care visits)
Dut-of-Pocket Maximum Individual \$5,000 \$10,000 \$20,000
Individual Family \$5,000 \$10,000 \$20,000 Includes deductible \$3,000,000 Non-Specialist Office Visit Unlimited visits General Physician, Family Practitioner, Pediatrician or Internist Specialist Visit (Includes Chiropractic Care visits) Specialist 4 Admission Hospital Admission Hospital Admission Urgent Care Facility Specialist and Non Specialist and Non Specialist share visit max. Hospital Admission The properties of the propert
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Lifetime Maximum* per insured Non-Specialist Office Visit Unlimited visits General Physician, Family Practitioner, Pediatrician or Internist Specialist Visit (Includes Chiropractic Care visits) Hospital Admission Hospital Admission Outpatient Surgery Urgent Care Facility Specialist Surgery Annual Routine Gyn Exam No waiting period, no calendar year max. Annual Pap/Mammogram Maternity Nisi 1-2 \$30 copay, deductible waived. Visit 3+ 30% after deductible. Specialist share visit max. Visit 1-2 \$30 copay, deductible waived. Visit 3+ 30% after deductibl
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Unlimited visits General Physician, Family Practitioner, Pediatrician or Internist Specialist 3+30% after deductible. Specialist and Non Specialist Share visit max. Specialist Visit Visit 1-2 \$30 copay, deductible waived. Visit 3+30% after deductible. Specialist and Non Specialist Share visit max. Specialist Admission Specialist Admission Specialist Share visit max. Sow after deductible waived. Specialist and Non Specialist share visit max. Sow after deductible After deductible Specialist Share visit max. Sow after deductible Specialist Share visit max. Sow after deductible After deductible After deductible After deductible Sow after deductible After deductible Sow after deductible waived After deductible Annual Routine Gyn Exam Sow consurance after deductible Annual Routine Gyn Exam Sow copay Sow after deductible waived Annual Routine Gyn Exam Sow copay Sow after deductible Annual Routine Gyn Exam Sow copay Sow after deductible Annual Routine Gyn Exam Sow copay Sow after deductible Annual Routine Gyn Exam Sow copay Sow after deductible S
General Physician, Family Practitioner, Pediatrician or Internist Specialist and Non Specialist share visit max. Hospital Admission Outpatient Surgery Urgent Care Facility Specialist Urgent Care Facility Specialist Specialist share visit max. 30% after deductible after deductible after deductible after deductible after deductible Urgent Care Facility Specialist and Non Specialist share visit max. 50% after deductible after deductible after deductible after deductible after deductible Specialist and Non Specialist share visit max. 50% after deductible after deductible after deductible after deductible Specialist and Non Specialist and Non Specialist share visit max. 50% after deductible after deductible after deductible Specialist and Non Speciali
Pediatrician or Internist after deductible. Specialist and Non Specialist share visit max. Visit 1-2 \$30 copay, deductible waived. Visit 3+ 30% after deductible. Specialist share visit max. Visit 1-2 \$30 copay, deductible waived. Visit 3+ 30% after deductible. Specialist and Non Specialist share visit max. Hospital Admission 30% after deductible after deductible after deductible after deductible after deductible after deductible S50 copay deductible waived after deductible Annual Routine Gyn Exam No waiting period, no calendar year max. Annual Pap/Mammogram Maternity Not covered (except for pregnancy complications) Preventive Health — \$50 copay \$50%
Specialist Share visit max. Visit 1-2 \$30 copay, deductible waived. Visit 3+ 30% after deductible. Specialist and Non Specialist share visit max. Hospital Admission Outpatient Surgery 30% after deductible after deductible after deductible after deductible waived. Specialist share visit max. Urgent Care Facility S50 copay after deductible after deductible after deductible after deductible after deductible after deductible waived after deductible waived after deductible waived after deductible waived if admitted) 30% coinsurance after deductible waived if admitted) 30% coinsurance after deductible waived after deductible waived if admitted) 30% coinsurance after deductible waived if admitted) 30% coinsurance after deductible waived after deductible waived if admitted) 30% coinsurance after deductible waived
Visit max. Visit 1-2 \$30 copay, deductible waived. Specialist Visit (Includes Chiropractic Care visits) Visit 1-2 \$30 copay, deductible waived. Visit 3+30% after deductible. Specialist and Non Specialist share visit max. Specialist share visit max. So% after deductible
Visit 1-2 \$30 copay, deductible waived. Visit 3+30% after deductible. Specialist and Non Specialist share visit max.
(Includes Chiropractic Care visits) deductible waived. Visit 3+ 30% after deductible. Specialist and Non Specialist share visit max. after deductible. Specialist share visit max. Hospital Admission 30% after deductible waived waiting period, no calendar year max. Annual Pap/Mammogram \$0 copay 50% after deductible waived if admitted) after deductible waived after deductible waived after deductible waived year max. Annual Pap/Mammogram Maternity Not covered (except for pregnancy complications) Preventive Health — \$50 copay 50%
Visit 3+ 30% after deductible Specialist and Non Specialist share visit max.
Specialist and Non Specialist share visit max.
Specialist share visit max.
Visit max. Visit max. 30% 50% after deductible S50 copay 50% deductible waived after deductible S100 copay** (waived if admitted) 30% coinsurance after deductible Annual Routine Gyn Exam S0 copay 50% deductible waived after deductible after deductible Annual Pap/Mammogram Not covered (except for pregnancy complications) Preventive Health — \$50 copay 50% S0%
Hospital Admission
Outpatient Surgery after deductible after deductible after deductible after deductible 550 copay deductible waived after deductible 30% coinsurance after deductible 30% coinsurance after deductible after deductible because of the deductible waived deductible waived after deductible after deduc
after deductible after deductible Urgent Care Facility \$50 copay deductible waived after deductible **Emergency Room** **Independent of the state
So copay deductible waived after deductible
deductible waived after deductible
Emergency Room \$100 copay** (waived if admitted) 30% coinsurance after deductible Annual Routine Gyn Exam No waiting period, no calendar year max. Annual Pap/Mammogram Maternity Not covered (except for pregnancy complications) Preventive Health — \$100 copay** (waived if admitted) 30% coinsurance after deductible deductible waived after deductible Not covered (except for pregnancy complications)
Annual Routine Gyn Exam No waiting period, no calendar year max. Annual Pap/Mammogram Maternity Preventive Health — 30% coinsurance after deductible \$0 copay deductible waived after deductible wideductible waived after deductible Not covered (except for pregnancy complications)
No waiting period, no calendar year max. Annual Pap/Mammogram Maternity Not covered (except for pregnancy complications) Preventive Health — \$50 copay 50%
year max. Annual Pap/Mammogram Not covered (except for pregnancy complications) Preventive Health — \$50 copay 50%
Maternity Not covered (except for pregnancy complications) Preventive Health — \$50 copay 50%
(except for pregnancy complications) Preventive Health — \$50 copay 50%
Preventive Health — \$50 copay 50%
Routine Physical deductible waived after deductible
Aetna will pay up to \$200 per exam*
No waiting period Includes lab work and X-rays
Lab/X-Ray 30% 50%
after deductible after deductible
Skilled Nursing — in lieu of hospital 30% 50%
30 days per calendar year* after deductible after deductible Physical/Occupational Therapy 30% 50%
24 visits per calendar year* after deductible after deductible
Aetna will pay a max. of \$25 per visit
Home Health Care — 30% 50%
in lieu of hospital after deductible after deductible
30 visits per calendar year*
Durable Medical Equipment 30% 50% Aetna will pay up to \$2000 per after deductible after deductible
Calefigal Veal"
calendar year* PHARMACY
PHARMACY
PHARMACY Pharmacy Deductible \$500 \$500
PHARMACY Pharmacy Deductible per individual
PHARMACY Pharmacy Deductible per individual Does not apply to generic Generic \$15 copay \$15 copay plus 50
PHARMACY Pharmacy Deductible per individual Does not apply to generic Generic \$15 copay Genuctible waived deductible waived
PHARMACY Pharmacy Deductible per individual Does not apply to generic Generic \$15 copay Geductible waived deductible waived
PHARMACY Pharmacy Deductible per individual Generic Oral Contraceptives Included Preferred Brand \$500 \$500 Does not apply to generic \$15 copay deductible waived deductible waived \$35 copay \$35 copay plus 50
PHARMACY Pharmacy Deductible per individual Does not apply to generic Generic Oral Contraceptives Included Preferred Brand Oral Contraceptives Included Non-Preferred Brand Oral Contraceptives Included S50 copay 450 copay 450 copay 550 copay J50 copay J50 copay J650 copay J65
PHARMACY Pharmacy Deductible per individual Does not apply to generic Generic \$15 copay Oral Contraceptives Included Preferred Brand Oral Contraceptives Included Oral Contraceptives Included The Copy of the Cop

Payment for out-of-network facility covered expenses is determined based on Aetna's Market Fee Schedule. Payment for out-of-network non-facility covered expenses is determined based on the negotiated charge that would apply if such services were received from a Network Provider.

Preventive and Hospital Care 1250

	Care 1250	
MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible		
Individual	\$1,250	\$2,500
Family	\$2,500	\$5,000
Coinsurance	20% after	50% after
(Member's responsibility)	deductible up to	deductible up to
	out-of pocket max.	out-of pocket max.
	\$0 once out-of-poo	cket max. is satisfied
Coinsurance Maximum		
Individual	\$2,500	\$5,000
Family	\$5,000	\$10,000
Out-of-Pocket Maximum	¢2.750	*7.500
Individual	\$3,750	\$7,500
Family	\$7,500	\$15,000
	Includes (deductible
Lifetime Maximum* per insured	\$5,00	00,000
Non-Specialist Office Visit	Not covered++	Not covered**
Unlimited visits		
General Physician, Family Practitioner,		
Pediatrician or Internist		
Specialist Visit	Not covered**	Not covered**
(Includes Chiropractic Care visits)		
Hospital Admission	20%	50%
	after deductible	after deductible
Outpatient Surgery	20%	50%
	after deductible**	after deductible**
Urgent Care Facility	Not covered	Not covered
Emergency Room		vaived if admitted) e after deductible**
Annual Routine Gyn Exam	\$0 copay	50%
No waiting period, no calendar	deductible waived	after deductible
year max. Annual Pap/Mammogram		
Maternity		overed
		ancy complications)
Preventive Health —	\$25 copay	50%
Routine Physical	deductible waived	after deductible
Aetna will pay up to \$200 per exam* No waiting period	Includes lab w	ork and X-rays
Lab/X-Ray	Not covered**	Not covered**
Skilled Nursing — in lieu of hospital	20% after deductible	50% after deductible
30 days per calendar year*	arter deductible	arter deddCtible
Physical/Occupational Therapy	20%	50%
24 visits per calendar year*	after deductible	after deductible
Home Health Care —	20%	50%
in lieu of hospital	after deductible	after deductible
30 visits per calendar year*		
Durable Medical Equipment	Not covered**	Not covered**
Aetna will pay up to \$2000 per		
calendar year*		
PHARMACY		
Pharmacy Deductible	Not Applicable	Not Applicable
per individual		
Generic Oral Contraceptives Included	\$15 copay	\$15 copay plus 50%
Preferred Brand	Not covered	Not covered
Oral Contraceptives Included	Aetna Discount Applies	
Non-Preferred Brand	Not covered	Not covered
Oral Contraceptives Included	Aetna Discount	Not covered
	Applies	
Calendar Year Maximum per individual*	Unlimited	Unlimited
	A CONTRACTOR OF THE PROPERTY O	

Preventive and Hospital Care 3000 (HSA Compatible)

	(HSA Compa	tible)
MEMBER BENEFITS	In-Network	Out-of-Network*
Deductible Individual Family	\$3,000 \$6,000	\$6,000 \$12,000
Coinsurance (Member's responsibility)	20% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
College and the same and the sa	\$0 once out-of-poo	ket max. is satisfied
Coinsurance Maximum Individual Family	\$2,000 \$4,000	\$4,000 \$8,000
Out-of-Pocket Maximum Individual Family	\$5,000 \$10,000	\$10,000 \$20,000
	Includes o	deductible
Lifetime Maximum* per insured	\$5,00	00,000
Non-Specialist Office Visit Unlimited visits General Physician, Family Practitioner, Pediatrician or Internist	Not covered**	Not covered**
Specialist Visit (Includes Chiropractic Care visits)	Not covered**	Not covered++
Hospital Admission	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible**	50% after deductible**
Urgent Care Facility	Not covered	Not covered
Emergency Room		vaived if admitted) e after deductible
Annual Routine Gyn Exam No waiting period, no calendar year max. Annual Pap/Mammogram	\$0 copay deductible waived	50% after deductible
Maternity		overed ancy complications)
Preventive Health — Routine Physical Aetna will pay up to \$200 per exam*	\$35 copay deductible waived	50% after deductible
No waiting period		ork and X-rays
Lab/X-Ray	Not covered**	Not covered**
Skilled Nursing — in lieu of hospital 30 days per calendar year*	20% after deductible	50% after deductible
Physical/Occupational Therapy 24 visits per calendar year*	20% after deductible	50% after deductible
Home Health Care — in lieu of hospital 30 visits per calendar year*	20% after deductible	50% after deductible
Durable Medical Equipment Aetna will pay up to \$2000 per calendar year*	Not covered**	Not covered**
PHARMACY	I	N . A . P . I I
Pharmacy Deductible per individual	Not Applicable	Not Applicable
Generic Oral Contraceptives Included	Not covered Aetna Discount Applies	Not covered
Preferred Brand Oral Contraceptives Included	Not covered Aetna Discount Applies	Not covered
Non-Preferred Brand Oral Contraceptives Included	Not covered Aetna Discount Applies	Not covered
Calendar Year Maximum per individual*	Not Applicable	Not Applicable

Payment for out-of-network facility care is determined based upon Aetna's Allowable Fee Schedule. Payment for other out-of-network facility care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider. Please see page 26 for a list of covered services.

Maximum applies to combined in and out-of-network benefits. Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

Aetna Advantage Plan options Individual Dental PPO Max plan

Annual Deductible per Member (Does not apply to Diagnostic and Preventive Services) Annual Maximum Benefit DIAGNOSTIC SERVICES Oral exams Periodic oral exam 100% ded. waived 100% ded. waiv	individual Dental P	PO Max pla	an
S75 family max. S75 family	MEMBER BENEFITS	Preferred	NonPreferred
Portioric Services Oral exams Periodic oral exam 100% ded. waived 100%	Annual Deductible per Member (Does not apply to Diagnostic and Preventive Services)		
Periodic oral exam 100% ded. waived 100% ded. waived 200% ded. waived 100%	Annual Maximum Benefit	Unlimited	Unlimited
Periodic oral exam 100% ded. waived 100% ded.	DIAGNOSTIC SERVICES		
Comprehensive oral exam 100% ded. waived 100%	Oral exams		
Problem-focused oral exam X-rays Bitewing — single film 100% ded. waived 100% de	Periodic oral exam	100% ded. waived	100% ded. waived
Eitewing — single film 100% ded. waived 100% ded. waived 200% ded. waived 100% ded. waived 200% ded. waived 100% ded. waived 200% ded. waived.	Comprehensive oral exam	100% ded. waived	100% ded. waived
Bitewing — single film 100% ded. waived 100% d	Problem-focused oral exam	100% ded. waived	100% ded. waived
Complete series 100% ded. waived 100% ded. waived PREVENTIVE SERVICES Adult cleaning 100% ded. waived with cleaning 100% ded. waived 100% ded	X-rays		
Adult cleaning 100% ded. waived 100% ded. waived Sealants — per tooth Discount Not covered Fluoride application — with cleaning Discount Not covered With cleaning Discount Not covered Fluoride application — with cleaning Discount Not covered Molar rot canal therapy Discount Not covered Discount Not cov	Bitewing — single film	100% ded. waived	100% ded. waived
Adult cleaning 100% ded. waived 100% ded. waived Child cleaning 100% ded. waived 100% ded. waived Sealants — per tooth Discount Not covered Fluoride application — 100% ded. waived 100% ded. waived with cleaning Space maintainers Discount Not covered PASIC SERVICES Amalgam fillings — 2 surfaces 100% after ded. 100% after ded. Resin fillings — 2 surfaces Discount Not covered Partial upper denture Partial upper denture (resin based) Discount Not covered Portic — Porcelain with noble metal Discount Not covered Portic — Porcelain with noble metal Discount Not covered Discount Discount Not covered Discount Discount Not covered Discount	Complete series	100% ded. waived	100% ded. waived
Child cleaning 100% ded. waived 100% ded. waived Sealants — per tooth Discount Not covered Fluoride application — with cleaning Discount Not covered 100% ded. waived with cleaning Space maintainers Discount Not covered BASIC SERVICES Arnalgam fillings — 2 surfaces 100% after ded. 100% after ded. Not covered Discount Discount Not covered Discount Not covered Discount Discount Not c	PREVENTIVE SERVICES		
Sealants — per tooth Discount Not covered Fluoride application — with cleaning Space maintainers Discount Not covered BASIC SERVICES Arnalgam fillings — 2 surfaces 100% after ded. 100% after ded. Resin fillings — 2 surfaces Discount Not covered Oral Surgery Extraction — exposed root or erupted tooth — Discount Not covered MAJOR SERVICES Complete upper denture Discount Not covered Partial upper denture (resin based) Discount Not covered Crown — Porcelain with noble metal Discount Not covered Inlay — Metallic (3 or more surfaces) Discount Not covered Oral Surgery Endodontic Services Bicuspid root canal therapy Discount Not covered Periodontic Services Scaling & root planing — per quadrant Discount Not covered Periodontic Services Scaling & root planing — Discount Not covered Periodontic Services Scaling & root planing — Discount Not covered Periodontic Services Scaling & root planing — Discount Not covered Periodontic Services Scaling & root planing — Discount Not covered Periodontic Services Scaling & root planing — Discount Not covered Not covered	Adult cleaning	100% ded. waived	100% ded. waived
Fluoride application — with cleaning Space maintainers Discount Not covered BASIC SERVICES Amalgam fillings — 2 surfaces Discount Not covered Not covered Discount Not covered Not covered Not covered Not covered Discount Not covered Not covered Not covered Discount Not covered	Child cleaning	100% ded. waived	100% ded. waived
with cleaning Space maintainers Discount Not covered BASIC SERVICES Amalgam fillings — 2 surfaces Resin fillings — 2 surfaces Discount Not covered Not covered Discount Not covered	Sealants — per tooth	Discount	Not covered
Amalgam fillings — 2 surfaces 100% after ded. 100% after ded. Resin fillings — 2 surfaces Discount Not covered Oral Surgery Extraction — exposed root or erupted tooth Extraction of impacted tooth — Discount Not covered Extraction of impacted tooth — Discount Not covered MAJOR SERVICES Complete upper denture Discount Not covered Partial upper denture (resin based) Discount Not covered Crown — Porcelain with noble metal Discount Not covered Pontic — Porcelain with noble metal Discount Not covered Inlay — Metallic (3 or more surfaces) Discount Not covered Oral Surgery Removal of impacted tooth — Discount Not covered Endodontic Services Bicuspid root canal therapy Discount Not covered Molar root canal therapy Discount Not covered Periodontic Services Scaling & root planing — Discount Not covered Posseous surgery — Discount Not covered Not covered Not covered	Fluoride application — with cleaning	100% ded. waived	100% ded. waived
Amalgam fillings — 2 surfaces Discount Not covered Partial upper denture (resin based) Discount Not covered Portic — Porcelain with noble metal Discount Not covered Portal Surgery Extraction of impacted tooth — Discount Not covered Partial upper denture (resin based) Discount Not covered Portic — Porcelain with noble metal Discount Not covered Portic — Porcelain with noble metal Discount Not covered Portic — Porcelain with noble metal Discount Not covered Portic — Porcelain with noble metal Discount Not covered Portic — Porcelain with noble metal Discount Not covered Portic — Porcelain with noble metal Discount Not covered Portic — Porcelain with noble metal Discount Not covered Portic — Porcelain with noble metal Discount Not covered Portic — Porcelain with noble metal Discount Not covered Portic — Porcelain with noble metal Discount Not covered Portic — Porcelain with noble metal Discount Not covered Portic — Porcelain With noble metal Discount Not covered Discount Not covered Periodontic Services Scaling & root planing — Discount Not covered Periodontic Services Scaling & root planing — Discount Not covered Portic — Porcelain Mot covered Portic — Portic — Discount Not covered Portic — Portic — Portic — Discount Not covered Portic — Portic — Portic — Discount Not covered Portic —	Space maintainers	Discount	Not covered
Resin fillings — 2 surfaces Discount Not covered Oral Surgery Extraction — exposed root or erupted tooth — Discount Sort tissue Extraction of impacted tooth — Discount Not covered Extraction of impacted tooth — Discount Not covered MAJOR SERVICES Complete upper denture Discount Not covered Partial upper denture (resin based) Discount Not covered Crown — Porcelain with noble metal Discount Not covered Pontic — Porcelain with noble metal Discount Not covered Inlay — Metallic (3 or more surfaces) Discount Not covered Oral Surgery Removal of impacted tooth — Discount Not covered Endodontic Services Bicuspid root canal therapy Discount Not covered Molar root canal therapy Discount Not covered Periodontic Services Scaling & root planing — Discount Not covered Periodontic Services Scaling & root planing — Discount Not covered Port of the results of th	BASIC SERVICES		
Oral Surgery Extraction — exposed root or erupted tooth Extraction of impacted tooth — Discount Mot covered Extraction of impacted tooth — Discount Mot covered MAJOR SERVICES Complete upper denture Partial upper denture (resin based) Crown — Porcelain with noble metal Discount Not covered Pontic — Porcelain with noble metal Discount Not covered Inlay — Metallic (3 or more surfaces) Discount Not covered Oral Surgery Removal of impacted tooth — Discount Partially bony Endodontic Services Bicuspid root canal therapy Discount Not covered Not covered Not covered Not covered Not covered Discount Not covered Not covered Not covered Not covered Discount Not covered Not covered Discount Not covered Not covered Periodontic Services Scaling & root planing — Discount Per quadrant Discount Not covered Not covered Not covered Not covered	Amalgam fillings — 2 surfaces	100% after ded.	100% after ded.
Extraction — exposed root or erupted tooth Extraction of impacted tooth — Discount Not covered soft tissue MAJOR SERVICES Complete upper denture Discount Not covered Partial upper denture (resin based) Discount Not covered Crown — Porcelain with noble metal Discount Not covered Pontic — Porcelain with noble metal Discount Not covered Inlay — Metallic (3 or more surfaces) Discount Not covered Oral Surgery Removal of impacted tooth — Discount Not covered Discount Not covered Pontic — Porcelain with noble metal Discount Not covered Discount Discount Not covered Discount Discount Discount Discount Discount Discount Discount Discoun	Resin fillings — 2 surfaces	Discount	Not covered
erupted tooth Extraction of impacted tooth — Discount Not covered Soft tissue MAJOR SERVICES Complete upper denture Discount Not covered Partial upper denture (resin based) Discount Not covered Crown — Porcelain with noble metal Discount Not covered Pontic — Porcelain with noble metal Discount Not covered Inlay — Metallic (3 or more surfaces) Discount Not covered Oral Surgery Removal of impacted tooth — Discount Not covered Discount Not covered Discount Not covered Pontic — Porcelain with noble metal Discount Not covered Discount Discount Not covered Discount Dis	Oral Surgery		
MAJOR SERVICES Complete upper denture Partial upper denture (resin based) Crown — Porcelain with noble metal Pontic — Porcelain with noble metal Inlay — Metallic (3 or more surfaces) Discount Not covered Not covered Not covered Not covered Discount Not covered Discount Not covered Discount Not covered Discount Not covered Not covered Discount Not covered	Extraction — exposed root or erupted tooth	Discount	Not covered
Complete upper denture Partial upper denture (resin based) Discount Not covered Portial upper denture (resin based) Crown — Porcelain with noble metal Pontic — Porcelain with noble metal Discount Not covered Not covered Not covered Not covered Not covered Discount Not covered Not covered Discount Not covered Discount Not covered Not covered Discount Not covered Not covered Discount Discount Not covered	Extraction of impacted tooth — soft tissue	Discount	Not covered
Partial upper denture (resin based) Discount Not covered Crown — Porcelain with noble metal Pontic — Porcelain with noble metal Discount Not covered Not covered Not covered Discount Not covered Not covered Discount Not covered Discount Not covered Discount Not covered Discount Not covered Not covered Discount Not covered	MAJOR SERVICES		
Crown — Porcelain with noble metal Discount Not covered Pontic — Porcelain with noble metal Discount Not covered Inlay — Metallic (3 or more surfaces) Discount Not covered Oral Surgery Removal of impacted tooth — Discount Not covered partially bony Endodontic Services Bicuspid root canal therapy Discount Not covered Molar root canal therapy Discount Not covered Periodontic Services Scaling & root planing — Discount Not covered per quadrant Osseous surgery — Discount Not covered Not covered	Complete upper denture	Discount	Not covered
Pontic — Porcelain with noble metal Discount Not covered Inlay — Metallic (3 or more surfaces) Discount Not covered Oral Surgery Removal of impacted tooth — Discount Not covered partially bony Endodontic Services Bicuspid root canal therapy Discount Not covered Molar root canal therapy Discount Not covered Periodontic Services Scaling & root planing — Discount Not covered per quadrant Discount Not covered Not covered Periodontic Services	Partial upper denture (resin based)	Discount	Not covered
Inlay — Metallic (3 or more surfaces) Discount Not covered Discount Not covered Not covered Discount Discount Not covered	Crown — Porcelain with noble metal	Discount	Not covered
Oral Surgery Removal of impacted tooth — Discount Not covered partially bony Endodontic Services Bicuspid root canal therapy Discount Not covered Not are all therapy Discount Not covered Periodontic Services Scaling & root planing — Discount Not covered per quadrant Discount Not covered Not covered Not covered Periodontic Services	Pontic — Porcelain with noble metal	Discount	Not covered
Removal of impacted tooth — Discount Not covered partially bony Endodontic Services Bicuspid root canal therapy Discount Not covered Not covered Molar root canal therapy Discount Not covered Periodontic Services Scaling & root planing — Discount Not covered per quadrant Osseous surgery — Discount Not covered per quadrant	Inlay — Metallic (3 or more surfaces)	Discount	Not covered
partially bony Endodontic Services Bicuspid root canal therapy Discount Not covered Molar root canal therapy Discount Not covered Periodontic Services Scaling & root planing — Discount Not covered per quadrant Osseous surgery — Discount Not covered Poscount Not covered Not covered	Oral Surgery		
Bicuspid root canal therapy Discount Not covered Molar root canal therapy Discount Not covered Periodontic Services Scaling & root planing — Discount Not covered per quadrant Discount Not covered Osseous surgery — Discount Not covered per quadrant	Removal of impacted tooth — partially bony	Discount	Not covered
Molar root canal therapy Discount Not covered Periodontic Services Scaling & root planing — Discount Not covered per quadrant Osseous surgery — Discount Not covered per quadrant	Endodontic Services		
Periodontic Services Scaling & root planing — Discount Not covered per quadrant Discount Not covered Poseous surgery — Discount Not covered per quadrant	Bicuspid root canal therapy	Discount	Not covered
Scaling & root planing — Discount Not covered per quadrant Discount Not covered per quadrant Discount Not covered per quadrant	Molar root canal therapy	Discount	Not covered
per quadrant Osseous surgery — Discount Not covered per quadrant	Periodontic Services		
per quadrant	Scaling & root planing — per quadrant	Discount	Not covered
ORTHODONTIC SERVICES Discount Not covered	Osseous surgery — per quadrant	Discount	Not covered
	ORTHODONTIC SERVICES	Discount	Not covered

Access to negotiated discounts: members are eligible to receive non-covered services, including cosmetic services such as tooth whitening, at the PPO negotiated rate when visiting a participating PPO dentist.

Nonpreferred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Nonpreterred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area. Above list of covered services is representative. A summary of exclusions is listed later in this brochure. For a full list of benefit coverage and exclusions refer to the plan documents. All products not available in all counties.

This material is for informational purposes only and is neither an offer of coverage nor dental advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract.



PPO 7500 with Unlimited Primary Care Visits plus Dental

FOR 2009	Visits plus De	ntal
MEMBED DENIFFIE	1	
MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible		
Individual	\$7,500	\$10,000
Family	\$15,000	\$20,000
Coinsurance	20% after	50% after
(Member's responsibility)	deductible up to	deductible up to
, , , , , , , , , , , , , , , , , , , ,	out-of-pocket max.	out-of-pocket max.
		ket max. is satisfied
Coinsurance Maximum	30 once out or poe	Ket max. is satisfied
Individual	\$2,500	\$2,500
		\$5,000
Family	\$5,000	\$5,000
Out-of-Pocket Maximum		
Individual	\$10,000	\$12,500
Family	\$20,000	\$25,000
	Includes o	deductible
Lifetime Maximum* per insured	\$5,00	0,000
	¢30	F00/
Non-Specialist Office Visit	\$30 copay	50%
Unlimited visits	deductible waived	after deductible
General Physician, Family Practitioner,		
Pediatrician or Internist		
Specialist Visit	20%	50%
(Includes Chiropractic Care visits)	after deductible	after deductible
Hospital Admission	20%	50%
	after deductible	after deductible
Outpatient Surgery	20%	50%
,	after deductible	after deductible
Urgent Care Facility		50%
Urgent Care Facility	\$50 copay deductible waived	
		after deductible
Emergency Room		aived if admitted)
		ductible
Annual Routine Gyn Exam	\$0 copay	50%
No waiting period, no calendar	deductible waived	after deductible
year max. Annual Pap/Mammogram		
Maternity	Not co	overed
•		ncy complications)
Preventive Health —	\$30 copay	50%
Routine Physical	deductible waived	after deductible
Aetna will pay up to \$200 per exam*	deductible walved	arter deductible
Aetila villi pay up to \$200 pel exalli	Includes lab	and X-rays
No waiting period		
No waiting period Lab/X-Ray	20%	50%
No waiting period Lab/X-Ray	20% after deductible	50% after deductible
No waiting period Lab/X-Ray	20%	50%
No waiting period Lab/X-Ray Skilled Nursing — in lieu of hospital	20% after deductible	50% after deductible
No waiting period Lab/X-Ray Skilled Nursing — in lieu of hospital 30 days per calendar year*	20% after deductible 20%	50% after deductible 50%
No waiting period Lab/X-Ray Skilled Nursing — in lieu of hospital 30 days per calendar year* Physical/Occupational Therapy	20% after deductible 20% after deductible	50% after deductible 50% after deductible
No waiting period Lab/X-Ray Skilled Nursing — in lieu of hospital 30 days per calendar year* Physical/Occupational Therapy	20% after deductible 20% after deductible 20% after deductible after deductible	50% after deductible 50% after deductible 50% after deductible after deductible
No waiting period Lab/X-Ray Skilled Nursing — in lieu of hospital 30 days per calendar year* Physical/Occupational Therapy 24 visits per calendar year*	20% after deductible 20% after deductible 20% after deductible Aetna will pay up to	50% after deductible 50% after deductible 50% after deductible 50% after deductible \$25 per visit max.*
No waiting period Lab/X-Ray Skilled Nursing — in lieu of hospital 30 days per calendar year* Physical/Occupational Therapy 24 visits per calendar year* Home Health Care —	20% after deductible 20% after deductible 20% after deductible Aetna will pay up to 20%	50% after deductible 50% after deductible 50% after deductible 50% after deductible \$25 per visit max.*
No waiting period Lab/X-Ray Skilled Nursing — in lieu of hospital 30 days per calendar year* Physical/Occupational Therapy 24 visits per calendar year* Home Health Care — in lieu of hospital	20% after deductible 20% after deductible 20% after deductible Aetna will pay up to	50% after deductible 50% after deductible 50% after deductible 50% after deductible \$25 per visit max.*
No waiting period Lab/X-Ray Skilled Nursing — in lieu of hospital 30 days per calendar year* Physical/Occupational Therapy 24 visits per calendar year* Home Health Care — in lieu of hospital 30 visits per calendar year*	20% after deductible 20% after deductible 20% after deductible Aetna will pay up to 20% after deductible	50% after deductible 50% after deductible 50% after deductible 50% after deductible \$25 per visit max.*
No waiting period Lab/X-Ray Skilled Nursing — in lieu of hospital 30 days per calendar year* Physical/Occupational Therapy 24 visits per calendar year* Home Health Care — in lieu of hospital 30 visits per calendar year* Durable Medical Equipment	20% after deductible 20% after deductible 20% after deductible Aetna will pay up to 20% after deductible	50% after deductible 50% after deductible 50% after deductible 50% after deductible \$25 per visit max.* 50% after deductible
No waiting period Lab/X-Ray Skilled Nursing — in lieu of hospital 30 days per calendar year* Physical/Occupational Therapy 24 visits per calendar year* Home Health Care — in lieu of hospital 30 visits per calendar year* Durable Medical Equipment Aetna will pay up to \$2000 per	20% after deductible 20% after deductible 20% after deductible Aetna will pay up to 20% after deductible	50% after deductible 50% after deductible 50% after deductible 50% after deductible \$25 per visit max.* 50% after deductible
No waiting period Lab/X-Ray Skilled Nursing — in lieu of hospital 30 days per calendar year* Physical/Occupational Therapy 24 visits per calendar year* Home Health Care — in lieu of hospital 30 visits per calendar year* Durable Medical Equipment Aetna will pay up to \$2000 per	20% after deductible 20% after deductible 20% after deductible Aetna will pay up to 20% after deductible	50% after deductible 50% after deductible 50% after deductible 50% after deductible \$25 per visit max.* 50% after deductible
No waiting period Lab/X-Ray Skilled Nursing — in lieu of hospital 30 days per calendar year* Physical/Occupational Therapy 24 visits per calendar year* Home Health Care — in lieu of hospital 30 visits per calendar year* Durable Medical Equipment Aetna will pay up to \$2000 per calendar year*	20% after deductible 20% after deductible 20% after deductible Aetna will pay up to 20% after deductible	50% after deductible 50% after deductible 50% after deductible 50% after deductible \$25 per visit max.* 50% after deductible
No waiting period Lab/X-Ray Skilled Nursing — in lieu of hospital 30 days per calendar year* Physical/Occupational Therapy 24 visits per calendar year* Home Health Care — in lieu of hospital 30 visits per calendar year* Durable Medical Equipment Aetna will pay up to \$2000 per calendar year* PHARMACY	20% after deductible 20% after deductible 20% after deductible Aetna will pay up to 20% after deductible	50% after deductible 50% after deductible 50% after deductible 50% after deductible \$25 per visit max.* 50% after deductible 50% after deductible
No waiting period Lab/X-Ray Skilled Nursing — in lieu of hospital 30 days per calendar year* Physical/Occupational Therapy 24 visits per calendar year* Home Health Care — in lieu of hospital 30 visits per calendar year* Durable Medical Equipment Aetna will pay up to \$2000 per calendar year* PHARMACY Pharmacy Deductible	20% after deductible 20% after deductible 20% after deductible Aetna will pay up to 20% after deductible	50% after deductible 50% after deductible 50% after deductible 50% after deductible \$25 per visit max.* 50% after deductible
No waiting period Lab/X-Ray Skilled Nursing — in lieu of hospital 30 days per calendar year* Physical/Occupational Therapy 24 visits per calendar year* Home Health Care — in lieu of hospital 30 visits per calendar year* Durable Medical Equipment Aetna will pay up to \$2000 per calendar year* PHARMACY Pharmacy Deductible per individual	20% after deductible 20% after deductible 20% after deductible Aetna will pay up to 20% after deductible 20% after deductible	50% after deductible 50% after deductible 50% after deductible 50% after deductible \$25 per visit max.* 50% after deductible 50% after deductible Not Applicable
No waiting period Lab/X-Ray Skilled Nursing — in lieu of hospital 30 days per calendar year* Physical/Occupational Therapy 24 visits per calendar year* Home Health Care — in lieu of hospital 30 visits per calendar year* Durable Medical Equipment Aetna will pay up to \$2000 per calendar year* PHARMACY Pharmacy Deductible per individual Generic	20% after deductible 20% after deductible 20% after deductible Aetna will pay up to 20% after deductible 20% after deductible Not Applicable \$15 copay	50% after deductible 50% after deductible 50% after deductible \$25 per visit max.* 50% after deductible 50% after deductible Not Applicable \$15 copay plus 50%
No waiting period Lab/X-Ray Skilled Nursing — in lieu of hospital 30 days per calendar year* Physical/Occupational Therapy 24 visits per calendar year* Home Health Care — in lieu of hospital 30 visits per calendar year* Durable Medical Equipment Aetna will pay up to \$2000 per calendar year* PHARMACY Pharmacy Deductible per individual Generic Oral Contraceptives Included	20% after deductible 20% after deductible 20% after deductible Aetna will pay up to 20% after deductible 20% after deductible	50% after deductible 50% after deductible 50% after deductible 50% after deductible \$25 per visit max.* 50% after deductible 50% after deductible Not Applicable
No waiting period Lab/X-Ray Skilled Nursing — in lieu of hospital 30 days per calendar year* Physical/Occupational Therapy 24 visits per calendar year* Home Health Care — in lieu of hospital 30 visits per calendar year* Durable Medical Equipment Aetna will pay up to \$2000 per calendar year* PHARMACY Pharmacy Deductible per individual Generic Oral Contraceptives Included	20% after deductible 20% after deductible 20% after deductible Aetna will pay up to 20% after deductible 20% after deductible Not Applicable \$15 copay	50% after deductible 50% after deductible 50% after deductible \$25 per visit max.* 50% after deductible 50% after deductible Not Applicable \$15 copay plus 50%
No waiting period Lab/X-Ray Skilled Nursing — in lieu of hospital 30 days per calendar year* Physical/Occupational Therapy 24 visits per calendar year* Home Health Care — in lieu of hospital 30 visits per calendar year* Durable Medical Equipment Aetna will pay up to \$2000 per calendar year* PHARMACY Pharmacy Deductible per individual Generic Oral Contraceptives Included Preferred Brand	20% after deductible 20% after deductible 20% after deductible Aetna will pay up to 20% after deductible 20% after deductible Not Applicable \$15 copay deductible waived	50% after deductible 50% after deductible 50% after deductible \$25 per visit max.* 50% after deductible 50% after deductible Not Applicable \$15 copay plus 50% deductible waived
No waiting period Lab/X-Ray Skilled Nursing — in lieu of hospital 30 days per calendar year* Physical/Occupational Therapy 24 visits per calendar year* Home Health Care — in lieu of hospital 30 visits per calendar year* Durable Medical Equipment Aetna will pay up to \$2000 per calendar year* PHARMACY Pharmacy Deductible per individual Generic Oral Contraceptives Included Preferred Brand Oral Contraceptives Included	20% after deductible 20% after deductible 20% after deductible Aetna will pay up to 20% after deductible 20% after deductible Not Applicable \$15 copay deductible waived Not covered	50% after deductible 50% after deductible 50% after deductible 50% after deductible \$25 per visit max.* 50% after deductible 50% after deductible Not Applicable \$15 copay plus 50% deductible waived Not covered
No waiting period Lab/X-Ray Skilled Nursing — in lieu of hospital 30 days per calendar year* Physical/Occupational Therapy 24 visits per calendar year* Home Health Care — in lieu of hospital 30 visits per calendar year* Durable Medical Equipment Aetna will pay up to \$2000 per calendar year* PHARMACY Pharmacy Deductible per individual Generic Oral Contraceptives Included Non-Preferred Brand Non-Preferred Brand	20% after deductible 20% after deductible 20% after deductible Aetna will pay up to 20% after deductible 20% after deductible Not Applicable \$15 copay deductible waived	50% after deductible 50% after deductible 50% after deductible \$25 per visit max.* 50% after deductible 50% after deductible Not Applicable \$15 copay plus 50% deductible waived
No waiting period Lab/X-Ray Skilled Nursing — in lieu of hospital 30 days per calendar year* Physical/Occupational Therapy 24 visits per calendar year* Home Health Care — in lieu of hospital 30 visits per calendar year* Durable Medical Equipment Aetna will pay up to \$2000 per calendar year* PHARMACY Pharmacy Deductible per individual Generic Oral Contraceptives Included Preferred Brand Oral Contraceptives Included	20% after deductible 20% after deductible 20% after deductible Aetna will pay up to 20% after deductible 20% after deductible Not Applicable \$15 copay deductible waived Not covered	50% after deductible 50% after deductible 50% after deductible 50% after deductible \$25 per visit max.* 50% after deductible 50% after deductible Not Applicable \$15 copay plus 50% deductible waived Not covered

Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

Payment for out-of-network facility care is determined based upon Aetna's
 Allowable Fee Schedule, Payment for other out-of-network facility care is
 determined based upon the negotiated charge that would apply if such services
 or supplies were received from a Preferred Provider.

Aetna special programs

Aetna Advantage plans include special programs¹ to complement our standard health insurance coverage. These programs include health information programs and tools, and offer you access to substantial savings on products to help you stay healthy. These programs are offered in addition to your Aetna Advantage Plan and are NOT insurance.

Aetna VisionSM Discount Program

Aetna VisionSM discount program offers special savings on eye exams, contact lenses, frames, lenses, LASIK eye surgery, and eye care accessories.

Aetna Natural Products and ServicesSM Discount Program

Eligible Aetna members and their families can access complementary health care products and services at reduced rates through the Aetna Natural Products and Services discount program. Members can save on acupuncture, chiropractic care, massage therapy and dietetic counseling as well as on over-the-counter vitamins, herbal and nutritional supplements and other health-related products.



Availability varies by plan.
 Talk with your Aetna representative for details.

Aetna FitnessSM Discount Program

Eligible Aetna members and their families can access the GlobalFit™ national network of nearly 10,000 fitness clubs, in the United States and Canada, at preferred rates*. In addition, members can access other programs such as at-home weight loss programs, home fitness options and even one-on-one health coaching** services.

Aetna Weight ManagementSM Discount Program

The Weight ManagementSM discount program can help you achieve your weight loss goals by providing you with a sensible weight loss plan and balanced nutrition guide to fit your lifestyle. This program provides Aetna members and their eligible family members access to discounts on Jenny Craig® weight loss programs and products.

Aetna HearingSM Discount Program

Aetna's Hearing[™] discount program help Aetna members and their families save on hearing exams, hearing services and hearing aids.

Aetna Rx Home Delivery®

With this mail order delivery program, order prescription medications through our convenient and easy-to-use mail order pharmacy. To learn more or obtain order forms, visit www.AetnaRxHomeDelivery.com.

Informed Health® Line

Our 24-hour toll-free number that puts you in touch with experienced registered nurses and an audio library for information on thousands of health topics.

Aetna Navigator®

Register and log on to Aetna Navigator, Aetna's secure member website, to check claims status, contact Aetna Member Services, estimate the costs of health care services, and more. Our new Aetna Navigator Health Information Guide provides a starting point to find answers about health care, types of treatment, cost of services and more to help members make more informed decisions. Plus, members have access to their own Personal Health Record***, a single, secure place where they can view their medical history and add other health information

- * At some clubs, participation in this program may be restricted to new club members.
- ** Provided by WellCall, Inc. through GlobalFit.
- *** The Aetna Personal Health Record should not be used as the sole source of information about your health conditions or medical treatment.



WANT TO SAVE ON DENTAL EXPENSES?

Vital Savings by Aetna® is a discount program that provides you with dental savings. This is not insurance. Enrolling in the program will give you access to a network of providers who have agreed to accept discounted rates for services. To sign up today, visit www.vitalsavings.com or call 1-877-698-4825.

The Vital Savings by Aetna® program (the "Program") is not insurance. The Program provides Members with access to discounted fees pursuant to schedules negotiated by Aetna Life Insurance Company for the Vital Savings by Aetna® discount program. The Program does not make payments directly to the providers participating in the Program. Each Member is obligated to pay for all services or products but will receive a discount from the providers who have contracted with the Discount Medical Plan Organization to participate in the Program. Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156, 1-877-698-4825, is the Discount Medical Plan Organization.

Things you need to know

To qualify for an Aetna Advantage Plan, you must be:

- Under age 64 3/4 (If applying as a couple, both you and your spouse must be under 64 3/4.)
- Dependents (includes grandchildren who are in the legal custody of the insured) up to age 21; between the ages of 21 and 24 with proof of full-time student status
- Legal residents in a state with products offered by the Aetna Advantage Plans
- Legal U.S. residents for at least six continuous months

Your premium payments

Your rates are guaranteed not to increase for 12 months from your effective date once you've been accepted for coverage. After that, your premiums may change. Final rates are subject to underwriting review.

Your coverage

Your coverage remains in effect as long as you pay the required premium charges on time, and as long as you maintain eligibility in the plan. Coverage will be terminated if you become ineligible due to any of the following circumstances:

- Non-payment of premiums
- Becoming a resident of a state or location in which Aetna Advantage Plans are not available
- Obtaining duplicate coverage
- For other reasons permissible by law

EASY-PAY

Simple Automatic Payments via Electronic Funds Transfer (EFT)

Registration: Complete the payment section of the Aetna Advantage Plans application. Select the EFT option to approve the automatic withdrawal of your initial premium and all subsequent premium payments.

Invoices: You will not receive a paper invoice when you are enrolled in EFT. Payments will appear on your bank statement as "Aetna Autodebit Coverage."

Terminating: To terminate EFT, you will need to provide Aetna with 10 days written notice prior to the date your next EFT payment will be deducted. Without this written notice, your bank account may be debited for the next month's premium. You will then need to contact Aetna to have funds placed back in the checking account.

Refunds: To process an EFT refund (placing money back in member's checking account), Aetna will require at least five days after the withdrawal was made to ensure valid payment.

Rejected transactions: If the EFT payment rejects for any reason, Aetna will automatically terminate the EFT and send you a letter saying you will receive paper invoices. Processing time to reinstate EFT will be 30–60 days. If an EFT payment is rejected, you will need to pay that payment by paper check or credit card.

Timing: Payments for Cycle 1 accounts (1st of the month effective date) will be taken from your bank account between the 3rd and the 10th of the month the premium is due. Payments for Cycle 2 accounts (15th of the month effective date) will be taken from your bank account between the 18th and 23rd of the month the premium is due.

Levels of coverage & enrollment

- You may be enrolled in your selected plan at the premium charge.
- You may be enrolled in your selected plan at a higher premium, based on medical underwriting.
- You may be declined coverage based on medical underwriting.

Medical underwriting requirements

The Aetna Advantage Plans are not guaranteed issue plans and require medical underwriting. Some individuals may qualify as federally eligible under the Health Insurance Portability Accountability Act (HIPAA) through the Louisiana Comprehensive Health Insurance Pool (CHIP).

All applicants, enrolling spouses and dependents are subject to medical underwriting to determine eligibility and appropriate premium rate level.

We offer various premium rate levels based on the medical underwriting of each applicant.

10-day right to review

Do not cancel your current insurance until you are notified that you have been accepted for coverage. We'll review your application to determine if you meet underwriting requirements. If you're denied, you'll be notified by mail. If you're approved, you'll be sent an Aetna Advantage Plan contract and ID card.

If, after reviewing the contract, you find that you're not satisfied for any reason, simply return the contract to us within 10 days. We will refund any premium you've paid (including any contract fees or other charges) less the cost of any services paid on behalf of you or any covered dependent.

Duplicate coverage

If you are currently covered by another carrier, you must agree to discontinue the other coverage before or on the effective date of the Aetna Advantage Plan. Do not cancel your current insurance until you are notified that you have been accepted for coverage and are certain that you are keeping your Aetna Advantage Plan coverage.

Limitations & exclusions

Medical

These medical plans do not cover all health care expenses and include exclusions and limitations. You should refer to your plan documents to determine which health care services are covered and to what extent.

The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s). Services and supplies that are generally not covered include, but are not limited to:

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates
- Ambulance coverage is limited to \$1,000 per trip.
- Cosmetic surgery
- Custodial care
- Donor egg retrieval
- Weight control services including surgical procedures for the treatment of obesity, medical treatment, and weight control/loss programs
- Experimental and investigational procedures, (except for coverage for medically necessary routine patient care costs for Members participating in a cancer clinical trial)
- Charges in connection with pregnancy care other than for pregnancy complications
- Immunizations for travel or work
- 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
- Non-medically necessary services or supplies
- Orthotics
- Over-the-counter medications and supplies
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling

PRE-EXISTING CONDITIONS

During the first 12 months following your effective date of coverage, no coverage will be provided for the treatment of a pre-existing condition unless you have prior creditable coverage.

A preexisting condition is an illness, disease, physical condition, or injury for which medical advice, or treatment was recommended or received and/or the use of prescription drugs of any kind within six months preceding the effective date of coverage. Services or supplies for the treatment of a preexisting condition are not covered for the first 12 months after the member's effective date. If the member had continuous prior creditable coverage within the 63 days immediately preceding the signature on the application and meets certain other requirements, then the preexisting condition exclusion of 12 months may not apply.

- Special or private duty nursing
- Therapy or rehabilitation other than those listed as covered in the plan documents
- Chemical dependency, and substance abuse not covered
- Mental health not covered, exept for Attention deficit/hyperactivity discorder
- Coverage for Diabetes includes equiptments, supplies and self-management training associated with Diabetes, Artificial limbs and prosthetic services

For the Preventive and Hospital Care Plans the following expenses are covered as it mandated according to Louisiana legislation:

Chiropractic Care (20% for in-network/50% for out-of-network)

Outpatient Hospital Expenses, Physician/ Specialist Office Visits Expenses, Outpatient diagnostic lab & X-ray expenses and Durable Medical/Surgical equipment for the following:

- Anesthesia and Associated Hospitalization for Certain Dental Care benefit
- Cleft Lip/Palate benefit
- Routine Screening for Cancer (including Colorectal Cancer)
- Diabetic Equipment, Supplies and Self-Management Education benefit
- Treatment of Attention Deficit/Hyperactivity Disorder benefit
- Coverage for Cancer Clinical Trials benefit
- Short-Term Rehabilitation Expenses benefit
- Hearing Aid Expenses for Children benefit
- Bone Density Measurements
- Mastectomy and Related Procedures

Dental

Listed below are some of the charges and services for which these dental plans do not provide coverage. For a complete list of exclusions and limitations, refer to plan documents.

- Dental Services or supplies that are primarily used to alter, improve or enhance appearance. Negotiated rates for cosmetic procedures available when a participating dentist is accessed.
- Experimental services, supplies or procedures
- Treatment of any jaw joint disorder, such as temporomandibular joint disorder
- Replacement of lost or stolen appliances and certain damaged appliances
- Services that Aetna defines as not necessary for the diagnosis, care or treatment of a condition involved
- All other limitations and exclusions in your plan documents



Call your broker.



If you need this material translated into another language, please call Member Services at 1-866-565-1236.

Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-866-565-1236.

This material is for information only and is not an offer or invitation to contract. Plan features and availability may vary by location. Plans may be subject to medical underwriting or other restrictions. Rates and benefits may vary by location. Health/Dental insurance plans contain exclusions and limitations. Investment services are independently offered by the HSA Administrator. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Not all health services are covered. See health insurance plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. Aetna receives rebates from drug makers 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. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Plan for Your Health is a public education program from Aetna and The Financial Planning Association. Information is believed to be accurate as of production date, however, it is subject to change.

For more information about Aetna plans, refer to **www.aetna.com**.

