PLAN DESIGN & BENEFITS

ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN NETWORK	OUT OF NETWORK
Deductible (per calendar year) **Provider**	None	$3,000 Individual/$6,000 Family
Deductible (per calendar year) **Facility**	**Level A:** $800 Individual/$1,600 Family **Level B:** $1,500 Individual/$3,000 Family	**Level C:** $3,000 Individual/$6,000 Family

In-Network and Out-of-Network deductibles are not combined.
Unless otherwise indicated, the Deductible must be met prior to benefits being payable.

Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.

Member Coinsurance	**Provider:** 20%, as noted **Facility**: **Level A:** 20% **Level B:** 40%	50% **Level C:** 50%

Applies to all expenses unless otherwise stated.

Out-of-Pocket Maximum (per calendar year) ***Medical and Pharmacy combined**	**Level A**: $4,000 Individual/$8,000 Family **Level B**: $6,000 Individual/$12,000 Family	**Level C**: $9,000 Individual/$18,000 Family

Out-of-Pocket Maximum for Pharmacy, In-Network Provider, Level A and Level B facility is combined and includes deductible, coinsurance and copays. Out-of-Network Provider, Pharmacy and Level C facility applies only to Out-of-Network care.
Certain member cost sharing elements may not apply toward the Out-of-Pocket Maximum.
Only those out-of-pocket expenses resulting from the application of pharmacy copays, medical coinsurance percentage, copays and deductibles (except any penalty amounts) may be used to satisfy the Out-of-Pocket maximum.
Once Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.

Lifetime Maximum	Unlimited except where otherwise indicated.	Unlimited except where otherwise indicated.

Certification Requirements -
Certification for certain types of Out-of-network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required.

Copayment Message	If you see more than one physician/specialist during one provider visit, multiple copayments may occur depending on services rendered.

PREVENTIVE CARE	IN NETWORK	OUT OF NETWORK
Routine Adult Physical Exams/ Immunizations 1 exam per calendar year for members age 18 and older.	No Charge	No Charge
Routine Well Child Exams/Immunizations 7 exams in first 12 months, 3 exams in second 12 months, 3 exams in third 12 months, 1 exam per calendar year thereafter to age 18.	No Charge	No Charge
Routine Gynecological Care Exams Age 21 and over: 1 exam per calendar year.	No Charge	No Charge
Routine Mammograms 1 baseline covered for ages 35-39. 1 per calendar year for females age 40 and over.	No Charge	No Charge
Routine Digital Rectal Exam / Prostate-specific Antigen Test 1 annual DRE & PSA for males age 40 & over.	No Charge	No Charge
Colorectal Cancer Screening For all members age 45 and over. Once every 10 years.	No Charge	No Charge
Routine Eye Exams 1 routine exam per calendar year.	$15 copay	50% coinsurance after deductible
Routine Hearing Exams	No Charge	No Charge

PHYSICIAN SERVICES	IN NETWORK	OUT OF NETWORK
Office Visits to PCP	$20 PCP copay	50% coinsurance after deductible
Specialist Office Visits	$50 Specialist copay	50% coinsurance after deductible
Telemedicine	$20 copay	50% coinsurance after deductible
Allergy Testing	$20 PCP or $50 Specialist copay	50% coinsurance after deductible

PLAN DESIGN & BENEFITS

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Allergy Injections	No Charge	50% coinsurance after deductible
If performed as part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician office visit member cost sharing.		
DIAGNOSTIC PROCEDURES	**IN NETWORK**	**OUT OF NETWORK**
Diagnostic Laboratory and X-ray	20% coinsurance, no deductible	50% coinsurance after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic X-ray for Complex Imaging Services	**Level A:** $150 copay after deductible + 20% coinsurance **Level B:** 40% coinsurance after deductible	**Level C:** 50% coinsurance after deductible
EMERGENCY MEDICAL CARE	**IN NETWORK**	**OUT OF NETWORK**
Urgent Care Provider	**Level A:** $30 copay + 10% coinsurance, no deductible **Level B**: $50 copay + 40% coinsurance, no deductible	**Level C:** 50% coinsurance, no deductible
Emergency Room	**Level A:** $300 copay + 20% coinsurance, no deductible **Level B:** $300 copay + 20% coinsurance, no deductible	**Level C:** $300 copay + 20% coinsurance, no deductible
Ambulance	20% coinsurance	50% coinsurance after deductible
HOSPITAL CARE	**IN NETWORK**	**OUT OF NETWORK**
Inpatient Coverage	**Level A:** 20% coinsurance after deductible **Level B**: 40% coinsurance after deductible	**Level C:** 50% coinsurance after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Maternity Coverage	**Level A:** 20% coinsurance after deductible **Level B:** 40% coinsurance after deductible	**Level C:** 50% coinsurance after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Surgery	**Level A:** $500 copay + 20% coinsurance after deductible **Level B:** $750 copay + 40% coinsurance after deductible	**Level C:** 50% coinsurance after deductible
Outpatient Hospital Expenses (excluding surgery)	**Level A:** 20% coinsurance after deductible **Level B:** 40% coinsurance after deductible	**Level C:** 50% coinsurance after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
MENTAL HEALTH SERVICES	**IN NETWORK**	**OUT OF NETWORK**
Inpatient	**Level A:** 20% coinsurance after deductible **Level B:** 40% coinsurance after deductible	**Level C:** 50% coinsurance after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient	$20 copay	50% coinsurance after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. Combined Mental Health and Alcohol/Drug maximum for preferred and non-preferred services.		
ALCOHOL/DRUG ABUSE SERVICES	**IN NETWORK**	**OUT OF NETWORK**
Inpatient	**Level A**: 20% coinsurance after deductible **Level B:** 40% coinsurance after deductible	**Level C:** 50% coinsurance after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient	$20 copay	50% coinsurance after deductible
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit. Combined Mental Health and Alcohol/Drug maximum for preferred and non-preferred services.		
OTHER SERVICES	**IN NETWORK**	**OUT OF NETWORK**
Skilled Nursing Facility	20% coinsurance, no deductible	50% coinsurance after deductible
Limited to 120 days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay.		

PLAN DESIGN & BENEFITS

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Home Health Care Limited to 90 visits per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.	20% coinsurance, no deductible	50% coinsurance after deductible
Hospice Care - Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% coinsurance, no deductible	50% coinsurance after deductible
Hospice Care - Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	20% coinsurance, no deductible	50% coinsurance after deductible
Private Duty Nursing $500 maximum per year.	20% coinsurance, no deductible	50% coinsurance after deductible
Outpatient Short-Term Rehabilitation Speech therapy maximum 30 visits per year; separate physical and occupational therapy combined maximum of 30 per year. No copay, deductible or limits for habilitation occupational, physical or speech therapy services for autism spectrum disorders.	**Level A:** $25 copay, no deductible **Level B:** 40% coinsurance after deductible	**Level C:** 50% coinsurance after deductible
Spinal Manipulation Therapy Limited to 30 visits per calendar year.	$25 copay	50% coinsurance after deductible
Acupuncture Limited to 30 visits per calendar year.	$50 copay	50% coinsurance after deductible
Hearing Aid $3,000 max every 36 months. Member is responsible for any costs that exceed plan maximum for service.	**Level A:** 20% coinsurance, no deductible **Level B**: 40% coinsurance, no deductible	**Level C**: Not Covered
Durable Medical Equipment	20% coinsurance, no deductible	50% coinsurance after deductible
Diabetic Supplies	$10 copay for 30 day supply, regardless of tier. Covers needles and syringes without purchase of insulin (separate copay applies to each purchase).	$10 copay for 30 day supply, regardless of tier. Covers needles and syringes without purchase of insulin (separate copay applies to each purchase).
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	No Charge	No Charge
FAMILY PLANNING	**IN NETWORK**	**OUT OF NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition.	$50 copay	50% coinsurance after deductible
Artificial Insemination	$50 copay	50% coinsurance after deductible
Male Voluntary Sterilization Including vasectomy.	$50 copay	50% coinsurance after deductible
Female Voluntary Sterilization Including Tubal Ligation	No Charge	No Charge
Pharmacy	**IN NETWORK**	**OUT OF NETWORK**
30-Day Supply	**Level A:** $9/$35/$50 . Specialty Drugs: $100 **Level B:** $10/$40/$60. Specialty Drugs: not covered unless cannot be filled by Level A pharmacy.	**Level C:** $10/$40/$60. Specialty Drugs: not covered unlesss cannot be filled by Level A pharmacy.
90-Day Supply Up to a 90-day supply from Carilion Medical Center Pharmacy by retail or mail order.	**Level A:** $22.50/$87.50/$125 **Level B:** Not Covered	**Level C:** Not Covered

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Mandatory 90-day Maintenance Program - You may receive two 30-day fills of your maintenance medication at any participating retail pharmacy (for example, a first fill and refill, or two refills) but then you will need to switch to Carilion Clinic's 90-day program. After that, you will be responsible for the full cost of the medication if you do not use the 90-day program administered at a Carilion Retail Pharmacy.

Mandatory Generic (MG) - If the member or the physician requests brand when generic is available, the member pays the generic copay plus the difference between the generic price and the brand price.

GENERAL PROVISIONS	
Dependents Eligibility	Spouse/Domestic Partner, children from birth to age 26
Pre-existing Conditions Exclusion	On effective date: Waived

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to
This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their 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) purchased by your employer.

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; Custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, 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;
Nonmedically necessary services or supplies; Orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member’s preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary.

They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Benefits are administered by Aetna Life Insurance Company.