APPENDIX E
2017-18 and 2018-19
HDHP Plan Option

PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Office Visits for Surgery	Covered 100%; after deductible	20% after deductible
Allergy Testing and Therapy	Covered 100%; after deductible	20% after deductible
Allergy Injections (serum)	Covered 100%; after deductible	20% after deductible
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Diagnostic Laboratory and X-ray	Covered 100%; after deductible	20% after deductible
Diagnostic X-ray for Complex Imaging Services	Covered 100%; after deductible	20% after deductible
EMERGENCY MEDICAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Urgent Care Provider (benefit availability may vary by location)	Covered 100%; after deductible	20% after deductible
Emergency Room	Covered 100%; after deductible	Covered 100%; after deductible
Ambulance	Covered 100%; after deductible	Covered 100%; after deductible
HOSPITAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Coverage	Covered 100%; after deductible	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Inpatient Maternity Coverage	Covered 100%; after deductible	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Hospital Expenses and Surgery	Covered 100%; after deductible	20% after deductible
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
MENTAL HEALTH SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	Covered 100%; after deductible	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	Covered 100%; after deductible	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	Covered 100%; after deductible	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	Covered 100%; after deductible	20% after deductible
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
OTHER SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Convalescent Facility	Covered 100%; after deductible	20% after deductible
Limited to 220 days per plan year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay		
Home Health Care	Covered 100%; after deductible	20% after deductible
Limited to 200 visits per calendar year.		
Hospice Care - Inpatient	Covered 100%; after deductible	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Hospice Care - Outpatient	Covered 100%; after deductible	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
Outpatient Short-Term Rehabilitation	Covered 100%; after deductible	20% after deductible
Includes Chiro, Physical/ Occupational Therapy and Speech Therapy. Combined 50 visits max. per member per plan year.		
Durable Medical Equipment	Covered 100%; after deductible	20% after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered 100%; after deductible	20% after deductible

APPENDIX E
2017-18 and 2018-19
HDHP Plan Option

OTHER SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	Covered 100%; after deductible	20% after deductible
Transplants	100% after deductible. Preferred coverage is provided at an IOE contracted facility only; after deductible	20% Non-Preferred coverage is provided at a Non-IOE facility; after deductible
Bariatric Surgery	Covered 100%; after deductible	20% after deductible
FAMILY PLANNING	**PREFERRED CARE**	**NON-PREFERRED CARE**
Infertility Treatment	Covered 100%; after deductible	20% after deductible
Voluntary Sterilization Including tubal ligation and vasectomy	Covered 100%; after deductible	20% after deductible
PHARMACY	**PREFERRED CARE**	**NON-PREFERRED CARE**
Retail	$10 copay for generic drugs, $25 copay for formulary brand-name drugs, and $40 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies, after deductible.	20% coinsurance for up to a 30 day supply at non-participating pharmacies, after deductible.
Mail Order	$10 copay for generic drugs, $25 copay for formulary brand-name drugs, $40 copay for non-formulary brand-name drugs up to a 31-100 day supply from Aetna Rx Home Delivery®, after deductible.	Not applicable
Mandatory Generic (MG) - If the member requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs, Diabetic supplies.		
Formulary Generic FDA-approved Women's Contraceptives covered 100% in network		
Precert for growth hormones included		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26	
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Full Postponement	

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;
- Non-accident related Dental care and X-rays;
- Donor egg retrieval;
- Experimental and investigational procedures;
- Hearing aids; except as state mandated.

- Non-medically necessary services or supplies;
- Non-medical condition Orthotics;
- Over-the-counter medications and supplies;
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling;
- Weight control services including 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.

Plans are administered by Aetna Life Insurance Company.