Quality health plans & benefits
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Ohio plan guide

Creating the right health benefits package starts with you and your employees

Plans effective January 1, 2015
For businesses with 2 – 50 eligible employees

www.aetna.com

64.10.300.1-OH C (8/14)

Choosing the right health plan

Every company has its own particular needs, driven in part by the health of its employees, by its commitment to health and wellness and, of course, by its financial resources.

We believe creating the right health benefits and insurance plan means combining these four options to meet a company's specific needs: **benefits, network, cost sharing, funding.**

Experience matters

We take the time to listen and learn about your needs. Our experience allows us to share knowledge and provide tools to help achieve the right balance of cost and coverage.

Our approach makes all the difference in the value you get from your plan, and in the satisfaction of your employees.

Today's health care environment demands a new set of solutions to meet new challenges. Together, we can create a healthy future for your company and your employees.

64.43.300.1-OH C (8/14)

Health benefits and health insurance, dental benefits/dental insurance, life insurance and disability insurance plans/policies are offered, underwritten or administered by Aetna Health Inc., Aetna Health Insurance Company and/or Aetna Life Insurance Company (Aetna). Each insurer has sole financial responsibility for its own products.

We want to make choosing the right benefits as easy as possible. So we've organized information in this easy-to-understand guide.

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Changes to your plan due to health care reform

Signed into law in March 2010, the Affordable Care Act is the most life-changing law since the passing of Medicare in the 1960s. We are committed to following the new health care law and to helping you understand its impact.

We have outlined below key changes that may impact your health care benefits.

Essential health benefits package

Aetna plans must offer standard coverage known as “essential health benefits.” This includes all plans inside and outside of the health insurance exchanges. These benefits provide your employees with essential health benefits, and limit cost sharing.

Here are the broad categories of essential benefits that will be included in your employees’ coverage:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric dental
- Pediatric vision

Out-of-pocket (OOP) maximum mandate

All cost sharing must apply toward the OOP maximum*, including in-network medical, behavioral health and pharmacy cost sharing. This does not include premiums, bills from non-network providers for amounts over the plan’s “allowed” charge, or spending for noncovered services.

The out-of-pocket maximum must include:

- Copays
- Deductibles
- Coinsurance

Fees

These fees are included in your premium:

- **Health Insurer Fee —** Annual fee to offset premium subsidies and tax credit related expenses
- **Transitional Reinsurance Program Contribution —** Helps finance the cost of high-risk individuals in the individual market
- **Patient-Centered Outcomes Research Fee (also known as the Comparative Effectiveness Fee) —** Fee to fund clinical outcomes effectiveness research

Guaranteed issue

Guaranteed issue of health insurance coverage applies to individual, small group and large group markets. Guaranteed issue is available for:

- Group health plans/insurance coverage (insured only)
- Individual health insurance coverage (including medical conversion)
- Pharmacy (insured only)
- Behavioral health (insured only)**

Guaranteed issue is not available for:

- Self-funded plans
- Standalone/separate dental or vision
- Hospital indemnity/Fixed indemnity
- Medicare and Medicare Supplement
- Medicaid
- Retiree-only plans
- Grandfathered plans
- Association/MEWA plans

Waiting period

Plans may not have any waiting periods longer than exactly 90 days. The maximum 90-day waiting period applies to fully insured and self-funded plans. This will go into effect for all groups on January 1, 2015.

*Prescription drugs may have a separate out-of-pocket maximum.
**No standalone insured behavioral health.

Pediatric dental/vision (2 to 50)

Pediatric dental and vision mandates are a separate essential health benefit category and are included with your medical benefits.

Pediatric dental

Plan name	PPO plans		HSA plans	
	In network	Out of network	In network	Out of network
Dental checkup (preventive/diagnostic)	0%; deductible waived	30% after deductible	0% after deductible	30% after deductible
Dental basic	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Dental major	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Dental ortho (after 24 months of continuous coverage)	50% after deductible	50% after deductible	50% after deductible	50% after deductible

Plan name	Savings Plus HNOption/HNOption		Indemnity
	In network	Out of network	No network
Dental checkup (preventive/diagnostic)	0%; deductible waived	30% after deductible	0%; deductible waived
Dental basic	30% after deductible	30% after deductible	30% after deductible
Dental major	50% after deductible	50% after deductible	50% after deductible
Dental ortho (after 24 months of continuous coverage)	50% after deductible	50% after deductible	50% after deductible

Pediatric vision

Plan name	PPO plans		HSA plans	
Pediatric vision	In network	Out of network	In network	Out of network
Vision exam (one exam per 12 months)	0%; deductible waived	Not covered	0%; deductible waived	Not covered
Frames, lenses or contacts (per 12 months)	P: 0%; deductible waived NP: 50% after deductible	Not covered	P: 0%; deductible waived NP: 50% after deductible	Not covered

Plan name	Savings Plus HNOption/HNOption		Indemnity
Pediatric vision	In network	Out of network	No network
Vision exam (one exam per 12 months)	P: 0%; deductible waived NP: 50% after deductible	Not covered	0%; deductible waived
Frames, lenses or contacts (per 12 months)	P: 0%; deductible waived NP: 50% after deductible	Not covered	0%; deductible waived

These plans do not cover all vision expenses and have exclusions and limitations. Members should refer to their plan documents to determine which services are covered and to what extent.

Choosing the right plan for your business

Our product portfolio includes a range of coverage and cost combinations. You'll find choices for different budgets and benefits strategies. And you'll see that we're more than medical. You can round out your benefits offering with dental as well as life and disability offerings.

Take a look at what's available.

Medical plans

- HNOption
- Savings Plus HNOption
- PPO
- Indemnity
- Consumer-directed plans

Plan levels

You can choose up to three levels of health plans. These levels are named using metals — bronze, silver and gold. Each level includes the same essential health benefits. But the levels differ in how much the health plan pays.

Health plan levels	Average amount the plan pays for covered services	Premium cost for employees
Bronze	60%	Lowest
Silver	70%	Lower
Gold	80%	Higher

Visit the health care reform section on **www.aetna.com** for more information. Or talk with your broker.

Tools to help your employees stay healthy, informed and productive

With Aetna health plans, your employees get online tools and helpful resources that let them make the most of their benefits. Our most popular tools include:

- **Secure member website.** Your employees get self-service tools, plus health plan and health information through their Aetna Navigator® website. Think of it as the key that unlocks the full value of their health benefits package. Encourage them to sign up at **www.aetna.com**.
- **Member Payment Estimator.** With an Aetna health plan, your employees can compare and estimate costs* for office visits, tests, surgeries and more. This means they can save money** — and avoid surprises. This online tool factors in their deductible, coinsurance and copays, plus contracted rates. They can see how much they have to pay and how much the plan will pay. They can log in to their Aetna Navigator member website to use the tool.
- **Online provider directory.** Finding doctors, specialists, hospitals and more in the Aetna network is easy with our DocFind® search tool. It's available at **www.aetna.com** and the Aetna Navigator member website.
- **My Life Values.** Your employees get 24/7 online services and support for managing their everyday personal and work matters.
- **iTriage.** This is a free mobile app that lets employees research symptoms and diseases, find a medical provider and even book an appointment — all from the convenience of their mobile device. iTriage will guide them to network doctors, hospitals and facilities based on your company health plan. It can help direct your employees to the most appropriate, cost-effective care.

*Estimated costs not available in all markets. The tool gives members an estimate of what they would owe for a particular service based on their plan at that very point in time. Actual costs may differ from the estimate if, for example, claims for other services are processed after they get the estimate but before the claim for this service is submitted. Or, if the doctor or facility performs a different service at the time of their visit.

**In 2011, members who used Member Payment Estimator before receiving care saved an average of $170 out of pocket on 34 common procedures, according to the Member Payment Estimator Study, Aetna Informatics and Product Development, August 2012.

Dental plans

- Dental Maintenance Organization or DMO® plan
- PPO
- PPO Max
- Freedom-of-Choice plan design
- Dual-Plan option
- Voluntary Dental option
- Aetna Dental Preventive Care℠ plan

Dental plan extras

There's extra value built into our dental portfolio:

- **Dental-medical integration.** Our program encourages preventive dental care among employees who have diabetes or heart disease, or who are pregnant. This can lead to more of your employees taking steps to stay healthy.

Vision plans

- Aetna Vision℠ Preferred Plans

Vision plan extras

- **Choice and convenience and flexibility.** Members have the choice to go to any vision provider. Plus, for added convenience, members can easily schedule an eye exam online with some participating providers. Our plans help members fit vision care in to their lifestyle and our bundled plan options provide the administrative ease of having one bill, one renewal and one trusted company to work for you.
- **The value of a balanced network.** We offer a balanced network of independent eye care providers as well as in-network retail providers that include the most preferred national optical retail chains offering flexible evening and weekend hours.
- **Discounts.** Aetna Vision Preferred plan offers additional savings on contact lenses, eyeglasses, prescription sunglasses, LASIK vision correction and more at most in-network locations. Availability varies by state.

Life and disability plans

- Basic life
- Supplemental life
- AD&D Ultra®
- Supplemental AD&D Ultra®
- Dependent life
- Short-term disability
- Long-term disability

Life and disability plan extras

- **Aetna Life Essentials℠.** Through our program, your employees get access to expert advice on legal and financial matters — at no added cost. Plus, they get discounts on health products and services, like fitness and vision care.*
- **Funeral planning and concierge service.** Through our collaboration with Everest, we offer our life members pre-planning and at-need services.
- **Aetna Return to Work Solutions℠ Program.** Our return to work solutions provide customers with the support and resources they need to help get valued employees back to work safely and as soon as possible.

*These services are discount programs, not insurance.

Choose from a wide range of health benefits and insurance options to fit your needs

About our benefits

Choose from numerous, integrated benefits options that can lead to improved employee engagement and health, while helping you manage your costs. This includes medical, pharmacy, dental, life, disability and vision. Plus, online tools that help employees use their benefits wisely and get help when they need it.

About our network

We have many full-network and tiered-network options to lower employer costs while still providing employees with access to quality care. Our doctor networks prioritize quality and efficiency to improve the health care experience and make it easy for individuals to get the care they need.

About our cost sharing

Some of our cost sharing-arrangements encourage employees to become more involved in their own health care and become better health care consumers. Employees with these plans receive more preventive care, have lower overall costs and use online tools more frequently.

About our funding options

We can show you how a combined network, cost sharing and benefits approach can help you manage your premium to meet your budget. We also offer a range of funding options — from traditional fully insured to enhanced self-insured solutions — that provide different levels of cost, plan control and information access.

Network options for healthy outcomes and lower costs

Our network solutions help lower your costs while providing employees with access to trusted doctors and hospitals. Your employees can still get care within the broad Aetna network. But they pay less out of pocket when they use doctors and hospitals in our special networks. The more they use health care providers in these networks, the more likely you are to see lower medical costs.

We make it easier for your employees, too. They get online tools for estimating costs and finding the right doctors and hospitals.

Cost sharing and premiums for every budget

Your focus is on lower costs. Increasingly, that means greater levels of employee cost sharing. With Aetna in your corner, you can map out a strategy based on your employee base and price point. And you can choose from the full spectrum of health plan types:

- Our fully insured portfolio, traditionally a mainstay for small businesses, provides plans with a range of robust coverage options.
- Emerging self-funded options for small businesses may help you manage costs while offering the needed administrative support.

Health and wellness programs

Having a happier, healthier workforce is important to you. So is cost management. We've found that helping your employees get more involved in managing their health and well-being is a great way to meet these goals. Talk to your broker or Aetna representative to learn more about our programs.

Wellness on us

Wellness for employees means a healthier business for employers. As always, our business health benefits and insurance plans offer $0 copays for in-network eye exams and $0 copay for in-network preventive care. It's one more way to help employees get a step closer to better health.

Preventive care benefits with no copay:

- Immunizations
- Routine physicals
- Child wellness visits
- Routine mammogram
- Routine OB/GYN visits

Wellness programs can make health and fitness part of everyday living

- Women's health and preventive health reminders
- Simple Steps To A Healthier Life program
- Informed Health® 24-hour nurse line*
- Aetna discount programs
- Personal Health Record

Women's preventive health benefits

These services are generally covered at no cost share, when provided in network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papillomavirus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies and counseling
- Generic formulary contraceptives and certain brand formulary contraceptives are covered without member copayment; certain religious organizations or religious employers may be exempt from offering contraceptive services

We make things easy for you

Health plan management and administration is our specialty, which makes it easier for you to manage your health benefits and insurance plans with:

- **eEnrollment.** Handle enrollments, terminations and other changes online, with less paperwork and greater efficiency.
- **eBilling.** Save time and simplify reconciliation and payment, anytime, anywhere, with our secure system. It lets you get, view and pay all your medical and dental bills online.

*While only a doctor can diagnose, prescribe or give medical advice, the Informed Health Line nurses can provide information on thousands of health topics. Members should contact their doctor first with any questions or concerns about their health care needs.

Aetna medical overview

Medical coverage can be a deal-breaker in recruiting and keeping talented employees. Our medical plan portfolio was designed with the needs of businesses like yours in mind. You'll find flexible options, from traditional indemnity to consumer-directed plans. You can choose the plan design and benefits level that fits your budget and achieve the right balance of cost and coverage for your business.

Medical overview

We offer the in-state portfolio (MC) and rating structure to out-of-state employees who live in an out-of-state network area. Out-of-state employees who do not live in an out-of-state network area will be eligible for an indemnity plan.

Product name	Product description	PCP required	Referrals required	Plan name
Aetna Health Network Option℠ (HNOption)	Aetna Health Network Option is a two-tiered product that allows members to access care in or out of network. Members have lower out-of-pocket costs when they use the in-network tier of the plan. Member cost sharing increases if they decide to go out of network. Members may go to their PCP or directly to a participating specialist without a referral. It is their choice, each time they seek care.	Optional	No	Aetna Health Network Option (Open Access)
Savings Plus Health Network Option	The Aetna Savings Plus Health Network Option plans in Ohio give members the flexibility and choice to best meet their needs. These plans use the Aetna Ohio Savings Plus network. Each Savings Plus plan has three levels of benefits: Two in-network: • Level 1 – When members use the Savings Plus network, they realize maximum savings. • Level 2 – When members use nondesignated network providers, they will see standard savings and higher member costs. Out-of-network: • Level 3 – When members use out-of-network providers, they will see the highest member cost. While members have the freedom to receive care from any hospital or specialist, they realize the highest benefit level and the lowest out-of-pocket costs when they access care through the Savings Plus network.	Optional	No	Savings Plus Network Option
PPO	Members can access any participating provider for covered services without a referral. When members seek health care, they have the freedom to choose either network providers at lower out-of-pocket costs, or non-network providers at higher out-of-pocket costs. Members are able to receive emergency services at the in-network coinsurance/copay level.	No	No	Open Choice® PPO
Traditional Choice® (TC)	This indemnity plan option is available for employees who live outside the plan's network service area. Members coordinate their own health care and may access any recognized provider for covered services without a referral.	No	No	N/A
Religious exemption plans	Available for every plan design and do not cover: • Contraceptives (oral drugs, injectable drugs and devices) • Contraceptive counseling • Voluntary sterilization (male and female) — tubal ligation and vasectomy • Elective abortions			

M

Aetna high-deductible, HSA-compatible Health Network Option and Traditional Choice plans

Aetna high-deductible Health Network Option and Traditional Choice health plans are compatible with a health savings account (HSA). HSA-compatible plans provide integrated medical and pharmacy benefits. Preventive care services are exempt from the deductible.

HSAs provide employers and their qualified employees with an affordable tax-advantaged solution that allows them to better manage their qualified medical and dental expenses.

- Employees can build a savings fund to help cover their future medical and dental expenses. HSAs can be funded by the employer or employee and are portable.
- Fund contributions may be tax deductible (limits apply).
- When funds are used to cover qualified out-of-pocket medical and dental expenses, they are not taxed.

It is completely at the discretion of the employer or employee whether or not to establish an HSA.

Note: Employers and employees should consult with their tax advisor to determine eligibility requirements and tax advantages for participation in the HSA plan.

Health savings account (HSA)

No set-up or administrative fees

The Aetna HealthFund® HSA, when coupled with a HSA-compatible high-deductible health benefits and health insurance plan, is a tax-advantaged savings account. Once enrolled, account contributions can be made by the employee and/or employer. The HSA can be used to pay for qualified expenses tax free.

HSA

- Member owns the HSA
- Contributions are tax free
- Member chooses how and when to use HSA dollars
- Roll it over each year and let it grow
- Earns interest, tax free

Today or in the future

- Use now for qualified expenses with tax-free dollars
- Plan for future and retiree health-related costs

High-deductible health plan

- Eligible in-network preventive care services will not be subject to the deductible
- Members pay 100 percent until deductible is met, then only pay a share of the cost
- Meet out-of-pocket maximum, then plan pays 100 percent

The HRA and the HSA provide members with financial support for higher out-of-pocket health care expenses. Our consumer-directed health products and services give members the information and resources they need to help make informed health care decisions for themselves and their families while helping lower employers' costs.

COBRA administration

Aetna COBRA administration offers a full range of notification, documentation and record-keeping processes that can help employers manage the complex billing and notification processes required for COBRA compliance, while also helping to save them time and money.

Section 125 cafeteria plans and Section 132 transit reimbursement accounts

Employees can reduce their taxable income, and employers can pay less in payroll taxes. There are three ways to save:

Flexible savings account (FSA)

FSAs give employees a chance to save for health expenses with pretax money. Health care spending accounts allow employees to set aside pretax dollars to pay for out-of-pocket expenses as defined by the IRS. Dependent care spending accounts allow participants to use pretax dollars to pay child or elder care expenses.

Transit reimbursement account (TRA)

TRAs allow participants to use pretax dollars to pay transportation and parking expenses for the purpose of commuting to and from work.

Administrative fees

Fee description	Fee	
Flexible spending account (FSA)*		
	Initial set-up	**Renewal fee**
2–25 employees	$360	$235
26–100 employees	$460	$285
Monthly fees**	$5.45 per participant	
Additional set-up fee for "stacked" plans (those electing an Aetna HRA and FSA simultaneously)	$150	
Participation fee for "stacked" participants	$10.45 per participant	
Minimum fees		
0–25 employees	$25 per month minimum	
26–100 employees	$50 per month minimum	
COBRA services		
Annual fee		
20–50 employees	$165	
Per employee per month		
20–50 employees	$0.95	
Initial notice fee	$3.00 per notice (includes notices at time of implementation and during ongoing administration)	
Minimum fees		
20–50 employees	$25 per month minimum	
Transit reimbursement account (TRA)		
Annual fee	$350	
Transit monthly fees	$4.25 per participant	
Parking monthly fees	$3.15 per participant	

*Aetna FSA pricing is inclusive for POP. Debit cards are available for FSA only. Contact Aetna for more information.

**For HRA, if the employer opts out of Streamline, the fee is increased $1.50 per participant. For FSA, the debit card is available for an additional $1 per participant per month. Mailing reimbursement checks direct to employee homes is an additional $1 per participant per month.

We reserve the right to change any of the above fees and to impose additional fees upon prior written notice.

M

HNOption plans

Plan name	Gold HNOption 500 80/50 Metallic Level: Gold		Gold HNOption 1000 80/50 Metallic Level: Gold	
Member benefits*	Network care	Out-of-network care	Network care	Out-of-network care
Calendar year deductible	$500/$1,000	$2,000/$4,000	$1,000/$2,000	$3,000/$6,000
Calendar year out-of-pocket limit	$2,750/$5,500	$8,250/$16,500	$3,500/$7,000	$10,500/$21,000
Deductible & out-of-pocket limit accumulation[1]	Embedded		Embedded	
Primary care physician office visit	$25 copay; deductible waived	50% after deductible	$20 copay; deductible waived	50% after deductible
Specialist office visit	$50 copay; deductible waived	50% after deductible	$50 copay; deductible waived	50% after deductible
Walk-in clinics	$25 copay; deductible waived	50% after deductible	$20 copay; deductible waived	50% after deductible
Diagnostic testing: Lab	$30 copay; deductible waived	50% after deductible	20% after deductible	50% after deductible
Diagnostic testing: X-ray	$50 copay; deductible waived	50% after deductible	20% after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Inpatient hospital facility	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient surgery	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency room	$200 copay; deductible waived	Paid as network care	$200 copay; deductible waived	Paid as network care
Urgent care	$75 copay; deductible waived	50% after deductible	$75 copay; deductible waived	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year.	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Pharmacy**	Network	Out of network	Network	Out of network
Pharmacy deductible	None	None	None	None
Preferred generic drugs***	T1A-$3 copay T1-$10 copay	T1A-$3 copay plus 30% T1-$10 copay plus 30%	T1A-$3 copay T1-$10 copay	T1A-$3 copay plus 30% T1-$10 copay plus 30%
Preferred brand drugs	$50 copay	$50 copay plus 30%	$50 copay	$50 copay plus 30%
Nonpreferred drugs†	$90 copay	$90 copay plus 30%	$90 copay	$90 copay plus 30%
Specialty drugs††	P: 30% up to $250 NP: 40% up to $400	Not covered	P: 30% up to $250 NP: 40% up to $400	Not covered

Refer to page 25 for footnotes.

HNOption plans

Plan name	Gold HNOption 1000 100/50 Metallic Level: Gold		Gold HNOption 1500 80/50 Metallic Level: Gold	
Member benefits*	Network care	Out-of-network care	Network care	Out-of-network care
Calendar year deductible	$1,000/$2,000	$3,000/$6,000	$1,500/$3,000	$4,500/$6,000
Calendar year out-of-pocket limit	$4,000/$8,000	$12,000/$24,000	$3,500/$7,000	$10,500/$21,000
Deductible & out-of-pocket limit accumulation[1]	Embedded		Embedded	
Primary care physician office visit	$25 copay; deductible waived	50% after deductible	$25 copay; deductible waived	50% after deductible
Specialist office visit	$50 copay; deductible waived	50% after deductible	$50 copay; deductible waived	50% after deductible
Walk-in clinics	$25 copay; deductible waived	50% after deductible	$25 copay; deductible waived	50% after deductible
Diagnostic testing: Lab	Covered in full after deductible	50% after deductible	20% after deductible	50% after deductible
Diagnostic testing: X-ray	Covered in full after deductible	50% after deductible	20% after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	Covered in full after deductible	50% after deductible	20% after deductible	50% after deductible
Inpatient hospital facility	$500 copay per admission after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient surgery	$250 copay after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency room	$350 copay; deductible waived	Paid as network care	$250 copay; deductible waived	Paid as network care
Urgent care	$75 copay; deductible waived	50% after deductible	$75 copay; deductible waived	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	Covered in full after deductible	50% after deductible	20% after deductible	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year.	Covered in full after deductible	50% after deductible	20% after deductible	50% after deductible
Pharmacy**	Network	Out of network	Network	Out of network
Pharmacy deductible	None	None	None	None
Preferred generic drugs***	T1A-$3 copay T1-$10 copay	T1A-$3 copay plus 30% T1-$10 copay plus 30%	T1A-$3 copay T1-$10 copay	T1A-$3 copay plus 30% T1-$10 copay plus 30%
Preferred brand drugs	$50 copay	$50 copay plus 30%	$50 copay	$50 copay plus 30%
Nonpreferred drugs†	$90 copay	$90 copay plus 30%	$90 copay	$90 copay plus 30%
Specialty drugs††	P: 30% up to $250 NP: 40% up to $400	Not covered	P: 30% up to $250 NP: 40% up to $400	Not covered

Refer to page 25 for footnotes.

HNOption plans

Plan name	Silver HNOption 1500 80/50 (Integrated) Metallic Level: Silver		Silver HNOption 2000 80/50 Metallic Level: Silver	
Member benefits*	Network care	Out-of-network care	Network care	Out-of-network care
Calendar year deductible	$1,500/$3,000	$4,500/$6,000	$2,000/$4,000	$6,000/$12,000
Calendar year out-of-pocket limit	$5,500/$11,000	$16,500/$33,000	$6,000/$12,000	$18,000/$36,000
Deductible & out-of-pocket limit accumulation[1]	Embedded		Embedded	
Primary care physician office visit	$35 copay; deductible waived	50% after deductible	$40 copay; deductible waived	50% after deductible
Specialist office visit	$65 copay; deductible waived	50% after deductible	$60 copay; deductible waived	50% after deductible
Walk-in clinics	$35 copay; deductible waived	50% after deductible	$40 copay; deductible waived	50% after deductible
Diagnostic testing: Lab	$40 copay; deductible waived	50% after deductible	$40 copay; deductible waived	50% after deductible
Diagnostic testing: X-ray	$75 copay; deductible waived	50% after deductible	$60 copay; deductible waived	50% after deductible
Imaging (CT/PET scans, MRIs)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Inpatient hospital facility	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient surgery	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency room	$350 copay; deductible waived	Paid as network care	20% after deductible	Paid as network care
Urgent care	$75 copay; deductible waived	50% after deductible	$75 copay; deductible waived	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year.	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Pharmacy**	Network	Out of network	Network	Out of network
Pharmacy deductible	Integrated with medical deductible; waived for generic drugs.	Integrated with medical deductible; waived for generic drugs.	None	None
Preferred generic drugs***	T1A-$3 copay; deductible waived T1-$10 copay; deductible waived	T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible	T1A-$3 copay T1-$10 copay	T1A-$3 copay plus 30% T1-$10 copay plus 30%
Preferred brand drugs	$50 copay after deductible	$50 copay plus 30% after deductible	$50 copay	$50 copay plus 30%
Nonpreferred drugs†	$90 copay after deductible	$90 copay plus 30% after deductible	$90 copay	$90 copay plus 30%
Specialty drugs††	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible	Not covered	P: 30% up to $250 NP: 40% up to $400	Not covered

Refer to page 25 for footnotes.

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HNOption plans

Plan name	Silver HNOption 2500 80/50 Metallic Level: Silver		Silver HNOption 3500 80/50 Metallic Level: Silver	
Member benefits*	Network care	Out-of-network care	Network care	Out-of-network care
Calendar year deductible	$2,500/$5,000	$7,500/$15,000	$3,500/$7,000	$10,500/$21,000
Calendar year out-of-pocket limit	$5,500/$11,000	$16,500/$33,000	$5,000/$10,000	$15,000/$30,000
Deductible & out-of-pocket limit accumulation[1]	Embedded		Embedded	
Primary care physician office visit	$35 copay; deductible waived	50% after deductible	$40 copay; deductible waived	50% after deductible
Specialist office visit	$60 copay; deductible waived	50% after deductible	$60 copay; deductible waived	50% after deductible
Walk-in clinics	$35 copay; deductible waived	50% after deductible	$40 copay; deductible waived	50% after deductible
Diagnostic testing: Lab	$50 copay; deductible waived	50% after deductible	$40 copay; deductible waived	50% after deductible
Diagnostic testing: X-ray	$100 copay; deductible waived	50% after deductible	$60 copay; deductible waived	50% after deductible
Imaging (CT/PET scans, MRIs)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Inpatient hospital facility	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient surgery	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency room	$400 copay; deductible waived	Paid as network care	$400 copay; deductible waived	Paid as network care
Urgent care	$75 copay; deductible waived	50% after deductible	$75 copay; deductible waived	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year.	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Pharmacy**	Network	Out of network	Network	Out of network
Pharmacy deductible	None	None	None	None
Preferred generic drugs***	T1A-$3 copay T1-$10 copay	T1A-$3 copay plus 30% T1-$10 copay plus 30%	T1A-$3 copay T1-$10 copay	T1A-$3 copay plus 30% T1-$10 copay plus 30%
Preferred brand drugs	$50 copay	$50 copay plus 30%	$50 copay	$50 copay plus 30%
Nonpreferred drugs†	$90 copay	$90 copay plus 30%	$90 copay	$90 copay plus 30%
Specialty drugs††	P: 30% up to $250 NP: 40% up to $400	Not covered	P: 30% up to $250 NP: 40% up to $400	Not covered

Refer to page 25 for footnotes.

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HNOption plans

Plan name	Silver HNOption 2500 100/50 (Integrated) Metallic Level: Silver		Silver HNOption 4000 80/50 Metallic Level: Silver	
Member benefits*	Network care	Out-of-network care	Network care	Out-of-network care
Calendar year deductible	$2,500/$5,000	$7,500/$15,000	$4,000/$8,000	$12,000/$24,000
Calendar year out-of-pocket limit	$5,500/$11,000	$16,500/$33,000	$6,600/$13,200	$19,800/$39,600
Deductible & out-of-pocket limit accumulation[1]	Embedded		Embedded	
Primary care physician office visit	$35 copay; deductible waived	50% after deductible	$40 copay; deductible waived	50% after deductible
Specialist office visit	$60 copay after deductible	50% after deductible	$60 copay; deductible waived	50% after deductible
Walk-in clinics	$35 copay; deductible waived	50% after deductible	$40 copay; deductible waived	50% after deductible
Diagnostic testing: Lab	Covered in full after deductible	50% after deductible	$40 copay; deductible waived	50% after deductible
Diagnostic testing: X-ray	Covered in full after deductible	50% after deductible	$60 copay; deductible waived	50% after deductible
Imaging (CT/PET scans, MRIs)	Covered in full after deductible	50% after deductible	20% after deductible	50% after deductible
Inpatient hospital facility	Covered in full after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient surgery	Covered in full after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency room	$250 copay after deductible	Paid as network care	$350 copay; deductible waived	Paid as network care
Urgent care	$75 copay; deductible waived	50% after deductible	$75 copay; deductible waived	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	Covered in full after deductible	50% after deductible	20% after deductible	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year.	Covered in full after deductible	50% after deductible	20% after deductible	50% after deductible
Pharmacy**	Network	Out of network	Network	Out of network
Pharmacy deductible	Integrated with medical deductible; waived for generic drugs.	Integrated with medical deductible; waived for generic drugs.	None	None
Preferred generic drugs***	T1A-$3 copay; deductible waived T1-$10 copay; deductible waived	T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible	T1A-$3 copay T1-$10 copay	T1A-$3 copay plus 30% T1-$10 copay plus 30%
Preferred brand drugs	$50 copay after deductible	$50 copay plus 30% after deductible	$50 copay	$50 copay plus 30%
Nonpreferred drugs†	$90 copay after deductible	$90 copay plus 30% after deductible	$90 copay	$90 copay plus 30%
Specialty drugs††	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible	Not covered	P: 30% up to $250 NP: 40% up to $400	Not covered

Refer to page 25 for footnotes.

HNOption plans

Plan name	Silver HNOption 5000 80/50 Metallic Level: Silver		Silver HNOption 2600 80/50 HSA EMB Metallic Level: Silver	
Member benefits*	Network care	Out-of-network care	Network care	Out-of-network care
Calendar year deductible	$5,000/$10,000	$15,000/$30,000	$2,600/$5,200	$7,800/$15,600
Calendar year out-of-pocket limit	$6,600/$13,200	$19,800/$39,600	$4,000/$8,000	$12,000/$24,000
Deductible & out-of-pocket limit accumulation[1]	Embedded		Embedded	
Primary care physician office visit	$40 copay; deductible waived	50% after deductible	$40 copay after deductible	50% after deductible
Specialist office visit	$60 copay; deductible waived	50% after deductible	$60 copay after deductible	50% after deductible
Walk-in clinics	$40 copay; deductible waived	50% after deductible	$30 copay after deductible	50% after deductible
Diagnostic testing: Lab	$40 copay; deductible waived	50% after deductible	20% after deductible	50% after deductible
Diagnostic testing: X-ray	$60 copay; deductible waived	50% after deductible	20% after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Inpatient hospital facility	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient surgery	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency room	$350 copay; deductible waived	Paid as network care	$300 copay after deductible	Paid as network care
Urgent care	$75 copay; deductible waived	50% after deductible	20% after deductible	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year.	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Pharmacy**	Network	Out of network	Network	Out of network
Pharmacy deductible	None	None	Integrated with medical deductible	Integrated with medical deductible
Preferred generic drugs***	T1A-$3 copay T1-$10 copay	T1A-$3 copay plus 30% T1-$10 copay plus 30%	T1A-$3 copay after deductible T1-$10 copay after deductible	T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible
Preferred brand drugs	$50 copay	$50 copay plus 30%	$50 copay after deductible	$50 copay plus 30% after deductible
Nonpreferred drugs†	$90 copay	$90 copay plus 30%	$90 copay after deductible	$90 copay plus 30% after deductible
Specialty drugs††	P: 30% up to $250 NP: 40% up to $400	Not covered	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible	Not covered

Refer to page 25 for footnotes.

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HNOption plans

Plan name	Silver HNOption 2600 100/50 HSA EMB Metallic Level: Silver		Silver HNOption 2600 100/50 HSA TIF Metallic Level: Silver	
Member benefits*	Network care	Out-of-network care	Network care	Out-of-network care
Calendar year deductible	$2,600/$5,200	$7,800/$15,600	$2,600/$5,200	$7,800/$15,600
Calendar year out-of-pocket limit	$5,200/$10,400	$15,600/$31,200	$5,200/$10,400	$15,600/$31,200
Deductible & out-of-pocket limit accumulation[1]	Embedded		True integrated family (TIF)	
Primary care physician office visit	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Specialist office visit	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Walk-in clinics	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Diagnostic testing: Lab	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Diagnostic testing: X-ray	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Inpatient hospital facility	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Outpatient surgery	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Emergency room	Covered in full after deductible	Paid as network care	Covered in full after deductible	Paid as network care
Urgent care	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year.	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Pharmacy**	Network	Out of network	Network	Out of network
Pharmacy deductible	Integrated with medical deductible	Integrated with medical deductible	Integrated with medical deductible	Integrated with medical deductible
Preferred generic drugs***	T1A-$3 copay after deductible T1-$10 copay after deductible	T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible	T1A-$3 copay after deductible T1-$10 copay after deductible	T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible
Preferred brand drugs	$50 copay after deductible	$50 copay plus 30% after deductible	$50 copay after deductible	$50 copay plus 30% after deductible
Nonpreferred drugs†	$90 copay after deductible	$90 copay plus 30% after deductible	$90 copay after deductible	$90 copay plus 30% after deductible
Specialty drugs††	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible	Not covered	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible	Not covered

Refer to page 25 for footnotes.

HNOption plans

Plan name	Bronze HNOption 3750 80/50 HSA EMB Metallic Level: Bronze		Bronze HNOption 3750 80/50 HSA TIF Metallic Level: Bronze	
Member benefits*	Network care	Out-of-network care	Network care	Out-of-network care
Calendar year deductible	$3,750/$7,500	$11,250/$22,500	$3,750/$7,500	$11,250/$22,500
Calendar year out-of-pocket limit	$6,450/$12,900	$19,350/$38,700	$6,450/$12,900	$19,350/$38,700
Deductible & out-of-pocket limit accumulation[1]	Embedded		True integrated family (TIF)	
Primary care physician office visit	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Specialist office visit	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Walk-in clinics	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Diagnostic testing: Lab	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Diagnostic testing: X-ray	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Inpatient hospital facility	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient surgery	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency room	20% after deductible	Paid as network care	20% after deductible	Paid as network care
Urgent care	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year.	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Pharmacy**	Network	Out of network	Network	Out of network
Pharmacy deductible	Integrated with medical deductible	Integrated with medical deductible	Integrated with medical deductible	Integrated with medical deductible
Preferred generic drugs***	T1A-$3 copay after deductible T1-$10 copay after deductible	T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible	T1A-$3 copay after deductible T1-$10 copay after deductible	T1A-$3 copay plus 30% T1-$10 copay plus 30%
Preferred brand drugs	$50 copay after deductible	$50 copay plus 30% after deductible	$50 copay after deductible	$50 copay plus 30%
Nonpreferred drugs†	$90 copay after deductible	$90 copay plus 30% after deductible	$90 copay after deductible	$90 copay plus 30%
Specialty drugs††	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible	Not covered	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible	Not covered

Refer to page 25 for footnotes.

HNOption plans

Plan name	Bronze HNOption 5000 80/50 HSA EMB Metallic Level: Bronze		Bronze HNOption 5000 100/50 HSA EMB Metallic Level: Bronze	
Member benefits*	Network care	Out-of-network care	Network care	Out-of-network care
Calendar year deductible	$5,000/$10,000	$15,000/$30,000	$5,000/$10,000	$15,000/$30,000
Calendar year out-of-pocket limit	$6,450/$12,900	$19,350/$38,700	$6,450/$12,900	$19,350/$38,700
Deductible & out-of-pocket limit accumulation[1]	Embedded		Embedded	
Primary care physician office visit	20% after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Specialist office visit	20% after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Walk-in clinics	20% after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Diagnostic testing: Lab	20% after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Diagnostic testing: X-ray	20% after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	20% after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Inpatient hospital facility	20% after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Outpatient surgery	20% after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Emergency room	20% after deductible	Paid as network care	Covered in full after deductible	Paid as network care
Urgent care	20% after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	20% after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year.	20% after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Pharmacy**	Network	Out of network	Network	Out of network
Pharmacy deductible	Integrated with medical deductible	Integrated with medical deductible	Integrated with medical deductible	Integrated with medical deductible
Preferred generic drugs***	T1A-$3 copay after deductible T1-$10 copay after deductible	T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible	T1A-$3 copay after deductible T1-$10 copay after deductible	T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible
Preferred brand drugs	$50 copay after deductible	$50 copay plus 30% after deductible	$50 copay after deductible	$50 copay plus 30% after deductible
Nonpreferred drugs†	$90 copay after deductible	$90 copay plus 30% after deductible	$90 copay after deductible	$90 copay plus 30% after deductible
Specialty drugs††	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible	Not covered	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible	Not covered

Refer to page 25 for footnotes.

HNOption plans

Plan name	Bronze HNOption 5000 100/50 HSA TIF Metallic Level: Bronze		Bronze HNOption 5500 80/50 (Integrated) Metallic Level: Bronze	
Member benefits*	Network care	Out-of-network care	Network care	Out-of-network care
Calendar year deductible	$5,000/$10,000	$15,000/$30,000	$5,500/$11,000	$16,500/$33,000
Calendar year out-of-pocket limit	$6,450/$12,900	$19,350/$38,700	$6,600/$13,200	$19,800/$39,600
Deductible & out-of-pocket limit accumulation[1]	True integrated family (TIF)		Embedded	
Primary care physician office visit	Covered in full after deductible	50% after deductible	$40 copay; deductible waived	50% after deductible
Specialist office visit	Covered in full after deductible	50% after deductible	$75 copay after deductible	50% after deductible
Walk-in clinics	Covered in full after deductible	50% after deductible	$40 copay; deductible waived	50% after deductible
Diagnostic testing: Lab	Covered in full after deductible	50% after deductible	$40 copay after deductible	50% after deductible
Diagnostic testing: X-ray	Covered in full after deductible	50% after deductible	$75 copay after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	Covered in full after deductible	50% after deductible	20% after deductible	50% after deductible
Inpatient hospital facility	Covered in full after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient surgery	Covered in full after deductible	50% after deductible	$500 copay after deductible	50% after deductible
Emergency room	Covered in full after deductible	Paid as network care	$750 copay after deductible	Paid as network care
Urgent care	Covered in full after deductible	50% after deductible	$75 copay; deductible waived	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	Covered in full after deductible	50% after deductible	20% after deductible	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year.	Covered in full after deductible	50% after deductible	20% after deductible	50% after deductible
Pharmacy**	Network	Out of network	Network	Out of network
Pharmacy deductible	Integrated with medical deductible	Integrated with medical deductible	Integrated with medical deductible; waived for generic drugs.	Integrated with medical deductible; waived for generic drugs.
Preferred generic drugs***	T1A-$3 copay after deductible T1-$10 copay after deductible	T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible	T1A-$3 copay; deductible waived T1-$10 copay; deductible waived	T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible
Preferred brand drugs	$50 copay after deductible	$50 copay plus 30% after deductible	$50 copay after deductible	$50 copay plus 30% after deductible
Nonpreferred drugs†	$90 copay after deductible	$90 copay plus 30% after deductible	$90 copay after deductible	$90 copay plus 30% after deductible
Specialty drugs††	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible	Not covered	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible	Not covered

Refer to page 25 for footnotes.

HNOption plans

Plan name	Bronze HNOption 6200 100/50 HSA EMB Metallic Level: Bronze		Bronze HNOption 6200 100/50 HSA TIF Metallic Level: Bronze	
Member benefits*	Network care	Out-of-network care	Network care	Out-of-network care
Calendar year deductible	$6,200/$12,400	$18,600/$37,200	$6,200/$12,400	$18,600/$37,200
Calendar year out-of-pocket limit	$6,450/$12,900	$19,350/$38,700	$6,450/$12,900	$19,350/$38,700
Deductible & out-of-pocket limit accumulation[1]	Embedded		True integrated family (TIF)	
Primary care physician office visit	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Specialist office visit	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Walk-in clinics	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Diagnostic testing: Lab	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Diagnostic testing: X-ray	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Inpatient hospital facility	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Outpatient surgery	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Emergency room	Covered in full after deductible	Paid as network care	Covered in full after deductible	Paid as network care
Urgent care	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year.	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Pharmacy**	Network	Out of network	Network	Out of network
Pharmacy deductible	Integrated with medical deductible	Integrated with medical deductible	Integrated with medical deductible	Integrated with medical deductible
Preferred generic drugs***	T1A-$3 copay after deductible T1-$10 copay after deductible	T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible	T1A-$3 copay after deductible T1-$10 copay after deductible	T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible
Preferred brand drugs	$50 copay after deductible	$50 copay plus 30% after deductible	$50 copay after deductible	$50 copay plus 30% after deductible
Nonpreferred drugs†	$90 copay after deductible	$90 copay plus 30% after deductible	$90 copay after deductible	$90 copay plus 30% after deductible
Specialty drugs††	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible	Not covered	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible	Not covered

Refer to page 25 for footnotes.

Footnotes

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All services are subject to the deductible unless noted otherwise.

Some benefits are subject to age and frequency schedules, limitations or visit maximums.

Members or providers may be required to precertify or obtain approval for certain services.

[1]Embedded – No one family member may contribute more than the individual deductible/out-of-pocket limit amount to the family deductible/out-of-pocket limit. Once the family deductible/out-of-pocket limit is met, all family members will be considered as having met their deductible/out-of-pocket limit for the remainder of the calendar year.

TIF – The individual deductible/out-of-pocket limit can only be met when a member is enrolled for self-only coverage with no dependent coverage. The family deductible/out-of-pocket limit can be met by a combination of family members or by any single individual within the family. Once the family deductible/out-of-pocket limit is met, all family members will be considered as having met their deductible/out-of-pocket limit for the remainder of the calendar year.

[2]Benefit limits are combined between network and out-of-network care.

*How we pay out-of-network providers:
We cover the cost of services based on whether doctors are "in network" or "out of network."

Members may choose a provider (doctor or hospital) in our network. They may choose to visit an out-of-network provider. When members choose a doctor who is out of network, the Aetna health plan may pay some of that doctor's bill. Most of the time, members will pay a lot more money out of pocket if they choose to use an out-of-network doctor or hospital.

When members choose out-of-network care, the plan limits the amount it will pay. This limit is called the "recognized" or "allowed" amount. Those amounts are:

Professional Services: 100% of Medicare

Facility Services: 100% of Medicare

Out-of-network doctors set their own rates. It may be higher — sometimes much higher — than what the Aetna plan "recognizes." Out-of-network doctors may bill for the dollar amount that the plan doesn't "recognize." Members must also pay any copayments, coinsurance and deductibles under the plan. No dollar amount above the "recognized charge" counts toward the deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit **www.aetna.com**. Type "how Aetna pays" in the search box.

Members can avoid these extra costs by getting care from our broad network of health care providers. Go to **www.aetna.com** and click on "Find a Doctor" on the left side of the page. Existing members may sign on to their Aetna Navigator member site.

This applies when members choose to get care out of network. When they have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if they received care in network. Members pay cost sharing and deductibles for the in-network level of benefits. Contact us if a health care provider asks for more. Members are not responsible for any outstanding balance billed by providers for emergency services beyond the cost sharing and deductibles.

**If the physician prescribes or the member requests a covered brand-name prescription drug when a generic prescription drug equivalent is available, the member will pay the difference in cost between the brand-name prescription drug and the generic prescription drug equivalent plus the applicable cost sharing. The cost difference between the generic and brand does not count toward the out of pocket limit.

Not all drugs are covered. It is important to look at the Preferred Drug List (Aetna Value Plus Formulary) to understand which drugs are covered.

***T1A=Value drugs; T1=Preferred generic drugs.

†Includes nonpreferred generic and brand drugs.

††P=Preferred specialty drugs; NP=Nonpreferred specialty drugs.

Note: For a summary list of limitations and exclusions, refer to page 66. Please refer to our Producer World® website at **www.aetna.com** for specific Summary of Benefits and Coverage documents. Or for more information, please contact your licensed agent or Aetna sales representative.

M

Saving Plus plans

Plan name	OH Gold SP HNOption 500 80/50 Metallic Level: Gold			OH Gold SP HNOption 1000 100/50 Metallic Level: Gold		
Networks	Cleveland, Cincinnati and Toledo			Cleveland, Cincinnati and Toledo		
Member benefits*	Network care designated provider	Network care nondesignated providers	Out-of-network care	Network care designated provider	Network care nondesignated providers	Out-of-network care
Calendar year deductible	$500/$1,000	$1,000/$2,000	$3,000/$6,000	$1,000/$2,000	$2,000/$4,000	$6,000/$12,000
Calendar year out-of-pocket limit	$2,500/$5,000	$3,500/$7,000	$10,500/$21,000	$3,500/$7,000	$6,000/$12,000	$18,000/$36,000
Deductible & out-of-pocket limit accumulation[1]	Embedded			Embedded		
Primary care physician office visit	$25 copay; deductible waived	40% after deductible	50% after deductible	$25 copay; deductible waived	20% after deductible	50% after deductible
Specialist office visit	$50 copay; deductible waived	40% after deductible	50% after deductible	$50 copay; deductible waived	20% after deductible	50% after deductible
Walk-in clinics	$25 copay; deductible waived	Paid at the designated level	50% after deductible	$25 copay; deductible waived	Paid at the designated level	50% after deductible
Diagnostic testing: Lab	$30 copay; deductible waived	Paid at the designated level	50% after deductible	Covered in full after deductible	Paid at the designated level	50% after deductible
Diagnostic testing: X-ray	$50 copay; deductible waived	40% after deductible	50% after deductible	Covered in full after deductible	20% after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	20% after deductible	40% after deductible	50% after deductible	Covered in full after deductible	20% after deductible	50% after deductible
Inpatient hospital facility	20% after deductible	40% after deductible	50% after deductible	$500 copay per admission after deductible	20% after deductible	50% after deductible
Outpatient surgery	20% after deductible	40% after deductible	50% after deductible	$250 copay after deductible	20% after deductible	50% after deductible
Emergency room	$200 copay; deductible waived	Paid at the network care designated level	Paid at the network care designated level	$350 copay; deductible waived	Paid at the network care designated level	Paid at the network care designated level
Urgent care	$75 copay; deductible waived	40% after deductible	50% after deductible	$75 copay; deductible waived	20% after deductible	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	20% after deductible	Paid at the designated level	50% after deductible	Covered in full after deductible	Paid at the designated level	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year	20% after deductible	Paid at the designated level	50% after deductible	Covered in full after deductible	Paid at the designated level	50% after deductible
Pharmacy**	Network		Out of network	Network		Out of network
Pharmacy deductible	None		None	None		None
Preferred generic drugs***	T1A-$3 copay T1-$10 copay		T1A-$3 copay plus 30% T1-$10 copay plus 30%	T1A-$3 copay T1-$10 copay		T1A-$3 copay plus 30% T1-$10 copay plus 30%
Preferred brand drugs	$50 copay		$50 copay plus 30%	$50 copay		$50 copay plus 30%
Nonpreferred drugs†	$90 copay		$90 copay plus 30%	$90 copay		$90 copay plus 30%
Specialty drugs††	P: 30% up to $250 NP: 40% up to $400		Not covered	P: 30% up to $250 NP: 40% up to $400		Not covered

Refer to page 36 for footnotes.

Saving Plus plans

Plan name	OH Gold SP HNOption 1000 80/50 Metallic Level: Gold			OH Gold SP HNOption 1500 80/50 Metallic Level: Gold		
Networks	Cincinnati, Cleveland and Toledo			Cincinnati, Cleveland and Toledo		
Member benefits*	Network care designated provider	Network care nondesignated providers	Out-of-network care	Network care designated provider	Network care nondesignated providers	Out-of-network care
Calendar year deductible	$1,000/$2,000	$2,000/$4,000	$6,000/$12,000	$1,500/$3,000	$3,000/$6,000	$9,000/$18,000
Calendar year out-of-pocket limit	$3,500/$7,000	$6,000/$12,000	$18,000/$36,000	$4,500/$9,000	$6,000/$12,000	$18,000/$36,000
Deductible & out-of-pocket limit accumulation[1]	Embedded			Embedded		
Primary care physician office visit	$20 copay; deductible waived	40% after deductible	50% after deductible	$20 copay; deductible waived	40% after deductible	50% after deductible
Specialist office visit	$50 copay; deductible waived	40% after deductible	50% after deductible	$40 copay; deductible waived	40% after deductible	50% after deductible
Walk-in clinics	$20 copay; deductible waived	Paid at the designated level	50% after deductible	$20 copay; deductible waived	Paid at the designated level	50% after deductible
Diagnostic testing: Lab	20% after deductible	Paid at the designated level	50% after deductible	20% after deductible	Paid at the designated level	50% after deductible
Diagnostic testing: X-ray	20% after deductible	40% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	20% after deductible	40% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Inpatient hospital facility	20% after deductible	40% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Outpatient surgery	20% after deductible	40% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Emergency room	$200 copay; deductible waived	Paid at the network care designated level	Paid at the network care designated level	$200 copay; deductible waived	Paid at the network care designated level	Paid at the network care designated level
Urgent care	$75 copay; deductible waived	40% after deductible	50% after deductible	$75 copay; deductible waived	40% after deductible	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	20% after deductible	Paid at the designated level	50% after deductible	20% after deductible	Paid at the designated level	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year	20% after deductible	Paid at the designated level	50% after deductible	20% after deductible	Paid at the designated level	50% after deductible
Pharmacy**	Network		Out of network	Network		Out of network
Pharmacy deductible	None		None	None		None
Preferred generic drugs***	T1A-$3 copay T1-$10 copay		T1A-$3 copay plus 30% T1-$10 copay plus 30%	T1A-$3 copay T1-$10 copay		T1A-$3 copay plus 30% T1-$10 copay plus 30%
Preferred brand drugs	$50 copay		$50 copay plus 30%	$50 copay		$50 copay plus 30%
Nonpreferred drugs†	$90 copay		$90 copay plus 30%	$90 copay		$90 copay plus 30%
Specialty drugs††	P: 30% up to $250 NP: 40% up to $400		Not covered	P: 30% up to $250 NP: 40% up to $400		Not covered

Refer to page 36 for footnotes.

Saving Plus plans

Plan name	OH Silver SP HNOption 1500 80/50 (Integ) Metallic Level: Silver			OH Silver SP HNOption 2000 80/50 Metallic Level: Silver		
Networks	Cincinnati, Cleveland and Toledo			Cincinnati, Cleveland and Toledo		
Member benefits*	Network care designated provider	Network care nondesignated providers	Out-of-network care	Network care designated provider	Network care nondesignated providers	Out-of-network care
Calendar year deductible	$1,500/$3,000	$2,500/$5,000	$7,500/$15,000	$2,000/$4,000	$3,500/$7,000	$10,500/$21,000
Calendar year out-of-pocket limit	$5,500/$11,000	$6,600/$13,200	$19,800/$39,600	$6,000/$12,000	$6,600/$13,200	$19,800/$39,600
Deductible & out-of-pocket limit accumulation[1]	Embedded			Embedded		
Primary care physician office visit	$35 copay; deductible waived	40% after deductible	50% after deductible	$40 copay; deductible waived	40% after deductible	50% after deductible
Specialist office visit	$65 copay; deductible waived	40% after deductible	50% after deductible	$60 copay; deductible waived	40% after deductible	50% after deductible
Walk-in clinics	$30 copay; deductible waived	Paid at the designated level	50% after deductible	$40 copay; deductible waived	Paid at the designated level	50% after deductible
Diagnostic testing: Lab	$40 copay; deductible waived	Paid at the designated level	50% after deductible	$40 copay; deductible waived	Paid at the designated level	50% after deductible
Diagnostic testing: X-ray	$75 copay; deductible waived	40% after deductible	50% after deductible	$60 copay; deductible waived	40% after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	20% after deductible	40% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Inpatient hospital facility	20% after deductible	40% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Outpatient surgery	20% after deductible	40% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Emergency room	$250 copay; deductible waived	Paid at the network care designated level	Paid at the network care designated level	20% after deductible	Paid at the network care designated level	Paid at the network care designated level
Urgent care	$75 copay; deductible waived	40% after deductible	50% after deductible	$75 copay; deductible waived	40% after deductible	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	20% after deductible	Paid at the designated level	50% after deductible	20% after deductible	Paid at the designated level	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year	20% after deductible	Paid at the designated level	50% after deductible	20% after deductible	Paid at the designated level	50% after deductible
Pharmacy**	Network		Out of network	Network		Out of network
Pharmacy deductible	Integrated with medical deductible; waived for generic drugs.		Integrated with medical deductible; waived for generic drugs.	None		None
Preferred generic drugs***	T1A-$3 copay; deductible waived T1-$10 copay; deductible waived		T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible	T1A-$3 copay T1-$10 copay		T1A-$3 copay plus 30% T1-$10 copay plus 30%
Preferred brand drugs	$50 copay after deductible		$50 copay plus 30% after deductible	$50 copay		$50 copay plus 30%
Nonpreferred drugs†	$90 copay after deductible		$90 copay plus 30% after deductible	$90 copay		$90 copay plus 30%
Specialty drugs††	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible		Not covered	P: 30% up to $250 NP: 40% up to $400		Not covered

Refer to page 36 for footnotes.

Saving Plus plans

Plan name	OH Silver SP HNOption 2500 100/50 (Integ) Metallic Level: Silver			OH Silver SP HNOption 2500 80/50 Metallic Level: Silver		
Networks	Cincinnati, Cleveland and Toledo			Cincinnati, Cleveland and Toledo		
Member benefits*	Network care designated provider	Network care nondesignated providers	Out-of-network care	Network care designated provider	Network care nondesignated providers	Out-of-network care
Calendar year deductible	$2,500/$5,000	$3,500/$7,000	$10,500/$21,000	$2,500/$5,000	$3,500/$7,000	$10,500/$21,000
Calendar year out-of-pocket limit	$5,500/$11,000	$6,600/$13,200	$19,800/$39,600	$5,500/$11,000	$6,600/$13,200	$19,800/$39,600
Deductible & out-of-pocket limit accumulation[1]	Embedded			Embedded		
Primary care physician office visit	$35 copay; deductible waived	20% after deductible	50% after deductible	$35 copay; deductible waived	40% after deductible	50% after deductible
Specialist office visit	$60 copay after deductible	20% after deductible	50% after deductible	$60 copay; deductible waived	40% after deductible	50% after deductible
Walk-in clinics	$35 copay; deductible waived	Paid at the designated level	50% after deductible	$35 copay; deductible waived	Paid at the designated level	50% after deductible
Diagnostic testing: Lab	Covered in full after deductible	Paid at the designated level	50% after deductible	$40 copay; deductible waived	Paid at the designated level	50% after deductible
Diagnostic testing: X-ray	Covered in full after deductible	20% after deductible	50% after deductible	$60 copay; deductible waived	40% after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	Covered in full after deductible	20% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Inpatient hospital facility	Covered in full after deductible	20% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Outpatient surgery	Covered in full after deductible	20% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Emergency room	$250 copay after deductible	Paid at the network care designated level	Paid at the network care designated level	$350 copay; deductible waived	Paid at the network care designated level	Paid at the network care designated level
Urgent care	$75 copay; deductible waived	20% after deductible	50% after deductible	$75 copay; deductible waived	40% after deductible	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	Covered in full after deductible	Paid at the designated level	50% after deductible	20% after deductible	Paid at the designated level	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year	Covered in full after deductible	Paid at the designated level	50% after deductible	20% after deductible	Paid at the designated level	50% after deductible
Pharmacy**	Network		Out of network	Network		Out of network
Pharmacy deductible	Integrated with medical deductible; waived for generic drugs.		Integrated with medical deductible; waived for generic drugs.	None		None
Preferred generic drugs***	T1A-$3 copay; deductible waived T1-$10 copay; deductible waived		T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible	T1A-$3 copay T1-$10 copay		T1A-$3 copay plus 30% T1-$10 copay plus 30%
Preferred brand drugs	$50 copay after deductible		$50 copay plus 30% after deductible	$50 copay		$50 copay plus 30%
Nonpreferred drugs†	$90 copay after deductible		$90 copay plus 30% after deductible	$90 copay		$90 copay plus 30%
Specialty drugs††	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible		Not covered	P: 30% up to $250 NP: 40% up to $400		Not covered

Refer to page 36 for footnotes.

Saving Plus plans

Plan name	OH Silver SP HNOpt 2600 100/50 HSA EMB Metallic Level: Silver			OH Silver SP HNOpt 2600 100/50 HSA TIF Metallic Level: Silver		
Networks	Cincinnati, Cleveland and Toledo			Cincinnati, Cleveland and Toledo		
Member benefits*	Network care designated provider	Network care nondesignated providers	Out-of-network care	Network care designated provider	Network care nondesignated providers	Out-of-network care
Calendar year deductible	$2,600/$5,200	$3,600/$7,200	$10,800/$21,600	$2,600/$5,200	$3,600/$7,200	$10,800/$21,600
Calendar year out-of-pocket limit	$5,200/$10,400	$6,450/$12,900	$19,350/$38,700	$5,200/$10,400	$6,450/$12,900	$19,350/$38,700
Deductible & out-of-pocket limit accumulation[1]	Embedded			True integrated family (TIF)		
Primary care physician office visit	Covered in full after deductible	20% after deductible	50% after deductible	Covered in full after deductible	20% after deductible	50% after deductible
Specialist office visit	Covered in full after deductible	20% after deductible	50% after deductible	Covered in full after deductible	20% after deductible	50% after deductible
Walk-in clinics	Covered in full after deductible	Paid at the designated level	50% after deductible	Covered in full after deductible	Paid at the designated level	50% after deductible
Diagnostic testing: Lab	Covered in full after deductible	Paid at the designated level	50% after deductible	Covered in full after deductible	Paid at the designated level	50% after deductible
Diagnostic testing: X-ray	Covered in full after deductible	20% after deductible	50% after deductible	Covered in full after deductible	20% after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	Covered in full after deductible	20% after deductible	50% after deductible	Covered in full after deductible	20% after deductible	50% after deductible
Inpatient hospital facility	Covered in full after deductible	20% after deductible	50% after deductible	Covered in full after deductible	20% after deductible	50% after deductible
Outpatient surgery	Covered in full after deductible	20% after deductible	50% after deductible	Covered in full after deductible	20% after deductible	50% after deductible
Emergency room	Covered in full after deductible	Paid at the network care designated level	Paid at the network care designated level	Covered in full after deductible	Paid at the network care designated level	Paid at the network care designated level
Urgent care	Covered in full after deductible	20% after deductible	50% after deductible	Covered in full after deductible	20% after deductible	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	Covered in full after deductible	Paid at the designated level	50% after deductible	Covered in full after deductible	Paid at the designated level	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year	Covered in full after deductible	Paid at the designated level	50% after deductible	Covered in full after deductible	Paid at the designated level	50% after deductible
Pharmacy**	Network		Out of network	Network		Out of network
Pharmacy deductible	Integrated with medical deductible		Integrated with medical deductible	Integrated with medical deductible		Integrated with medical deductible
Preferred generic drugs***	T1A-$3 copay after deductible T1-$10 copay after deductible		T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible	T1A-$3 copay after deductible T1-$10 copay after deductible		T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible
Preferred brand drugs	$50 copay after deductible		$50 copay plus 30% after deductible	$50 copay after deductible		$50 copay plus 30% after deductible
Nonpreferred drugs†	$90 copay after deductible		$90 copay plus 30% after deductible	$90 copay after deductible		$90 copay plus 30% after deductible
Specialty drugs††	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible		Not covered	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible		Not covered

Refer to page 36 for footnotes.

Saving Plus plans

Plan name	OH Silver SP HNOpt 2600 80/50 HSA EMB Metallic Level: Silver			OH Silver SP HNOption 3500 80/50 Metallic Level: Silver		
Networks	Cincinnati, Cleveland and Toledo			Cincinnati, Cleveland and Toledo		
Member benefits*	Network care designated provider	Network care nondesignated providers	Out-of-network care	Network care designated provider	Network care nondesignated providers	Out-of-network care
Calendar year deductible	$2,600/$5,200	$3,600/$7,200	$10,800/$21,600	$3,500/$7,000	$4,500/$9,000	$13,500/$27,000
Calendar year out-of-pocket limit	$3,800/$7,600	$6,450/$12,900	$19,350/$38,700	$5,000/$10,000	$6,000/$12,000	$18,000/$36,000
Deductible & out-of-pocket limit accumulation[1]	Embedded			Embedded		
Primary care physician office visit	$40 copay after deductible	40% after deductible	50% after deductible	$40 copay; deductible waived	40% after deductible	50% after deductible
Specialist office visit	$60 copay after deductible	40% after deductible	50% after deductible	$60 copay; deductible waived	40% after deductible	50% after deductible
Walk-in clinics	$40 copay after deductible	Paid at the designated level	50% after deductible	$40 copay; deductible waived	Paid at the designated level	50% after deductible
Diagnostic testing: Lab	20% after deductible	Paid at the designated level	50% after deductible	$40 copay; deductible waived	Paid at the designated level	50% after deductible
Diagnostic testing: X-ray	20% after deductible	40% after deductible	50% after deductible	$60 copay; deductible waived	40% after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	20% after deductible	40% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Inpatient hospital facility	20% after deductible	40% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Outpatient surgery	20% after deductible	40% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Emergency room	$300 copay after deductible	Paid at the network care designated level	Paid at the network care designated level	$400 copay; deductible waived	Paid at the network care designated level	Paid at the network care designated level
Urgent care	20% after deductible	40% after deductible	50% after deductible	$75 copay; deductible waived	40% after deductible	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	20% after deductible	Paid at the designated level	50% after deductible	20% after deductible	Paid at the designated level	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year	20% after deductible	Paid at the designated level	50% after deductible	20% after deductible	Paid at the designated level	50% after deductible
Pharmacy**	Network		Out of network	Network		Out of network
Pharmacy deductible	Integrated with medical deductible		Integrated with medical deductible	None		None
Preferred generic drugs***	T1A-$3 copay after deductible T1-$10 copay after deductible		T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible	T1A-$3 copay T1-$10 copay		T1A-$3 copay plus 30% T1-$10 copay plus 30%
Preferred brand drugs	$50 copay after deductible		$50 copay plus 30% after deductible	$50 copay		$50 copay plus 30%
Nonpreferred drugs†	$90 copay after deductible		$90 copay plus 30% after deductible	$90 copay		$90 copay plus 30%
Specialty drugs††	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible		Not covered	P: 30% up to $250 NP: 40% up to $400		Not covered

Refer to page 36 for footnotes.

Saving Plus plans

Plan name	OH Bronze SP HNOpt 3750 80/50 HSA EMB Metallic Level: Bronze			OH Bronze SP HNOpt 3750 80/50 HSA TIF Metallic Level: Bronze		
Networks	Cincinnati, Cleveland and Toledo			Cincinnati, Cleveland and Toledo		
Member benefits*	Network care designated provider	Network care nondesignated providers	Out-of-network care	Network care designated provider	Network care nondesignated providers	Out-of-network care
Calendar year deductible	$3,750/$7,500	$5,750/$11,500	$17,250/$34,500	$3,750/$7,500	$5,750/$11,500	$17,250/$34,500
Calendar year out-of-pocket limit	$6,450/$12,900	$6,450/$12,900	$19,350/$38,700	$6,450/$12,900	$6,450/$12,900	$19,350/$38,700
Deductible & out-of-pocket limit accumulation[1]	Embedded			True integrated family (TIF)		
Primary care physician office visit	20% after deductible	40% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Specialist office visit	20% after deductible	40% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Walk-in clinics	20% after deductible	Paid at the designated level	50% after deductible	20% after deductible	Paid at the designated level	50% after deductible
Diagnostic testing: Lab	20% after deductible	Paid at the designated level	50% after deductible	20% after deductible	Paid at the designated level	50% after deductible
Diagnostic testing: X-ray	20% after deductible	40% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	20% after deductible	40% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Inpatient hospital facility	20% after deductible	40% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Outpatient surgery	20% after deductible	40% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Emergency room	20% after deductible	Paid at the network care designated level	Paid at the network care designated level	20% after deductible	Paid at the network care designated level	Paid at the network care designated level
Urgent care	20% after deductible	40% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	20% after deductible	Paid at the designated level	50% after deductible	20% after deductible	Paid at the designated level	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year	20% after deductible	Paid at the designated level	50% after deductible	20% after deductible	Paid at the designated level	50% after deductible
Pharmacy**	Network		Out of network	Network		Out of network
Pharmacy deductible	Integrated with medical deductible		Integrated with medical deductible	Integrated with medical deductible		Integrated with medical deductible
Preferred generic drugs***	T1A-$3 copay after deductible T1-$10 copay after deductible		T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible	T1A-$3 copay after deductible T1-$10 copay after deductible		T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible
Preferred brand drugs	$50 copay after deductible		$50 copay plus 30% after deductible	$50 copay after deductible		$50 copay plus 30% after deductible
Nonpreferred drugs†	$90 copay after deductible		$90 copay plus 30% after deductible	$90 copay after deductible		$90 copay plus 30% after deductible
Specialty drugs††	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible		Not covered	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible		Not covered

Refer to page 36 for footnotes.

Saving Plus plans

Plan name	OH Silver SP HNOption 4000 80/50 Metallic Level: Silver			OH Bronze SP HNOpt 5000 100/50 HSA EMB Metallic Level: Bronze		
Networks	Cincinnati, Cleveland and Toledo			Cincinnati, Cleveland and Toledo		
Member benefits*	Network care designated provider	Network care nondesignated providers	Out-of-network care	Network care designated provider	Network care nondesignated providers	Out-of-network care
Calendar year deductible	$4,000/$8,000	$5,000/$10,000	$15,000/$30,000	$5,000/$10,000	$6,000/$12,000	$18,000/$36,000
Calendar year out-of-pocket limit	$6,000/$12,000	$6,600/$13,200	$19,800/$39,600	$6,450/$12,900	$6,450/$12,900	$19,350/$38,700
Deductible & out-of-pocket limit accumulation[1]	Embedded			Embedded		
Primary care physician office visit	$40 copay; deductible waived	40% after deductible	50% after deductible	Covered in full after deductible	20% after deductible	50% after deductible
Specialist office visit	$60 copay; deductible waived	40% after deductible	50% after deductible	Covered in full after deductible	20% after deductible	50% after deductible
Walk-in clinics	$40 copay; deductible waived	Paid at the designated level	50% after deductible	Covered in full after deductible	Paid at the designated level	50% after deductible
Diagnostic testing: Lab	$40 copay; deductible waived	Paid at the designated level	50% after deductible	Covered in full after deductible	Paid at the designated level	50% after deductible
Diagnostic testing: X-ray	$60 copay; deductible waived	40% after deductible	50% after deductible	Covered in full after deductible	20% after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	20% after deductible	40% after deductible	50% after deductible	Covered in full after deductible	20% after deductible	50% after deductible
Inpatient hospital facility	20% after deductible	40% after deductible	50% after deductible	Covered in full after deductible	20% after deductible	50% after deductible
Outpatient surgery	20% after deductible	40% after deductible	50% after deductible	Covered in full after deductible	20% after deductible	50% after deductible
Emergency room	$350 copay; deductible waived	Paid at the network care designated level	Paid at the network care designated level	Covered in full after deductible	Paid at the network care designated level	Paid at the network care designated level
Urgent care	$75 copay; deductible waived	40% after deductible	50% after deductible	Covered in full after deductible	20% after deductible	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	20% after deductible	Paid at the designated level	50% after deductible	Covered in full after deductible	Paid at the designated level	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year	20% after deductible	Paid at the designated level	50% after deductible	Covered in full after deductible	Paid at the designated level	50% after deductible
Pharmacy**	Network		Out of network	Network		Out of network
Pharmacy deductible	None		None	Integrated with medical deductible		Integrated with medical deductible
Preferred generic drugs***	T1A-$3 copay T1-$10 copay		T1A-$3 copay plus 30% T1-$10 copay plus 30%	T1A-$3 copay after deductible T1-$10 copay after deductible		T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible
Preferred brand drugs	$50 copay		$50 copay plus 30%	$50 copay after deductible		$50 copay plus 30% after deductible
Nonpreferred drugs†	$90 copay		$90 copay plus 30%	$90 copay after deductible		$90 copay plus 30% after deductible
Specialty drugs††	P: 30% up to $250 NP: 40% up to $400		Not covered	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible		Not covered

Refer to page 36 for footnotes.

Saving Plus plans

Plan name	OH Bronze SP HNOpt 5000 100/50 HSA TIF Metallic Level: Bronze			OH Silver SP HNOption 5000 80/50 Metallic Level: Silver		
Networks	Cincinnati, Cleveland and Toledo			Cincinnati, Cleveland and Toledo		
Member benefits*	Network care designated provider	Network care nondesignated providers	Out-of-network care	Network care designated provider	Network care nondesignated providers	Out-of-network care
Calendar year deductible	$5,000/$10,000	$6,000/$12,000	$18,000/$36,000	$5,000/$10,000	$5,500/$11,000	$16,500/$33,000
Calendar year out-of-pocket limit	$6,450/$12,900	$6,450/$12,900	$19,350/$38,700	$6,000/$12,000	$6,600/$13,200	$19,800/$39,600
Deductible & out-of-pocket limit accumulation[1]	True integrated family (TIF)			Embedded		
Primary care physician office visit	Covered in full after deductible	20% after deductible	50% after deductible	$40 copay; deductible waived	40% after deductible	50% after deductible
Specialist office visit	Covered in full after deductible	20% after deductible	50% after deductible	$60 copay; deductible waived	40% after deductible	50% after deductible
Walk-in clinics	Covered in full after deductible	Paid at the designated level	50% after deductible	$40 copay; deductible waived	Paid at the designated level	50% after deductible
Diagnostic testing: Lab	Covered in full after deductible	Paid at the designated level	50% after deductible	$40 copay; deductible waived	Paid at the designated level	50% after deductible
Diagnostic testing: X-ray	Covered in full after deductible	20% after deductible	50% after deductible	$60 copay; deductible waived	40% after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	Covered in full after deductible	20% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Inpatient hospital facility	Covered in full after deductible	20% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Outpatient surgery	Covered in full after deductible	20% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Emergency room	Covered in full after deductible	Paid at the network care designated level	Paid at the network care designated level	$350 copay; deductible waived	Paid at the network care designated level	Paid at the network care designated level
Urgent care	Covered in full after deductible	20% after deductible	50% after deductible	$75 copay; deductible waived	40% after deductible	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	Covered in full after deductible	Paid at the designated level	50% after deductible	20% after deductible	Paid at the designated level	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year	Covered in full after deductible	Paid at the designated level	50% after deductible	20% after deductible	Paid at the designated level	50% after deductible
Pharmacy**	Network		Out of network	Network		Out of network
Pharmacy deductible	Integrated with medical deductible		Integrated with medical deductible	None		None
Preferred generic drugs***	T1A-$3 copay after deductible T1-$10 copay after deductible		T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible	T1A-$3 copay T1-$10 copay		T1A-$3 copay plus 30% T1-$10 copay plus 30%
Preferred brand drugs	$50 copay after deductible		$50 copay plus 30% after deductible	$50 copay		$50 copay plus 30%
Nonpreferred drugs†	$90 copay after deductible		$90 copay plus 30% after deductible	$90 copay		$90 copay plus 30%
Specialty drugs††	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible		Not covered	P: 30% up to $250 NP: 40% up to $400		Not covered

Refer to page 36 for footnotes.

Saving Plus plans

Plan name	OH Bronze SP HNOpt 5000 80/50 HSA EMB Metallic Level: Bronze			OH Bronze SP HNOption 5500 80/50 (Integ) Metallic Level: Bronze		
Networks	Cincinnati, Cleveland and Toledo			Cincinnati, Cleveland and Toledo		
Member benefits*	Network care designated provider	Network care nondesignated providers	Out-of-network care	Network care designated provider	Network care nondesignated providers	Out-of-network care
Calendar year deductible	$5,000/$10,000	$6,000/$12,000	$18,000/$36,000	$5,500/$11,000	$6,000/$12,000	$18,000/$36,000
Calendar year out-of-pocket limit	$6,450/$12,900	$6,450/$12,900	$19,350/$38,700	$6,600/$13,200	$6,600/$13,200	$19,800/$39,600
Deductible & out-of-pocket limit accumulation[1]	Embedded			Embedded		
Primary care physician office visit	20% after deductible	40% after deductible	50% after deductible	$40 copay; deductible waived	40% after deductible	50% after deductible
Specialist office visit	20% after deductible	40% after deductible	50% after deductible	$75 copay after deductible	40% after deductible	50% after deductible
Walk-in clinics	20% after deductible	Paid at the designated level	50% after deductible	$40 copay; deductible waived	Paid at the designated level	50% after deductible
Diagnostic testing: Lab	20% after deductible	Paid at the designated level	50% after deductible	$40 copay after deductible	Paid at the designated level	50% after deductible
Diagnostic testing: X-ray	20% after deductible	40% after deductible	50% after deductible	$75 copay after deductible	40% after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	20% after deductible	40% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Inpatient hospital facility	20% after deductible	40% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Outpatient surgery	20% after deductible	40% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Emergency room	20% after deductible	Paid at the network care designated level	Paid at the network care designated level	$750 copay after deductible	Paid at the network care designated level	Paid at the network care designated level
Urgent care	20% after deductible	40% after deductible	50% after deductible	$75 copay; deductible waived	40% after deductible	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	20% after deductible	Paid at the designated level	50% after deductible	20% after deductible	Paid at the designated level	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year	20% after deductible	Paid at the designated level	50% after deductible	20% after deductible	Paid at the designated level	50% after deductible
Pharmacy**	Network		Out of network	Network		Out of network
Pharmacy deductible	Integrated with medical deductible		Integrated with medical deductible	Integrated with medical deductible; waived for generic drugs.		Integrated with medical deductible; waived for generic drugs.
Preferred generic drugs***	T1A-$3 copay after deductible T1-$10 copay after deductible		T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible	T1A-$3 copay; deductible waived T1-$10 copay; deductible waived		T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible
Preferred brand drugs	$50 copay after deductible		$50 copay plus 30% after deductible	$50 copay after deductible		$50 copay plus 30% after deductible
Nonpreferred drugs†	$90 copay after deductible		$90 copay plus 30% after deductible	$90 copay after deductible		$90 copay plus 30% after deductible
Specialty drugs††	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible		Not covered	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible		Not covered

Refer to page 36 for footnotes.

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Footnotes

All services are subject to the deductible unless noted otherwise.

Some benefits are subject to age and frequency schedules, limitations or visit maximums.

Members or providers may be required to precertify or obtain approval for certain services.

[1]Embedded – No one family member may contribute more than the individual deductible/out-of-pocket limit amount to the family deductible/out-of-pocket limit. Once the family deductible/out-of-pocket limit is met, all family members will be considered as having met their deductible/out-of-pocket limit for the remainder of the calendar year.

TIF – The individual deductible/out-of-pocket limit can only be met when a member is enrolled for self-only coverage with no dependent coverage. The family deductible/out-of-pocket limit can be met by a combination of family members or by any single individual within the family. Once the family deductible/out-of-pocket limit is met, all family members will be considered as having met their deductible/out-of-pocket limit for the remainder of the calendar year.

[2]Benefit limits are combined between network care designated providers, network care non-designated providers and out of network care.

*How we pay out-of-network providers:
We cover the cost of services based on whether doctors are "in network" or "out of network."

Members may choose a provider (doctor or hospital) in our network. They may choose to visit an out-of-network provider. When members choose a doctor who is out of network, the Aetna health plan may pay some of that doctor's bill. Most of the time, members will pay a lot more money out of pocket if they choose to use an out-of-network doctor or hospital.

When members choose out-of-network care, the plan limits the amount it will pay. This limit is called the "recognized" or "allowed" amount. Those amounts are:

Professional Services: 100% of Medicare

Facility Services: 100% of Medicare

Out-of-network doctors set their own rates. It may be higher — sometimes much higher — than what the Aetna plan "recognizes." Out-of-network doctors may bill for the dollar amount that the plan doesn't "recognize." Members must also pay any copayments, coinsurance and deductibles under the plan. No dollar amount above the "recognized charge" counts toward the deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit **www.aetna.com**. Type "how Aetna pays" in the search box.

Members can avoid these extra costs by getting care from our broad network of health care providers. Go to **www.aetna.com** and click on "Find a Doctor" on the left side of the page. Existing members may sign on to their Aetna Navigator member site.

This applies when members choose to get care out of network. When they have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if they received care in network. Members pay cost sharing and deductibles for the in-network level of benefits. Contact us if a health care provider asks for more. Members are not responsible for any outstanding balance billed by providers for emergency services beyond the cost sharing and deductibles.

**If the physician prescribes or the member requests a covered brand-name prescription drug when a generic prescription drug equivalent is available, the member will pay the difference in cost between the brand-name prescription drug and the generic prescription drug equivalent plus the applicable cost sharing. The cost difference between the generic and brand does not count toward the out of pocket limit.

Not all drugs are covered. It is important to look at the Preferred Drug List (Aetna Value Plus Formulary) to understand which drugs are covered.

***T1A=Value drugs; T1=Preferred generic drugs.

†Includes nonpreferred generic and brand drugs.

††P=Preferred specialty drugs; NP=Nonpreferred specialty drugs.

Note: For a summary list of limitations and exclusions, refer to page 66. Please refer to our Producer World® website at **www.aetna.com** for specific Summary of Benefits and Coverage documents. Or for more information, please contact your licensed agent or Aetna sales representative.

PPO plans

Plan name	OH Gold PPO 1000 100/50 Metallic Level: Gold		OH Gold PPO 1000 80/50 Metallic Level: Gold	
Member benefits*	Network care	Out-of-network care	Network care	Out-of-network care
Calendar year deductible	$1,000/$2,000	$3,000/$6,000	$1,000/$2,000	$3,000/$6,000
Calendar year out-of-pocket limit	$4,000/$8,000	$12,000/$24,000	$3,500/$7,000	$10,500/$21,000
Deductible & out-of-pocket limit accumulation[1]	Embedded		Embedded	
Primary care physician office visit	$25 copay; deductible waived	50% after deductible	$20 copay; deductible waived	50% after deductible
Specialist office visit	$50 copay; deductible waived	50% after deductible	$50 copay; deductible waived	50% after deductible
Walk-in clinics	$25 copay; deductible waived	50% after deductible	$20 copay; deductible waived	50% after deductible
Diagnostic testing: Lab	Covered in full after deductible	50% after deductible	20% after deductible	50% after deductible
Diagnostic testing: X-ray	Covered in full after deductible	50% after deductible	20% after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	Covered in full after deductible	50% after deductible	20% after deductible	50% after deductible
Inpatient hospital facility	$500 copay per admission after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient surgery	$250 copay after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency room	$350 copay; deductible waived	Paid as network care	$200 copay; deductible waived	Paid as network care
Urgent care	$75 copay; deductible waived	50% after deductible	$75 copay; deductible waived	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	Covered in full after deductible	50% after deductible	20% after deductible	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year	Covered in full after deductible	50% after deductible	20% after deductible	50% after deductible
Pharmacy**	Network	Out of network	Network	Out of network
Pharmacy deductible	None	None	None	None
Preferred generic drugs***	T1A-$3 copay T1-$10 copay	T1A-$3 copay plus 30% T1-$10 copay plus 30%	T1A-$3 copay T1-$10 copay	T1A-$3 copay plus 30% T1-$10 copay plus 30%
Preferred brand drugs	$50 copay	$50 copay plus 30%	$50 copay	$50 copay plus 30%
Nonpreferred drugs†	$90 copay	$90 copay plus 30%	$90 copay	$90 copay plus 30%
Specialty drugs††	P: 30% up to $250 NP: 40% up to $400	P: 30% up to $250 NP: 40% up to $400	P: 30% up to $250 NP: 40% up to $400	P: 30% up to $250 NP: 40% up to $400

Refer to page 41 for footnotes.

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PPO plans

Plan name	OH Silver PPO 2000 80/50 Metallic Level: Silver		OH Silver PPO 4000 80/50 Metallic Level: Silver	
Member benefits*	Network care	Out-of-network care	Network care	Out-of-network care
Calendar year deductible	$2,000/$4,000	$6,000/$12,000	$4,000/$8,000	$12,000/$24,000
Calendar year out-of-pocket limit	$6,000/$12,000	$18,000/$36,000	$6,600/$13,200	$19,800/$39,600
Deductible & out-of-pocket limit accumulation[1]	Embedded		Embedded	
Primary care physician office visit	$40 copay; deductible waived	50% after deductible	$40 copay; deductible waived	50% after deductible
Specialist office visit	$60 copay; deductible waived	50% after deductible	$60 copay; deductible waived	50% after deductible
Walk-in clinics	$40 copay; deductible waived	50% after deductible	$40 copay; deductible waived	50% after deductible
Diagnostic testing: Lab	$40 copay; deductible waived	50% after deductible	$40 copay; deductible waived	50% after deductible
Diagnostic testing: X-ray	$60 copay; deductible waived	50% after deductible	$60 copay; deductible waived	50% after deductible
Imaging (CT/PET scans, MRIs)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Inpatient hospital facility	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient surgery	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency room	20% after deductible	Paid as network care	$350 copay; deductible waived	Paid as network care
Urgent care	$75 copay; deductible waived	50% after deductible	$75 copay; deductible waived	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Pharmacy**	Network	Out of network	Network	Out of network
Pharmacy deductible	None	None	None	None
Preferred generic drugs***	T1A-$3 copay T1-$10 copay	T1A-$3 copay plus 30% T1-$10 copay plus 30%	T1A-$3 copay T1-$10 copay	T1A-$3 copay plus 30% T1-$10 copay plus 30%
Preferred brand drugs	$50 copay	$50 copay plus 30%	$50 copay	$50 copay plus 30%
Nonpreferred drugs†	$90 copay	$90 copay plus 30%	$90 copay	$90 copay plus 30%
Specialty drugs††	P: 30% up to $250 NP: 40% up to $400	P: 30% up to $250 NP: 40% up to $400	P: 30% up to $250 NP: 40% up to $400	P: 30% up to $250 NP: 40% up to $400

Refer to page 41 for footnotes.

PPO plans

Plan name	OH Silver PPO 2600 100/50 HSA TIF Metallic Level: Silver		OH Bronze PPO 5000 100/50 HSA EMB Metallic Level: Bronze	
Member benefits*	Network care	Out-of-network care	Network care	Out-of-network care
Calendar year deductible	$2,600/$5,200	$7,800/$15,600	$5,000/$10,000	$15,000/$30,000
Calendar year out-of-pocket limit	$5,200/$10,400	$15,600/$31,200	$6,450/$12,900	$19,350/$38,700
Deductible & out-of-pocket limit accumulation[1]	True integrated family (TIF)		Embedded	
Primary care physician office visit	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Specialist office visit	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Walk-in clinics	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Diagnostic testing: Lab	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Diagnostic testing: X-ray	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Inpatient hospital facility	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Outpatient surgery	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Emergency room	Covered in full after deductible	Paid as network care	Covered in full after deductible	Paid as network care
Urgent care	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
Pharmacy**	Network	Out of network	Network	Out of network
Pharmacy deductible	Integrated with medical deductible	Integrated with medical deductible	Integrated with medical deductible	Integrated with medical deductible
Preferred generic drugs***	T1A-$3 copay after deductible T1-$10 copay after deductible	T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible	T1A-$3 copay after deductible T1-$10 copay after deductible	T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible
Preferred brand drugs	$50 copay after deductible	$50 copay plus 30% after deductible	$50 copay after deductible	$50 copay plus 30% after deductible
Nonpreferred drugs†	$90 copay after deductible	$90 copay plus 30% after deductible	$90 copay after deductible	$90 copay plus 30% after deductible
Specialty drugs††	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible

Refer to page 41 for footnotes.

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PPO plans

Plan name	OH Bronze PPO 6200 100/50 HSA EMB Metallic Level: Bronze	
Member benefits*	Network care	Out-of-network care
Calendar year deductible	$6,200/$12,400	$18,600/$37,200
Calendar year out-of-pocket limit	$6,450/$12,900	$19,350/$38,700
Deductible & out-of-pocket limit accumulation[1]	Embedded	
Primary care physician office visit	Covered in full after deductible	50% after deductible
Specialist office visit	Covered in full after deductible	50% after deductible
Walk-in clinics	Covered in full after deductible	50% after deductible
Diagnostic testing: Lab	Covered in full after deductible	50% after deductible
Diagnostic testing: X-ray	Covered in full after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	Covered in full after deductible	50% after deductible
Inpatient hospital facility	Covered in full after deductible	50% after deductible
Outpatient surgery	Covered in full after deductible	50% after deductible
Emergency room	Covered in full after deductible	Paid as network care
Urgent care	Covered in full after deductible	50% after deductible
Rehabilitation services (PT/OT/ST)[2] Coverage is limited to 20 visits each PT, OT & ST per calendar year.	Covered in full after deductible	50% after deductible
Chiropractic[2] Coverage is limited to 12 visits per calendar year	Covered in full after deductible	50% after deductible
Pharmacy**	Network	Out of network
Pharmacy deductible	Integrated with medical deductible	Integrated with medical deductible
Preferred generic drugs***	T1A-$3 copay after deductible T1-$10 copay after deductible	T1A-$3 copay plus 30% after deductible T1-$10 copay plus 30% after deductible
Preferred brand drugs	$50 copay after deductible	$50 copay plus 30% after deductible
Nonpreferred drugs†	$90 copay after deductible	$90 copay plus 30% after deductible
Specialty drugs††	P: 30% up to $250 after deductible NP: 40% up to $400 after deductible	50% after deductible

Refer to page 41 for footnotes.

Footnotes

All services are subject to the deductible unless noted otherwise.

Some benefits are subject to age and frequency schedules, limitations or visit maximums.

Members or providers may be required to precertify or obtain approval for certain services.

[1]Embedded – No one family member may contribute more than the individual deductible/out-of-pocket limit amount to the family deductible/out-of-pocket limit. Once the family deductible/out-of-pocket limit is met, all family members will be considered as having met their deductible/out-of-pocket limit for the remainder of the calendar year.

TIF – The individual deductible/out-of-pocket limit can only be met when a member is enrolled for self-only coverage with no dependent coverage. The family deductible/out-of-pocket limit can be met by a combination of family members or by any single individual within the family. Once the family deductible/out-of-pocket limit is met, all family members will be considered as having met their deductible/out-of-pocket limit for the remainder of the calendar year.

[2]Benefit limits are combined between network and out-of-network care.

*How we pay out-of-network providers: We cover the cost of services based on whether doctors are "in network" or "out of network."

Members may choose a provider (doctor or hospital) in our network. They may choose to visit an out-of-network provider. When members choose a doctor who is out of network, the Aetna health plan may pay some of that doctor's bill. Most of the time, members will pay a lot more money out of pocket if they choose to use an out-of-network doctor or hospital.

When members choose out-of-network care, the plan limits the amount it will pay. This limit is called the "recognized" or "allowed" amount. Those amounts are:

Professional Services: 100% of Medicare

Facility Services: 100% of Medicare

Out-of-network doctors set their own rates. It may be higher — sometimes much higher — than what the Aetna plan "recognizes." Out-of-network doctors may bill for the dollar amount that the plan doesn't "recognize." Members must also pay any copayments, coinsurance and deductibles under the plan. No dollar amount above the "recognized charge" counts toward the deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit **www.aetna.com**. Type "how Aetna pays" in the search box.

Members can avoid these extra costs by getting care from our broad network of health care providers. Go to **www.aetna.com** and click on "Find a Doctor" on the left side of the page. Existing members may sign on to their Aetna Navigator member site.

This applies when members choose to get care out of network. When they have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if they received care in network. Members pay cost sharing and deductibles for the in-network level of benefits. Contact us if a health care provider asks for more. Members are not responsible for any outstanding balance billed by providers for emergency services beyond the cost sharing and deductibles.

**If the physician prescribes or the member requests a covered brand-name prescription drug when a generic prescription drug equivalent is available, the member will pay the difference in cost between the brand-name prescription drug and the generic prescription drug equivalent plus the applicable cost sharing. The cost difference between the generic and brand does not count toward the out of pocket limit.

Not all drugs are covered. It is important to look at the Preferred Drug List (Aetna Value Plus Formulary) to understand which drugs are covered.

***T1A=Value drugs; T1=Preferred generic drugs.

†Includes nonpreferred generic and brand drugs.

††P=Preferred specialty drugs; NP=Nonpreferred specialty drugs.

Note: For a summary list of limitations and exclusions, refer to page 66. Please refer to our Producer World® website at **www.aetna.com** for specific Summary of Benefits and Coverage documents. Or for more information, please contact your licensed agent or Aetna sales representative.

M

Indemnity plan

Plan name	OH Silver Indemnity 2000 80% Metallic Level: Silver	
Member benefits		
Calendar year deductible	$2,000/$4,000	
Calendar year out-of-pocket limit	$6,000/$12,000	
Deductible & out-of-pocket limit accumulation[1]	Embedded	
Primary care physician office visit	20% after deductible	
Specialist office visit	20% after deductible	
Walk-in clinics	Not covered	
Diagnostic testing: Lab	20% after deductible	
Diagnostic testing: X-ray	20% after deductible	
Imaging (CT/PET scans, MRIs)	20% after deductible	
Inpatient hospital facility	20% after deductible	
Outpatient surgery	20% after deductible	
Emergency room	20% after deductible	
Urgent care	20% after deductible	
Rehabilitation services (PT/OT/ST) Coverage is limited to 20 visits each PT, OT & ST per calendar year.	20% after deductible	
Chiropractic Coverage is limited to 12 visits per calendar year	20% after deductible	
Pharmacy*	Network	Out of network
Pharmacy deductible	None	None
Preferred generic drugs**	T1A-$3 copay T1-$10 copay	T1A-$3 copay T1-$10 copay
Preferred brand drugs	$50 copay	$50 copay
Nonpreferred drugs***	$90 copay	$90 copay
Specialty drugs†	P: 30% up to $250 NP: 40% up to $400	P: 30% up to $250 NP: 40% up to $400

Refer to page 43 for footnotes.

Footnotes

M

All services are subject to the deductible unless noted otherwise.

Some benefits are subject to age and frequency schedules, limitations or visit maximums.

Members or providers may be required to precertify or obtain approval for certain services.

[1]Embedded – No one family member may contribute more than the individual deductible/out-of-pocket limit amount to the family deductible/out-of-pocket limit. Once the family deductible/out-of-pocket limit is met, all family members will be considered as having met their deductible/out-of-pocket limit for the remainder of the calendar year.

*If the physician prescribes or the member requests a covered brand-name prescription drug when a generic prescription drug equivalent is available, the member will pay the difference in cost between the brand-name prescription drug and the generic prescription drug equivalent plus the applicable cost sharing. The cost difference between the generic and brand does not count toward the out of pocket limit.

Not all drugs are covered. It is important to look at the Preferred Drug List (Aetna Value Plus Formulary) to understand which drugs are covered.

**T1A=Value drugs; T1=Preferred generic drugs.

***Includes nonpreferred generic and brand drugs.

†P=Preferred specialty drugs; NP=Nonpreferred specialty drugs.

Note: For a summary list of limitations and exclusions, refer to page 66. Please refer to our Producer World® website at **www.aetna.com** for specific Summary of Benefits and Coverage documents. Or for more information, please contact your licensed agent or Aetna sales representative.

Aetna dental plans

Dental coverage is sure to put a smile on your employees' faces. Our affordable plan design options make it possible for you to add this valuable benefit to your package.

Dental
overview

The Mouth Matters℠

Research suggests that serious gum disease, known as periodontitis, may be associated with many health problems. This is especially true if gum disease continues without treatment.[1] Now, here's the good news. Researchers are discovering that a healthy mouth may be important to your overall health.[1]

The Aetna Dental/Medical Integration℠ program* is available at no additional charge when you have both medical and dental coverage with us. The program focuses on those who are pregnant or have diabetes, coronary artery disease (heart disease) or cerebrovascular disease (stroke) and have not had a recent dental visit. We proactively educate those at-risk members about the impact oral health care can have on their condition. Our member outreach has been proven to successfully motivate those at-risk members who do not normally seek dental care to visit the dentist. Once at the dentist, these at-risk members will receive enhanced dental benefits including an extra cleaning and full coverage for certain periodontal services.

The Dental Maintenance Organization (DMO®)

Members select a primary care dentist to coordinate their care from the available managed dental network. Each family member may choose a different primary care dentist and may switch dentists at any time on Aetna Navigator or with a call to Member Services. If specialty care is needed, the primary care dentist can refer the member to a participating specialist. However, members may visit orthodontists without a referral. There are virtually no claim forms to file, and benefits are not subject to deductibles or annual maximums.

Preferred Provider Organization (PPO) plan

Members can choose a dentist who participates in the network or choose a licensed dentist who does not. Participating dentists have agreed to offer our members covered services at a negotiated rate and will not bill members for amounts over the plan's "allowed" charge.

PPO Max plan

While the PPO Max dental insurance plan uses the PPO network, when members use out-of-network dentists the service will be covered based on the PPO fee schedule, rather than the usual and prevailing charge. The member will share in more of the costs and non-network dentists may bill members for amounts above the fee schedule. This plan offers members a quality dental insurance plan with a significantly lower premium that encourages in-network usage.

Freedom-of-Choice plan design option

Get maximum flexibility with our two-in-one dental plan design. The Freedom-of-Choice plan design option provides the administrative ease of one plan, yet members get to choose between the DMO and PPO plans on a monthly basis. One blended rate is paid. Members may switch between the plans on a monthly basis by calling Member Services. Plan changes must be made by the 15th of the month to be effective the following month.

Dual option** plan

In the dual option plan design, the DMO must be packaged with any one of the PPO plans. Employees may choose between the DMO and PPO offerings at annual enrollment.

Voluntary dental option

The voluntary dental option provides a solution to meet the individual needs of members in the face of rising health care costs. Administration is easy, and members benefit from low group rates and the convenience of payroll deductions.

Aetna Dental Preventive Care℠ plan

The Aetna Dental Preventive Care plan is a lower cost dental plan that covers preventive and diagnostic procedures. Members pay nothing for these services when visiting an Aetna PPO dentist.

[1] **MayoClinic.com**. "Oral health: A window to your overall health." **www.mayoclinic.com/health/dental/DE00001**. February 5, 2011. Accessed July 2014.

*DMI may not be available in all states.

**Dual option does not apply to preventive plans.

D

Standard dental plans 2 – 9

	Option 1 DMO Access	Option 2 Freedom-of-Choice — Monthly selection between the DMO and the PPO Max		Option 3 PPO Max 1000	Option 4 PPO Max 1500
	DMO plan 42 (DMO Access)	DMO plan 100/90/60	PPO Max plan 100/70/40	PPO Max plan 100/50/50	PPO Max plan 100/80/50
Office visit copay	$10	$5	N/A	N/A	N/A
Annual deductible per member (does not apply to diagnostic and preventive services)	None	None	$50; 3X family maximum	$50; 3X family maximum	$50; 3X family maximum
Annual maximum benefit	Unlimited	Unlimited	$1,000	$1,000	$1,500
Diagnostic services					
Oral exams					
Periodic oral exam	No charge	100%	100%	100%	100%
Comprehensive oral exam	No charge	100%	100%	100%	100%
Problem-focused oral exam	No charge	100%	100%	100%	100%
X-rays					
Bitewing – single film	No charge	100%	100%	100%	100%
Complete series	No charge	100%	100%	100%	100%
Preventive services					
Adult cleaning	No charge	100%	100%	100%	100%
Child cleaning	No charge	100%	100%	100%	100%
Sealants – per tooth	$10	100%	100%	100%	100%
Fluoride application – child	No charge	100%	100%	100%	100%
Space maintainers	$100	100%	100%	100%	100%
Basic services					
Amalgam filling – 2 surfaces	$32	90%	70%	50%	80%
Resin filling – 2 surfaces, anterior	$55	90%	70%	50%	80%
Oral surgery					
Extraction – exposed root or erupted tooth	$30	90%	70%	50%	80%
Extraction of impacted tooth – soft tissue	$80	90%	70%	50%	80%
Major services*					
Complete upper denture	$500	60%	40%	50%	50%
Partial upper denture (resin base)	$513	60%	40%	50%	50%
Crown – porcelain with noble metal[1]	$488	60%	40%	50%	50%
Pontic – porcelain with noble metal[1]	$488	60%	40%	50%	50%
Inlay – metallic (3 or more surfaces)	$463	60%	40%	50%	50%
Oral surgery					
Removal of impacted tooth – partially bony	$175**	60%	40%	50%	80%
Endodontic services					
Bicuspid root canal therapy	$195	90%	40%	50%	80%
Molar root canal therapy	$435**	60%	40%	50%	80%
Periodontic services					
Scaling and root planing – per quadrant	$65	90%	40%	50%	80%
Osseous surgery – per quadrant	$445**	60%	40%	50%	80%
Orthodontic services	Not covered	Not covered	Not covered	Not covered	Not covered
Orthodontic lifetime maximum	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply

Refer to page 52 for footnotes.

Standard dental plans 2 – 9

	Option 5 Freedom-of-Choice — Monthly selection between the DMO and the PPO		**Option 6 Active PPO Plan**		**Option 7 PPO 1500**	**Option 8 Aetna Dental Preventive Care℠ PPO Max**
	DMO plan 100/90/60	PPO plan 100/70/40 (90th OON)	Preferred plan 100/80/50	Nonpreferred plan 80/60/40 (90th OON)	PPO plan 100/80/50 (90th OON)	PPO Max 100/0/0
Office visit copay	$10	N/A	N/A	N/A	N/A	N/A
Annual deductible per member (does not apply to diagnostic and preventive services)	None	$50; 3X family maximum	$50; 3X family maximum	$50; 3X family maximum	$50; 3X family maximum	None
Annual maximum benefit	Unlimited	$1,000	$1,500	$1,000	$1,500	Unlimited
Diagnostic services						
Oral exams						
Periodic oral exam	100%	100%	100%	80%	100%	100%
Comprehensive oral exam	100%	100%	100%	80%	100%	100%
Problem-focused oral exam	100%	100%	100%	80%	100%	100%
X-rays						
Bitewing – single film	100%	100%	100%	80%	100%	100%
Complete series	100%	100%	100%	80%	100%	100%
Preventive services						
Adult cleaning	100%	100%	100%	80%	100%	100%
Child cleaning	100%	100%	100%	80%	100%	100%
Sealants – per tooth	100%	100%	100%	80%	100%	100%
Fluoride application – child	100%	100%	100%	80%	100%	100%
Space maintainers	100%	100%	100%	80%	100%	100%
Basic services						
Amalgam filling – 2 surfaces	90%	70%	80%	60%	80%	Not covered
Resin filling – 2 surfaces, anterior	90%	70%	80%	60%	80%	Not covered
Oral surgery						
Extraction – exposed root or erupted tooth	90%	70%	80%	60%	80%	Not covered
Extraction of impacted tooth – soft tissue	90%	70%	80%	60%	80%	Not covered
Major services*						
Complete upper denture	60%	40%	50%	40%	50%	Not covered
Partial upper denture (resin base)	60%	40%	50%	40%	50%	Not covered
Crown – porcelain with noble metal[1]	60%	40%	50%	40%	50%	Not covered
Pontic – porcelain with noble metal[1]	60%	40%	50%	40%	50%	Not covered
Inlay – metallic (3 or more surfaces)	60%	40%	50%	40%	50%	Not covered
Oral surgery						
Removal of impacted tooth – partially bony	60%	40%	50%	40%	50%	Not covered
Endodontic services						
Bicuspid root canal therapy	90%	40%	50%	40%	50%	Not covered
Molar root canal therapy	60%	40%	50%	40%	50%	Not covered
Periodontic services						
Scaling and root planing – per quadrant	90%	40%	50%	40%	50%	Not covered
Osseous surgery – per quadrant	60%	40%	50%	40%	50%	Not covered
Orthodontic services	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Orthodontic lifetime maximum	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply

Refer to page 52 for footnotes.

D

Voluntary dental plans 3 – 9

	Voluntary Option 1 DMO Access	Voluntary Option 2 Freedom-of-Choice — Monthly selection between the DMO and the PPO		Voluntary Option 3 PPO Max	Voluntary Option 4 Aetna Dental Preventive Care[SM] PPO Max
	DMO plan 42	DMO plan 100/90/60	PPO plan 100/70/40	PPO Max plan 100/80/50	PPO Max 100/0/0
Office visit copay	$15	$10	N/A	N/A	N/A
Annual deductible per member (does not apply to diagnostic and preventive services)	None	None	$75; 3X family maximum	$75; 3X family maximum	None
Annual maximum benefit	Unlimited	Unlimited	$1,000	$1,500	Unlimited
Diagnostic services					
Oral exams					
Periodic oral exam	No charge	100%	100%	100%	100%
Comprehensive oral exam	No charge	100%	100%	100%	100%
Problem-focused oral exam	No charge	100%	100%	100%	100%
X-rays					
Bitewing – single film	No charge	100%	100%	100%	100%
Complete series	No charge	100%	100%	100%	100%
Preventive services					
Adult cleaning	No charge	100%	100%	100%	100%
Child cleaning	No charge	100%	100%	100%	100%
Sealants – per tooth	$10	100%	100%	100%	100%
Fluoride application – child	No charge	100%	100%	100%	100%
Space maintainers	$100	100%	100%	100%	100%
Basic services					
Amalgam filling – 2 surfaces	$32	90%	70%	80%	Not covered
Resin filling – 2 surfaces, anterior	$55	90%	70%	80%	Not covered
Oral surgery					
Extraction – exposed root or erupted tooth	$30	90%	70%	80%	Not covered
Extraction of impacted tooth – soft tissue	$80	90%	70%	80%	Not covered
Major services*					
Complete upper denture	$500	60%	40%	50%	Not covered
Partial upper denture (resin base)	$513	60%	40%	50%	Not covered
Crown – porcelain with noble metal[1]	$488	60%	40%	50%	Not covered
Pontic – porcelain with noble metal[1]	$488	60%	40%	50%	Not covered
Inlay – metallic (3 or more surfaces)	$463	60%	40%	50%	Not covered
Oral surgery					
Removal of impacted tooth – partially bony	$175**	60%	40%	50%	Not covered
Endodontic services					
Bicuspid root canal therapy	$195	90%	40%	50%	Not covered
Molar root canal therapy	$435**	60%	40%	50%	Not covered
Periodontic services					
Scaling and root planing – per quadrant	$65	90%	40%	50%	Not covered
Osseous surgery – per quadrant	$445**	60%	40%	50%	Not covered
Orthodontic services	Not covered	Not covered	Not covered	Not covered	Not covered
Orthodontic lifetime maximum	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply

Refer to page 52 for footnotes.

Standard and voluntary dental plan selections 10–50

	Option 1A DMO Coinsurance	Option 2A Freedom-of-Choice – PPO Max — Monthly selection between the DMO and the PPO Max		Option 3A Freedom-of-Choice – PPO 90th — Monthly selection between the DMO and the PPO	
	DMO plan 100/100/60	DMO plan 100/100/60	PPO plan Max 100/80/50	DMO plan 100/100/60	100/90/60 (90th OON)
Office visit copay	$5	$5	N/A	$5	N/A
Annual deductible per member (does not apply to diagnostic and preventive services)	None	None	$50; 3X family maximum	None	$50; 3X family maximum
Annual maximum benefit	Unlimited	Unlimited	$1,000	Unlimited	$1,500
Diagnostic services					
Oral exams					
Periodic oral exam	100%	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%	100%
X-rays					
Bitewing – single film	100%	100%	100%	100%	100%
Complete series	100%	100%	100%	100%	100%
Preventive services					
Adult cleaning	100%	100%	100%	100%	100%
Child cleaning	100%	100%	100%	100%	100%
Sealants – per tooth	100%	100%	100%	100%	100%
Fluoride application – child	100%	100%	100%	100%	100%
Space maintainers	100%	100%	100%	100%	100%
Basic services					
Amalgam filling – 2 surfaces	100%	100%	80%	100%	90%
Resin filling – 2 surfaces, anterior	100%	100%	80%	100%	90%
Endodontic services					
Bicuspid root canal therapy	100%	100%	80%	100%	90%
Periodontic services					
Scaling & root planing – per quadrant	100%	100%	80%	100%	90%
Oral surgery					
Extraction – exposed root or erupted tooth	100%	100%	80%	100%	90%
Extraction of impacted tooth – soft tissue	100%	100%	80%	100%	90%
Major services					
Complete upper denture	60%	60%	50%	60%	60%
Partial upper denture (resin base)	60%	60%	50%	60%	60%
Crown – porcelain with noble metal	60%	60%	50%	60%	60%
Pontic – porcelain with noble metal	60%	60%	50%	60%	60%
Inlay – metallic (3 or more surfaces)	60%	60%	50%	60%	60%
Oral surgery					
Removal of impacted tooth – partially bony	60%	60%	80%	60%	90%
Endodontic services					
Molar root canal therapy	60%	60%	80%	60%	90%
Periodontic services					
Osseous surgery – per quadrant	60%	60%	80%	60%	90%
Orthodontic services	$2,300 copay	$2,300 copay	50%	$2,300 copay	50%
Orthodontic lifetime maximum	Does not apply	Does not apply	$1,000	Does not apply	$1,500

Refer to page 53 for footnotes.

Standard and voluntary dental plan selections 10 – 50

	Option 4A PPO Max 1000	Option 4B PPO 1000 (90th OON)	Option 5A Active PPO Plan (90th OON)	
	PPO Max 100/80/50	PPO plan 100/80/50	Preferred plan 100/90/60	Nonpreferred plan 100/80/50
Office visit copay	N/A	N/A	N/A	N/A
Annual deductible per member (does not apply to diagnostic and preventive services)	$50; 3X family maximum	$50; 3X family maximum	$50; 3X family maximum	$50; 3X family maximum
Annual maximum benefit	$1,000	$1,000	$1,500	$1,000
Diagnostic services				
Oral exams				
Periodic oral exam	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%
X-rays				
Bitewing – single film	100%	100%	100%	100%
Complete series	100%	100%	100%	100%
Preventive services				
Adult cleaning	100%	100%	100%	100%
Child cleaning	100%	100%	100%	100%
Sealants – per tooth	100%	100%	100%	100%
Fluoride application – child	100%	100%	100%	100%
Space maintainers	100%	100%	100%	100%
Basic services				
Amalgam filling – 2 surfaces	80%	80%	90%	80%
Resin filling – 2 surfaces, anterior	80%	80%	90%	80%
Endodontic services				
Bicuspid root canal therapy	80%	80%	90%	80%
Periodontic services				
Scaling & root planing – per quadrant	80%	80%	90%	80%
Oral surgery				
Extraction – exposed root or erupted tooth	80%	80%	90%	80%
Extraction of impacted tooth – soft tissue	80%	80%	90%	80%
Major services				
Complete upper denture	50%	50%	60%	50%
Partial upper denture (resin base)	50%	50%	60%	50%
Crown – porcelain with noble metal	50%	50%	60%	50%
Pontic – porcelain with noble metal	50%	50%	60%	50%
Inlay – metallic (3 or more surfaces)	50%	50%	60%	50%
Oral surgery				
Removal of impacted tooth – partially bony	80%	80%	90%	80%
Endodontic services				
Molar root canal therapy	80%	80%	90%	80%
Periodontic services				
Osseous surgery – per quadrant	80%	80%	90%	80%
Orthodontic services	50%	50%	50%	50%
Orthodontic lifetime maximum	$1,000	$1,000	$1,500	$1,500

Refer to page 53 for footnotes.

Standard and voluntary dental plan selections 10 – 50

	Option 6A PPO 1500 (90th OON)	Option 7A PPO 2000 (90th OON)
	PPO plan 100/80/50	PPO plan 100/90/60
Office visit copay	N/A	N/A
Annual deductible per member (does not apply to diagnostic and preventive services)	$50; 3X family maximum	$50; 3X family maximum
Annual maximum benefit	$1,500	$2,000
Diagnostic services		
Oral exams		
Periodic oral exam	100%	100%
Comprehensive oral exam	100%	100%
Problem-focused oral exam	100%	100%
X-rays		
Bitewing – single film	100%	100%
Complete series	100%	100%
Preventive services		
Adult cleaning	100%	100%
Child cleaning	100%	100%
Sealants – per tooth	100%	100%
Fluoride application – child	100%	100%
Space maintainers	100%	100%
Basic services		
Amalgam filling – 2 surfaces	80%	90%
Resin filling – 2 surfaces, anterior	80%	90%
Endodontic services		
Bicuspid root canal therapy	80%	90%
Periodontic services		
Scaling & root planing – per quadrant	80%	90%
Oral surgery		
Extraction – exposed root or erupted tooth	80%	90%
Extraction of impacted tooth – soft tissue	80%	90%
Major services		
Complete upper denture	50%	60%
Partial upper denture (resin base)	50%	60%
Crown – porcelain with noble metal	50%	60%
Pontic – porcelain with noble metal	50%	60%
Inlay – metallic (3 or more surfaces)	50%	60%
Oral surgery		
Removal of impacted tooth – partially bony	80%	90%
Endodontic services		
Molar root canal therapy	80%	90%
Periodontic services		
Osseous surgery – per quadrant	80%	90%
Orthodontic services	50%	60%
Orthodontic lifetime maximum	$1,500	$2,000

Refer to page 53 for footnotes.

D

Footnotes

Standard dental plans 2 – 9

*Coverage waiting period: Must be an enrolled member of the plan for 12 months before becoming eligible for coverage of any major service. Does not apply to the DMO in plan options 1, 2 and 5 and the PPO in plan option 8.

[1]There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures on the DMO in DMO plan option 1.

Fixed dollar amounts including the office visit and ortho copays on the DMO in plan options 1, 2 and 5 are member responsibility.

Most oral surgery, endodontic and periodontic services are covered as basic services on the DMO in plan options 1, 2 and 5. All oral surgery, endodontic and periodontic services are covered as basic in PPO Max option 4.

Out-of-network plan payments are limited by geographic area on the PPO in plan options 5, 6 and 7 to the prevailing fees at the 90th percentile.

For plan options 2, 3, 4 and 8; PPO Max 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.

The DMO in plan option 1 cannot be sold as full-replacement coverage. Must be combined with plan options 3, 4, 6 or 7 in a dual option offering.

**Specialist procedures are not covered by the plan when performed by a participating specialist. However, the service is available to the member at a discount.

DMO Access: Apart from the DMO network and DMO plan of benefits, members under this plan also have access to the Aetna Dental Access® network. Dental care providers who participate in the Aetna Dental Access network have agreed to charge a negotiated discounted fee. Members can access this network for any service. However, the DMO benefits do not apply. In situations where the dentist participates in both the Aetna Dental Access network and the Aetna DMO network, DMO benefits take precedence over all other discounts, including discounts through the Aetna Dental Access network.

Plan features and availability may vary by location and are subject to change. Information is believed to be accurate as of the production date; however, it is subject to change.

Above list of covered services is representative. Full list with limitations as determined by Aetna appears in the plan booklet/certificate. For a summary list of limitations and exclusions, refer to page 67.

Voluntary dental plans 3 – 9

*Coverage waiting period: Must be an enrolled member of the plan for 12 months before becoming eligible for coverage of any major service. Does not apply to the DMO in voluntary plan options 1 and 2.

[1]There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures on the DMO in DMO plan option 1.

Fixed dollar copay amounts including the office visit and ortho indicated are member responsibility on the DMO in voluntary plan options 1 and 2.

Voluntary plan option 3 and 4; PPO Max 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.

The DMO in voluntary plan option 1 cannot be sold as full-replacement coverage. Must be combined with plan option 3 in a dual option offering.

Most oral surgery, endodontic and periodontic services are covered as basic services on the DMO in voluntary options 1 and 2.

If there is a lapse in coverage, members may not re-enroll in the plan for a period of two years from the date of termination. If they are eligible for coverage at that time, they may re-enroll, subject to all provisions of the plan, including, but not limited to, the coverage waiting period.

**Specialist procedures are not covered by the plan when performed by a participating specialist. However, the service is available to the member at a discount.

Plan features and availability may vary by location and are subject to change. Information is believed to be accurate as of the production date; however, it is subject to change.

DMO Access: Apart from the DMO network and DMO plan of benefits, members under this plan also have access to the Aetna Dental Access network. Dental care providers who participate in the Aetna Dental Access network have agreed to charge a negotiated discounted fee. Members can access this network for any service. However, the DMO benefits do not apply. In situations where the dentist participates in both the Aetna Dental Access network and the Aetna DMO network, DMO benefits take precedence over all other discounts, including discounts through the Aetna Dental Access network.

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of limitations and exclusions, refer to page 67.

Standard and voluntary dental plan selections 10–50

Fixed dollar amounts including the office visit and ortho copays on the DMO in plan options 1A–3A are member responsibility.

Most oral surgery, endodontic and periodontic services are covered as basic services on the DMO in plan options 1A–3A. All oral surgery, endodontic and periodontic services are covered as basic on the PPO in plan options 2A–7A and 4B.

Out-of-network plan payments are limited by geographic area on the PPO in plan options 3A, 5A–7A and 4B to the prevailing fees at the 90th percentile.

Plan options 2A and 4A; PPO Max 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.

Coverage for implants is included as a major service on the PPO in plan option 3A, 6A and 7A.

The DMO in plan option 1 cannot be sold as full-replacement coverage. Must be combined with plan options 4A–7A and 4B in a dual option offering.

Orthodontic coverage is available to dependent children only.

Plan features and availability may vary by location and are subject to change. Information is believed to be accurate as of the production date; however, it is subject to change.

Voluntary plan: if there is a lapse in coverage, members may not re-enroll in the plan for a period of two years from the date of termination. If they are eligible for coverage at that time, they may re-enroll, subject to all provisions of the plan, including, but not limited to, the coverage waiting period.

Above list of covered services is representative. Full list with limitations as determined by Aetna appears in the plan booklet/certificate. For a summary list of limitations and exclusions, refer to page 67.

Aetna vision plans

Value you can see — our Premier, Plus and Basic Aetna Vision℠ Preferred plans were designed to provide affordable premiums, network choice and low member out-of-pocket expense.

Vision
overview

See why Aetna Vision Preferred is the right choice for you and your employees

- Members can go where they want and buy what they want; in- and out-of-network benefits included for most services
- Offer as a voluntary benefit with affordable premiums and no extra cost to your bottom line
- Pretax advantages for both you and your employees
- Four-year rate guarantee included
- Administrative ease when you have multiple benefits with Aetna — one bill, one renewal, one trusted company to work with
- Award-winning live customer service and self-service tools available seven days a week
- Low member out-of-pocket expense
- Value, choice, and convenience; members can choose any frame available includes value-priced frames to high-quality designer frames with no confusing frame towers or formularies
- Discounts on additional eyeglass purchases and noncovered items including LASIK surgery*
- Informational welcome packet is sent to each enrolled subscriber and includes member ID card, benefit summary and nearest provider locations to the member's home ZIP code

Keep an eye on your employee's health

We are committed to vision wellness, patient education and the associated preventive care.

Encouraging employees to get vision care can help lower unnecessary costs and improve overall health. During a routine eye exam, all aspects of vision are checked, including the eye's structure and how well the eyes work together. Annual eye exams allow eye care providers to monitor the health of the eyes and track changes that can occur from year to year. Besides measuring vision, eye exams help find early signs of certain chronic health conditions including diabetes, high blood pressure, high cholesterol and eye disease.[1]

Discover the freedom to see any licensed vision office or retailer

Nearly 60 percent of eyewear dollars in the United States are spent at optical retailers.[2] With Aetna Vision Preferred, you and your employees will have access to one of the largest national networks with over 65,000 vision office and retailers, featuring the most desired national retailers,[3] including LensCrafters®, Pearle Vision®, Sears® Optical , Target Optical® and JCPenney Optical. Most have evening and weekend hours, including Sundays and are located in or near shopping centers for added convenience. Can't find your provider in our network? No problem. We reimburse for most services from out-of-network vision care providers, so members are covered no matter who they see for routine eye care.

Low member out-of-pocket costs

Aetna Vision Preferred offers savings in or out of network for routine eye exams, contact lenses and eyeglasses, including prescription sunglasses and designer frames.

Sample out-of-pocket costs for a member**

	Retail price	Out-of-pocket costs with Aetna Vision Preferred	Savings with Aetna Vision Preferred
Exam	$114.00	$10.00	$104.00
Frames	$124.41	$0	$124.41
Lenses	$ 83.00	$10.00	$ 73.00
Total	$321.41	$20.00	$301.41

*Discounts may not be available in all states.

**Results will vary for different plan designs. Example does not include premiums.

[1]**Allaboutvision.com/eye-exam/importance.htm**, April 2012. Accessed July 2014.

[2]Jobson Vision Watch, Vision Council Member Benefits Report, June 2011.

[3]Jobson Consumer Perceptions of Managed Vision Care Report 2011.

Aetna Vision Preferred – Premier plan

	In network	Out of network
	In-network amount represents member copay, plan allowance or fixed discounted fee. Out-of-network amount represents the maximum reimbursement amount.	
Exam – coverage allowed for one eye exam every rolling 12 months		
Routine eye exam	$10 copay	$25 reimbursement
Standard contact lens fit/follow	$40 discounted fee	Not covered
Premium contact lens fit/follow	10% off retail	Not covered
Frames – coverage allowed for one eyeglass frame every rolling 12 or 24 months (rates vary by frame frequency)		
Any frame available at location	$130 plan allowance	$65 reimbursement
Lens – coverage allowed for one pair of prescription eyeglass lenses every rolling 12 months (in lieu of contact lenses per benefit period)		
Single vision lenses	$10 copay	$20 reimbursement
Bifocal vision lenses	$10 copay	$40 reimbursement
Trifocal vision lenses	$10 copay	$65 reimbursement
Lenticular vision lenses	$10 copay	$65 reimbursement
Standard progressive lenses	$75 copay	$40 reimbursement
Premium progressive lenses	20% discount off retail minus $120 allowance plus $75 copay = member out of pocket	$40 reimbursement
UV treatment	$15 discounted fee	Not covered
Tint (solid and gradient)	$15 discounted fee	Not covered
Standard plastic scratch coating	$15 discounted fee	Not covered
Standard polycarbonate lenses – child to age 19	$40 discounted fee	Not covered
Standard polycarbonate lenses – adult	$40 discounted fee	Not covered
Standard anti-reflective coating	$45 discounted fee	Not covered
Contacts – coverage for one order of contact lenses every rolling 12 months (in lieu of eyeglass lenses per benefit period)		
Conventional contact lenses	$115 plan allowance	$80 reimbursement
Disposable contact lenses	$115 plan allowance	$80 reimbursement
Medically necessary contact lenses	$0 copay	$200 reimbursement

Discounts

Available at in-network locations

- 15 percent off balance over the plan allowance on conventional contact lenses
- 20 percent off balance over the plan allowance on frames
- Up to 40 percent off additional pairs of eyeglasses or prescription sunglasses
- 15 percent discount off retail or 5 percent discount off the promotional price for LASIK vision correction or PRK from U.S. Laser Network only. Call **1-800-422-6600**
- 20 percent off noncovered items, including photochromic/transition and polarized lenses
- Receive significant savings after lens benefit has been exhausted by ordering replacement contact lenses online at **www.aetnavision.com**

Discounts may not be available in all states.

Aetna Vision Preferred – Plus plan

	In network	Out of network
	In-network amount represents member copay, plan allowance or fixed discounted fee. Out-of-network amount represents the maximum reimbursement amount.	
Exam – coverage allowed for one eye exam every rolling 12 months		
Routine eye exam	$10 copay	$25 reimbursement
Standard contact lens fit/follow	$40 discounted fee	Not covered
Premium contact lens fit/follow	10% off retail	Not covered
Frames – coverage allowed for one eyeglass frame every rolling 12 or 24 months (rates vary by frame frequency)		
Any frame available at location	$130 plan allowance	$65 reimbursement
Lens – coverage allowed for one pair of prescription eyeglass lenses every rolling 12 months (in lieu of contact lenses per benefit period)		
Single vision lenses	$25 copay	$10 reimbursement
Bifocal vision lenses	$25 copay	$25 reimbursement
Trifocal vision lenses	$25 copay	$55 reimbursement
Lenticular vision lenses	$25 copay	$55 reimbursement
Standard progressive lenses	$90 copay	$25 reimbursement
Premium progressive lenses	20% discount off retail minus $120 allowance plus $90 copay = member out of pocket	$25 reimbursement
UV treatment	$15 discounted fee	Not covered
Tint (solid and gradient)	$15 discounted fee	Not covered
Standard plastic scratch coating	$0 copay	$15 reimbursement
Standard polycarbonate lenses – child to age 19	$0 copay	$35 reimbursement
Standard polycarbonate lenses – adult	$40 discounted fee	Not covered
Standard anti-reflective coating	$45 discounted fee	Not covered
Contacts – coverage for one order of contact lenses every rolling 12 months (in lieu of eyeglass lenses per benefit period)		
Conventional contact lenses	$130 plan allowance	$90 reimbursement
Disposable contact lenses	$130 plan allowance	$90 reimbursement
Medically necessary contact lenses	$0 Copay	$200 reimbursement

Discounts

Available at in-network locations

- 15 percent off balance over the plan allowance on conventional contact lenses
- 20 percent off balance over the plan allowance on frames
- Up to 40 percent off additional pairs of eyeglasses or prescription sunglasses
- 15 percent discount off retail or 5 percent discount off the promotional price for LASIK vision correction or PRK from U.S. Laser Network only. Call **1-800-422-6600**
- 20 percent off noncovered items, including photochromic/transition and polarized lenses
- Receive significant savings after lens benefit has been exhausted by ordering replacement contact lenses online at **www.aetnavision.com**

Discounts may not be available in all states.

Aetna Vision Preferred – Basic plan

	In network	Out of network
	In-network amount represents member copay, plan allowance or fixed discounted fee. Out-of-network amount represents the maximum reimbursement amount.	
Exam – coverage allowed for one eye exam every rolling 12 months		
Routine eye exam	$20 copay	$20 reimbursement
Standard contact lens fit/follow	$40 discounted fee	Not covered
Premium contact lens fit/follow	10% off retail	Not covered
Frames – coverage allowed for one eyeglass frame every rolling 12 or 24 months (rates vary by frame frequency)		
Any frame available at location	$100 plan allowance	$50
Lens – coverage allowed for one pair of prescription eyeglass lenses every rolling 12 months (in lieu of contact lenses per benefit period)		
Single vision lenses	$20 copay	$15 reimbursement
Bifocal vision lenses	$20 copay	$30 reimbursement
Trifocal vision lenses	$20 copay	$60 reimbursement
Lenticular vision lenses	$20 copay	$60 reimbursement
Standard progressive lenses	$85 copay	$30 reimbursement
Premium progressive lenses	20% discount off retail minus $120 allowance plus $85 copay = member out of pocket	$30 reimbursement
UV treatment	$15 discounted fee	Not covered
Tint (solid and gradient)	$15 discounted fee	Not covered
Standard plastic scratch coating	$15 discounted fee	Not covered
Standard polycarbonate lenses – child to age 19	$40 discounted fee	Not covered
Standard polycarbonate lenses – adult	$40 discounted fee	Not covered
Standard anti-reflective coating	$45 discounted fee	Not covered
Contacts – coverage for one order of contact lenses every rolling 12 months (in lieu of eyeglass lenses per benefit period)		
Conventional contact lenses	$105 plan allowance	$75 reimbursement
Disposable contact lenses	$105 plan allowance	$75 reimbursement
Medically necessary contact lenses	$0 copay	$200 reimbursement

Discounts

Available at in-network locations

- 15 percent off balance over the plan allowance on conventional contact lenses
- 20 percent off balance over the plan allowance on frames
- Up to 40 percent off additional pairs of eyeglasses or prescription sunglasses
- 15 percent discount off retail or 5 percent discount off the promotional price for LASIK vision correction or PRK from U.S. Laser Network only. Call **1-800-422-6600**
- 20 percent off noncovered items, including photochromic/transition and polarized lenses
- Receive significant savings after lens benefit has been exhausted by ordering replacement contact lenses online at **www.aetnavision.com**

Discounts may not be available in all states.

Aetna life & disability

With Aetna as your insurer, you can round out employee benefits package with even more coverage. Our group life and disability is an affordable way to offer your employees — and their families — the extra financial protection of life insurance and disability benefits.

L&D

Life & disability
overview

For groups of 2 to 50, Aetna Life Insurance Company (Aetna) offers several options for small group life and disability insurance plans. All are easy to understand and offer affordable benef its to help your employees protect their families in the event of illness,injury or death. You'll benefit from stream lined plan installation, administration and claims processing.

- Life insurance
- Long-term disability (10-50 only)

Life insurance

We know that life insurance is an important part of the benefits package you offer your employees. That's why our products and programs are designed to meet your needs for:

- Flexibility
- Added value
- Cost efficiency
- Experienced support

We help you give employees what they're looking for in lifestyle protection, through our selected group life insurance options. And we look beyond the benefits payout to include useful enhancements through the **Aetna Life Essentials**^SM program.

So what's the bottom line? A portfolio of value-packed products and programs to attract and retain workers— while making the most of the benefits dollars you spend.

Giving you (and your employees) what you want

Employees are looking for cost-efficient plan features and value-added programs that help them make better decisions for themselves and their dependents.

Our life insurance plans come with a variety of features including:

Accelerated death benefit – Also called the "living benefit," the accelerated death benefit provides payment to terminally ill employees or spouses. This payment can be up to 75 percent of the life insurance benefit.

Premium waiver provision – Employee coverage may stay in effect up to the amended normal Social Security retirement age without premium payments (unless they retire sooner), if an employee becomes permanently and totally disabled while insured due to an illness or injury before age 60.

Optional dependent life – This feature allows employees to add optional additional coverage for eligible spouses and children for employers with 10 or more employees. This employee-paid benefit enables employees to cover their spouses and dependent children.

Our fresh approach to life

With **Aetna Life Essentials**, your employees have access to programs during their active lives to help promote healthy, fulfilling lifestyles. In addition, Aetna Life Essentials provides for critical caring and support resources for often-overlooked needs during the end of one's life. And we also include value for beneficiaries and their loved ones well beyond the financial support from a death benefit.

AD&D Ultra®

AD&D Ultra is standardly included with our small group term life plans and in our packaged life and disability plans, and provides employees and their families with the same coverage as a typical accidental death and personal loss plan — and then some. This includes extra benefits at no additional cost to you, such as coverage for education or child-care expenses that make this protection even more valuable.

Covered losses include:

- Death
- Loss of limb
- Loss of sight
- Loss of speech
- Loss of hearing
- Third-degree burns
- Paralysis
- Coma
- Total disability
- Exposure and disappearance

Extra benefits for the following:

- Passenger restraint use and airbag deployment*
- Education assistance for dependent child and/or spouse*
- Child care*
- Repatriation of mortal remains*

Disability insurance

Did you know the ability to earn an income is the most important financial resource for an individual? Yet, few take steps to help protect this important resource from the threat of a disability.

No one wants to think about it, but injury or illness can happen at any time. It can impact both your business and your employees' financial well-being. Your business can lose the productivity of valued employees. Your employees can lose their paycheck.

That is why disability insurance is so important. It provides protection for your business and your employees.

We understand disability

We have experienced and caring professionals who understand the challenges of disability. We realize how important it is for your employees to be able to work. That is why we are dedicated to providing solutions.

Here are a few ways our disability plans protect you and your employees:

- Consultative support from your account team is based on the unique needs of your business
- Our embedded **Behavioral Health Unit** (BHU) has compassionate licensed therapists and psychiatric nurses who recognize the complexities of behavioral health conditions. They work with your employees and their health care providers to overcome barriers blocking successful return to work
- Master's level **Vocational Rehabilitation Consultants** offer a coordinated productivity approach centered on the employee's abilities to aid your employee's transition back to the workforce

More choices for interaction

Our best-in-class technology offers more choices for you and your employees to interact with us. Whether you choose mail, phone, e-mail, mobile application or our convenient WorkAbility® Absence Management System online portal, information is available on your schedule, not ours.

For a summary list of limitations and exclusions, refer to pages 67 – 68.

*Only available if insured loses life.

Life insurance policies and disability insurance plans/policies are offered and/or underwritten by Aetna Life Insurance Company (Aetna).

L&D

Life: 2–9 Standard QRS and 10–50 Life Simplified plans

Life benefits	2–9 eligible lives	10–50 eligible lives
Benefit amount	Flat dollar amounts: $10,000, $15,000, $20,000 or $50,000	Flat dollar amounts: $10,000, $15,000, $20,000,$25,000, $30,000, $50,000, $75,000, $100,000, $125,000, $150,000, $175,000, $200,000 OR 1 or 2X basic annual earning (BAE) (rounded to next higher $1,000)
Minimum/maximum amounts	$10,000/$50,000	Flat dollar amounts: 10,000/$200,000 Salary-based amounts: $10,000/$200,000
Guaranteed issue	$20,000	$200,000
Participation requirement	100%	100% employer pays all, 50% employee contributes
Contribution requirement	100% employer paid	50%–100% employer paid
Eligible/minimum hours	Active employees/20 hrs./wk.	Active employees/20 hrs./wk.
Rate structure	Age-graded rates	Contributory: age graded Noncontributory: composite
Rate guarantee	Two years	Two years
Age reduction schedule	65% at age 65, 40% at age 70, 25% at age 75	**Option 1:** 65% at age 65, 40% at age 70, 25% at age 75 **Option 2:** 65% at age 70, 40% at age 75, 25% at age 80 **Option 3:** 50% at age 70 **Option 4:** 65% at age 65, 50% at age 70
Waiver of premium	Premium waiver 60	Premium waiver 60
Funding	Prospective	Prospective
Conversion	Included	Included
Portability	Not included	Not included
Value added services	Aetna Life Essentials Beneficiary Solutions Everest Funeral Services	Aetna Life Essentials Beneficiary Solutions Everest Funeral Services
Accelerated death benefit	Up to 75% of life benefit	Up to 75% of life benefit amount
AD&D Ultra amount	Matches life benefit amount	Matches life benefit amount
Optional spouse life	Not available	Flat dollar amount: $25,000
Optional child life	Not available	Flat dollar amount: $10,000 (child covered birth to age 26)
Spouse/child life rate structure	N/A	Spouse: per $1,000–age graded; Child: per $1,000, per family unit
Spouse/child life guarantee issue	N/A	Spouse: $25,000 Child: $10,000
Spouse/child AD&D	Not available	Spouse: 50% employee amount (40% if child included) Child: 15% employee amount (10% if spouse included)
Supplemental life	Not available	Up to $400,000 (increments $10,000 or $25,000) OR 1–5 X basic annual earnings (BAE) rounded to next $1,000
Supplemental AD&D	Not available	Matches supplemental life benefit; automatically included in supplemental life rate
Class schedules	Only one class allowed	Up to three classes (minimum three employees in each class)

Life insurance policies and disability insurance plans/policies are offered and/or underwritten by Aetna Life Insurance Company (Aetna).

Short-Term Disability*: 2 – 9 Standard QRS and 10 – 50 Simplified plans

Short-term disability benefits*	2 – 9 eligible lives	10 – 50 eligible lives
Weekly benefit	$100-$500 flat amount in $100 increments	50% or 60% of earnings
Elimination period – injury/illness	1/8 or 8/8	1/8, 8/8 or 15/15
Maximum benefit	$500	$500, $750, $1,000, $1,500 or $2,000
Maximum benefit period	26 weeks	13 weeks or 26 weeks
Maternity benefit	Maternity is treated same as illness but subject to pre-existing condition exclusion. If pregnant before plan effective date, pregnancy is not covered unless employee has prior credible coverage.	Maternity is treated same as illness
Types of disability covered	Non-occupational	Non-occupational
Pre-existing condition rule	3/12	3/12 for late applicants and voluntary plans
Actively-at-work rule	Applies	Applies
Other income offset integration	None	Full offsets, including family SSDI
Definition of disability	Own occupation, 20% earnings loss	Own occupation, 20% earnings loss
Separate periods of disability	15 days	15 days
Funding	Prospective	Prospective
Minimum participation requirement	100%	Contributory: 50% Noncontributory: 100%
Contribution requirement	100% employer paid	Contributory: 50% – 99% employer paid Noncontributory: 100% employer paid
Eligible/minimum hours	Active employees/20 hrs./wk.	Active employees/20 hrs./wk.
Rate structure	Age-graded rates	Age-graded rates
Rate guarantee	Two years	Two years
Class schedules	Only one class allowed	Up to three classes (with a minimum requirement of three employees in each class) available for groups of 10 or more employees

*For 2 to 50 lives: short term disability is not available in CA, NJ, NY, HI or RI. These states have mandated state cash disability plans.

Life insurance policies and disability insurance plans/policies are offered and/or underwritten by Aetna Life Insurance Company (Aetna).

Long-Term Disability: 10–50 Simplified plan

Long-term disability benefits	10–50 eligible lives
Monthly benefit	50% or 60% of earnings
Elimination period–injury and illness	30 days, 90 days or 180 days
Maximum benefit	$2,000, $3,500, $5,000, $6,000 or $8,000
Maximum benefit period	Two years or five years
Maternity benefit	Maternity is treated same as illness
Types of disability covered	Occupational and non-occupational
Pre-existing condition rule	3/12 for new coverage and increases in coverage
Actively-at-work rule	Applies
Other income offset integration	Full offsets, including family SSDI
Definition of disability	Own occupation for 24 months 80%; after 24 months, any reasonable occupation 60%
Separate periods of disability	30-day EP: 15 days during EP, three months after 90-day EP: 15 days during EP, three months after 180-day EP: 15 days during EP, six months after
Work incentive benefit adjustment	Proportional loss after 12 months
Limitations–mental/nervous and drug/alcohol	24 months of benefits per disability; 90 day extension if hospital confined
Waiver of premium	Included
Vocational rehabilitation* and incentive	Mandatory; 10%
Survivor benefit	Included–three months
Conversion	Not included
Funding	Prospective
Minimum participation requirement	Contributory: 50% Noncontributory: 100%
Contribution requirement	Contributory: 50%–99% employer paid Noncontributory: 100% employer paid
Eligible/minimum hours	Active employees/20 hrs./wk.
Rate structure	Age-graded rates
Rate guarantee	Two years
Class schedules	Up to three classes (with a minimum requirement of three employees in each class) available for groups of 10 or more employees

*Mandatory vocational rehabilitation is prohibited in CA and NJ. CT prohibits mandatory vocational rehabilitation if the plan is contributory or voluntary

Life insurance policies and disability insurance plans/policies are offered and/or underwritten by Aetna Life Insurance Company (Aetna).

L&D

Packaged Life and Disability*: 2–9 and 10–50 QRS Standard plans

Life plan design	Low option	Low option 2	Medium option	Medium option 2	High option
Benefit	Flat $10,000	Flat $15,000	Flat $20,000	Flat $25,000	Flat $50,000
Guaranteed issue **2–9 lives**	$10,000	$15,000	$20,000	$20,000	$20,000
10–50 lives	$10,000	$15,000	$20,000	$25,000	$50,000
Reduction schedule	Employee's original life amount reduces to 65% at age 65; 40% at age 70; 25% at age 75				
Premium waiver	Premium waiver 60	Premium waiver 60	Premium waiver 60	Premium waiver 60	Premium waiver 60
Conversion	Included	Included	Included	Included	Included
Accelerated death benefit	Up to 75% of benefit; 24-month acceleration				
Dependent life	Spouse $5,000 Child $2,000	Spouse $5,000 Child $2,000	Spouse $5,000 Child $2,000	Spouse $5,000 Child $2,000	Spouse $5,000 Child $2,000
AD&D Ultra					
AD&D ultra schedule	Matches basic life benefit	Matches basic life benefit	Matches basic life benefit	Matches basic life benefit	Matches basic life benefit
AD&D ultra extra benefits	Passenger restraint use and airbag deployment, education benefit for your child and/or spouse, child care and repatriation of mortal remains.				
Disability plan design					
Monthly benefit	Flat $500 No offsets	Flat $1,000; offsets are workers' compensation, any state disability plan and primary and family Social Security benefits.			
Elimination period	30 days	30 days	30 days	30 days	30 days
Definition of disability	Own occupation; earnings loss of 20% or more	Own occupation; earnings loss of 20% or more	Own occupation; earnings loss of 20% or more	Own occupation; earnings loss of 20% or more	First 24 months of benefits: own occupation; earnings loss of 20% or more; any reasonable occupation thereafter; 40% earnings loss
Benefit duration	24 months	24 months	24 months	24 months	60 months
Pre-existing condition limitation	3/12	3/12	3/12	3/12	3/12
Types of disability	Occupational & non-occupational	Occupational & non-occupational	Occupational & non-occupational	Occupational & non-occupational	Occupational & non-occupational
Separate periods of disability	15 days during elimination period; six months thereafter				
Mental health/substance abuse	Duration same as all other conditions	Duration same as all other conditions	Duration same as all other conditions	Duration same as all other conditions	Duration same as all other conditions
Waiver of premium	Included	Included	Included	Included	Included
Other plan provisions					
Eligibility	Active full-time employees	Active full-time employees	Active full-time employees	Active full-time employees	Active full-time employees
Employer contribution	2–9 lives: 100% employer paid 10–50 lives: 50-100% employer paid				
Minimum participation	2–9 lives: 100% 10–50 lives: 75%				
Class schedules	2-9 lives: not available 10-50 lives: Up to three classes (with a minimum requirement of three employees in each class) — the benefit amount of the highest class can not be more than five times the benefit amount of the lowest class even if only two classes are offered.				
Rate guarantee	One year	One year	One year	One year	One year
Rates PEPM	$8.00	$10.00	$15.00	$16.00	$27.00

*For 2 to 50 lives: packaged life and disability plans are not available in CA, NJ, NY, HI or RI. These states have mandated state cash disability plans.

Life and disability products are underwritten or administered by Aetna Life Insurance Company (Aetna).

Limitations and exclusions

Medical

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.

Groups of one will be offered Ohio individual off exchange plans. For the plan design benefits descriptions, please refer to our Producer World® website at **www.aetna.com** or contact your licensed agent or Aetna sales representative.

Aetna Savings Plus Health Network Option and Aetna Health Network Option plans

Services and supplies that are generally not covered include, but are not limited to:

- All medical and hospital services not specifically covered in, or that are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates
- Cosmetic surgery
- Custodial care
- Dental care and dental X-rays
- Donor egg retrieval
- Experimental and investigational procedures (except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial)
- 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
- Nonmedically 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
- Special duty nursing
- Therapy or rehabilitation other than those listed as covered in the plan documents

Aetna PPO plan and Traditional Choice (TC) plan

Services and supplies that are generally not covered include, but are not limited to:

- All medical or hospital services not specifically covered in, or that 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
- 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
- Special duty nursing

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

Dental, AD&D Ultra and disability

Dental, AD&D Ultra and disability plans include limitations, exclusions and charges or services that these plans do not cover. For a complete list of all limitations and exclusions or charges and services that are not covered, please refer to your Aetna group plan documents. Limitations, exclusions and charges or services may vary by state or group size.

Dental

Not every dental care service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are medically necessary. Charges for the following services or supplies are limited or may be excluded:

- Dental services or supplies that are primarily used to alter, improve or enhance appearance
- Experimental services, supplies or procedures
- Treatment of any jaw joint disorder, such as temporomandibular joint disorder
- Replacement of lost, missing or stolen appliances and certain damaged appliances
- Those services that Aetna defines as not necessary for the diagnosis, care or treatment of a condition involved
- Specific service limitations:
  - DMO plans: Oral exams (four per year)
  - PPO plans: Oral exams (two routine and two problem-focused per year)
  - All plans:
    - Bitewing X-rays (one set per year)
    - Complete series X-rays (one set every three years)
    - Cleanings (two per year)
    - Fluoride (one per year; children under 16)
    - Sealants (one treatment per tooth, every three years on permanent molars; children under 16)
    - Scaling & root planing (four quadrants every two years)
    - Osseous surgery (one per quadrant every three years)
- All other limitations and exclusions in your plan documents

AD&D Ultra®

Not all events that may be ruled accidental are covered by this plan. No benefits are payable for a loss caused or contributed to by:

- Air or space travel, unless a person is a passenger, with no duties at all, on an aircraft being used only to carry passengers (with or without cargo)
- Bodily or mental infirmity
- Commission of or attempt to commit a criminal act
- Illness, ptomaine or bacterial infection*
- Inhalation of poisonous gases
- Intended or accidental contact with nuclear or atomic energy by explosion and/or release
- Ligature strangulation resulting from auto-erotic asphyxiation
- Intentionally self-inflicted injury
- Medical or surgical treatment*
- Third-degree burns resulting from sunburn
- Use of alcohol
- Use of drugs, except as prescribed by a physician
- Use of intoxicants
- Use of alcohol or intoxicants or drugs while operating any form of a motor vehicle whether or not registered for land, air or water use. A motor vehicle accident will be deemed to be caused by the use of alcohol, intoxicants or drugs if it is determined that at the time of the accident the member or covered dependent was:
  - Operating the motor vehicle while under the influence of alcohol at a level that meets or exceeds the level at which intoxication would be presumed under the laws of the state where the accident occurred. If the accident occurs outside of the United States, intoxication will be presumed if the person's blood alcohol level meets or exceeds .08 grams per deciliter; or
  - Operating the motor vehicle while under the influence of an intoxicant or illegal drug; or
  - Operating the motor vehicle while under the influence of a prescription drug in excess of the amount prescribed by the physician; or
  - Operating the motor vehicle while under the influence of an over-the-counter medication taken in an amount above the dosage instructions
- Suicide or attempted suicide (while sane or insane)
- War or any act of war (declared or not declared)

*These do not apply if the loss is caused by:
- An infection that results directly from the injury
- Surgery needed because of the injury

The injury must not be one that is excluded by the terms of this section.

Disability

Disability coverage also does not cover any disability that:

- Is due to an occupational illness or occupational injury except in the case of sole proprietors or partners who cannot be covered by workers' compensation
- Is due to insurrection, rebellion, or taking part in a riot or civil commotion
- Is due to intentionally self-inflicted injury (while sane or insane)
- Is due to war or any act of war (declared or not declared).
- Results from the commission of, or attempt to commit a criminal act
- Results from a motor vehicle accident caused by operating the vehicle while under the influence of alcohol. A motor vehicle accident will be deemed to be caused by the use of alcohol if it is determined that at the time of the accident the member was operating the motor vehicle while under the influence of alcohol at a level that meets or exceeds the level at which intoxication would be presumed under the laws of the state where the accident occurred.) If the accident occurs outside of the United States, intoxication will be presumed if the person's blood alcohol level meets or exceeds .08 grams per deciliter

Disability coverage does not cover any disability on any day that the member is confined in a penal or correctional institution for conviction of a criminal act or other public offense. The member will not be considered to be disabled, and no benefits will be payable.

No benefit is payable for any disability that occurs during the first 12 months of coverage and is due to a pre-existing condition for which the member was diagnosed, treated or received services, treatment, drugs or medicines three months prior to the coverage effective date.

Employee and dependent life insurance

The plan may not pay a benefit for deaths caused by suicide, while sane or insane, or from an intentionally self-inflicted injury, within two years from the effective date of the person's coverage. If death occurs after two years of the effective date but within two years of the date that any increase in coverage becomes effective, no death benefit will be payable for any such increased amount.

Vision

Benefits are not provided for services or materials arising from: orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; medical and/or surgical treatment of the eye, eyes or supporting structures; any eye or vision examination, or any corrective eyewear required by a policyholder as a condition of employment; safety eyewear; services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Plano (nonprescription) lenses and/or contact lenses; nonprescription sunglasses; two pair of glasses in lieu of bifocals; services or materials provided by any other group benefit plan providing vision care; certain brand-name vision materials in which the manufacturer imposes a no-discount policy; or services rendered after the date an insured person ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days from the date of such order. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans.

New business checklist

It's so easy

To help ensure the underwriting of your case is quick and easy, we are providing this simple checklist.

☐ **1. Employer application**

☐ **2. Employee enrollment and waiver applications**

- For all eligible employees enrolling or waiving health coverage
- Waivers may be submitted in a separate Excel waiver spreadsheet with the reason for waiving included

Or EList

- Enrollment census must include plan selection and tobacco status
- Be sure and include a separate listing for waivers with the reason for waiving included

☐ **3. Copy of initial premium check payable to Aetna or ACH/EFT Form**

☐ **4. Quarterly wage and tax statement**

- 2 to 9 enrolled employees – provide a QWTS
- 10 to 50 enrolled with no prior coverage – provide a QWTS
- 10 to 50 enrolled with prior coverage – upon request, the underwriter will contact you if a QWTS is necessary

☐ **5. Dental benefit summary**

- For major and orthodontia credit for standard 2 to 9 and voluntary 3 to 50 eligible employees

☐ **6. Illustrative quote with sold plan marked**

- Signed and dated by the plan sponsor

Any missing information may result in the effective date being moved forward to the next available date.

Send all enrollment materials to:

E-mail: **IN-OH-KY-Sold@aetna.com**
Secure File Transport (FTP): **https://st3.aetna.com**

If you do not have access to the FTP server, please contact your Aetna sales executive for access or visit us at Producer World.

Effective dates may be the 1st or 15th of the month.

Effective date	Submission deadline
1st of month	End of the business day on the requested effective date
15th of month	End of the business day on the requested effective date

For help with your new case submissions, please contact your Aetna account executive or call us at **1-888-380-7821 options 1-1-4**.

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits may vary by location. Health/Dental benefits, health/dental insurance, life and disability insurance plans/policies contain exclusions and limitations. 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 features and availability may vary by location and group size. Investment services are independently offered through HealthEquity, Inc. Aetna HealthFund HRAs are subject to employer-defined use and forfeiture rules and are unfunded liabilities of your employer. Fund balances are not vested benefits. The Aetna Personal Health Record should not be used as the sole source of information about the member's medical history. Discount programs provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Providers are independent contractors and not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Not all health, dental and disability services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features may vary, may be unavailable in some states, and are subject to change. Aetna receives rebates from drug manufacturers that may be taken into account in determining the Aetna Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Information is believed to be accurate as of the production date; however, it is subject to change. Vision insurance plans are underwritten by Aetna Life Insurance Company (Aetna). Certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care ("EyeMed"), LLC. Providers participating in the Aetna Vision network are contracted through EyeMed Vision Care, LLC. EyeMed and Aetna are independent contractors and not employees or agents of each other. Participating vision providers are credentialed by and subject to the credentialing requirements of EyeMed. Aetna does not provide medical/ vision care or treatment and is not responsible for outcomes. Aetna does not guarantee access to vision care services or access to specific vision care providers and provider network composition is subject to change without notice. For more information about Aetna plans, refer to **www.aetna.com**.

www.aetna.com

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