

# PPO Medical Plan - Aetna Health Fund

## July 1, 2008 - June 30, 2009

Information provided is in summary format. Any difference between the summary provided and actual contract will be settled in favor of the contract.

	<u><b>In-Network</b></u>	<u><b>Out-Of-Network</b></u>
<b>PPO Network</b>	Preferred Providers	Non-Preferred Providers
<b>Health Fund Allotment</b>	Eligible expenses are paid through the health fund and the member's deductible and fund balance are simultaneously reduced. <b>Fund allotment is \$750/Individual and \$1,500 Family.</b> One family member can utilize the \$1,500. Account is to be used for covered out-of-pocket expenses with unused dollars carried over to next year's account balance (subject to continued enrollment in the Aetna Health Fund product.)	
<b>Deductible</b>	\$2,000 Individual \$6,000 Family	\$4,000 Individual \$12,000 Family
<b>Coinsurance</b>	80% after deductible	60% after deductible
<b>Out-of-Pocket Maximum/Yr*</b>	\$5,000 Individual \$15,000 Family	\$10,000 Individual \$30,000 Family
<b>Lifetime Maximum Benefit</b>	Unlimited except where otherwise indicated	
<b>Office Visits - Specialist</b>	80% after deductible	60% after deductible
<b>Office Visits - Non Specialist</b>	80% after deductible	60% after deductible
<b>Immunizations</b> - 7 exams to age 1, 2 exams from 13-24 months, 1 exam per 12 months to age 18	100%, deductible waived	60% after deductible
<b>Routine Adult Physicals</b> - One annual exam	100%, deductible waived	60% after deductible
<b>Diagnostic Lab &amp; X-ray</b>	80% after deductible	60% after deductible
<b>Ambulance</b>	80% after deductible	
<b>Hospital Inpatient**</b>	80% after deductible	60% after deductible
<b>Emergency Room</b>	80% after deductible	
<b>Urgent Care</b>	80% after deductible	60% after deductible
<b>Maternity</b>	Paid as any other condition	
<b>Spinal Manipulations</b> - 20 visits/yr	80% after deductible	60% after deductible
<b>Rehabilitation Therapy:</b>		
<b>Inpatient Rehabilitation**</b>	80% after deductible	60% after deductible
<b>Outpatient Physical, Speech and Occupational Therapy</b>	80% after deductible	60% after deductible

<b>Mental Health Services:</b>		
<b>Inpatient**</b> - 30 days/yr	80% after deductible	60% after deductible
<b>Outpatient</b> - 20 visits/yr	80% after deductible	60% after deductible
<b>Chemical Dependency:</b>	\$15,000 max per plan year	
<b>Inpatient**</b>	80% after deductible	60% after deductible
<b>Outpatient</b>	80% after deductible	60% after deductible
<b>Prescription Drugs - Retail</b>	100% after applicable copays Generic: \$15 Copay Formulary Brand: \$25 Copay Non Formulary Brand: \$40 Copay	60% after applicable copays  Generic: \$15 Copay Formulary Brand: \$25 Copay Non Formulary Brand: \$40 Copay
<b>RX Dosages - Retail</b>	30-day supply	
<b>Mail Order Prescriptions</b>	Generic: \$30 Copay Formulary Brand: \$50 Copay Non Formulary Brand: \$80 Copay	No Coverage
<b>RX Dosages - Mail Order</b>	90-day supply	
<b>Routine Hearing Exam</b> - one per yr	100%, deductible waived	60% after deductible
<b>Routine Vision Exam</b> - one per yr	100%, deductible waived	60% after deductible
<b>Vision Hardware</b>	\$200 every 24 months	
<b>Aetna Vision One Brochure</b>	<a href="#">Click Here</a>	

\*Includes deductible & coinsurance

\*\*Prior authorization required for inpatient hospitalization.