RESOLUTION NO. 17 - 2448

A RESOLUTION OF THE TOWN COMMISSION OF THE TOWN OF SURFSIDE, FLORIDA, APPROVING GROUP HEALTH INSURANCE COVERAGE WITH AETNA, DENTAL AND VISION COVERAGE WITH GUARDIAN, AND TERM LIFE INSURANCE, ACCIDENTAL DEATH, SHORT TERM DISABILITY, AND LONG TERM DISABILITY WITH MUTUAL OF OMAHA; TERMINATING THE PRIOR PAYMENT AGREEMENT WITH THE TOWN'S INSURANCE BROKER, ADAMS BENEFIT, AND ACCEPTING THE PAYMENT TERMS WITH ADAMS BENEFIT INCORPORATED AS PART OF THE AETNA FEE ARRANGEMENT; PROVIDING FOR APPROVAL AND AUTHORIZATION; PROVIDING FOR IMPLEMENTATION; AND PROVIDING FOR AN EFFECTIVE DATE.

WHEREAS, the Town of Surfside ("Town") is authorized pursuant to Section 112.08, Florida Statutes, to provide and pay for group insurance for employees and to enter into contracts with insurance providers for such group insurance; and

WHEREAS, Adams Benefit is the Town's insurance broker of record and has analyzed the best proposals from competitive health care and other benefit providers for Town employees and dependents; and

WHEREAS, based on the proposals obtained and analysis provided by Adams Benefit, the Town has determined that changing group health insurance provider from UnitedHealthcare to Aetna, dental and vision coverage with Guardian, and term life insurance, accidental death, short term disability, and long term disability with Mutual of Omaha for qualified Town employees and dependents for Fiscal Year 2017-2018 is in the best interests of the Town (See Attachment "A").

WHEREAS, pursuant to the requirements of the Aetna rates as filed with the State of Florida, all payments for insurance brokerage services must be paid through the Aetna contract at a set monthly fee per covered employee.

NOW THEREFORE, BE IT RESOLVED BY THE TOWN COMMISSION OF THE TOWN OF SURFSIDE, FLORIDA, AS FOLLOWS:

Section 1. Recitals. The above and foregoing recitals are true and correct and are incorporated herein by reference.

Section 2. **Approval and Authorization.**

A. The Town Commission hereby approves and authorizes the Town Manager and/or designee to enter into an agreement for group health coverage with Aetna, dental and vision coverage with Guardian and term life insurance, accidental death, short term disability, and long term disability with Mutual of Omaha for qualified Town employees and dependents for Fiscal Year 2017-2018 (See Attachment "A").

B. The Town Commission hereby terminates the payment arrangement with Adams Benefit approved in Resolution No. 15-2319 on September 8, 2015 and authorizes the Town Manager or designee to accept the payment terms for the continued brokerage services of Adams Benefit, Inc. through the Aetna contract.

Section 3. **Implementation.** The Town Manager and/or designee are hereby authorized to take all action necessary to implement the purposes of this Resolution

Section 4. **Effective Date**. This Resolution shall become effective immediately upon its adoption.

PASSED AND ADOPTED this 18th day of September 2017.

Motion by Commissioner Paul,

Second by Commissioner Karukin.

FINAL VOTE ON ADOPTION

Commissioner Daniel Gielchinsky	yes
Commissioner Michael Karukin	yes
Commissioner Tina Paul	yes
Vice Mayor Barry Cohen	yes
Mayor Daniel Dietch	yes

Daniel Dietch, Mayor

ATTEST:

Sandra Novoa, MMC, Town Clerk

APPROVED AS TO FORM AND LEGAL SUFFICIENCY FOR THE TOWN OF SURFSIDE ONLY:

Town Attorney

Town of Surfside

Alternate Provider(s) - Aetna

	UHC			Aetna	Aetna	
	AHNT	AHM8 H.S.A.		HNOnly 1000 80	HNOption 2000 80 H.S.A. T	
	In-Network	In-Network	Out-Network	In-Network	In-Network	Out-Network
Deductible	$1,000 Ind. $2,000 Family	$1,500 Ind. $3,000 Family	$5,000 Ind. $10,000 Family	$1,000 Ind. $2,000 Family	$2,000 Ind. $4,000 Family	$4,000 Ind. $8,000 Family
Co-Insurance	100%	90%	50%	80%	80%	50%
Physicians Office	$20 co-pay	10% after deductible	50% after deductible	$25 co-pay	20% after deductible	50% after deductible
Specialist Office	$40 co-pay	10% after deductible	50% after deductible	$50 co-pay	20% after deductible	50% after deductible
Inpatient Hospital	0% after deductible	10% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible
Out-Patient Surgery	0% after deductible	10% after deductible	50% after deductible	$500 co-pay for hospital, after ded; $300 co-pay freestanding	20% after deductible	50% after deductible
Out-Patient Minor Diagnostic (X-Ray & Lab)	No charge	10% after deductible	50% after deductible	Lab: No charge X-ray: $50 co-pay	20% after deductible	50% after deductible
Out-Patient Major Diagnostic (e.g., MRI, MRA, PET, CT)	0% after deductible	10% after deductible	50% after deductible	$300 co-pay	20% after deductible	50% after deductible
Emergency Room	$350 co-pay	10% after deductible	10% after deductible	$300 co-pay	20% after deductible	20% after deductible
Urgent Care Center	$100 co-pay	10% after deductible	50% after deductible	$75 copay	20% after deductible	50% after deductible
Prescription Drugs	$10/$35/$60/$100	CYD; $10/$35/$60		$3/$10 / $50 / $75 Pref. Spc: 30% to $300 Non Pref. Spc: 50% to $500	CYD; $3/10 / $40 / $65 Pref. Spc: 30% to $300 Non Pref. Spc: 50% to $500	
Out of Pocket Maximum	$3,000 Ind. $6,000 Family	$4,000 Ind. $6,000 Family	$10,000 Ind. $20,000 Family	$3,500 Ind. $7,000 Family	$4,000 Ind. $6,550 Family	$12,000 Ind. $24,000 Family
Provider Search	www.myuhc.com	www.myuhc.com		www.aetna.com	www.aetna.com	www.aetna.com

		2016		2016		2017		2017
Employee	9	$603.74	36	$445.82	9	$611.00	36	$514.00
Employee + Spouse	4	$1,292.01	12	$954.06	4	$1,464.00	12	$1,234.00
Employee + Child(ren)	2	$1,231.62	6	$909.47	2	$1,240.00	6	$1,045.00
Employee + Family	3	$1,847.44	18	$1,364.21	3	$1,934.00	18	$1,631.00
	18	$18,607.26	72	$57,510.84	18	$19,637.00	72	$68,940.00

Total Monthly	90	$76,118.10	$88,577.00

This is a brief summary of the benefits and rates offered. The Certificate of Coverage is the governing document for all benefits, requirements and limitations.
If there is a variation between this summary and the Certificate of Coverage, the Certificate will govern.
Final premium rates may change from those quoted based upon actual enrollment as of the effective date and any premium adjustments determined during the medical underwriting revi

Adams BENEFIT

Town of Surfside

Ancillary Coverage

Dental - DMO	Guardian
	Current
Employee	$ 14.14
Employee + Spouse	$ 28.30
Employee + Child(ren)	$ 36.75
Employee + Family	$ 52.06

Vision	Guardian
	Current
Employee	$ 7.23
Employee + Spouse	$ 13.34
Employee + Child(ren)	$ 13.97
Employee + Family	$ 20.92

Dental - PPO	Guardian
	Current
Employee	$ 41.78
Employee + Spouse	$ 92.75
Employee + Child(ren)	$ 114.45
Employee + Family	$ 160.66

Life & AD&D	Mutual of Omaha	
	Current	Renewal
Basic Life	*In rate guarantee until 2018*	

LTD	Mutual of Omaha	
	Current	Renewal
LTD/$100 of covered monthly payroll	*In rate guarantee until 2018*	

STD	Mutual of Omaha	
	Current	Renewal
STD/$10	*In rate guarantee until 2018*	

This is a brief summary of the benefits and rates offered. The Certificate of Coverage is the governing document for all benefits, requirements and limitations.
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Adams BENEFIT

Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

aetna®

2017 Broker commission in Florida

For agents, brokers and consultants selling to employer groups with 1 – 100 employees.

Commission highlights

Aetna Group Medical (1[+] – 100 employees) excluding AP/Sam's Club
(All counties with the exception of southern Florida, as set forth below)

Number of eligible employees enrolled	Commission per employee, per month (PEPM)	
	New	**Renewal**
1 – 3 employees	$1.50	$1.50
4 – 50 employees	$24.00 (ACA*) N/A (KWYH**)	$22.50 (ACA*) $30.50 (KWYH**)
51 – 100 employees	$32.00 Premier*** $28.00 Standard***	$30.50 Premier*** $26.50 Standard***

Aetna Group Medical (1[+] – 100 employees) excluding AP/Sam's Club
(All southern Florida counties: Brevard, Broward, Martin, Miami-Dade, Palm Beach, St. Lucie and Volusia counties)

Number of eligible employees enrolled	Commission per employee, per month (PEPM)	
	New	**Renewal**
1 – 3 employees	$1.50	$1.50
4 – 50 employees	$28.50 (ACA*) N/A (KWYH**)	$27.00 (ACA*) $36.50 (KWYH**)
51 – 100 employees	$38.00 Premier*** $32.00 Standard***	$36.50 Premier*** $30.50 Standard***

*Affordable Care Act
**Keep What You Have

***Premier and Standard producers as defined the Aetna Florida broker agreement

[+]In Florida, groups of less than two are eligible for medical coverage only and are subject to the commission schedule above.

Aetna Group Dental		
	Annual premium level	**Commission percentage**
2 – 50 employees	All Sold with medical	9% Additional 1%
51 – 100 employees	All	10%

Aetna Vision℠ Preferred		
	Annual premium level	**Commission percentage**
51 – 100 employees	All	10%

Aetna Group Life, AD&D and Disability		
	Annual premium level	**Commission percentage**
2 – 100 employees	All	15%

Commission question?

Send it to BrokerComm@aetna.com.

Brokers can directly e-mail the Aetna Producer Compensation Unit with questions or issues concerning commissions.

All your e-mail needs to include is:

- Customer, group or control number
- Your question
- Your name, Social Security number or National Producer Number (NPN) (if appointed with Aetna as an individual)
- Your name, agency name and tax ID (if appointed with Aetna as a firm)

For more information about Aetna's products, plans, and licensing and appointment procedures, visit www.aetna.com and select "Producers." While there, you can register with Aetna's Producer World® online service center, developed to meet the informational needs of our producers and general agents.

This material is intended for brokers only. The group commission schedules apply to new sales with effective dates on or after January 15, 2017. This schedule supersedes the group commissions in Addendum B of the Aetna Producer Agreement and in prior Producer Agreements, as well as group compensation scales presented within those agreements or in any other form. The additional one percent of dental premium is applicable when written with medical sales and is for the first year only. Commission scales reflect applicable regulatory requirements and may be subject to regulatory approval. Commissions are subject to change by Aetna at any time. Information is believed to be accurate as of the production date; however, it is subject to change.

www.aetna.com

75.03.023.1-FLA (1/17)

PROPOSAL FOR

Town of Surfside

RATES SHOWN ARE VALID FROM:
October 1, 2017 - December 15, 2017

Sales Representative: Michael Murray
Telephone: (813) 472-6144

SIC Code: 9111 State & Zip: FL 33154
Created: August 24, 2017

Guardian® Group Benefits in sync Innovative Solutions

PLAN DESIGN

We offer comprehensive benefits plans that can be customized to the needs of employers. To help you evaluate the plans, we have provided detailed benefits summaries within this package.

RATES

Rates and premiums presented are based on the employee data submitted in your request for a proposal. Final rates and premiums are based on the plans selected and the information provided on the enrollment forms.

BROAD RANGE OF PRODUCTS

We offer a variety of flexible, cost-effective employee benefits plans that can help employers meet the needs of employees and their families, and manage costs at the same time. Our benefits plans include Dental, Disability, Life, Vision, Critical Illness, and many more.

WHY GUARDIAN?

- **Enrollment Support** – Dedicated professionals help ensure smooth plan implementation
- **Multi-Product Discounts** – Combine plans to meet customer needs and save money
- **Convenient Access to Service** – One phone number and one secure website
- **Streamlined Billing** – All plans billed on one invoice
- **Experience & Expertise** – Over 50 years group benefits experience with exemplary ratings

Vision

RATES

Plan #1

All Eligible Employees	Employee	Employee & Spouse	Employee & Child(ren)	Full Family	Monthly Premium	Annual Premium
Monthly Rate	$7.14	$12.81	$13.07	$20.68	$484.47	$5,813.64
Census	24	6	7	7		
Rate Guarantee	1 Year					

Proposal Assumptions:

- *Commission: Flat 10%*

BENEFITS

	All Eligible Employees
Contribution/Participation	Voluntary, Assumes 45% of eligible employees. Vision is sold with Dental.
Dependent Age Limits	To Age 26
Network/Plan	Davis/Full Feature - Designer B
Copay	
Split(Exams/Materials)	$10/$25

SERVICE FREQUENCIES

	Once Every:
Eye Exams	Calendar Year
Lenses Benefit	Calendar Year
Contact Lenses	Calendar Year
Frames	Other Calendar Year

REIMBURSEMENT SCHEDULE

	In Network (Copay)	Out Network (Before Copay)
Eye Exams Benefit	$10	$50 max
Lenses Benefit		
Single Vision	$25	$48 max
Bifocal	$25	$67 max
Trifocal	$25	$86 max
Lenticular	$25	$126 max
Contact Lenses Benefit**		
Medically Necessary	Covered (Copay waived)	$210 max (Copay waived)
Elective	$130 max + 15% off balance (Copay waived)	$105 max (Copay waived)
Frames Benefit	$130 retail max + 20% off balance	$48 max

****In lieu of eyeglass lenses and/or frames**

PLAN HIGHLIGHTS

- Guardian's affiliation with Davis Vision offers access to over 43,000 provider locations nationwide, including private practice providers and many convenient retailers such as Wal-Mart, Sam's Club,Target, Sears, JC Penney and Pearle locations. On average 95% of members use an in network provider. Just visit GuardianLife.com and select "Looking for a dentist or vision provider?".
- All plan eyeglasses at national retailers come with a breakage warranty for repair or replacement of the frame and/or lenses for a period of one year from the date of delivery. At private practice providers the warranty would cover all lenses and frames from the Davis Vision Collection only.
- For calendar year plans, this plan allows for frames every two calendar years, regardless of whether the member obtained elective contact lenses the previous year.

(continued)

PLAN HIGHLIGHTS (continued)

- With our Designer plans, members will receive significant discounts on lens options, discounts will range from 20-60% off the U&C. For example, standard progressive lenses will cost $50 and scratch resistant coating will cost $20. Oversized lenses and fashion or gradient tinting of plastic lenses are covered in full.
- Full Feature plans receive a 20% discount off the amount exceeding the copay and allowance on non-Collection frames and 15% off the amount exceeding the copay and allowance on non-Collection contact lenses purchased from a participating provider. These discounts are not available at Wal-Mart and Sam's Club locations.
- With our Designer plans, frames from Davis' Fashion or Designer collections are covered in full in excess of the plan's materials copay. Frames from Davis' Premier collection are covered in full in excess of a $25 copay applied in addition to the plan's materials copay. Frames not in the collections are covered up to the plan's retail allowance in excess of the plan's materials copay. The Collections are available at most participating independent provider offices but not in retail locations.
- Contact lenses purchased from the Davis Collection are covered in full after the copay, if any, and the contact lens fitting and evaluations are included at no additional charge. The Collection is available at most participating independent provider offices but not in retail locations.

IMPORTANT NOTES

Rates and premiums are based on the employee data submitted. Final rates and premiums are based on the plan and employee/dependent data provided on the enrollment forms. State specific requirements apply.

- The covered person must remain enrolled until the plan's next vision annual open enrollment period. Someone who waives or drops coverage can't enroll until the plan's next vision annual open enrollment period. These requirements do not apply if the vision plan is sold on a non-contributory basis or if enrollment is tied-to a dental or medical plan.
- If an employee has employee/spouse vision coverage and the spouse obtains new employment and elects vision coverage with the new employer, Guardian lock-in does not apply to that spouse and the spouse is free to move with no negative impact.
- If an employee has employee/spouse vision coverage and **both** the employee and spouse elect to move over to the spouse's new employer's vision plan, again, Guardian lock-in does not apply to either spouse or employee.
- If an employee gets married and wishes to go on the new spouse's plan, the member may decline outside of open enrollment only if the member actually goes on the new spouse's plan.
- We reserve the right to adjust rates if actual participation is below assumed level. See the participation table for other participation rates. We reserve the right to withdraw this proposal if actual participation is below 25%.

Please see the Participation Section and the Summary of Plan Limitations and Exclusions that appears either on this page or the last page of this coverage.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

aetna : FL HNOnly 1000 80

Coverage Period: 10/01/2017 - 09/30/2018

Coverage for: Employee + Family | **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage at **https://www.aetna.com/sbcsearch/getpolicydocs?u=071200-100020-261698** or by calling **1-866-529-2517**. For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider**, or other underlined terms see the Glossary. You can view the Glossary at **https://www.healthcare.gov/sbc-glossary/** or call 1-866-529-2517 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall **deductible**?	In-network: Employee **$1,000** / Family **$2,000**.	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your **deductible**?	Certain office visits, preventive care, emergency care, urgent care and prescription drugs in-network.	This **plan** covers some items and services even if you haven't yet met the annual **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost sharing** and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other **deductibles** for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the **out-of-pocket limit** for this plan?	In-network: Employee **$3,500** / Family **$7,000**.	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the **out-of-pocket limit?**	Premiums and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a **network provider**?	Yes. See **www.aetna.com/docfind** or call 1-866-529-2517 for a list of in-network providers.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays (**balance billing**). Be aware, your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a **referral** to see a **specialist**?	No.	You can see the **specialist** you choose without a **referral**.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit, deductible does not apply	Not covered	None
	Specialist visit	$50 copay/visit, deductible does not apply	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that are not preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab: No charge; X-ray: $50 copay/visit, deductible does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	$300 copay/visit, deductible does not apply	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetna.com/pharmacy-insurance/individuals-families SG Value Plus Five Tier Open Formulary	Preferred generic drugs	Tier 1A: $3 copay (retail), $6 copay (mail order); Tier 1: $10 copay (retail), $20 copay (mail order)	Not covered	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Applicable cost share plus difference (brand minus generic cost) applies for brand when generic available unless Dispense as Written. No charge for preferred generic FDA-approved women's contraceptives in-network. Precertification and step therapy required.
	Preferred brand drugs	$50 copay (retail), $100 copay (mail order)	Not covered	
	Non-preferred generic/brand drugs	$75 copay (retail), $150 copay (mail order)	Not covered	
	Preferred specialty drugs, non-preferred specialty drugs	Preferred: 30% coinsurance up to a $300 maximum for up to a 30 day supply; Non-preferred: 50% coinsurance up to a $500 maximum for up to a 30 day supply	Not covered	Aetna Specialty CareRx℠ – First Prescription must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy®. Subsequent fills must be through Aetna Specialty Pharmacy®. Your plan may include access to CVS retail pharmacies for certain specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 copay/visit for hospital facility; $300 copay/visit for free standing facility, deductible does not apply	Not covered	None
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	$300 copay/visit, deductible does not apply	$300 copay/visit, deductible does not apply	Copay waived if admitted. Out-of-network emergency room care cost-share same as in-network. No coverage for non-emergency care.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network cost-share same as in-network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	$75 copay/visit, deductible does not apply	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	None
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay/visit, deductible does not apply	Not covered	None
	Inpatient services	20% coinsurance	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Coverage is limited to 60 visits.
	Rehabilitation services	20% coinsurance	Not covered	Coverage is limited to 35 visits for Physical Therapy, Occupational Therapy, Speech Therapy & Chiropractic care combined.
	Habilitation services	20% coinsurance	Not covered	Coverage is limited to 35 visits for Physical Therapy, Occupational Therapy, Speech Therapy & Chiropractic care combined, rehabilitation & habilitation combined.
	Skilled nursing care	20% coinsurance	Not covered	Coverage is limited to 60 days.
	Durable medical equipment	20% coinsurance, deductible does not apply	Not covered	Excludes vehicle modifications, home modifications & exercise equipment.
	Hospice services	20% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture - except as form of anesthesia.
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child) - except accidental injury.
- Glasses (Child)
- Hearing aids
- Infertility treatment - except the diagnosis and surgical treatment of underlying conditions.
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs - except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - Coverage is limited to 35 visits for Physical Therapy, Occupational Therapy, Speech Therapy & Chiropractic care combined, rehabilitation & habilitation combined.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Florida Department of Financial Services, Division of Consumer Services, (877) 693-5236, **http://www.floir.com/consumers**.

- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.
- If your coverage is a church **plan**, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.
- Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance **Marketplace**. For more information about the **Marketplace**, visit **www.HealthCare.gov** or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your **plan** for a denial of a **claim**. This complaint is called a **grievance** or **appeal**. For more information about your rights, look at the explanation of benefits you will receive for that medical **claim**. Your **plan** documents also provide complete information to submit a **claim appeal** or a **grievance** for any reason to your **plan**. For more information about your rights, this notice, or assistance, contact us by calling the toll free number on your Medical ID Card.

- Florida Department of Financial Services, Division of Consumer Services, (877) 693-5236, **http://www.floir.com/consumers**.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan Meet Minimum Value Standard? Yes.

If your **plan** doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a **plan** through the **Marketplace.**

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*----------

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this **plan** might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the **cost sharing** amounts (**deductibles**, **copayments** and **coinsurance**) and **excluded services** under the **plan**. Use this information to compare the portion of costs you might pay under different health **plans**. Please note these coverage examples are based on self-only coverage.

Peg is Having a baby

(9 months of in-network pre-natal care and a hospital delivery)

The **plan's** overall **deductible**	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other **coinsurance**	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copays	$100
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,260**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The **plan's** overall **deductible**	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other **coinsurance**	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copays	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The **plan's** overall **deductible**	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other **coinsurance**	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$800
Copays	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

Note: These numbers assume the patient does not participate in the **plan's** wellness program. If you participate in the **plan's** wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-866-529-2517.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-529-2517.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

TTY: 711

Language Assistance:

For language assistance in your language call 1-866-529-2517 at no cost.

Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-866-529-2517
Chinese -	欲取得繁體中文語言協助，請撥打 1-866-529-2517，無需付費。
French -	Pour une assistance linguistique en français appeler le 1-866-529-2517 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-866-529-2517 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-866-529-2517 an.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-866-529-2517 પર કોલ કરો.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-866-529-2517.
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-529-2517번으로 전화해 주십시오.
Polish -	Aby uzyskać pomoc w języku polskim zadzwoń bezpłatnie pod numer 1-866-529-2517.
Portuguese -	Para obter assistência linguística em português ligue para o 1-866-529-2517 gratuitamente.
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-529-2517.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-866-529-2517.
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-529-2517 nang walang bayad.
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-866-529-2517 ฟรีไม่มีค่าใช้จ่าย
Vietnamese -	Đê ̉được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-866-529-2517.

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PLAN DESIGN AND BENEFITS - FL 51-100 HNOption 2000 80 HSA (2016)

FL Group Business 51-100 Employees

PLAN FEATURES	NETWORK CARE	OUT-OF-NETWORK CARE
Primary Care Physician Selection	Not Required	Not Required
Deductible (per calendar year)	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family
Unless otherwise indicated, the deductible must be met before benefits can be paid.		
Claims from in-network and out-of-network providers do not cross-accumulate to satisfy the deductible.		
As indicated in the plan, member cost sharing for certain services are excluded from the charges to meet the deductible.		
Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the calendar year.		
Member Coinsurance (applies to all expenses unless otherwise stated)	20%	50%
Out-of-Pocket (OOP) Maximum (per calendar year, includes deductible)	$4,000 Individual $6,550 Family	$12,000 Individual $24,000 Family
Claims from in-network and out-of-network providers do not cross-accumulate to satisfy the out-of-pocket maximums.		
Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and copays may be used to satisfy the out of pocket maximum.		
Once the family payment limit is met, all family members will be considered as having met their payment limit for the remainder of the calendar year.		
Payment for Out-of-Network Care*	Not applicable	Professional: 90% of Medicare Facility: 90% of Medicare
Certification Requirements		
Certification for certain types of out-of-network care must be obtained to avoid a reduction in benefits paid for that care. Certification for hospital admissions, treatment facility admissions, skilled nursing facility admissions, home health care, and hospice care is required. If the necessary certification is not received, payment for services will be reduced by $400 per occurrence		
Referral Requirement	Not Required	Not applicable
PHYSICIAN SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Office Visits to Non-Specialist	20% after deductible	50% after deductible
Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illness or injury.		
Specialist Office Visits	20% after deductible	50% after deductible
Walk-in Clinics	20% after deductible	Not covered
Walk-in clinics are network, free-standing health care facilities. They are an alternative to a doctor's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor an outpatient department of a hospital, is considered a walk-in clinic.		
Maternity - Delivery and Post-Partum Care	20% after deductible	50% after deductible
Allergy Testing (given by a physician)	Member cost sharing is based on the type of service performed and the place rendered.	Not covered
Allergy Injections (not given by a physician)	Member cost sharing is based on the type of service performed and the place rendered.	50% after deductible
PREVENTIVE CARE	NETWORK CARE	OUT-OF-NETWORK CARE
Preventive care services are covered in accordance with Health Care Reform.		
Routine Adult Physical Exams and Immunizations Limited to 1 exam every 12 months.	Covered in full	50% after deductible
Well Child Exams and Immunizations Provides coverage for 7 exams in the first year of life; 3 exams in the second year; 3 exams in the third year; and 1 exam per 12 months from age 3 to age 22.	Covered in full	50% after deductible
Routine Gynecological Exams Includes Pap smear, HPV screening and related lab fees. Limited to 1 exam every 12 months.	Covered in full	50% after deductible

Routine Mammograms For covered females age 40 and over. Frequency schedule applies.	Covered in full	50% after deductible
Women's Health Includes: Screening for gestational diabetes; HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted infections; counseling and screening for human immunodeficiency virus; screening and counseling for interpersonal and domestic violence; breastfeeding support, supplies and counseling; Limitations may apply.	Covered in full	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Prenatal Maternity	Covered in full	50% after deductible
Routine Digital Rectal Exam / Prostate-Specific Antigen Test For covered males age 40 and over. Frequency schedule applies.	Covered in full	50% after deductible
Colorectal Cancer Screening Sigmoidoscopy and Double Contrast Barium Enema - 1 every 5 years for all members age 50 and over. Preventive Colonoscopy - 1 every 10 years for all members age 50 and over. Fecal Occult Blood Testing - 1 every year for all members age 50 and over.	Covered in full	50% after deductible
Routine Eye and Hearing Screenings	Paid as part of routine physical exam.	Paid as part of routine physical exam.
HEARING SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Hearing Exam (by Specialist)	Not covered	Not covered
Hearing Aid	Not covered	Not covered
VISION SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Adult Routine Eye Exams (Refraction)	Not covered	Not covered
Pediatric Routine Eye Exams (Refraction)	Not covered	Not covered
Adult Vision Hardware	Not covered	Not covered
Pediatric Vision Hardware	Not covered	Not covered
DIAGNOSTIC PROCEDURES	NETWORK CARE	OUT-OF-NETWORK CARE
Outpatient Diagnostic Laboratory	20% after deductible	50% after deductible
Outpatient Diagnostic X-ray (except for Complex Imaging Services)	20% after deductible	50% after deductible
Outpatient Diagnostic X-ray for Complex Imaging Services Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required.	20% after deductible	50% after deductible
EMERGENCY MEDICAL CARE	NETWORK CARE	OUT-OF-NETWORK CARE
Urgent Care Provider (Benefit Availability may vary by location.)	20% after deductible	50% after deductible
Non-Urgent Use of Urgent Care Provider	Not covered	Not covered
Emergency Room	20% after deductible	Paid as in-network
Non-Emergency care in an Emergency Room	Not covered	Not covered
Emergency Ambulance	20% after deductible	Paid as in-network
Non-Emergency Ambulance	20% after deductible	50% after deductible

HOSPITAL CARE	NETWORK CARE	OUT-OF-NETWORK CARE
Inpatient Coverage Including maternity (prenatal, delivery and postpartum) and transplants.	20% after deductible	50% after deductible
Outpatient Surgery Provided in an outpatient hospital department.	20% after deductible	50% after deductible
Outpatient Surgery Provided in a freestanding surgical facility.	20% after deductible	50% after deductible
Colonoscopy (non-preventive)	Member cost sharing is based on the type of service performed and the place rendered.	Member cost sharing is based on the type of service performed and the place rendered.
Transplants Coverage is limited to IOE facilities only.	20% after deductible	Not covered
MENTAL HEALTH and ALCOHOL/DRUG ABUSE SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Inpatient Mental Health	20% after deductible	50% after deductible
Outpatient Mental Health	20% after deductible	50% after deductible
Inpatient Detoxification	20% after deductible	50% after deductible
Outpatient Detoxification	20% after deductible	50% after deductible
Inpatient Rehabilitation	20% after deductible	50% after deductible
Outpatient Rehabilitation	20% after deductible	50% after deductible
OTHER SERVICES AND PLAN DETAILS	NETWORK CARE	OUT-OF-NETWORK CARE
Skilled Nursing Facility Coverage is limited to 60 days per calendar year. Network and Out-of-Network combined.	20% after deductible	50% after deductible
Home Health Care Coverage is limited to 60 visits per calendar year. Network and Out-of-Network combined; 1 visit equals a period of 4 hours or less.	20% after deductible	50% after deductible
Infusion Therapy Provided in the home or physician's office.	20% after deductible	50% after deductible
Infusion Therapy Provided in the outpatient hospital department of freestanding facility.	20% after deductible	50% after deductible
Inpatient Hospice Care	20% after deductible	50% after deductible
Outpatient Hospice Care	20% after deductible	50% after deductible
Private Duty Nursing -Outpatient	Not covered	Not covered
Outpatient Short-Term Rehabilitation - Physical Therapy If provided in the outpatient hospital department, paid under outpatient hospital benefit. Coverage is limited to 35 visits per calendar year PT/OT/ST/Chiro combined, rehabilitation & habilitation combined. Network and Out-of-Network combined.	20% after deductible	50% after deductible

Outpatient Short-Term Rehabilitation - Occupational Therapy If provided in the outpatient hospital department, paid under outpatient hospital benefit. Coverage is limited to 35 visits per calendar year PT/OT/ST/Chiro combined, rehabilitation & habilitation combined. Network and Out-of-Network combined.	20% after deductible	50% after deductible
Outpatient Short-Term Rehabilitation - Speech Therapy If provided in the outpatient hospital department, paid under outpatient hospital benefit. Coverage is limited to 35 visits per calendar year PT/OT/ST/Chiro combined, rehabilitation & habilitation combined. Network and Out-of-Network combined.	20% after deductible	50% after deductible
Outpatient Chiropractic If provided in the outpatient hospital department, paid under outpatient hospital benefit. Coverage is limited to 35 visits per calendar year PT/OT/ST/Chiro combined, rehabilitation & habilitation combined.	20% after deductible	50% after deductible
Acupuncture	Not covered	Not covered
Durable Medical Equipment	20% after deductible	50% after deductible
Diabetic Supplies not obtainable at a pharmacy	Covered same as any other medical expense.	Covered same as any other medical expense.
FAMILY PLANNING	NETWORK CARE	OUT-OF-NETWORK CARE
Infertility Treatment - Diagnostic only Covered only for the diagnosis and treatment of the underlying medical condition.	Member cost sharing is based on the type of service performed and the place rendered.	50% after deductible
Infertility Treatment - Artificial Insemination or Ovulation Induction	Not covered	Not covered
Advanced Reproductive Technology. Including, but not limited to, GIFT, ZIFT, IVF, ICSI, ovum microsurgery and cryopreserved embryo transfers.	Not covered	Not covered
Voluntary Sterilization - Vasectomy	Member cost sharing is based on the type of service performed and the place rendered.	50% after deductible
Voluntary Sterilization - Tubal Ligation	Covered in full	50% after deductible
ADULT DENTAL SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Adult Dental Services (not oral surgery)	Not covered	
PEDIATRIC DENTAL SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Preventive & Diagnostic (includes exams, cleanings, x-rays, fluoride, sealants)	Not covered	Not covered
Basic (includes space maintainers, fillings, anesthesia, denture adjustments)	Not covered	Not covered
Major (includes crowns, endodontics, periodontics, oral surgery, dentures, bridges)	Not covered	Not covered
Orthodontia (limited to medically necessary orthodontia)	Not covered	Not covered
PHARMACY DEDUCTIBLE	NETWORK CARE	OUT-OF-NETWORK CARE

Prescription drug calendar year deductible	Prescription drugs purchased at a network pharmacy are subject to the in-network medical deductible which must be satisfied before any prescription drug benefits are paid.	Prescription drugs purchased at a non-network pharmacy are subject to the non-network medical deductible which must be satisfied before any prescription drug benefits are paid.
PHARMACY - PRESCRIPTION DRUG BENEFITS	NETWORK CARE	OUT-OF-NETWORK CARE
Retail Up to a 30-day supply		
Generic Drugs	Low Cost Generic: $3 copayment after deductible Generic: $10 copayment after deductible	Not covered Not covered
Preferred Brand Drugs	$40 copayment after deductible	Not covered
Non-Preferred Drugs	Generic & Brand: $65 copayment after deductible	Not covered
Specialty Drugs Includes self-injectable, infused and oral specialty drugs (retail and mail order up to a 30-day supply, excludes insulin).	Specialty Preferred: 30% up to $300 after deductible Specialty Nonpreferred: 50% up to $500 after deductible	Not covered Not covered
Mail Order Delivery	When you fill your prescription by mail order, you may save money 31-90 days when compared to the cost to purchase your prescriptions at your local retail pharmacy.	
Generic Drugs	Low Cost Generic: $6 copayment after deductible Generic: $20 copayment after deductible	Not covered Not covered
Preferred Brand Drugs	$80 copayment after deductible	Not covered
Non-Preferred Drugs	Generic & Brand: $130 copayment after deductible	Not covered
Specialty Drugs Includes self-injectable, infused and oral specialty drugs	Not covered Not covered	Not covered Not covered
Specialty CareRx℠ -First Prescription for a specialty drugs must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy®. Subsequent fills must be through Aetna Specialty Pharmacy®. For more information, please go to **www.aetnaspecialtycarerx.com**		

Precertification - Not applicable

Step Therapy - Not applicable

Pharmacy Plan includes:

Diabetic supplies obtainable from a pharmacy (Including: needles, syringes, test strips, lancets and alcohol swabs - available at retail or mail order).

Coverage is excluded for lifestyle/performance drugs.

Formulary generic FDA-approved Womens Contraceptives covered 100% in network.

In-Network and Out-of-Network Providers

We cover the cost of services based on whether doctors are "in-network" or "out-of-network". We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

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

Your doctor sets his or her own rate to charge you. It may be higher - sometimes much higher - than what your Aetna plan "recognizes". Your non-network doctor may bill you for the dollar amount that Aetna doesn't "recognize". You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your 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.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to **www.aetna.com** and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site.

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

What's Not Covered

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design purchased.

- All medical or hospital services not specifically covered in or which are limited or excluded in the plan documents
- Charges related to any eye surgery mainly to correct refractive errors
- Cosmetic surgery, including breast reduction
- Custodial care
- Adult 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
- Non-medically necessary services or supplies
- Orthotics except as specified in the plan
- Over-the-counter medications and supplies
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs
- Special duty nursing
- Weight reduction programs, or dietary supplements

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

Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. Precertification requirements may vary.

If your plan covers outpatient prescription drugs, your plan includes a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step therapy, please refer to our website at **www.aetna.com**, or the Aetna Medication Formulary Guide. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. In addition, in circumstances where your prescription plan uses copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage.

Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna, Inc., that is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated charge with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services.

While this information is believed to be accurate as of the print date, it is subject to change.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

In-network benefits are provided by Aetna Health Inc. (AHI).

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