



PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	None Individual None Family	\$100 Individual \$200 Family
<p>All covered expenses accumulate separately toward the preferred or non-preferred Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Deductible amount.</p>		
Member Coinsurance	Covered 100%	10%
<p>Applies to all expenses unless otherwise stated.</p>		
Payment Limit (per calendar year)	None Individual None Family	\$600 Individual \$1,200 Family
<p>All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Payment Limit amount.</p>		
Lifetime Maximum	Unlimited except where otherwise indicated.	
Payment for Non-Preferred Care**	Not Applicable	Professional: 300% of Medicare Facility: 300% of Medicare
Primary Care Physician Selection	Not Applicable	Not Applicable
<p>Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is \$300 per occurrence.</p>		
Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/ Immunizations	Covered 100%	10%; after deductible
<p>1 exam every 12 months for members age 22 and older.</p>		
Routine Well Child Exams/Immunizations	Covered 100%	10%; after deductible
<p>7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 22.</p>		
Routine Gynecological Care Exams	Covered 100%	10%; after deductible
<p>Includes routine tests and related lab fees. One per calendar year.</p>		
Routine Mammograms	Covered 100%	10%; after deductible
<p>Recommended: One baseline mammogram for covered females age 35-39, one mammogram per calendar year for covered females age 40 and over.</p>		
Routine Digital Rectal Exam	Covered 100%	10%; after deductible
<p>Recommended for covered males age 40 and over.</p>		
Prostate-specific Antigen Test	Covered 100%	10%; after deductible
<p>Recommended for covered males age 40 and over.</p>		
Colorectal Cancer Screening	Covered 100%	10%; after deductible
<p>Recommended: For all members age 50 and over.</p>		



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Routine Hearing Screenings	Covered 100%	10%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to non-Specialist (non-surgical) Includes services of an internist, general physician, family practitioner or pediatrician.	Covered 100%	10%; after deductible
Specialist Office Visits (non-surgical)	Covered 100%	10%; after deductible
Office Visits for Surgery	Covered 100%	10%; after deductible
Audiometric Hearing Exam	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%	10% after deductible
Walk-in Clinics Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician'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 the outpatient department of a hospital, shall be considered a Walk-in Clinic.	Covered 100%	10%; after deductible
Allergy Testing	Your cost sharing is based on the type of service and where it is performed.	Your cost sharing is based on the type of service and where it is performed.
Allergy Injections	Your cost sharing is based on the type of service and where it is performed. Covered 100% when an office visit charge is not applicable.	Your cost sharing is based on the type of service and where it is performed.
DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	Covered 100%	10%; after deductible
Diagnostic Laboratory If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	Covered 100%	10%; after deductible
Diagnostic Outpatient Complex Imaging	Covered 100%	10%; after deductible
EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Provider	Covered 100%	10%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	Covered 100%	Same as in-network care; deductible waived
Non-Emergency Care in an Emergency Room	50%	50%; after deductible
Emergency Use of Ambulance	Covered 100%	10%; after deductible
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%	10%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%	10%; after deductible



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Outpatient Hospital Expenses	Covered 100%	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery	Covered 100%	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	Covered 100%	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	Covered 100%	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%	10%; after deductible
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	Covered 100%	10%; after deductible
Outpatient	Covered 100%	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%	10%; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Convalescent Facility	Covered 100%	10%; after deductible
Limited to 120 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	Covered 100%	10%; after deductible
Limited to 120 visits per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit. Includes Private Duty Nursing limited to 70 eight hour shifts per plan year, up to 8 hours of Private Duty Nursing equals 1 shift.		
Hospice Care - Inpatient	Covered 100%	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	Covered 100%	10%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Spinal Manipulation Therapy	Covered 100%	10%; after deductible
Limited to 60 visits per calendar year.		
Outpatient Short-Term Rehabilitation	Covered 100%	10%; after deductible
Includes speech, physical, and occupational therapy. Limited to 60 combined visits per calendar year.		
Autism Behavioral Therapy	Covered 100%	10%; after deductible
Covered same as any other Outpatient Mental Health benefit		
Autism Applied Behavior Analysis	Covered 100%	10%; after deductible
Covered same as any other Outpatient Mental Health Other Services benefit		
Autism Physical Therapy	Covered 100%	10%; after deductible
Autism Occupational Therapy	Covered 100%	10%; after deductible
Autism Speech Therapy	Covered 100%	10%; after deductible
Durable Medical Equipment	Covered 100%	10%; after deductible
Hearing Hardware	Covered 100%	Covered 100%; deductible waived
Limited to \$500 per ear per 36-month period.		



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Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Prescription Drugs	Prescriptions at a Retail facility Covered under Non-Preferred Care	10% after deductible (payable as any other covered expense) for up to 30-day supply obtained at a Retail facility
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%	40% (payable as any other covered expense) after medical deductible
Transplants	Covered 100% Preferred coverage is provided at an IOE contracted facility only.	10%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
"Other" Health Care -- 10% member coinsurance for services that are neither "preferred" nor "non-preferred".		
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed. Diagnosis and treatment of the underlying medical condition.	Your cost sharing is based on the type of service and where it is performed.
Comprehensive Infertility Services	Not Covered	Not Covered
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
Vasectomy	Your cost sharing is based on the type of service and where it is performed.	Your cost sharing is based on the type of service and where it is performed.
Tubal Ligation	Your cost sharing is based on the type of service and where it is performed.	Your cost sharing is based on the type of service and where it is performed.
PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Retail	Covered under Non-Preferred medical plan.	Covered under Non-Preferred medical plan.
Mail Order	\$5 copay for generic drugs and \$15 copay for brand-name drugs. Up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not Applicable

Plan Includes: Diabetic supplies, contraceptive drugs and devices obtainable from a pharmacy.
 Precert for growth hormones included



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GENERAL PROVISIONS

Dependents Eligibility Spouse, children from birth to age 26

**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 we pay 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 doctor who is out of network, your health plan may pay some of that doctor'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.

When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.

- For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.
- For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don'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 our website.

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 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 network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us 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.

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance, and deductibles for your in-network level of benefits. Under federal health care reform (Affordable Care Act), the government will allow some plans an exception to this rule. Contact us if your provider asks you to pay more. We will help you determine if you need to pay that bill.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.



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See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval.
- Durable medical Equipment
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids
- Home births
- Immunizations for travel or work, except where medically necessary or indicated.
- 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.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- Orthotics except diabetic orthotics.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Treatment of behavioral disorders.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

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. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.



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

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862**.

Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862**.

Plan features and availability may vary by location and group size.

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

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