



Aetna Health Inc.

PLAN DESIGN AND BENEFITS – POS Open Access Plan 713

PLAN FEATURES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Deductible (per calendar year)	\$5,250 Individual \$10,500 Family	\$7,000 Individual \$14,000 Family
<p>Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.</p>		
Member Coinsurance	0%	30%
Out-of-Pocket Maximum (per calendar year, includes deductible)	\$5,250 Individual \$10,500 Family	\$11,000 Individual \$22,000 Family excludes any applicable precertification penalty
<p>Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductible and copays (except any penalty amounts) may be used to satisfy the Out-of-Pocket Maximum. All covered expenses accumulate separately toward the participating and non-participating participating provider Out-of-Pocket Maximum. Once the Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.</p>		
Lifetime Maximum		\$5,000,000 per lifetime
<p>All covered expenses accumulate toward both the participating and non-participating participating provider Lifetime Maximum.</p>		
Payment for services from a Non-Participating Provider	Not applicable	Recognized Charge*
Primary Care Physician Selection	Not Required	Not applicable
<p>Precertification Requirement- certain non-participating provider services require precertification or benefits will be reduced. Refer to your plan documents for a complete list of services that require precertification.</p>		
Referral Requirement	None	None
PHYSICIAN SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Primary Care Physician Visits	0%, after deductible	30%, after deductible
Specialist Office Visits	0%, after deductible	30%, after deductible
Maternity OB Visits	0%, after deductible	30%, after deductible
Allergy Treatment	Same as applicable participating provider office visit member cost sharing.	30%, after deductible
Allergy Testing	Same as applicable participating provider office visit member cost sharing.	30%, after deductible



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PREVENTIVE CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Routine Adult Physical Exams / Immunizations age Age and frequency schedules apply.	\$0 copay; deductible waived	30%, after deductible
Well Child Exams / Immunizations Age and frequency schedules apply.	\$0 copay; deductible waived	30%, after deductible
Routine Gynecological Exams Frequency schedule applies. Includes Pap smear and related lab fees.	\$0 copay; deductible waived	30%, after deductible
Routine Mammograms One baseline mammogram for females age 35 – 39; and one annual mammogram for females age 40 and over.	\$0 copay; deductible waived	30%, after deductible
Routine Digital Rectal Exams /Prostate Specific Antigen Test Age/Frequency Schedule may apply.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Colorectal Cancer Screening For all members age 50 and over. Frequency schedule applies.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Routine Eye Exams at Specialist Age/Frequency Schedule may apply.	0%, after deductible	30%, after deductible
Routine Hearing Screening at Specialist (not optional – not an exam by audiologist – PCP screening only.)	Subject to Routine Physical Exam cost sharing.	30%, after deductible
DIAGNOSTIC PROCEDURES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Diagnostic Laboratory – (if performed as a part of a physician’s office visit and billed by the physician, expenses are covered subject to the applicable physician’s office visit member cost sharing.)	0%, after deductible	30%, after deductible
Diagnostic X-ray except for Complex Imaging Services – outpatient hospital or other outpatient facility	0%, after deductible	30%, after deductible
Diagnostic X-ray for Complex Imaging Services (including but not limited to MRI, MRA, PET and CT Scans)	0%, after deductible	30%, after deductible
EMERGENCY MEDICAL CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Urgent Care Provider	0%, after deductible	30%, after deductible
Non-Urgent use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room (waived if admitted)	0%, after deductible	Refer to participating provider benefit.
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Ambulance	0%, after deductible	Refer to participating provider benefit.

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HOSPITAL CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Inpatient Coverage (including maternity and transplants. Transplant Coverage is provided at an IOE contracted facility only.)	0%, after deductible	30%, after deductible
Outpatient Surgery	0%, after deductible	30%, after deductible
MENTAL HEALTH SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Inpatient Limited to 30 days per member per calendar year, Participating and Non-Participating combined.	0%, after deductible	Not Covered
Outpatient Limited to 20 visits per member per calendar year, Participating and Non-Participating combined.	0%, after deductible	Not Covered
ALCOHOL/DRUG ABUSE SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Inpatient Detoxification	0%, after deductible	30%, after deductible
Outpatient Detoxification	Not Covered	Not Covered
Inpatient Rehabilitation	Not Covered	Not Covered
Outpatient Rehabilitation	Not Covered	Not Covered
OTHER SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Skilled Nursing Facility Limited to 60 days per member per calendar year, Participating and Non-Participating combined.	0%, after deductible	30%, after deductible
Home Health Care Limited to 60 visits per member per calendar year Participating and Non-Participating combined; 1 visit equals a period of 4 hours or less.	0%, after deductible	30%, after deductible
Infusion Therapy Provided in the home or physician's office	0%, after deductible	30%, after deductible
Infusion Therapy Provided in an outpatient hospital department or freestanding facility	0%, after deductible	30%, after deductible
Hospice Care – Inpatient	0%, after deductible	30%, after deductible
Hospice Care – Outpatient	0%, after deductible	30%, after deductible
Outpatient Rehabilitation Therapy Includes speech, physical and occupational therapy. Limited to 30 visits per calendar year, Participating and Non-Participating combined.	0%, after deductible	30%, after deductible



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Georgia Small Group Choice POS
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Subluxation (Chiropractic) Limited to 20 visits per Calendar Year, Participating and Non-Participating combined.	0%, after deductible	30%, after deductible
Durable Medical Equipment Maximum benefit \$5000 per member per calendar year, Participating and Non-Participating combined.	0%, after deductible	30%, after deductible
Diabetic Supplies	0%, after deductible	Not covered
FAMILY PLANNING	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Infertility Treatment	Subject to applicable service type member cost sharing	Subject to applicable service type member cost sharing
Coverage for only the diagnosis and surgical treatment of the underlying medical cause.		
Voluntary Sterilization Including tubal ligation and vasectomy.	Subject to applicable service type member cost sharing	Subject to applicable service type member cost sharing
PHARMACY – PRESCRIPTION DRUG BENEFITS	PARTICIPATING PHARMACIES	NON-PARTICIPATING PHARMACIES
Retail Includes Self-Injectable drugs. Up to a 30 day supply at participating pharmacies.	0%, after deductible for generic formulary drugs, brand-name formulary drugs and non-formulary drugs.	Not covered
Mail Order Includes Self-Injectable drugs. 31- 90 day supply at participating pharmacies.	0%, after deductible for generic formulary drugs, brand-name formulary drugs and non-formulary drugs.	Not covered
Mandatory Generic with DAW override (MG w/DAW Override) - The member pays the applicable coinsurance only, if the physician requires brand. If the member requests brand when a generic is available, the member pays the applicable coinsurance plus the difference between the generic price and the brand price. Plan includes contraceptive drugs and devices obtainable from a pharmacy and diabetic supplies. Precertification and 90 day Transition of Care (TOC) for Precertification included.		

*Non-Participating Provider payments for facility charges are determined based upon Aetna's Allowable Fee Schedule. Non-Participating Provider payments for other charges are determined based upon the negotiated charge that would apply if such services or supplies were received from a Participating Provider. These charges are referred to in your plan documents as "recognized" charges.

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 or rider(s) purchased.**

- All medical and hospital services not specifically covered in, or which 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

PLAN DESIGN AND BENEFITS – POS Open Access Plan 713

Members participating in a cancer clinical trial).

- Hearing aids.
- Home births.
- 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.
- Non-medically 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, counseling, and prescription drugs.
- Special duty nursing.
- Surgical weight reduction procedures
- Therapy or rehabilitation other than those listed as covered in the plan documents.
- Treatment of behavioral disorders.

This plan imposes a pre-existing conditions exclusion, which may be waived in some circumstances (that is, creditable coverage) and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis or treatment was recommended or received or for which the individual took prescribed drugs within 180 days.

Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, 180 day lookback period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period.

If you had prior credible coverage within 90 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.

If you had no prior creditable coverage within the 90 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 90 day gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion.

In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any Certificates of Creditable Coverage you have. Please contact your Aetna Member Services representative at 1-888-702-3862 if you need assistance in obtaining a Certificate of Creditable Coverage from your prior carrier or if you have any questions on the information noted above.

The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment; the pre-existing exclusion will be applied from the individual's effective date of coverage

This material is for informational purposes only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Plan features and availability may vary by location and group size. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. With the exception of Aetna Rx Home Delivery, Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of

PLAN DESIGN AND BENEFITS – POS Open Access Plan 713

an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

If your plan covers outpatient prescription drugs, your plan may include 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 not 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 Aetna's website at 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 utilizes 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.

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

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

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

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