Aetna Advantage Plans for Individuals, Families and the Self-Employed

Pennsylvania

A Guide to Understanding Your Choices and Selecting a Quality Health Benefits or Insurance Plan

We want you to know®

Aetna®

13.02.311.1-PA (7/07)

Choose the Aetna Advantage plan that best fits your needs

We offer a variety of Aetna Advantage health coverage plans in Pennsylvania. Your Aetna Advantage plan choices are:

Aetna Open Access HMO Plans — No Referrals

Flexibility and no referrals needed for participating providers. With these health benefits plans, members may choose how they access covered benefits. Members can visit a participating Primary Care Physician and pay a lower copay or go directly to any participating physician and pay a higher copay. Members never need a referral when visiting a participating specialist for covered services.

The Open Access HMO — No Referrals provides:

- Freedom to choose a participating specialist without a referral.
- Flexibility — there's no referral needed from PCP to visit participating providers.
- No claim forms.
- No lifetime dollar maximums.
- Large provider network.

Aetna HMO Plans

Members access care through a participating Primary Care Physician. With these health benefits plans, members begin by selecting a PCP from Aetna's participating network of providers. A member selects a PCP who will coordinate their health care needs. Each covered member of the family may choose their own PCP.

The Aetna HMO provides:

- Large provider networks.
- Low out-of-pocket costs.
- No claim forms.
- Member's PCP coordinates their covered health care services.
- Fixed out-of-pocket costs for covered services.
- No lifetime dollar maximums.
- Referral is required for most specialist care.

PPO Plans

With the Pennsylvania PPO health insurance plans, you can visit any doctor or hospital you choose. (Your out-of-pocket costs will be lower if you select a provider from Aetna's wide network of participating physicians and hospitals.) In addition, there are no claim forms to fill out when you visit a network provider, and no referrals are required to see a specialist.

Preventative and Hospital Care Plans

The Preventative and Hospital Care Plans are ideal for individuals that are primarily looking for affordability when selecting a coverage option. This plan provides inpatient hospital coverage coupled with limited benefits for outpatient surgery, skilled nursing or home health care charges in lieu of hospitalization. In addition, these plans provide coverage for preventive care including annual GYN exam, well child care and physical exam every 24 months. The deductible on the Preventative and Hospital Care Plan applies to most covered expenses. NOTE: This plan provides limited benefits only and does not constitute a comprehensive health insurance plan. As such, it may not cover all the expenses associated with your health care needs.

High-Deductible PPO Plans (HSA-Compatible)

With the Pennsylvania High-Deductible PPO health insurance plans, you'll pay lower premiums in exchange for higher annual deductibles — at least $2,750 for individuals and $5,500 for families. A key advantage of this plan is that it can be paired with a Health Savings Account (HSA), a special account that lets you pay for qualified medical expenses with tax-advantaged funds.

What does "tax-advantaged" mean? It means you or an eligible family member can make contributions to your HSA tax-free. Those dollars earn interest tax-free. And when you make withdrawals to pay for qualified health care expenses, they're tax-free, too.

An HSA has other advantages as well. Among them:

- You own your HSA, so even if you change jobs or health insurance plans, the money in your account is yours to keep.
- Any money remaining in your HSA at the end of the year rolls over to the next year. You don't lose it.
- You can withdraw money directly from your HSA to cover qualified expenses. Account holders have convenient access to HSA funds with an Aetna Visa Debit Card or checkbook. Or, you can allow the account to grow over time and use it to help pay for future health-related expenses — like long-term care insurance premiums, COBRA premiums and certain retiree expenses.

First Dollar PPO Plans

With the First Dollar PPO Plans, you have the freedom to select any provider or hospital that you choose. If you select a participating provider or hospital from Aetna's wide network of participating providers and hospitals, you will have no deductible for medical services and pay a nominal copay for provider visits. A pharmacy deductible will apply.

Child Only Coverage

All of the Advantage plans in Pennsylvania are available for Child only. That is, you may choose to enroll your child even if no other family member enrolls. Coverage includes immunizations, well child visits, emergency room and dental preventive services (if dental is selected).

Note that if one of the HSA plans is selected for Child only enrollment, an HSA account is not available for the child.

Dental PPO Max Plan

With the Aetna Advantage Dental PPO Max insurance plan, you can obtain services from either a participating or non-participating dentist. Participating dentists have agreed to provide services at a negotiated rate for both covered services, **as well as non-covered services such as cosmetic tooth whitening and orthodontic care**, so you generally pay less out-of-pocket. You also have the flexibility to visit a dentist who does not participate in Aetna's network, though you will not benefit from negotiated fees.

Things You Need to Know to Enroll

To qualify for Aetna Advantage Plan, you must be:

- Under age 64 3/4 (If applying as a couple, both you and your spouse must be under 64 3/4)
- Over age 64 3/4 and not Medicare eligible.
- Under age 19 for dependent children
- Between ages 19 and 22 for unmarried dependent children with proof of full-time student status
- Legal residents in a state with products offered by the Aetna Advantage Plans
- Legal U.S. residents for at least 6 continuous months

Medical underwriting requirements

- The Aetna Advantage Plans are not guaranteed issue plans and require medical underwriting. Some individuals can be federally eligible under the Health Insurance Portability Accountability Act (HIPAA) for a special guaranteed issue plan under Pennsylvania laws and regulations.
- All applicants, enrolling spouses and dependents are subject to medical underwriting to determine eligibility and appropriate level of coverage.
- We offer various levels of coverage based on the known and predicted medical risk factors of each applicant.

Dental Coverage Requirements

- Dental is optional coverage to medical plans.
- Dental must be selected at time of medical enrollment and requires a 12 month commitment.

Levels of coverage and enrollment

- You may be enrolled in your selected plan at the standard premium charge.
- You may be enrolled in your selected plan at a higher rate, based on medical findings.
- You may be declined coverage based on significant medical risk factors.

Duplicate coverage

- If you are currently covered by another carrier, you must agree to discontinue the other coverage prior to or on the effective date of the Aetna Advantage Plan.

Pre-existing conditions

- During the first 12 months following your effective date of coverage, no coverage will be provided for the treatment of a pre-existing condition unless you have creditable prior coverage.
- A pre-existing condition is an illness or injury for which medical advice or treatment was recommended or received within 6 months preceding the effective date of coverage.

Terms of coverage

For the HMO plans your rates are guaranteed not to increase for 6 months from your effective date! For all other plans your rates are guaranteed not to increase for 12 months from your effective date. Final rates are subject to underwriting review.

Coverage remains in effect as long as you pay the required premium charges on time, and as long as you maintain membership eligibility. Coverage will be terminated if you become ineligible due to any of the following circumstances:

- Non-payment of premiums
- Residency requirements
- Obtaining duplicate coverage
- For other reasons permissible by law

Have Questions? Call your broker.

Is your doctor in the network?

Which local physicians, hospitals, pharmacies and eyewear providers participate in the Aetna Advantage Plan network? Use Aetna's online DocFind® tool at www.aetna.com/ docfind/custom/advplans. If you don't have Internet access, just call your broker and ask for a directory of providers.

All You Need to Know About Easy-Pay

Simple Automatic Payments via Electronic Funds Transfer (EFT)

Simple registration
- Complete the payment section of the Aetna Advantage Plans application. Initial payment can be made with EFT. Your payment will be deducted upon approval of the application.

Terminating EFT
- To terminate EFT, you will need to provide Aetna with 10 days written notice prior to the date your next EFT payment will be deducted.
- Without this written notice, your bank account may be debited for the next month's premium. You will then need to contact Aetna to have funds placed back in the checking account.

Refunds on EFT Accounts
- To process an EFT refund (placing money back in member's checking account), Aetna will require at least 5 days after the withdrawal was made to ensure valid payment.

Invoices for EFT Accounts
- You will not receive a paper invoice when you are enrolled in EFT. Payments will appear on your bank statement as "Aetna Autodebit Coverage."

Rejected EFT Transactions
- If the EFT payment rejects for any reason, Aetna will automatically terminate the EFT and send you a letter saying you will receive paper invoices. Processing time to reinstate EFT will be 30–60 days.
- If an EFT payment is rejected, you will need to pay that payment by paper check or credit card.

Timing for EFT
- Payments for Cycle 1 accounts (1st of the month effective date) will be taken from your bank account between the 3rd and the 10th of the month the premium is due.
- Payments for Cycle 2 account (15th of the month effective date) will be taken from your bank account between the 18th and 23rd of the month the premium is due.

Aetna's Pennsylvania Service Area*

The Pennsylvania counties where Aetna Advantage Plans are offered.

WESTERN

Allegheny
Armstrong
Beaver
Blair
Butler
Cambria
Clarion
Erie
Fayette
Greene
Indiana
Jefferson
Lawrence
Mercer
Somerset
Washington
Westmoreland

Bolded counties indicate HMO & PPO plans available.

CENTRAL

Adams
Cumberland
Dauphin
Franklin
Fulton
Lancaster
Lebanon
Perry
Schuylkill
York

SOUTHEASTERN

Berks
Bucks
Carbon
Chester
Delaware
Lehigh
Monroe
Montgomery
Northampton
Philadelphia

NORTHEASTERN

Bradford
Clinton
Columbia
Lackawanna
Luzerne
Lycoming
Northumberland
Pike
Snyder
Sullivan
Susquehanna
Wayne
Wyoming

*Networks may not be available in all zip codes and are subject to change.

PENNSYLVANIA AETNA ADVANTAGE PLAN OPTIONS

	OPEN ACCESS HMO 10	HMO 15	HMO 20
MEMBER BENEFITS			
Primary Care Physician Visit	$10 copay	$15 copay	$20 copay
Specialist Visit	$20 copay	$25 copay	$30 copay
Hospital Admission (also see Maternity)	$100 copay per day (5 day maximum per admission)	$200 copay per day (5 day maximum per admission)	$400 copay per day (5 day maximum per admission)
Outpatient Surgery	$100 copay	$200 copay	$400 copay
Emergency Room (waived if admitted)	$100 copay	$100 copay	$100 copay
Annual Routine Gyn Exam (Annual Pap/Mammogram)	$20 copay (1 visit per 365 consecutive day period)	$25 copay (1 visit per 365 consecutive day period)	$30 copay (1 visit per 365 consecutive day period)
Maternity Obstetrician Visits	$20 copay for Initial Visit, $0 thereafter	$25 copay for Initial Visit, $0 thereafter	$30 copay for Initial Visit, $0 thereafter
Maternity Hospital (Includes Newborn Services)	$100 copay per day up to 5-day maximum per admission	$200 copay per day up to 5-day maximum per admission	$400 copay per day up to 5-day maximum per admission
Preventive Health (Annual Physical)	$10 copay	$15 copay	$20 copay
Lab/X-Ray	$20 copay	$25 copay	$30 copay
Skilled Nursing (60 days per calendar year)	$100 copay per day (5 day maximum per admission) (waived if a member is transferred from a hospital to a skilled nursing facility)	$200 copay per day (5 day maximum per admission) (waived if a member is transferred from a hospital to a skilled nursing facility)	$400 copay per day (5 day maximum per admission) (waived if a member is transferred from a hospital to a skilled nursing facility)
Outpatient Therapies (60 consecutive day period per instance of illness or injury)	$20 copay/visit	$25 copay/visit	$30 copay/visit
Home Health Care (60 visits per calendar year)	$20 copay/visit	$25 copay/visit	$30 copay/visit
Durable Medical Equipment ($1,000 per calendar year)	50% of the contracted rate per item	50% of the contracted rate per item	50% of the contracted rate per item
Out-of-Pocket Maximum Individual/Family	$2,000/$4,000	$3,000/$6,000	$4,000/$8,000
PHARMACY			
Calendar Year Deductible Individual/Family	$100/$300	$100/$300	$250/$750
Generic/Preferred Brand/ Non-Preferred Brand (Oral Contraceptives and Diabetic Supplies Included)	$15/$25/$35	$15/$25/$35	$15/$25/$35
Calendar Year Maximum Individual/Family	$2,500/$5,000	$2,500/$5,000	$2,500/$5,000

Members selecting an HMO Plan are required to select a Pennsylvania Participating Primary Care Physician (PCP) and obtain services within the Pennsylvania service area, except in an emergency or urgent situation. Rates are based on the service area of your Pennsylvania PCP.

A summary of exclusions is listed on page 21–22. For a full list of benefit coverage and exclusions refer to the plan documents.

PENNSYLVANIA AETNA ADVANTAGE PLAN OPTIONS

	PPO 20		PPO 25		PPO 30	
MEMBER BENEFITS	In-Network	Out-of-Network**	In-Network	Out-of-Network**	In-Network	Out-of-Network**
Deductible Individual Family	 $500 $1,000	 $500 $1,000	 $1,500 $3,000	 $1,500 $3,000	 $2,500 $5,000	 $2,500 $5,000
Coinsurance	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Coinsurance Maximum Individual Family	 $2,000 $4,000	 $2,000 $4,000	 $3,000 $6,000	 $3,000 $6,000	 $5,000 $10,000	 $5,000 $10,000
Lifetime Maximum* per insured	$5,000,000		$5,000,000		$5,000,000	
Non-specialist Office Visit (General Physician, Family Practitioner, Pediatrician or Internist)	$20 copay not subject to deductible	50% after deductible	$25 copay not subject to deductible	50% after deductible	$30 copay not subject to deductible	50% after deductible
Specialist Visit	$30 copay not subject to deductible	50% after deductible	$35 copay not subject to deductible	50% after deductible	$40 copay not subject to deductible	50% after deductible
Hospital Admission (also see Maternity)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency Room after deductible	$100 copay (waived if admitted) and 20%		$100 copay (waived if admitted) and 20%		$100 copay (waived if admitted) and 20%	
Annual Routine Gyn Exam (Annual Pap/Mammogram)	$30 copay not subject to deductible	50% after deductible	$35 copay not subject to deductible	50% after deductible	$40 copay not subject to deductible	50% after deductible
Maternity Obstetrician Visits	$30 copay Initial Visit $0 thereafter not subject to deductible	50% after deductible	$35 copay Initial Visit $0 thereafter not subject to deductible	50% after deductible	$40 copay Initial Visit $0 thereafter not subject to deductible	50% after deductible
Maternity Hospital	$2,000 copay 20% after deductible	$2,000 copay 50% after deductible	$2,000 copay 20% after deductible	$2,000 copay 50% after deductible	$2,000 copay 20% after deductible	$2,000 copay 50% after deductible
Preventive Health (Annual Physical) ($200 per calendar year*)	$20 copay not subject to deductible	50% after deductible	$25 copay not subject to deductible	50% after deductible	$30 copay not subject to deductible	50% after deductible
Lab/X-Ray	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Skilled Nursing (in lieu of hospital) (30 days per calendar year*)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Physical Therapy/Spinal Manipulation (24 combined visits max per calendar year*)	20% after deductible up to $25 maximum benefit	50% after deductible up to $25 maximum benefit	20% after deductible up to $25 maximum benefit	50% after deductible up to $25 maximum benefit	20% after deductible up to $25 maximum benefit	50% after deductible up to $25 maximum benefit
Home Health Care (30 visits per calendar year*)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Durable Medical Equipment ($2,000 per calendar year*)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
PHARMACY						
Generic (Oral Contraceptives and Diabetic Supplies Included)	$15 copay not subject to deductible	$15 copay plus 50% not subject to deductible	$15 copay not subject to deductible	$15 copay plus 50% not subject to deductible	$15 copay not subject to deductible	$15 copay plus 50% not subject to deductible
Calendar Year Deductible per Individual	$250 (does not apply to generic)		$250 (does not apply to generic)		$500 (does not apply to generic)	
Preferred Brand/Non-Preferred Brand (Oral Contraceptives and Diabetic Supplies Included)	$25/$40 copay after deductible	$25/$40 copay plus 50% after deductible	$25/$40 copay after deductible	$25/$40 copay plus 50% after deductible	$25/$40 copay after deductible	$25/$40 copay plus 50% after deductible
Calendar Year Maximum per Individual*	$5,000		$5,000		$5,000	

* Calendar year maximum also applies to combined in and out of network benefits

** Payment for out-of-network facility care is determined based upon Aetna's Allowable Fee Schedule. Payment for other out-of-network care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider.

A summary of exclusions is listed on page 21–22. For a full list of benefit coverage and exclusions refer to the plan documents.

PENNSYLVANIA AETNA ADVANTAGE PLAN OPTIONS

	PPO 40		HIGH DEDUCTIBLE PPO 1 (HSA COMPATIBLE)		HIGH DEDUCTIBLE PPO 2 (HSA COMPATIBLE)	
MEMBER BENEFITS	In-Network	Out-of-Network**	In-Network	Out-of-Network**	In-Network	Out-of-Network**
Deductible Individual Family	 $5,000 $10,000	 $5,000 $10,000	 $2,750 $5,500	 $5,500 $11,000	 $5,000 $10,000	 $10,000 $20,000
Coinsurance	20% after deductible	50% after deductible	20% after deductible	50% after deductible	0% after deductible	0% after deductible
Coinsurance Maximum Individual Family	 $7,500 $15,000	 $7,500 $15,000	 $5,000 $10,000	 $10,000 $20,000	 $5,000 $10,000	 $10,000 $20,000
Lifetime Maximum* per insured	$5,000,000		$5,000,000 per member lifetime		$5,000,000 per member lifetime	
Non-specialist Office Visit (General Physician, Family Practitioner, Pediatrician or Internist)	$40 copay not subject to deductible	50% after deductible	$20 copay after deductible	50% after deductible	0% after deductible	0% after deductible
Specialist Visit	$50 copay not subject to deductible	50% after deductible	$30 copay after deductible	50% after deductible	0% after deductible	0% after deductible
Hospital Admission (also see Maternity)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	0% after deductible	0% after deductible
Outpatient Surgery	20% after deductible	50% after deductible	20% after deductible	50% after deductible	0% after deductible	0% after deductible
Emergency Room after deductible	$100 copay (waived if admitted) and 20%		$100 copay (waived if admitted) and 20%		0% after deductible	0% after deductible
Annual Routine Gyn Exam (Annual Pap/Mammogram)	$50 copay not subject to deductible	50% after deductible	0% not subject to deductible	50% after deductible	0% not subject to deductible	0% after deductible
Maternity Obstetrician Visits	$50 copay Initial Visit $0 thereafter not subject to deductible	50% after deductible	$30 copay after deductible for Initial Visit $0 thereafter	50% after deductible	0% after deductible	0% after deductible
Maternity Hospital	$2,000 copay 20% after deductible	$2,000 copay 50% after deductible	20% after deductible	50% after deductible	0% after deductible	0% after deductible
Preventive Health (Annual Physical) ($200 per calendar year*)	$40 copay not subject to deductible	50% after deductible	$20 copay not subject to deductible	50% after deductible	$25 copay not subject to deductible	0% after deductible
Lab/X-Ray	20% after deductible	50% after deductible	20% after deductible	50% after deductible	0% after deductible	0% after deductible
Skilled Nursing (in lieu of hospital) (30 days per calendar year*)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	0% after deductible	0% after deductible
Physical Therapy/Spinal Manipulation (24 combined visits max per calendar year*)	20% after deductible up to $25 maximum benefit	50% after deductible up to $25 maximum benefit	20% after deductible up to $25 maximum benefit	50% after deductible up to $25 maximum benefit	0% after deductible up to $25 maximum benefit	0% after deductible up to $25 maximum benefit
Home Health Care (30 visits per calendar year*)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	0% after deductible	0% after deductible
Durable Medical Equipment ($2,000 per calendar year*)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	0% after deductible	0% after deductible
PHARMACY						
Generic (Oral Contraceptives and Diabetic Supplies Included)	$15 copay not subject to deductible	$15 copay plus 50% not subject to deductible	$15 copay after deductible	$15 copay plus 50% after deductible	0% after deductible	0% after deductible
Calendar Year Deductible per Individual	$500 (does not apply to generic)		Integrated Medical/RX deductible		Integrated Medical/RX deductible	
Preferred Brand/Non-Preferred Brand (Oral Contraceptives and Diabetic Supplies Included)	$25/$40 copay after deductible	$25/$40 copay plus 50% after deductible	$25/$40 copay after deductible	$25/$40 copay plus 50% after deductible	0% after deductible	0% after deductible
Calendar Year Maximum per Individual*	$5,000		$5,000		$5,000	

* Calendar year maximum also applies to combined in and out of network benefits

** Payment for out-of-network facility care is determined based upon Aetna's Allowable Fee Schedule. Payment for other out-of-network care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider.

A summary of exclusions is listed on page 21–22. For a full list of benefit coverage and exclusions refer to the plan documents.

PENNSYLVANIA AETNA ADVANTAGE PLAN OPTIONS

	PREVENTATIVE AND HOSPITAL CARE 1250		PREVENTATIVE AND HOSPITAL CARE 3000 (HSA-COMPATIBLE)	
MEMBER BENEFITS	In-Network	Out-of-Network+	In-Network	Out-of-Network+
Deductible Individual	$1,250	$2,500	$3,000	$6,000
Deductible Family	2 Person Max.**	2 Person Max.**	$6,000	$12,000
Coinsurance (Member's responsibility)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Coinsurance Maximum Individual Family	 $2,500 2 Person Max.++	 $5,000 2 Person Max.++	 $5,000 $10,000	 $10,000 $20,000
Lifetime Maximum* per insured	$5,000,000	$5,000,000	$5,000,000	$5,000,000
Non-Specialist Office Visit (General Physician, Family Practitioner Pediatrician or Internist)	Not Covered	Not Covered	Not Covered	Not Covered
Specialist Visit	Not Covered	Not Covered	Not Covered	Not Covered
Hospital Admission	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency Room (after deductible)	$100 copay (waived if admitted) 20%		$100 copay (waived if admitted) 20%	
Annual Routine Gyn Exam (Annual Pap/Mammogram)	$35 copay not subject to deductible	50% after deductible	$40 copay not subject to deductible	50% after deductible
Maternity	Not Covered	Not Covered	Not Covered	Not Covered
Preventative Health (Physical-every 24 months*) ($200 per exam)	$25 copay not subject to deductible	50% after deductible	$35 copay not subject to deductible	50% after deductible
Lab/X-Ray	Not Covered	Not Covered	Not Covered	Not Covered
Skilled Nursing (in lieu of hospital) (30 days per calendar year*)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Physical/Occupational/Chiropractic Services/Speech Therapy	Not Covered	Not Covered	Not Covered	Not Covered
Home Health Care (30 visits per calendar year*)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Durable Medical Equipment	Not Covered	Not Covered	Not Covered	Not Covered
PHARMACY				
Pharmacy Deductible per individual	Not Covered***	Not Covered***	Not Covered***	Not Covered***
Generic (Oral Contraceptives Included)	Not Covered***	Not Covered***	Not Covered***	Not Covered***
Preferred Brand	Not Covered***	Not Covered***	Not Covered***	Not Covered***
Non-Preferred Brand (Oral Contraceptives Included)	Not Covered***	Not Covered***	Not Covered***	Not Covered***
Calendar Year Maximum per Individual	Not Covered***	Not Covered***	Not Covered***	Not Covered***

* Maximum applies to combined in and out of network benefits.

** Once two members of the Family each meet their individual calendar year deductibles, from then on each other member of the family will be considered to have met their deductibles for the calendar year.

*** Discount card available

\+ Payment for out-of-network facility care is determined based upon Aetna's Allowable Fee Schedule. Payment for other out-of network care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider.

++ Once two members of a family reach their individual Payment Limit in a Calendar Year, benefits will be payable for all family members at 100% (copays will still apply) for Covered Medical Expenses incurred by all family members during the rest of that Calendar Year. Deductible does not apply to Coinsurance Maximum.

A summary of exclusions is listed on page 21–22. For a full list of benefit coverage and exclusions refer to the plan documents.

PENNSYLVANIA AETNA ADVANTAGE PLAN OPTIONS

	FIRST DOLLAR PPO 25		FIRST DOLLAR PPO 35	
MEMBER BENEFITS	In-Network	Out-of-Network+	In-Network	Out-of-Network+
Deductible Individual	$0	$5,000	$0	$7,000
Deductible Family	$0	2 Person Max.**	$0	2 Person Max.**
Coinsurance (Member's responsibility)	25%	50% after deductible	35%	50% after deductible
Coinsurance Maximum Individual Family	$2,500 2 Person Max.++	$5,000 2 Person Max.++	$3,500 2 Person Max.++	$5,500 2 Person Max.++
Lifetime Maximum	$5,000,000		$5,000,000	
Non-Specialist Office Visit (General Physician, Family Practitioner Pediatrician or Internist)	$25 copay	50% after deductible	$35 copay	50% after deductible
Specialist Visit	$35 copay	50% after deductible	$45 copay	50% after deductible
Hospital Admission	25%	50% after deductible	35%	50% after deductible
Outpatient Surgery	25%	50% after deductible	35%	50% after deductible
Emergency Room (after deductible)	$100 copay (waived if admitted) 25%		$100 copay (waived if admitted) 35%	
Annual Routine Gyn Exam (Annual Pap/Mammogram)	$35 copay	50% after deductible	$45 copay	50% after deductible
Maternity	Not Covered	Not Covered	Not Covered	Not Covered
Preventative Health (Physical-every 24 months*) ($200 per exam)	$25 copay	50% after deductible	$35 copay	50% after deductible
Lab/X-Ray	25%	50% after deductible	35%	50% after deductible
Skilled Nursing (in lieu of hospital) (30 days per calendar year*)	25%	50% after deductible	35%	50% after deductible
Physical/Occupational/Chiropractic Services/Speech Therapy (24 visits per calendar year*)	25%	50% after deductible	35%	50% after deductible
Home Health Care (30 visits per calendar year*)	25%	50% after deductible	35%	50% after deductible
Durable Medical Equipment ($2,000 per calendar year*)	25%	50% after deductible	35%	50% after deductible
PHARMACY				
Pharmacy Deductible per individual	$250		$500	
Generic (Oral Contraceptives Included)	$15 copay not subject	$15 copay plus 50% not subject to deductible	$15 copay not subject	$15 copay plus 50% not subject to deductible
Preferred Brand	$25 copay after deductible	$25 copay plus 50% after deductible	$25 copay after deductible	$25 copay plus 50% after deductible
Non-Preferred Brand (Oral Contraceptives Included)	$40 copay after deductible	$40 copay plus 50% after deductible	$40 copay after deductible	$40 copay plus 50% after deductible
Calendar Year Maximum per Individual	$5,000		$5,000	

* Maximum applies to combined in and out of network benefits.

** Once two members of the Family each meet their individual calendar year deductibles, from then on each other member of the family will be considered to have met their deductibles for the calendar year.

\+ Payment for out-of-network facility care is determined based upon Aetna's Allowable Fee Schedule. Payment for other out-of network care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider.

++ Once two members of a family reach their individual Payment Limit in a Calendar Year, benefits will be payable for all family members at 100% for Covered Medical Expenses incurred by all family members during the rest of that Calendar Year. Deductible does not apply to Coinsurance Maximum.

A summary of exclusions is listed on page 21–22. For a full list of benefit coverage and exclusions refer to the plan documents.

INDIVIDUAL DENTAL PPO MAX PLAN

MEMBER BENEFITS	PREFERRED	NONPREFERRED
Annual Deductible per Member (Does not apply to Diagnostic and Preventive Services)	$25; $75 family maximum	$25; $75 family maximum
Annual Maximum Benefit	Unlimited	Unlimited
DIAGNOSTIC SERVICES		
Oral Exams		
Periodic oral exam	100% not subject to ded	50% not subject to ded
Comprehensive oral exam	100% not subject to ded	50% not subject to ded
Problem-focused oral exam	100% not subject to ded	50% not subject to ded
X-rays		
Bitewing — single film	100% not subject to ded	50% not subject to ded
Complete series	100% not subject to ded	50% not subject to ded
PREVENTIVE SERVICES		
Adult cleaning	100% not subject to ded	50% not subject to ded
Child cleaning	100% not subject to ded	50% not subject to ded
Sealants — per tooth	Discount	Not Covered
Fluoride application — with cleaning	100% not subject to ded	50% not subject to ded
Space maintainers	Discount	Not Covered
BASIC SERVICES		
Amalgam filling — 2 surfaces	100% after ded	50% after ded
Resin filling — 2 surfaces anterior	Discount	Not Covered
Oral Surgery	Discount	Not Covered
Extraction – exposed root or erupted tooth	Discount	Not Covered
Extraction of impacted tooth —soft tissue	Discount	Not Covered
MAJOR SERVICES		
Complete upper denture	Discount	Not Covered
Partial upper denture (resin base)	Discount	Not Covered
Crown — Porcelain with noble metal	Discount	Not Covered
Pontic — Porcelain with noble metal	Discount	Not Covered
Inlay — Metallic (3 or more surfaces)	Discount	Not Covered
Oral Surgery		
Removal of impacted tooth — partially bony	Discount	Not Covered
Endodontic Services		
Bicuspid root canal therapy	Discount	Not Covered
Molar root canal therapy	Discount	Not Covered
Periodontic Services		
Scaling & root planing — per quadrant	Discount	Not Covered
Osseous surgery — per quadrant	Discount	Not Covered
ORTHODONTIC SERVICES	Discount	Not Covered

Access to negotiated discounts: members are eligible to receive non covered services, including cosmetic services such as tooth whitening, at the PPO negotiated rate when visiting a participating PPO dentist at any time.

Nonpreferred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate.
All products not available in all counties. Please refer to the county list on page 8.

A summary of exclusions is listed on page 21–22. For a full list of benefit coverage and exclusions refer to the plan documents.

Pennsylvania Limitations and Exclusions

Medical

These medical plans do not cover all health care expenses and include 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.

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

- 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
- Donor egg retrieval
- Weight control services including surgical procedures for the treatment of obesity, medical treatment, and weight control/loss programs
- Experimental and investigational procedures, (except for coverage for medically necessary routine patient care costs for Members participating in a cancer clinical trial)
- Charges in connection with pregnancy complications are covered on plans that do not offer maternity coverage.
- 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
- Medical expenses for a pre-existing condition are not covered for the first 365 days after the member's effective date. Lookback period for determining a pre-existing condition (conditions for which diagnosis, care or treatment was recommended or received) is 6 months prior to the effective date of coverage. If the applicant had prior creditable coverage within 63 days immediately before the signature on the application, then the pre-existing conditions exclusion of the plan will be waived.
- Nonmedically necessary services or supplies
- Orthotics
- Over-the-counter medications and supplies
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling
- Special or private duty nursing
- Therapy or rehabilitation other than those listed as covered in the plan documents
- Mental health in-network services for PPO plans not covered, except for severe biologically based mental or nervous disorders

Dental

Listed below are some of the charges and services for which these dental plans do not provide coverage. For a complete list of exclusions and limitations, refer to plan documents

- Dental Services or supplies that are primarily used to alter, improve or enhance appearance. *Negotiated rates for cosmetic procedures available when a participating dentist is accessed.*
- Experimental services, supplies or procedures
- Treatment of any jaw joint disorder, such as temporomandibular joint disorder
- Replacement of lost or stolen appliances and certain damaged appliances
- Those services that Aetna defines as not necessary for the diagnosis, care or treatment of a condition involved
- All other limitations and exclusions in your plan documents

10-day right to review

Do not cancel your current insurance until you are notified that you have been accepted for coverage.

We'll review your application to determine if you meet underwriting requirements. If you're denied, you'll be notified by mail. If you're approved, you'll be sent an Aetna Advantage Plan contract and ID card.

If, after reviewing the contract, you find that you're not satisfied for any reason, simply return the contract to us within 10 days. We will refund any premium you've paid (including any contract fees or other charges) less the cost of any services paid on behalf of you or any covered dependent.

The Aetna Advantage Plans for individuals and families are offered, underwritten or administered by Aetna Life Insurance Company through an out-of-state blanket trust and/or Aetna Health Inc.

This managed care plan may not cover all of your health care expenses. Read your contract carefully to determine which health care services are covered. To contact the plan if you are a member, call the number on your ID card; all others, call 1-888-98-AETNA (1-888-982-3862).

If you need this material translated into another language, please call Member Services at 1-866-565-1236.

Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-866-565-1236.

This material is for information only and is not an offer or invitation to contract. Plan features and availability may vary by location. Plans may be subject to medical underwriting or other restrictions. Rates and benefits may vary by location. Investment services are independently offered through JPMorgan Institutional Investors, Inc., a subsidiary of JPMorgan Chase Bank. 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. Not all health services are covered. See health insurance plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. Aetna receives rebates from drug makers 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. Information is subject to change. Health benefits and health insurance plans contain exclusions and limitations.

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

We want you to know®

Aetna®

www.aetna.com

13.02.311.1-PA (7/07)