Aetna Health Inc.
Aetna Health Insurance Company

PLAN DESIGN AND BENEFITS – POS Open Access Plan 943

PLAN FEATURES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Deductible (per calendar year)	$2,250 Individual $4,500 Family	$4,000 Individual $8,000 Family

Unless otherwise indicated, the Deductible must be met prior to benefits being payable. All covered expenses accumulate separately toward the participating and non-participating Deductible. Member cost sharing for certain services including copayments and member cost sharing for prescription drugs, as indicated in the plan, are excluded from 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. No one family member may contribute more than the Individual Deductible amount to the Family Deductible.

Member Coinsurance	30%	50%
Out-of-Pocket Maximum (per calendar year, excludes deductible)	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family excludes any applicable precertification penalty

All covered expenses accumulate separately toward the participating and non-participating Out-of-Pocket Maximum. Only those out-of-pocket expenses resulting from the application of coinsurance percentage and copays for inpatient admissions and outpatient surgery (except any penalty amounts) may be used to satisfy the 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. No one family member may contribute more than the Individual Out-of-Pocket Maximum amount to the Family Out-of-Pocket Maximum.

Lifetime Maximum	$5,000,000 per lifetime

All covered expenses accumulate toward both the participating and non-participating participating provider Lifetime Maximum.

Payment for services from a Non-Participating Provider	Not applicable	Recognized Charge*
Primary Care Physician Selection	Not Required	Not applicable
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.		
Referral Requirement	None	None

PHYSICIAN SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Primary Care Physician Visits	$40 copay; deductible waived	50%, after deductible
Specialist Office Visits	$60 copay; deductible waived	50%, after deductible
Maternity OB Visits	30%, after deductible	50%, after deductible

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Primary Care Physician E-Visits An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor.	$40 copay; deductible waived	Not Covered
Specialist E-Visits An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor.	$60 copay; deductible waived	Not Covered
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 an outpatient department of a hospital, shall be considered a Walk-in Clinic.	$60 copay; deductible waived	50%, after deductible
Allergy Treatment	Same as applicable participating provider office visit member cost sharing.	50%, after deductible
Allergy Testing	Same as applicable participating provider office visit member cost sharing.	50%, after deductible
PREVENTIVE CARE	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Routine Adult Physical Exams / Immunizations One exam every 24 months to age 65, then annually thereafter.	$40 copay; deductible waived	50%, after deductible
Well Child Exams / Immunizations Ages birth-6 months: One exam every 2 months Ages 9-18 months: One exam every 3 months Ages 2-18 years: One exam per calendar year	$40 copay; deductible waived	50%, after deductible
Routine Gynecological Exams Frequency schedule applies. Includes Pap smear and related lab fees.	$40 copay; deductible waived	50%, after deductible
Routine Mammograms One baseline mammogram for females age 35 – 39; and one annual mammogram for females age 40 and over, or as directed by provider.	$40 copay; deductible waived	50%, 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.	50%, after deductible

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Routine (or Preventive) Colorectal Cancer Screening Sigmoidoscopy and Double Contrast Barium Enema (DCBE) - 1 every 5 years for all members age 50 and over; Colonoscopy - 1 every 10 years for all members age 50 and over; Fecal Occult Blood Testing (FOBT) - 1 every year for all members age 50 and over	$40 copay; deductible waived	50%, after deductible
Routine Eye Exams at Specialist Age/Frequency Schedule may apply.	$40 copay; deductible waived	50%, after deductible
Routine Hearing Screening at PCP	Subject to Routine Physical Exam cost sharing.	50%, 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 copay; deductible waived	50%, after deductible
Diagnostic X-ray except for Complex Imaging Services – outpatient hospital or other outpatient facility	30%, after deductible	50%, after deductible
Diagnostic X-ray for Complex Imaging Services (including but not limited to MRI, MRA, PET and CT Scans)	30%, after deductible	50%, after deductible
EMERGENCY MEDICAL CARE	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Urgent Care Provider	$75 copay; deductible waived	50%, after deductible
Non-Urgent use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room (waived if admitted)	$200 copay; deductible waived	Refer to participating provider benefit.
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Ambulance	30%, after deductible	Refer to participating provider benefit.
HOSPITAL CARE	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Inpatient Coverage (including maternity and transplants. Transplant Coverage is provided at an IOE contracted facility only.)	30% after $1000 per admission; after deductible	50%, after deductible
Outpatient Surgery	30% after $500 copay; after deductible	50%, after deductible
MENTAL HEALTH SERVICES	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Inpatient /Residential Treatment	30% after $1000 per admission; after deductible	50%, after deductible
Outpatient	$60 copay; deductible waived	50%, after deductible

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ALCOHOL/DRUG ABUSE SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Inpatient Detoxification	30% after $1000 per admission; after deductible	50%, 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.	30% after $1000 per admission; after deductible	50%, 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.	30%, after deductible	50%, after deductible
Infusion Therapy Provided in the home or physician's office	$60 copay; deductible waived	50%, after deductible
Infusion Therapy Provided in an outpatient hospital department or freestanding facility	30%, after deductible	50%, after deductible
Hospice Care – Inpatient	30% after $1000 per admission; after deductible	50%, after deductible
Hospice Care – Outpatient	30%, after deductible	50%, after deductible
Outpatient Rehabilitation Therapy Includes speech, physical and occupational therapy. Limited to 30 visits per calendar year, Participating and Non-Participating combined.	$60 copay; deductible waived	50%, after deductible
Chiropractic Limited to 20 visits per Calendar Year, Participating and Non-Participating combined.	$60 copay; deductible waived	50%, after deductible
Durable Medical Equipment Maximum benefit $5000 per member per calendar year, Participating and Non-Participating combined.	30%, after deductible	50%, after deductible
Diabetic Supplies	Prescription drug copay	Not covered
FAMILY PLANNING	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Infertility Treatment Coverage for only the diagnosis and surgical treatment of the underlying medical cause.	Subject to applicable service type member cost sharing	Subject to applicable service type member cost sharing
Voluntary Sterilization Including tubal ligation and vasectomy.	Subject to applicable service type member cost sharing	Subject to applicable service type member cost sharing

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PHARMACY – PRESCRIPTION DRUG BENEFITS	PARTICIPATING PHARMACIES	NON-PARTICIPATING PHARMACIES
Retail Includes Self-Injectable drugs. Up to a 30 day supply at participating pharmacies.	$15 copay for generic formulary drugs, $45 copay for brand-name formulary drugs, and $70 copay for non-formulary drugs	Not covered
Mail Order Includes Self-Injectable drugs. 31- 90 day supply at participating pharmacies.	$37.50 copay for generic formulary drugs, $112.50 copay for brand-name formulary drugs, and $175 copay for non-formulary drugs	Not covered
No Mandatory Generic (No MG) – Member is responsible to pay the applicable copay only.		
Plan includes contraceptive drugs and devices obtainable from a pharmacy and diabetic supplies, Plan excludes: Lifestyle/performance enhancing drugs		
Precertification, Step-Therapy and 90 day Transition of Care (TOC) for Step Therapy and Precertification included		

* You may choose providers in Aetna's network (physicians and facilities) or you may visit an out-of-network provider. Typically, you will pay substantially more money out of your own pocket if you choose to use an out-of-network doctor. The out-of-network provider will be paid based on Aetna's "recognized charge." This is not the same as the billed charge from the doctor.

Aetna pays a percentage of the recognized charge, as defined in your plan. You may have to pay the difference between the out-of-network provider's billed charge and Aetna's recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the doctor bills you above Aetna's recognized charge does not count toward your deductible or out-of-pocket maximums.

For out-of-network physicians and other out-of-network providers, the recognized charge is based on the Aetna Market Fee Schedule (also referred to as Aetna Out-of-Network Rates), which are Aetna's standard rates used to begin contract negotiations with providers who participate in our network. Since not all network doctors contract at standard rates, our payment to an out-of-network provider may be based on rates lower than we pay to providers in our network. For out-of-network hospitals and other out-of-network facilities the recognized charge is based on the Aetna Facility Fee Schedule.

This benefit applies when you *choose* to get care out of network. When you have no choice in the doctors you see (for example, an emergency room visit after a car accident), your deductible and coinsurance for the in-network level of benefits will be applied, and you should contact Aetna if your doctor asks you to pay more. Generally, you are not responsible for any outstanding balance billed by your doctors in an emergency situation.

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.

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- 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.
- 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 heath 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 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.