PLAN DESIGN AND BENEFITS - New York Open Access MC 3-11 HSA Compatible

PLAN FEATURES	NETWORK CARE	OUT-OF-NETWORK CARE
Deductible (per plan year)	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. All covered expenses accumulate separately toward the network and out-of-network Deductible. The Individual Deductible can only be met when a member is enrolled for self only coverage with no dependent coverage. The Family Deductible can be met by a combination of family members or by any single individual within the family. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the plan year.		
Member Coinsurance (applies to all expenses unless otherwise stated)	20% after deductible	40% after deductible
Maximum Out-of-Pocket Limit (per plan year, includes deductible)	$5,500 Individual $11,000 Family	$9,000 Individual $18,000 Family
All covered expenses accumulate separately toward the network and out-of-network Maximum Out-of-Pocket Limit. Only those network & out-of-network expenses resulting from the application of deductible, coinsurance percentage and copays, including prescription drug copays (not including any penalty amounts), may be used to satisfy the Maximum Out-of-Pocket Limit. The Individual Maximum Out-of-Pocket Limit can only be met when a member is enrolled for self only coverage with no dependent coverage. The Family Maximum Out-of-Pocket Limit can be met by a combination of family members or by any single individual within the family. Once the Family Maximum Out-of-Pocket Limit is met, all family members will be considered as having met their Maximum Out-of-Pocket Limit for the remainder of the plan year. Members must continue to pay any penalty amounts after meeting their Out-of-Pocket Maximum.		
Lifetime Maximum (per member lifetime)	Unlimited	Unlimited
Payment for Out-of-Network Care*	Not applicable	Professional: 110% of Medicare Facility: 140% of Medicare

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

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your Aetna 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, Aetna limits the amount it will pay. This limit is called the “recognized” or “allowed” amount. When you choose out-of-network care, Aetna “recognizes” an amount based on what Medicare pays for these services. The government sets the Medicare rate.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna plan "recognizes." Your doctor may bill you for the dollar amount that Aetna doesn't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit Aetna.com. Type "how Aetna pays" in the search box.

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

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

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PLAN FEATURES, cont.	NETWORK CARE	OUT-OF-NETWORK CARE
Primary Care Physician Selection	Not applicable	Not applicable
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, and Hospice Care is required. Benefits will be reduced by $400 per occurrence if Certification is not obtained.		
Referral Requirement	None	None
PHYSICIAN SERVICES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Office Visits to Primary Care Physician Includes services of an internist, general physician, family practitioner or pediatrician for routine care as well as diagnosis and treatment of an illness or injury	20% after deductible	40% after deductible
Specialist Office Visits	20% after deductible	40% after deductible
Maternity OB Visits	20% after deductible	40% after deductible
Surgery (in office)	20% after deductible	40% after deductible
Allergy Testing (given by a physician)	20% after deductible	40% after deductible
Allergy Injections (not given by a physician)	20% after deductible	40% after deductible
PREVENTIVE CARE	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Routine Adult Physical Exams / Immunizations 1 exam every 12 months ages 19 and over Network and Out-of-Network combined	$0 copay; deductible waived	40% after deductible / 0%; deductible waived
Well Child Exams / Immunizations 7 exams in the first 12 months of life; 3 visits in the second 12 months of life; 3 visits in the third 12 months of life;1 exam per year thereafter to age 19 Network and Out-of-Network combined	$0 copay; deductible waived	0%; deductible waived
Routine Gynecological Care Exams Two routine exams per plan year Network and Out-of-Network combined	$0 copay; deductible waived	40% after deductible
Routine Mammograms One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over Network and Out-of-Network combined	$0 copay; deductible waived	40% after deductible
Routine Digital Rectal Exam / Prostate-Specific Antigen Test 1 exam per plan year for men with prior history, 1 exam per plan year age 50 and over if asymptomatic, 1 exam per plan year ages 40 and over if family history or other risk factor Network and Out-of-Network combined	$0 copay; deductible waived	40% after deductible

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PREVENTIVE CARE, cont.	NETWORK CARE	OUT-OF-NETWORK CARE
Routine 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 Network and Out-of-Network combined	$0 copay; deductible waived	40% after deductible
Routine Eye Exams at Specialist One routine exam every 24 months Network and Out-of-Network combined	$0 copay; deductible waived	40% after deductible
Routine Hearing Exams	Not covered	Not covered
DIAGNOSTIC PROCEDURES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Outpatient 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	20% after deductible	40% after deductible
Outpatient Diagnostic X-ray including Complex Imaging Services 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	20% after deductible	40% after deductible
EMERGENCY MEDICAL CARE	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Urgent Care Provider	20% after deductible	40% after deductible
Non-Urgent Use of Urgent Care Provider	Not covered	Not covered
Emergency Room	20% after deductible	Paid as Network Care
Non-Emergency care in an Emergency	Not covered	Not covered
Emergency Ambulance	20% after deductible	Paid as Network Care
HOSPITAL CARE	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Inpatient Coverage Including maternity (prenatal, delivery and postpartum) & transplants Transplant coverage is provided at an Institute of Excellence™ contracted facility only	20% after deductible	40% after deductible
Outpatient Surgery Provided in an outpatient hospital department or a freestanding surgical facility	20% after deductible	40% after deductible
Outpatient Hospital Services other than Surgery Including, but not limited to, dialysis, radiation therapy and infusion therapy	20% after deductible	40% after deductible
MENTAL HEALTH SERVICES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Inpatient Biologically Based Mental Illness and Children with Serious Emotional Disturbances Unlimited days per member per plan year Network and Out-of-Network combined	20% after deductible	40% after deductible

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MENTAL HEALTH SERVICES, cont.	NETWORK CARE	OUT-OF-NETWORK CARE
Outpatient Biologically Based Mental Illness and Children with Serious Emotional Disturbances Unlimited visits per member per plan year Network and Out-of-Network combined	20% after deductible	40% after deductible
Inpatient Other than Biologically Based Mental Illness and Children with Serious Emotional Disturbances Limited to 30 days per member per plan year Network and Out-of-Network combined	20% after deductible	40% after deductible
Outpatient Other than Biologically Based Mental Illness and Children with Serious Emotional Disturbances Limited to 20 visits per member per plan year Network and Out-of-Network combined	20% after deductible	40% after deductible
ALCOHOL / DRUG ABUSE SERVICES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Inpatient Detoxification Limited to 7 days per member per plan year Network and Out-of-Network combined	20% after deductible	40% after deductible
Outpatient Detoxification Limited to 60 visits per member per plan year, including 20 visits per plan year for family counseling Network and Out-of-Network combined	20% after deductible	40% after deductible
Inpatient Rehabilitation Limited to 30 days per member per plan year Network and Out-of-Network combined	20% after deductible	40% after deductible
Outpatient Rehabilitation Limited to 60 visits per member per plan year, including 20 visits per plan year for family counseling Network and Out-of-Network combined	20% after deductible	40% after deductible
OTHER SERVICES AND PLAN DETAILS	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Skilled Nursing Facility Limited to 60 days per member per plan year Network and Out-of-Network combined	20% after deductible	40% after deductible
Home Health Care Limited to 40 visits per member per plan year; Limited to 3 intermittent visits per day by a Home Health Care agency, 1 visit equals a period of 4 hours or less Network and Out-of-Network combined	25% after deductible	40% after deductible
Inpatient Hospice Care	20% after deductible	40% after deductible
Outpatient Hospice Care	20% after deductible	40% after deductible
Private Duty Nursing - Outpatient	Not covered	Not covered

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OTHER SERVICES AND PLAN DETAILS, cont.	NETWORK CARE	OUT-OF-NETWORK CARE
Outpatient Short-Term Rehabilitation Includes speech, physical and occupational therapy Limited to 30 combined visits per member per plan year Network and Out-of-Network combined	20% after deductible	40% after deductible
Outpatient Spinal Manipulation Therapy (Chiropractic)	20% after deductible	40% after deductible
Durable Medical Equipment Maximum benefit of $1,500 per member per plan year Network and Out-of-Network combined	50% after deductible	50% after deductible
Diabetic Drugs and Supplies obtainable at a pharmacy Including, but not limited to, insulin, test strips, lancets and syringes	20% after deductible	40% after deductible
Diabetic Supplies not obtainable at a pharmacy Including, but not limited to, insulin pumps and insulin pump supplies	Covered same as any other medical expense	Covered same as any other medical expense
Contraceptive drugs and devices not obtainable at a pharmacy Includes coverage for contraceptive visits	Covered same as any other medical expense	Covered same as any other medical expense
Glasses and Contact Lens Reimbursement Network and Out-of-Network combined	Not covered	
FAMILY PLANNING	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Infertility Treatment Covered only for the diagnosis and treatment of the underlying medical condition	Member cost sharing is based on the type of service performed and the place rendered	40% after deductible
Comprehensive Infertility Services	Member cost sharing is based on the type of service performed and the place rendered	40% after deductible
Voluntary Sterilization Including tubal ligation and vasectomy	Member cost sharing is based on the type of service performed and the place rendered	40% after deductible

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PHARMACY - PRESCRIPTION DRUG BENEFITS	PARTICIPATING PHARMACIES	NON-PARTICIPATING PHARMACIES
Prescription drug plan year deductible Must be satisfied before any prescription drug benefits are paid	Integrated with medical plan	Integrated with medical plan
Retail Up to a 30-day supply	After plan deductible is met, $15 copay for generic drugs, $35 copay for brand name formulary drugs, and $70 copay for brand name non-formulary drugs	After plan deductible is met, 30% of submitted cost after $15 copay for generic drugs,$35 copay for brand name formulary drugs, and $70 copay for brand name non-formulary drugs
Mail Order Delivery 31-90 day supply	After plan deductible is met, $30 copay for generic drugs, $70 copay for brand name formulary drugs, and $140 copay for brand name non-formulary drugs	Not covered
Specialty CareRx - First Prescription for a specialty drug must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy®. Subsequent fills must be through Aetna Specialty Pharmacy®.		
Mandatory Generic (MG) - If the member or the physician requests brand when generic is available, the member pays the applicable copay and/or coinsurance plus the difference between the generic price and the brand price		
Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy		
Precertification included and 90 day Transition of Care (TOC) for Precertification included		

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 or hospital services not specifically covered in, or which are limited or excluded in the plan documents;
- Charges related to any eye surgery mainly to correct refractive errors;
- Cosmetic surgery, other than reconstructive surgery following a mastectomy;
- Custodial care;
- Dental care and x-rays, other than treatment of sound natural teeth due to an accidental injury within 12 months following the injury or care needed to repair congenital defects or anomalies;
- Donor egg retrieval;
- Experimental and investigational procedures, except in connection with certain types of clinical trials;
- Hearing aids;
- Nonmedically necessary services or supplies;
- Orthotics;
- Over-the-counter medications and supplies;
- Reversal of sterilization;
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs, unless medically necessary; and
- Treatment of those services for or related to treatment of obesity or for diet or weight control, unless medically necessary.

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Pre-existing Conditions Exclusion Provision

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 6 months.

Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6 month period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 12 months 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 creditable coverage within 63 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 63 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 63 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 1-800-80-AETNA 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 under the age of 19. 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.

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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.

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

If your plan covers outpatient prescription drugs, your plan 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.

Plans are provided by Aetna Life Insurance Company.

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