Aetna

Aetna Health Inc. (Participating)
Aetna Health Insurance Company (Non-Participating)

PA Small Group QPOS
Plan Effective Date: 10/1/2010

PLAN DESIGN AND BENEFITS - PA POS COST-SHARING 3.4 ($1,500 DED)

PLAN FEATURES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Deductible (per calendar year)	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 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. The participating Deductible applies to the following participating benefits: Inpatient Hospital Care (including maternity); Outpatient Surgery; Inpatient Serious Mental Illness; Inpatient Non-Serious Mental Illness; Inpatient Detoxification; Inpatient Rehabilitation; Skilled Nursing Facility; Inpatient Hospice and Transplants. The non-participating Deductible applies to all non-participating benefits unless state mandated. 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. Deductible credit applies. Deductible carryover does not apply.		
Plan Coinsurance *	Not Applicable	50%
Out-of-Pocket Maximum (per calendar year, includes deductible)	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family
Amounts over the Recognized Charge, failure to pre-certification penalties and member cost-sharing for prescription drug benefits do not apply toward the Out-of-Pocket Maximum. All covered expenses accumulate separately toward the participating and non-participating 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	Unlimited	Unlimited
Payment for services from a Non-Participating Provider	Not Applicable	Professional: 105% of Medicare** Facility: 140% of Medicare**
Primary Care Physician Selection	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	Required for all non-emergency, non-urgent and non-Primary Care Physician services, except direct access services.	Not Applicable
PHYSICIAN SERVICES	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Primary Care Physician Visits	Office Hours: $30 Copay, deductible waived After Office Hours/Home: $35 Copay, deductible waived	50% after deductible
Specialist Office Visits	$50 Copay, deductible waived	50% after deductible
Maternity OB Visits	$50 Copay for Initial Visit Only, deductible waived	50% after deductible
Allergy Treatment	Same as applicable participating provider office visit member cost sharing.	50% after deductible
Allergy Testing	$50 Copay, deductible waived	50% after deductible

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PREVENTIVE CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Routine Adult Physical Exams/ Immunizations (Limited to one exam per calendar year. Participating and Non-Participating combined.)	$0 Copay, deductible waived	50%, deductible waived
Well Child Exams/Immunizations (Age and frequency schedules apply. Participating and Non-Participating combined.)	$0 Copay, deductible waived	50%, deductible waived
Routine Gynecological Exams (One routine exam and pap smear per 365 days. Participating and Non-Participating combined.)	$0 Copay, deductible waived	50%, deductible waived
Routine Mammograms (One annual mammogram for females age 40 and over. Participating and Non-Participating combined.)	$0 Copay, deductible waived	50% after deductible
Routine Digital Rectal Exams/Prostate Specific Antigen Test (For covered males age 40 and over. Age and frequency schedules may apply. Participating and Non-Participating combined.)	$0 Copay, deductible waived	Member cost sharing is based on the type of service performed and the place rendered.
Colorectal Cancer Screening (For all members age 50 and over. Frequency schedule applies. Participating and Non-Participating combined.)	$0 Copay, deductible waived	Member cost sharing is based on the type of service performed and the place rendered.
Routine Eye Exams at Specialist (Limited to one routine exam per 24 months. Participating and Non-Participating combined.)	$0 Copay, deductible waived	50% after deductible
Vision Corrective Lenses/ Contact Lenses Allowance	$100 reimbursement payable once for 24-month period, deductible waived	Refer to participating provider benefit.
Routine Hearing Screening at PCP Covered only as part of a physical exam.	Subject to Routine Physical Exam cost sharing.	Subject to Routine Physical Exam cost sharing.
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 cost sharing.)	$0 Copay, deductible waived	50% after deductible
Diagnostic X-ray (except for Complex Imaging Services) - Outpatient Hospital or Other Outpatient Facility	$50 Copay, deductible waived	50% after deductible
Diagnostic X-ray for Complex Imaging Services (Includes MRA/MRS, MRI, PET and CAT Scans)	$200 Copay, deductible waived	50% after deductible

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EMERGENCY MEDICAL CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Urgent Care Provider	$200 Copay, deductible waived	50% after deductible
Non-Urgent use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room (Copay waived if admitted.)	$200 Copay, deductible waived	Refer to participating provider benefit.
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Emergency Ambulance	$0 Copay, deductible waived	Refer to participating provider benefit.
Non-Emergency Ambulance	$0 Copay, deductible waived	50% after deductible
HOSPITAL CARE	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Inpatient Coverage (Including maternity and transplants) (Transplants: Coverage, provided at an IOE contracted facility only, is subject to Participating cost-sharing. Coverage provided at a non-IOE contracted facility, is subject to Non-Participating cost-sharing.)	$0 Copay per admission after deductible	50% after deductible
Outpatient Surgery	$0 Copay after deductible	50% after deductible
MENTAL HEALTH SERVICES	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Inpatient Serious Mental Illness (Limited to 30 days per member per calendar year. May convert inpatient days to outpatient visits on a 1 to 4 basis. Maximum 10 inpatient days for 40 additional outpatient visits; 1 inpatient day may be exchanged for 2 days of partial hospitalization and/or outpatient electroshock therapy. Participating and Non-Participating combined.)	$0 Copay per admission after deductible	50% after deductible
Outpatient Serious Mental Illness (Limited to 60 visits per member per calendar year. Participating and Non-Participating combined.)	$50 Copay, deductible waived	50% after deductible
Inpatient Non-Serious Mental Illness (Limited to 30 days per member per calendar year. May convert inpatient days to outpatient visits on a 1 to 4 basis. Maximum 10 inpatient days for 40 additional outpatient visits; 1 inpatient day may be exchanged for 2 days of partial hospitalization and/or outpatient electroshock therapy. Participating and Non-Participating combined.)	$0 Copay per admission after deductible	50% after deductible
Outpatient Non-Serious Mental Illness (Limited to 20 visits per member per calendar year. Participating and Non-Participating combined.)	$50 Copay, deductible waived	50% after deductible

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ALCOHOL/DRUG ABUSE SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Inpatient Detoxification (***Participating*** : Unlimited days per member per calendar year. ***Non-Participating:*** 7 days per member per admission; 4 admissions per member per lifetime. Participating and Non-Participating combined.)	$0 Copay per admission after deductible	50% after deductible
Outpatient Detoxification	$50 Copay, deductible waived	50% after deductible
Inpatient Rehabilitation (Limited to 30 days per member per calendar year; 90 days per member per lifetime. Participating and Non-Participating combined.)	$0 Copay per admission after deductible	50% after deductible
Outpatient Rehabilitation (Limited to 60 visits per member per calendar year; 120 visits per member per lifetime. Thirty (30) full or partial session visits of the 60 visits may be exchanged on a 2 for 1 basis for up to 15 non-hospital residential substance abuse treatment days. Participating and Non-Participating combined.)	$50 Copay, deductible waived	50% after deductible
OTHER SERVICES	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Skilled Nursing Facility (Limited to 120 days per member per calendar year. Participating and Non-Participating combined.)	$0 Copay per admission after deductible	50% after deductible
Home Health Care (Limited to 60 visits per member per calendar year. 1 visit equals a period of 4 hours or less. Participating and Non-Participating combined.)	$50 Copay, deductible waived	50% after deductible
Infusion Therapy (Provided in the home or physician's office)	$50 Copay, deductible waived	50% after deductible
Infusion Therapy (Provided in an outpatient hospital department or freestanding facility.)	$0 Copay after deductible	50% after deductible
Hospice Care - Inpatient	$0 Copay per admission after deductible	50% after deductible
Hospice Care - Outpatient	$0 Copay, deductible waived	50% after deductible
Outpatient Physical and Occupational Therapy (Physical and Occupational Therapy limited to 30 visits [combined] per member per calendar year. Participating and Non-Participating combined.)	$50 Copay, deductible waived	50% after deductible
Outpatient Speech Therapy (Limited to 30 visits per member per calendar year. Participating and Non-Participating combined.)	$50 Copay, deductible waived	50% after deductible

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OTHER SERVICES (CONTINUED)	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Subluxation (Chiropractic) (Limited to 20 visits per member per calendar year. Participating and Non-Participating combined.)	$50 Copay, deductible waived	50% after deductible
Durable Medical Equipment (Maximum benefit of $2,500 per member per calendar year. Participating and Non-Participating combined.)	50%, deductible waived	50% after deductible (Must pre-certify if over $1,500.)
FAMILY PLANNING	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Infertility Treatment (Coverage for only the diagnosis and surgical treatment of the underlying medical cause.)	Member cost sharing is based on the type of service performed and the place rendered.	50% after deductible
Voluntary Sterilization (Including tubal ligation and vasectomy.)	Member cost sharing is based on the type of service performed and the place rendered.	50% after deductible
PHARMACY- PRESCRIPTION DRUG BENEFITS	**PARTICIPATING PHARMACIES**	**NON-PARTICIPATING PHARMACIES**
Prescription Drug Deductible	Not Applicable	Not Applicable
Retail Up to a 30-day supply	$15 Copay for generic formulary drugs, $40 Copay for brand-name formulary drugs, and $70 Copay for generic and brand-name non-formulary drugs	Not Covered
Mail Order 31-90 day supply	$30 Copay for generic formulary drugs, $80 Copay for brand-name formulary drugs, and $140 Copay for generic and brand-name non-formulary drugs	Not Covered
Specialty CareRx℠ Drugs	90% plan coinsurance, 10% member coinsurance, for formulary and 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®.		
No Mandatory Generic (No MG) - Member is responsible to pay the applicable copay or coinsurance.		
Plan includes diabetic supplies, contraceptive drugs and devices obtainable from a pharmacy.		
Precertification and step-therapy included and 90 day Transition of Care (TOC) for Precertification and Step Therapy included.		

* The dollar amount copayments indicate what the member is required to pay and the percentage copayments indicate what Aetna is required to pay.

** You may choose providers in our network (physicians and facilities) or 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 or hospital. 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. The recognized charge for out-of-network hospitals, doctors and other out-of-network health care providers is a percentage (100 percent or above) of the rate that Medicare pays them.

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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 or hospital bills you above Aetna's recognized charge does not count toward your deductible or out-of-pocket maximums.

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.**

(1) All medical or 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.
(2) Cosmetic surgery.
(3) Custodial care.
(4) Dental care and x-rays.
(5) Donor egg retrieval.
(6) Experimental and investigational procedures (except for coverage for medically necessary routine patient care costs for Members participating in a cancer clinical trial).
(7) Hearing aids.
(8) Home births.
(9) Immunizations for travel or work.
(10) Implantable drugs and certain injectable drugs including injectable infertility drugs.
(11) 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.
(12) Nonmedically necessary services or supplies.
(13) Orthotics.
(14) Over-the-counter medications and supplies.
(15) Reversal of sterilization.
(16) Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs.
(17) Special duty nursing.
(18) Therapy or rehabilitation other than those listed as covered in the plan documents.
(19) Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

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, for HMO and QPOS products call: 1-888-70-AETNA. For Health Network Option products call: 1- 866-529-2517. For Traditional/PPO products call: 1-888-80-AETNA.

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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. Rates and benefits vary by location. Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change.

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

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 pre-certification 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.

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group subsidiary companies. For more information about Aetna plans, refer to www.aetna.com. Information is subject to change.