PLAN DESIGN AND BENEFITS – HMO Open Access Plan 709a

PLAN FEATURES	PARTICIPATING PROVIDERS
Deductible (per calendar year)	$10,000 Individual $10,000 Family
Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.	
Member Coinsurance	0%
Out-of-Pocket Maximum (per calendar year, includes deductible)	$10,000 Individual $10,000 Family
Only those out-of-pocket expenses resulting from the application of coinsurance percentage and deductibles may be used to satisfy the Out-of-Pocket Maximum. All covered expenses accumulate separately toward the participating and non-participating participating provider Out-of-Pocket Maximum. Once the Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.	
Lifetime Maximum	$5,000,000
Primary Care Physician Selection	Not Required
Referral Requirement	None
PHYSICIAN SERVICES	**PARTICIPATING PROVIDERS**
Primary Care Physician Visits	$35 copay, deductible waived
Specialist Office Visits	0%, after deductible
Maternity OB Visits	0%, after deductible
Allergy Treatment	Applicable office visit copay
Allergy Testing	0%, after deductible
PREVENTIVE CARE	**PARTICIPATING PROVIDERS**
Routine Adult Physical Exams / Immunizations Age and frequency schedules apply.	$35 copay, deductible waived
Well Child Exams / Immunizations Age and frequency schedules apply.	$35 copay, deductible waived
Routine Gynecological Exams Includes Pap smear and related lab fees One routine exam per calendar year	$35 copay, deductible waived
Routine Mammograms One baseline mammogram for females age 35 – 39; and one annual mammogram for females age 40 and over.	$35 copay, deductible waived

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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.
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	$35 copay, deductible waived
Routine Eye Exams at Specialist Age/Frequency Schedule may apply.	$35 copay, deductible waived
Routine Hearing Screening by PCP	Covered as part of a routine physical exam
DIAGNOSTIC PROCEDURES	**PARTICIPATING PROVIDERS**
Diagnostic Laboratory – (if performed as a part of a physician's office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.)	0%, after deductible
Diagnostic X-ray outpatient hospital or other outpatient facility	0%, after deductible
Diagnostic X-ray for Complex Imaging Services (including but not limited to MRI, MRA, PET and CT Scans)	0%, after deductible
EMERGENCY MEDICAL CARE	**PARTICIPATING PROVIDERS**
Urgent Care Provider	0%, after deductible
Non-Urgent use of Urgent Care Provider	Not Covered
Emergency Room (waived if admitted)	0%, after deductible
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Ambulance	0%, after deductible
HOSPITAL CARE	**PARTICIPATING PROVIDERS**
Inpatient Coverage (including maternity & transplants – transplant coverage is provided at National Medical Excellence contracted facility only)	0%, after deductible
Outpatient Surgery Provided in an outpatient hospital department or freestanding surgical facility.	0%, after deductible
MENTAL HEALTH SERVICES	**PARTICIPATING PROVIDERS**
Inpatient Limited to 30 days per member per calendar year	0%, after deductible
Outpatient Limited to 20 visits per member per calendar year	0%, after deductible
ALCOHOL/DRUG ABUSE SERVICES	**PARTICIPATING PROVIDERS**
Inpatient Detoxification	0%, after deductible
Outpatient Detoxification	Not Covered
Inpatient Rehabilitation	Not Covered
Outpatient Rehabilitation	Not Covered

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OTHER SERVICES	PARTICIPATING PROVIDERS
Skilled Nursing Facility Limited to 60 days per member per calendar year	0%, after deductible
Home Health Care Limited to 60 visits per member per calendar year; 1 visit equals a period of 4 hours or less.	0%, after deductible
Infusion Therapy Provided in the home or physician's office	0%, after deductible
Infusion Therapy Provided in an outpatient hospital department or freestanding facility	0%, after deductible
Inpatient Hospice Care	0%, after deductible
Outpatient Hospice Care	0%, after deductible
Outpatient Rehabilitation Therapy Includes speech, physical and occupational therapy. Limited to 30 visits per calendar year	0%, after deductible
Chiropractic Limited to 20 visits per calendar year	0%, after deductible
Durable Medical Equipment Maximum benefit $5000 per member per calendar year	0%, after deductible
FAMILY PLANNING	**PARTICIPATING PROVIDERS**
Infertility Treatment Coverage for only the diagnosis and surgical treatment of the underlying medical cause.	0%, after deductible
Voluntary Sterilization Including tubal ligation and vasectomy.	0%, after deductible
PHARMACY – PRESCRIPTION DRUG BENEFITS	**PARTICIPATING PHARMACIES**
Retail (includes self-injectable drugs) Up to a 30 day supply at participating pharmacies.	$20 copay for generic formulary drugs, $50 copay for brand-name formulary drugs, and $70 copay for non-formulary drugs
Mail Order (includes self-injectable drugs) 31- 90 day supply at participating pharmacies.	$50 copay for generic formulary drugs, $125 copay for brand-name formulary drugs, and $175 copay for non-formulary drugs
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. Precertification, Step-Therapy and 90 day Transition of Care for Step Therapy and 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 and hospital services not specifically covered in, or which are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates.
- Cosmetic surgery.

- Custodial care.
- Dental care and dental x-rays.
- Donor egg retrieval.
- Experimental and investigational procedures, (except for coverage for medically necessary routine patient care costs for 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.
- Therapy or rehabilitation other than those listed as covered in the plan documents.
- Treatment of behavioral disorders.
- 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 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

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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. 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 manufactures 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.

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

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