PLAN DESIGN AND BENEFITS- MC POS OA 14-07 (Value Limited)

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	$2,500 Individual $5,000 Family	$5,000 Individual $10,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. All covered expenses accumulate separately toward the preferred and non-preferred 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		
Plan Coinsurance	80%	60%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year, excludes deductible)	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family
All covered expenses accumulate separately toward the preferred and non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit: Deductible, amounts over allowable, prescription copays, office visit copays, payment for failure to pre-certify for certain out-of-network services, mental disorders and substance abuse. Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year.		
Lifetime Maximum $5,000,000 per member's lifetime, Preferred care and Non-Preferred care combined.		
Payment for Non-Preferred Care	Not applicable	Recognized Charge*
Primary Care Physician Selection	Not applicable	Not applicable
Certification Requirements - Certification for certain types of Non-Preferred 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 $1000 or 50%, which ever is less per occurrence if Certification is not obtained.		
Referral Requirement	None	None
PHYSICIAN SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Office Visits to Non-Specialist 3 office visits per cal yr; Combined Preferred/Non-Preferred Care	$25 copay, deductible waived	60%, after deductible
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.		
Specialist Office Visits	See office visits	See office visits
Maternity OB Visits	80%, after deductible	60% after deductible
Surgery (in office)	80%, after deductible	60%, after deductible
Allergy Testing (given by a physician)	See office visits	See office visits
Allergy Injections (not given by a physician)	See office visits	See office visits

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PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE
Routine Adult Physical Exams/ Immunizations Combined Preferred/Non-Preferred Care	See office visits	See office visits
Well Baby/Child Exams/Immunizations Combined Preferred/Non-Preferred Care	See office visits	See office visits
Routine Gynecological Care Exams Includes Pap smear and related lab fees. One exam per calendar year. Combined Preferred/Non-Preferred Care	$25 copay, deductible waived	60%, after deductible
Routine Mammograms One baseline mammogram for covered females age 35-39 and one per calendar year for covered females age 40 and above; Combined Preferred/Non-Preferred Care	$25 copay, deductible waived	60%, after deductible
Routine Digital Rectal Exam / Prostate-Specific Antigen Test Age 40 and over for African American males and age 40 and over for males with a Family history of Prostate cancer. Combined Preferred/Non-Preferred Care	Member cost sharing is based on the type of service performed and the place rendered.	60%, after deductible
Colorectal Cancer Screening Once every 3 years for all members age 50 and over and screening for persons who may be classified as high-risk for colorectal cancer. Preferred/Non-Preferred Care	Member cost sharing is based on the type of service performed and the place rendered; includes lab related fees.	Member cost sharing is based on the type of service performed and the place rendered; includes lab related fees.
Routine Eye Exams at Specialist	See office visits	See office visits
Routine Hearing Exams **C**overed only as part of a routine physical exam.	See office visits; Paid as part of a routine physical exam	See office visits
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Outpatient Diagnostic Laboratory and X-ray If performed as a part of a physician's office visit and billed by the physician, expenses are covered subject to applicable physician's office visit member cost sharing.	Not covered	Not covered
Outpatient Diagnostic X-ray for Complex Imaging Services (including, but not limited to, MRI, MRA, PET and CT Scans)	Not covered	Not covered
EMERGENCY MEDICAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Urgent Care Provider	80%, after deductible	60%, after deductible
Non-Urgent Use of Urgent Care Provider	50% after deductible or $1000 whichever less	50% after deductible or $1000 whichever less
Emergency Room Copay waived if admitted	80%, after deductible	Paid as Preferred Care.
Non-Emergency care in an Emergency Room	50% after deductible or $1000 whichever less	50% after deductible or $1000 whichever less
Emergency Ambulance	80%, after deductible	Paid as Preferred Care.
HOSPITAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Coverage Including maternity (prenatal, delivery and postpartum) & transplants. If transplant is performed through an Institute of Excellence® facility, benefits would be paid at the preferred level. If procedure is not performed through an Institutes of Excellence® facility, benefits would be paid at the non-preferred level.	80%, after deductible	60%, after deductible
Outpatient Surgery If provided in an outpatient hospital department or in a freestanding surgical facility.	80%, after deductible	60%, after deductible
Outpatient Hospital Services other than Surgery Including, but not limited to, physical therapy, speech therapy, occupation therapy, spinal manipulation, dialysis and radiation therapy.	80%, after deductible	60%, after deductible

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MENTAL HEALTH SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Mental Illness Limited to 30 days per member per calendar year. Combined Preferred/Non-Preferred Care	80%, after deductible	60%, after deductible
Outpatient Mental Illness Limited to 20 visits per member per calendar year. Combined Preferred/Non-Preferred Care	$25 copay, deductible waived	See office visits
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Detoxification/Alcohol	80%, after deductible	60%, after deductible
Outpatient Detoxification	Not Covered	Not Covered
Inpatient Rehabilitation	Not Covered	Not Covered
Outpatient Rehabilitation	Not Covered	Not Covered
OTHER SERVICES AND PLAN DETAILS	**PREFERRED CARE**	**NON-PREFERRED CARE**
Skilled Nursing Facility Limited to 60 days per member per calendar year. Combined Preferred/Non-Preferred Care	80%, after deductible (includes any assoc. ancillary and professional services)	60%, after deductible (includes any assoc. ancillary and professional services)
Home Health Care Limited to 60 visits per member per calendar year. Combined Preferred/Non-Preferred combined Care; 1 visit equals a period of 4 hours or less.	80%, after deductible	60%, after deductible
Infusion Therapy Provided at Home or in the Physician's Office	$25 office visit copay, deductible waived	60%, after deductible Supplies/Service -Aetna pays a maximum of $50/visit; Amounts over allowable do not apply to OOP; Drugs - (1) based on the Aetna Market Fee Schedule and if none is available it will be 60% of billed charges or (2) will be 70% of the Average Wholesale Price or other comparable resource.
Infusion Therapy Provided in OP Hospital or Facility	80%, after deductible	60%, after deductible Supplies/Service -Aetna pays a maximum of $50/visit; Amounts over allowable do not apply to OOP; Drugs - (1) based on the Aetna Market Fee Schedule and if none is available it will be 60% of billed charges or (2) will be 70% of the Average Wholesale Price or other comparable resource.
Hospice Care - Inpatient Limited to $10,000 combined inpatient and outpatient. Combined Preferred/Non-Preferred Care	80%, after deductible	60%, after deductible
Hospice Care - Outpatient Limited to $10,000 combined inpatient and outpatient. Combined Preferred/Non-Preferred Care	80%, after deductible	60%, after deductible
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Outpatient Speech Therapy	See office visits	See office visits
Outpatient Physical/Occupational Therapy and Spinal Manipulation Therapy (Chiropractic)	See office visits	See office visits
Durable Medical Equipment	Not Covered	Not Covered
Diabetic Supplies not obtainable at a pharmacy	Covered same as any other medical expense.	Covered same as any other medical expense.

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FAMILY PLANNING	PREFERRED CARE	NON-PREFERRED 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.	Member cost sharing is based on the type of service performed and the place rendered.
Comprehensive Infertility Services Services and supplies are only covered for groups with 26 or more eligible	Member cost sharing is based on the type of service performed and the place rendered. Does not apply towards Payment Limit	Member cost sharing is based on the type of service performed and the place rendered. Does not apply towards Payment Limit
Advanced Reproductive Technology (ART) Services and supplies are only covered for groups with 26 or more eligible	Member cost sharing is based on the type of service performed and the place rendered. Does not apply towards Payment Limit	Member cost sharing is based on the type of service performed and the place rendered. Does not apply towards Payment Limit
ART coverage includes: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery.		
Voluntary Sterilization Including tubal ligation and vasectomy.	80%, after deductible	60%, after deductible
PHARMACY-PRESCRIPTION DRUG BENEFITS	**PARTICIPATING PHARMACIES**	**NON-PARTICIPATING PHARMACIES**
Retail Up to a 30-day supply	$15 generic only	70% after $15 copay
Mail Order Delivery 31-90 day supply	$30 generic only	Not Covered
Precertification included and 90 day Transition of Care (TOC) for Precertification included		
Plan includes: contraceptive drugs and devices obtainable from a pharmacy and diabetic supplies obtainable from a pharmacy.		

*Payment for Non-Preferred facility care is determined based upon Aetna's Allowable Fee Schedule, which is subject to change. Payment for other Non-Preferred care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider. These charges are referred to in your plan documents as "recognized" charges.

†This plan provides limited benefits only and does not constitute as a comprehensive health insurance plan. As such, it may not cover all the expenses associated with your health care needs.

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SMALL GROUP
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, including breast reduction;
- Custodial care;
- Dental care and X-rays;
- Donor egg retrieval*;
- Durable Medical Equipment
- Experimental and investigational procedures;
- Hearing aids;
- Immunizations for travel or work;
- Infertility services including, but not limited to, 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*
- 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;
- Special duty nursing; and
- 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 exclusion only applies to groups with 25 or fewer eligibles and includes injectable infertility drugs. Services and supplies are covered for groups with 26 or more eligibles.

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, 6 months 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 less than 12 months of creditable coverage immediately before the date you enrolled, your plan's pre-existing conditions exclusion period will be reduced by the amount (that is, number of days) of that prior coverage.

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 days 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 1-888-802-3862 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.

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.

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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.