PLAN DESIGN AND BENEFITS - New York Managed Choice Open Access 22-07*

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	$1,000 Individual $3,000 Family	$2,000 Individual $6,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. All covered expenses accumulate separately toward the 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. Member cost sharing for certain services, including member cost sharing for prescription drugs, as indicated in the plan, are excluded from charges to meet the Deductible.		
Member Coinsurance (applies to all expenses unless otherwise stated)	0% after deductible	30% after deductible
Payment Limit (per calendar year, excludes deductible)	Not applicable	$3,000 Individual $9,000 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. Only those preferred & non-preferred expenses resulting from the application of coinsurance percentage (except any penalty amounts) may be used to satisfy the Payment Limit. Once the 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 (per member lifetime, Preferred and Non-Preferred combined)	Unlimited	$2,000,000
Payment for Non-Preferred Care	Not applicable	Usual & Customary**
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 $400 per occurrence if Certification is not obtained.		
Referral Requirement	None	None
PHYSICIAN SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Office Visits to Non-Specialist 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 and in-office surgery	$25 copay; deductible waived	30% after deductible
Specialist Office Visits	$50 copay; deductible waived	30% after deductible
Maternity OB Visits	0% after deductible	30% after deductible
Surgery (in office)	0% after deductible	30% after deductible
Allergy Testing (given by a physician)	$50 copay; deductible waived	30% after deductible
Allergy Injections (not given by a physician)	Member cost sharing is based on the type of service performed and the place rendered	30% after deductible
PREVENTIVE CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Routine Adult Physical Exams / Immunizations 1 exam every 12 months ages 19 and over Preferred and Non-Preferred combined	$25 copay; deductible waived / 0%; deductible waived	30% after deductible / 0%; deductible waived

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PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE
Well Child Exams / Immunizations 7 exams ages birth to 12 months, 2 exams ages 1-2, 1 exam every 12 months ages 2-19 Preferred and Non-Preferred combined	0%; deductible waived	0%; deductible waived
Routine Gynecological Care Exams Two routine exams per calendar year Preferred and Non-Preferred combined	$50 copay; deductible waived	30% after deductible
Routine Mammograms One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over Preferred and Non-Preferred combined	$50 copay; deductible waived	30% after deductible
Routine Digital Rectal Exam / Prostate-Specific Antigen Test 1 exam per calendar year for men with prior history, 1 exam per calendar year age 50 and over if asymptomatic, 1 exam per calendar year ages 40 and over if family history or other risk factor Preferred and Non-Preferred combined	Member cost sharing is based on the type of service performed and the place rendered	30% after deductible
Colorectal Cancer Screening For all members age 50 and over Frequency schedule applies	Member cost sharing is based on the type of service performed and the place rendered	30% after deductible
Routine Eye Exams at Specialist One routine exam every 24 months Preferred and Non-Preferred combined	$50 copay; deductible waived	30% after deductible
Routine Hearing Exams	Paid as part of a routine physical exam	Paid as part of a routine physical exam
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 the applicable physician's office visit member cost sharing	$50 copay; deductible waived	30% after deductible
EMERGENCY MEDICAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Urgent Care Provider	$75 copay; deductible waived	30% after deductible
Non-Urgent Use of Urgent Care Provider	Not covered	Not covered
Emergency Room Copay waived if admitted	$100 copay; deductible waived	Paid as Preferred Care
Non-Emergency care in an Emergency	Not covered	Not covered
Emergency Ambulance	0%; deductible waived	Paid as Preferred Care

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HOSPITAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Coverage Including maternity (prenatal, delivery and postpartum) & transplants If transplant is performed through a National Medical Excellence® facility, benefits would be paid at the preferred level. If procedure is not performed through a National Medical Excellence® facility, benefits would be paid at the non-preferred level.	0% after deductible	30% after deductible
Outpatient Surgery Provided in an outpatient hospital department or a freestanding surgical facility	0% after deductible	30% after deductible
Outpatient Hospital Services other than Surgery Including, but not limited to, physical therapy, speech therapy, occupational therapy, spinal manipulation, dialysis, radiation therapy and infusion therapy	0% after deductible	30% after deductible
MENTAL HEALTH SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Limited to 30 days per member per calendar year Preferred and Non-Preferred combined	0% after deductible	30% after deductible
Outpatient Limited to 30 visits per member per calendar year Preferred and Non-Preferred combined	$50 copay; deductible waived	30% after deductible
ALCOHOL / DRUG ABUSE SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Detoxification Limited to 30 days per member per calendar year Preferred and Non-Preferred combined	0% after deductible	30% after deductible
Outpatient Detoxification Limited to 60 visits per member per calendar year, including 20 visits per calendar year of family counseling Preferred and Non-Preferred combined	$50 copay; deductible waived	30% after deductible
Inpatient Rehabilitation Limited to 30 days per member per calendar year Preferred and Non-Preferred combined	0% after deductible	30% after deductible
Outpatient Rehabilitation Limited to 60 visits per member per calendar year, including 20 visits per calendar year of family counseling Preferred and Non-Preferred combined	$50 copay; deductible waived	30% after deductible

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OTHER SERVICES AND PLAN DETAILS	PREFERRED CARE	NON-PREFERRED CARE
Convalescent Facility (Skilled Nursing Facility) Limited to 120 days per member per calendar year Preferred and Non-Preferred combined	0% after deductible	30% after deductible
Home Health Care Limited to 40 visits per member per calendar year; 1 visit equals a period of 4 hours or less Preferred and Non-Preferred combined	0% after deductible	30% after deductible
Inpatient Hospice Care Limited to 210 combined days/visits per member per lifetime with Outpatient Hospice Care Preferred and Non-Preferred combined	0% after deductible	30% after deductible
Outpatient Hospice Care Limited to 210 combined days/visits per member per lifetime with Inpatient Hospice Care Preferred and Non-Preferred combined	0% after deductible	30% after deductible
Private Duty Nursing - Outpatient	Not covered	Not covered
Outpatient Short-Term Rehabilitation Includes speech, physical and occupational therapy If provided in the outpatient hospital department, paid under the outpatient hospital benefit Limited to 60 combined visits per member per calendar year Preferred and Non-Preferred combined	0% after deductible	30% after deductible
Outpatient Spinal Manipulation Therapy (Chiropractic) If provided in the outpatient hospital department, paid under the outpatient hospital benefit	$50 copay; deductible waived	30% after deductible
Durable Medical Equipment Maximum benefit of $2,500 per member per calendar year Preferred and Non-Preferred 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	$25 copay; deductible waived	30% 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

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Glasses and Contact Lens Reimbursement Preferred and Non-Preferred combined	$200 per member every 24 months

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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	30% after deductible
Comprehensive Infertility Services	Member cost sharing is based on the type of service performed and the place rendered	30% after deductible
Voluntary Sterilization Including tubal ligation and vasectomy	Member cost sharing is based on the type of service performed and the place rendered	30% after deductible
PHARMACY - PRESCRIPTION DRUG BENEFITS*	**PARTICIPATING PHARMACIES**	**NON-PARTICIPATING PHARMACIES**
Retail Up to a 30-day supply	**Plan A:** $10 copay for generic drugs, $20 copay for brand name formulary drugs, and $35 copay for brand name non-formulary drugs **Plan B:** $15 copay for generic drugs, $35 copay for brand name formulary drugs, and $50 copay for brand name non-formulary drugs **Plan C:** $15 copay for generic drugs, and 50% for brand name formulary and non-formulary drugs	**Plan A:** 30% of submitted cost after $10 copay for generic drugs,$20 copay for brand name formulary drugs, and $35 copay for brand name non-formulary drugs **Plan B:** 30% of submitted cost after $15 copay for generic drugs,$35 copay for brand name formulary drugs, and $50 copay for brand name non-formulary drugs **Plan C:** $15 copay for generic drugs, and 50% for brand name formulary and non-formulary drugs
Mail Order Delivery 31-90 day supply	**Plan A:** $20 copay for generic drugs, $40 copay for brand name formulary drugs, and $70 copay for brand name non-formulary drugs **Plan B:** $30 copay for generic drugs, $70 copay for brand name formulary drugs, and $100 copay for brand name non-formulary drugs **Plan C:** $30 copay for generic drugs, and 50% for brand name formulary and non-formulary drugs	Not covered
No Mandatory Generic (No MG) - Member is responsible to pay the applicable copay and/or coinsurance only		
Plan Includes: 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		

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* This medical plan is offered with one of three prescription drug benefits (A, B and C).
**Payment for Non-Preferred care is determined based upon the lowest of the provider's usual charge for furnishing it or the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made. These charges are referred to in your plan documents as "reasonable" or "recognized" charges.

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.

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 credible 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.

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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 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 neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Some benefits are subject to limitations or visit maximums. 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. Many drugs, including many of those listed on the formulary, are subject to rebate arrangements between Aetna and the manufacturer of the drugs. Rebates received by Aetna from drug manufacturers are not reflected in the cost paid by a member for a prescription drug. 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.

While this information is believed to be accurate as of the print date, it is subject to change.

Plans are provided by Aetna Life Insurance Company.