



## PLAN DESIGN AND BENEFITS

PROVIDED BY AETNA HEALTH INC. AND AETNA LIFE INSURANCE COMPANY - FULL RISK

PLAN FEATURES	PARTICIPATING PROVIDERS / REFERRED	NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED
<b>Deductible (per calendar year)</b>	None Employee None Family	\$5,000 Employee \$10,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable.		
<b>Member Coinsurance</b>	Covered 100%	50%
<b>Out-of-pocket maximum</b> (per calendar year)	\$1,500 Employee \$3,000 Family	\$10,000 Employee \$20,000 Family
Member cost sharing for certain services may not apply toward the out-of-pocket maximum Only those participating providers/referred and non-participating providers/participating providers self referred out-of- expenses resulting from the application of coinsurance percentage, deductibles and copays (except any penalty amounts and pharmacy cost sharing) may be used to satisfy the out-of- maximum. Once 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.		
<b>Lifetime Maximum</b>	Unlimited except where otherwise indicated.	\$1,000,000 per lifetime
<b>Primary Care Physician Selection</b>	Required	Not applicable
<b>Precertification Requirement</b> Certain participating provider self-referred services require precertification or benefits will be reduced. Refer to your plan documents for a complete list of services that require precertification.		
<b>Referral Requirements</b>	Required for all non-emergency, non-urgent and non-Primary Care physicians services, except direct access services.	None
PREVENTIVE CARE	PARTICIPATING PROVIDERS / REFERRED	NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED
<b>Routine Adult Physical Exams/ Immunizations</b> (Age and frequency schedules apply)	\$10 copay	Not Covered
<b>Well Child Exams / Immunizations</b> (Age and frequency schedules apply)	\$10 copay	50% for children from birth through age 6; not covered age 7 and over; after deductible
<b>Routine Gynecological Care Exams</b> Includes routine tests and related lab fees. One routine exam per 365 days.	\$20 copay	Not Covered
<b>Routine Mammograms</b> One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	Covered 100%	Covered 100% after deductible
<b>Routine Digital Rectal Exams / Prostate Specific Antigen Test</b> For males age 40 and over.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Not Covered
<b>Colorectal Cancer Screening</b> For all members 50 and over. Frequency schedule applies.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Not Covered
<b>Routine Eye Exam</b> Age/Frequency Schedule may apply.	\$20 copay	Not Covered
<b>Routine Hearing Screening</b>	Subject to Routine Physical Exam cost sharing.	Not Covered
<b>Hearing Aids</b> Hearing aids for children twelve years of age or younger. Limited to \$1,000 within a 24 month period.	Covered 100%	50% after deductible
<b>Audiometric Hearing Exams</b> 1 exam every 24 months for children under age 13, including one hearing aid, limited to \$1,000 per calendar year.	\$20 copay	50% after deductible



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<b>PHYSICIAN SERVICES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>	<b>NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED</b>
<b>Office Visits to member's selected Primary Care Physician</b>	Office Hours : \$10 copay After Office Hours/Home : \$15 copay	50% after deductible
<b>Specialist Office Visits</b> Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.	\$20 copay	50% after deductible
<b>Maternity OB Visits</b>	\$20 copay; for initial visit only, thereafter covered 100%	50% after deductible
<b>Allergy Treatment</b>	Same as applicable participating provider office visit member cost sharing	50% after deductible
<b>Allergy Testing</b>	Same as applicable participating provider office visit member cost sharing	50% after deductible
<b>DIAGNOSTIC PROCEDURES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>	<b>NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED</b>
<b>Diagnostic Laboratory</b> 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.	Covered 100%	50% after deductible
<b>Diagnostic X-ray</b> Outpatient hospital or other Outpatient facility (except for Complex Imaging Services)	Covered 100%	50% after deductible
<b>Diagnostic X-ray for Complex Imaging Services</b>	\$10 copay. Member copays will not exceed \$375 in a calendar year for all complex imaging services.	50% after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>	<b>NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED</b>
<b>Urgent Care</b>	\$35 copay	50% after deductible
<b>Non-Urgent use of Urgent Care Provider</b>	Not Covered	Not Covered
<b>Emergency Room</b>	\$100 copay	Refer to participating provider benefit;
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered	Not Covered
<b>Ambulance</b>	Covered 100%	Refer to participating provider benefit;
<b>HOSPITAL CARE</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>	<b>NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED</b>
<b>Inpatient Coverage</b> The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	\$500 per admission copay	50% per admission after deductible
<b>Inpatient Maternity Coverage</b> The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	\$500 per admission copay	50% per admission after deductible
<b>Outpatient Surgery</b> The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	\$75 per visit copay	50% per visit after deductible
<b>MENTAL HEALTH SERVICES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>	<b>NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED</b>
<b>Inpatient Mental Illness</b>	\$500 per admission copay	50% per admission after deductible



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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.

<b>Outpatient Mental Illness</b>	\$20 per visit copay	50% per visit after deductible
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The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.

<b>ALCOHOL/DRUG ABUSE SERVICES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>	<b>NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED</b>
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<b>Inpatient Detoxification</b>	\$500 per admission copay	50% per admission after deductible
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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.

<b>Outpatient Detoxification</b>	\$20 per visit copay	50% per visit after deductible
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The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.

<b>Inpatient Rehabilitation</b>	\$500 per admission copay	50% per admission after deductible
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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.

<b>Outpatient Rehabilitation</b>	\$20 per visit copay	50% per visit after deductible
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The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.

<b>OTHER SERVICES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>	<b>NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED</b>
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<b>Skilled Nursing Facility</b>	\$500 per admission copay	50% per admission after deductible
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Limited to 120 days per calendar year.

The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.

<b>Home Health Care</b>	Covered 100% 80 visits/cal year	50% per visit after deductible
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<b>Hospice Care - Inpatient</b>	\$500 per admission copay	50% per admission (\$10,000 lifetime maximum combined inpatient and outpatient care.) after deductible
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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.

<b>Hospice Care - Outpatient</b>	Covered 100%	50% per visit (\$10,000 lifetime maximum combined inpatient and outpatient care.) after deductible
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The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.

<b>Private Duty Nursing</b>	Not Covered	Not Covered
<b>Outpatient Rehabilitation Therapy</b> (Includes speech, physical and occupational therapy)	\$20 per visit copay	50% per visit after deductible

Treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment.

<b>Subluxation</b>	\$20 per visit copay	50% per visit after deductible
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<b>Durable Medical Equipment</b>	Covered 100%	(must pre-certify if over \$1,500) after deductible
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<b>Diabetic Supplies</b>	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies	50% after deductible
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<b>Dental</b>	Not Covered	Not Covered
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<b>Transplants</b>	\$500 per admission copay Coverage is provided at an IOE contracted facility only	50% per admission Coverage is provided at an Non-IOE contracted facility only; after deductible
<b>FAMILY PLANNING</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>	<b>NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED</b>
<b>Infertility Treatment</b> Diagnosis and treatment of the underlying medical condition	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Member cost sharing is based on the type of service performed and the place of service where it is rendered;
<b>Comprehensive Infertility Services</b> Coverage includes Artificial Insemination, limited to 3 courses per lifetime, and Ovulation Induction, limited to 4 courses per lifetime. For covered females under age 40 only.	Applicable copay applies	50% after deductible
<b>Advanced Reproductive Technology (ART)</b> ART coverage includes 2 cycles with not more than 2 embryos per cycle of In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), and gamete intrafallopian transfer (GIFT), combined, per lifetime. For covered females under age 40 only.	Covered 100%	50% after deductible
<b>Voluntary Sterilization</b> Including tubal ligation and vasectomy.	Subject to applicable service type member cost sharing	Subject to applicable service type member cost sharing after deductible
<b>PHARMACY - PRESCRIPTION DRUG BENEFITS</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>	<b>NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED</b>
<b>Retail</b>	\$15 copay for formulary generic drugs, \$25 copay for formulary brand-name drugs, and \$40 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.	Not Covered
<b>Mail order</b>	\$30 copay for formulary generic drugs, \$50 copay for formulary brand-name drugs, and \$80 copay for non-formulary brand-name and generic drugs up to a 31-90 day supply at participating pharmacies.	Not Covered

**No Mandatory Generic (NO MG)** - Member is responsible to pay the applicable copay only.**Plan Includes:** Contraceptive drugs and devices obtainable from a pharmacy.

Precert included and Step-therapy included

**GENERAL PROVISIONS**

<b>Dependents Eligibility</b>	Dependent unmarried children under 26 years of age.  Dependent unmarried children under the age of 26 who attend school on a regular full-time basis.
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For any service or supply that is subject to a maximum visit, day, or dollar limitation, such maximums will be reduced by any services or supplies which are covered as participating providers / referred and non-participating providers / participating providers self referred benefits under this plan.

**Exclusions and Limitations**

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Plans are provided by: Aetna Health Inc and Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

The following is a 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 by your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval.
- Durable medical Equipment
- 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 except where medically necessary or indicated.
- Implantable drugs and certain injectible drugs including injectible 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.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- Orthotics except diabetic orthotics.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling or prescription drug
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- 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.

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. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.



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

Translation of the material into another language may be available. Please call Member Services at **1-888-98-AETNA (1-888-982-3862)**.

Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-98-AETNA (1-888-982-3862)**.

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **[www.aetna.com](http://www.aetna.com)**.

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