



Proposed effective date: 10-01-2010
Aetna HMO Classic

**PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA HEALTH INC. - FULL RISK**

PLAN FEATURES	PARTICIPATING PROVIDERS
Deductible (per calendar year) Unless otherwise indicated, the Deductible must be met prior to benefits being payable. 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. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.	\$500 Individual \$1,000 Family
Out-of-Pocket Maximum (per calendar year) Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. Only those participating providers out of pocket 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-Pocket 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.	\$5,000 Individual \$10,000 Family
Lifetime Maximum	Unlimited unless otherwise indicated.
Primary Care Physician Selection	Not Required
Referral Requirements	None
PREVENTIVE CARE	PARTICIPATING PROVIDERS
Routine Adult Physical Exams / Immunizations (Age and frequency schedules apply)	\$30 copay; deductible waived
Well Child Exams / Immunizations (Age and frequency schedules apply)	\$30 copay; deductible waived
Routine Gynecological Care Exams Includes Pap smear and related lab fees. Ob/Gyn providers may be chosen as PCP's. One exam per calendar year.	\$50 copay; deductible waived
Routine Mammograms One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over	\$50 copay; deductible waived
Routine Digital Rectal Exams / Prostate Specific Antigen Test 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.
Colorectal Cancer Screening 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.
Routine Eye Exam Age/Frequency Schedule may apply.	\$50 copay; deductible waived
Routine Hearing Screening	Subject to Routine Physical Exam cost sharing; deductible waived
PHYSICIAN SERVICES	PARTICIPATING PROVIDERS
Primary Care Physician Visits	Office Hours: \$30 copay; deductible waived After Office Hours/Home: \$35 copay; deductible waived
Specialist Office Visits	\$50 copay; deductible waived
Maternity OB Visits	\$50 copay for initial visit only, thereafter covered 100% ; deductible waived
Allergy Treatment	Same as applicable participating provider office visit member cost sharing
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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 cost sharing.	Covered 100%; deductible waived
Diagnostic X-ray Outpatient hospital or other Outpatient facility (except for Complex Imaging Services)	\$50 copay; deductible waived
Diagnostic X-ray for Complex Imaging Services	\$250 copay; deductible waived
EMERGENCY MEDICAL CARE	PARTICIPATING PROVIDERS
Urgent Care	\$75 copay; deductible waived
Non-Urgent use of Urgent Care Provider	Not Covered
Emergency Room	\$150 copay; deductible waived
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	Covered 100%; deductible waived
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	PARTICIPATING PROVIDERS
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% per admission; after deductible
Inpatient Maternity Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% per admission; after deductible
Outpatient Surgery The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	20% per visit; after deductible
MENTAL HEALTH SERVICES	PARTICIPATING PROVIDERS
Inpatient Mental Illness The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% per admission; after deductible
Outpatient Mental Illness The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	\$50 copay per visit ; deductible waived
ALCOHOL/DRUG ABUSE SERVICES	PARTICIPATING PROVIDERS
Inpatient Detoxification The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% per admission; after deductible
Outpatient Detoxification The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	\$50 copay; deductible waived
Inpatient Rehabilitation The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% per admission; after deductible
Residential Treatment Facility	20% ; after deductible
Outpatient Rehabilitation The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	\$50 Copay; deductible waived
OTHER SERVICES	PARTICIPATING PROVIDERS
Skilled Nursing Facility The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% per admission; after deductible
Home Health Care Coverage includes nutritional counseling and services of a medical social worker.	Covered 100%; deductible waived
Hospice Care - Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% per admission; after deductible
Hospice Care - Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered 100%; deductible waived
Private Duty Nursing	Not Covered
Outpatient Rehabilitation Therapy (Includes speech, physical and occupational therapy) Treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment.	\$50 copay; deductible waived



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Subluxation Limited to 20 visits per calendar year	\$50 copay; deductible waived
Durable Medical Equipment	Covered 100%; deductible waived
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.
Dental	Not Covered
Vision Eyewear	Not Covered
Transplants Coverage is provided at an IOE contracted facility only	20% per admission; after deductible
Bariatric Surgery The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Not Covered
FAMILY PLANNING	PARTICIPATING PROVIDERS
Infertility Treatment 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.
Comprehensive Infertility Services Coverage includes Artificial Insemination (limited to six courses of treatment per member's lifetime) and Ovulation Induction (limited to six courses of treatment per member's lifetime). Lifetime maximum applies to all procedures covered by any Aetna plan or where no other coverage was provided, except where prohibited by law.	Applicable copay applies; deductible waived
Advanced Reproductive Technology (ART) ART coverage includes In-Vitro Fertilization (IVF), Zygote Intra-Fallopian Transfer (ZIFT), Gamete Intra-Fallopian Transfer (GIFT), cryopreserved embryo transfers, Intra-Cytoplasmic Sperm Injection (ICSI) or ovum microsurgery.	Not Covered
Voluntary Sterilization Including tubal ligation and vasectomy.	Subject to applicable service type member cost sharing
PHARMACY - PRESCRIPTION DRUG BENEFITS	PARTICIPATING PROVIDERS
Retail	\$20 copay for formulary generic drugs, \$40 copay for formulary brand-name drugs, and \$70 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.
Mail Order	\$40 copay for formulary generic drugs, \$80 copay for formulary brand-name drugs, and \$140 copay for non-formulary brand-name and generic drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.
Aetna Specialty CareRx First prescription fill at any retail drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®	
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 Step Therapy included	
Spouse, dependent children covered from birth until the end of the calendar year in which they attain age 26, regardless of student status.	



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This health insurance issuer believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 1-888-982-3862. If your plan is governed by ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This web site has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Exclusions and Limitations

Plans are provided by: Aetna Health Inc., and Aetna Health 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.



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- 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 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.
- 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 drugs.
- 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.

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

If you require language assistance from an Aetna representative, please call Member Services' multilingual hotline at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).

Si necesita asistencia lingüística de un representante de Aetna, contamos con una línea directa de Servicios a Miembros disponible en varios idiomas. Comuníquese al 1-888-982-3862 (140 idiomas disponibles. Debe solicitar un intérprete). TDD 1-800-628-3323 (para personas con problemas de audición únicamente).

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

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



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