



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

<b>PLAN FEATURES</b>	<b>PARTICIPATING PROVIDERS</b>
<b>Deductible</b> (per calendar year)	None Individual None Family
<b>Out-of-Pocket Maximum</b> (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 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.	\$2,500 Individual \$5,000 Family
<b>Lifetime Maximum</b>	Unlimited unless otherwise indicated.
<b>Primary Care Physician Selection</b>	Not Required
<b>Referral Requirements</b>	None
<b>PREVENTIVE CARE</b>	<b>PARTICIPATING PROVIDERS</b>
<b>Routine Adult Physical Exams / Immunizations</b> (Age and frequency schedules apply)	\$20 copay
<b>Well Child Exams / Immunizations</b> (Age and frequency schedules apply)	\$20 copay
<b>Routine Gynecological Care Exams</b> Includes Pap smear and related lab fees. Ob/Gyn providers may be chosen as PCP's. One exam per calendar year.	\$50 copay
<b>Routine Mammograms</b> One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over	\$50 copay
<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.
<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.
<b>Routine Eye Exam</b> Age/Frequency Schedule may apply.	\$50 copay
<b>Routine Hearing Screening</b>	Subject to Routine Physical Exam cost sharing
<b>PHYSICIAN SERVICES</b>	<b>PARTICIPATING PROVIDERS</b>
<b>Primary Care Physician Visits</b>	Office Hours: \$20 copay After Office Hours/Home: \$25 copay
<b>Specialist Office Visits</b>	\$50 copay
<b>Maternity OB Visits</b>	\$50 copay for initial visit only, thereafter covered 100%
<b>Allergy Treatment</b>	Same as applicable participating provider office visit member cost sharing
<b>Allergy Testing</b>	Same as applicable participating provider office visit member cost sharing
<b>DIAGNOSTIC PROCEDURES</b>	<b>PARTICIPATING PROVIDERS</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%
<b>Diagnostic X-ray</b> Outpatient hospital or other Outpatient facility (except for Complex Imaging Services)	\$50 copay
<b>Diagnostic X-ray for Complex Imaging Services</b>	\$250 copay



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<b>EMERGENCY MEDICAL CARE</b>	<b>PARTICIPATING PROVIDERS</b>
<b>Urgent Care</b>	\$75 copay
<b>Non-Urgent use of Urgent Care Provider</b>	Not Covered
<b>Emergency Room</b>	\$150 copay
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered
<b>Emergency Use of Ambulance</b>	Covered 100%
<b>Non-Emergency Use of Ambulance</b>	Not Covered
<b>HOSPITAL CARE</b>	<b>PARTICIPATING PROVIDERS</b>
<b>Inpatient Coverage</b>	\$350 per day for the first 5 days per admission, thereafter Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
<b>Inpatient Maternity Coverage</b>	\$350 per day for the first 5 days per admission, thereafter Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
<b>Outpatient Surgery</b>	\$100 copay per visit
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
<b>MENTAL HEALTH SERVICES</b>	<b>PARTICIPATING PROVIDERS</b>
<b>Inpatient Mental Illness</b>	\$350 per day for the first 5 days per admission, thereafter Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
<b>Outpatient Mental Illness</b>	\$50 copay per visit
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</b>
<b>Inpatient Detoxification</b>	\$350 per day for the first 5 days per admission, thereafter Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
<b>Outpatient Detoxification</b>	\$50 copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
<b>Inpatient Rehabilitation</b>	\$350 per day for the first 5 days per admission, thereafter Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
<b>Residential Treatment Facility</b>	Not Covered
<b>Outpatient Rehabilitation</b>	\$50 copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
<b>OTHER SERVICES</b>	<b>PARTICIPATING PROVIDERS</b>
<b>Skilled Nursing Facility</b>	\$350 per day for the first 5 days per admission, thereafter Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
<b>Home Health Care</b>	Covered 100%
Coverage includes nutritional counseling and services of a medical social worker.	
<b>Hospice Care - Inpatient</b>	\$350 per day for the first 5 days per admission, thereafter Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
<b>Hospice Care - Outpatient</b>	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	



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<b>Private Duty Nursing</b>	Not Covered
<b>Outpatient Rehabilitation Therapy</b> (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
<b>Subluxation</b> Limited to 20 visits per calendar year	\$50 copay
<b>Durable Medical Equipment</b>	Covered 100%
<b>Diabetic Supplies</b>	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.
<b>Dental</b>	Not Covered
<b>Vision Eyewear</b>	Not Covered
<b>Transplants</b>	\$350 per day for the first 5 days per admission, thereafter Covered 100%
Coverage is provided at an IOE contracted facility only	
<b>Bariatric Surgery</b> The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Not Covered
<b>FAMILY PLANNING</b>	<b>PARTICIPATING PROVIDERS</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.
<b>Comprehensive Infertility Services</b> 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
<b>Advanced Reproductive Technology (ART)</b> 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
<b>Voluntary Sterilization</b> Including tubal ligation and vasectomy.	Subject to applicable service type member cost sharing
<b>PHARMACY - PRESCRIPTION DRUG BENEFITS</b>	<b>PARTICIPATING PROVIDERS</b>
<b>Retail</b>	\$15 copay for formulary generic drugs, \$35 copay for formulary brand-name drugs, and \$60 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.
<b>Mail Order</b>	\$30 copay for formulary generic drugs, \$70 copay for formulary brand-name drugs, and \$120 copay for non-formulary brand-name and generic drugs up to a 31-90 day supply from Aetna Rx Home Delivery <sup>®</sup> .
<b>Pharmacy Managed Self Injectables (PMSI)</b> First prescription fill at any retail facility. Subsequent fills must be through Aetna Specialty Pharmacy <sup>®</sup>	
<b>No Mandatory Generic (NO MG)</b> - Member is responsible to pay the applicable copay only.	
<b>Plan Includes</b> : 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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**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. 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 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.



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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.

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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