



PLAN DESIGN AND BENEFITS - PA PPO 3.3

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	Not Applicable	\$500 Individual \$1,500 Family
Unless otherwise indicated, the Non-Preferred Deductible must be met prior to Non-Preferred benefits being payable. Member cost sharing for prescription drugs, self-injectables, childhood immunizations, routine gynecological care exam (including pap smear), maternity post partum health care visits and phenyl-free enteral formula are excluded from charges to meet the Non-Preferred Deductible. Once the Non-Preferred Family Deductible is met, all family members will be considered as having met their Non-Preferred Deductible for the remainder of the calendar year. No one family member may contribute more than the Individual Deductible amount to the Family Deductible. Deductible credit applies. Deductible carryover does not apply.		
Plan Coinsurance *	100%	70%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year, includes deductible)	Not Applicable	\$5,000 Individual \$15,000 Family
All covered expenses, except amounts over Recognized Charge, failure to pre-certify penalties and member cost-sharing for prescription drugs and self-injectables, apply toward the Non-Preferred Payment Limit. Once Non-Preferred Family Payment Limit is met, all family members will be considered as having met their Non-Preferred Payment Limit for the remainder of the calendar year. No one family member may contribute more than the Individual Payment Limit to the Family Payment Limit.		
Lifetime Maximum	Unlimited except where otherwise indicated.	\$1,000,000 per lifetime
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 \$400 per occurrence if Certification is not obtained.		
Referral Requirement	Not Applicable	Not Applicable
PHYSICIAN SERVICES		
	PREFERRED CARE	NON-PREFERRED CARE
Office Visits to Non-Specialist	\$10 Copay	70% 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	\$20 Copay	70% after deductible
Maternity OB Visits	\$20 Copay	70% after deductible
Allergy Treatment	Same as applicable office visit member cost sharing.	70% after deductible
Allergy Testing	\$20 Copay	70% after deductible
PREVENTIVE CARE		
	PREFERRED CARE	NON-PREFERRED CARE
Routine Adult Physical Exams/ Immunizations (Limited to 1 exam every 12 months for members age 18 and older. Preferred Care and Non-Preferred Care combined.)	\$0 Copay	70% after deductible
Well Child Exams / Immunizations (Provides coverage for 7 exams in the first 12 months of life; 2 exams in the 13th – 24th months of life; 1 exam per 12 months thereafter. Preferred Care and Non-Preferred Care combined.)	\$0 Copay	70% after deductible, except deductible waived for immunizations



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PREVENTIVE CARE (CONTINUED)	PREFERRED CARE	NON-PREFERRED CARE
Routine Gynecological Care Exams (Includes pap smear and related lab fees. Limited to one annual exam and pap smear. Preferred Care and Non-Preferred Care combined.)	\$0 Copay	70%, deductible waived
Routine Mammograms (Limited to one annual mammogram for females age 40 and over. Preferred Care and Non-Preferred Care combined.)	\$0 Copay	70% after deductible
Routine Digital Rectal Exam / Prostate-Specific Antigen Test (For covered males age 40 and over. Frequency schedule applies. Preferred Care and Non-Preferred Care combined.)	Member cost sharing is based on the type of service performed and the place rendered.	70% after deductible
Colorectal Cancer Screening (For all members age 50 and over. Frequency schedule applies. Preferred Care and Non-Preferred Care combined.)	Member cost sharing is based on the type of service performed and the place rendered.	70% after deductible
Routine Eye Exams at Specialist (Limited to one routine exam per 24 months. Preferred Care and Non-Preferred Care combined. No referral required.)	\$0 Copay	70% after deductible
Vision Corrective Lenses/ Contact Lenses Allowance	\$100 reimbursement payable once for 24-month period (deductible waived) Preferred Care and Non-Preferred Care combined.	
Routine Hearing Exams Covered only as part of a routine physical exam.	Paid as part of a routine physical exam.	70% after deductible
DIAGNOSTIC PROCEDURES	PREFERRED CARE	NON-PREFERRED CARE
Outpatient Diagnostic Laboratory and X-ray (except for Complex Imaging Services) - (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.)	\$20 Copay	70% after deductible
Outpatient Diagnostic X-ray for Complex Imaging Services (Includes MRA/MRS, MRI, PET and CAT Scans)	\$150 Copay	70% after deductible
EMERGENCY MEDICAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Urgent Care Provider	\$150 Copay	70% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room (Copay waived if admitted.)	\$150 Copay	Paid as Preferred Care
Non-Emergency care in Emergency Room	Not Covered	Not Covered
Ambulance	\$0 Copay	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 an Institute of Excellence [®] facility, benefits would be paid at the preferred level. If procedure is not performed through Institutes of Excellence [®] facility, benefits would be paid at the non-preferred level.)	\$0 Copay per admission	70% after deductible
Outpatient Surgery	\$0 Copay	70% after deductible
MENTAL HEALTH SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Serious Mental Illness or Biologically Based Mental Illness (Limited to 30 days per member per calendar year. Preferred Care and Non-Preferred Care combined.)	\$0 Copay per admission	70% after deductible
Outpatient Serious Mental Illness or Biologically Based Mental Illness (Limited to 60 visits per member per calendar year. Preferred Care and Non-Preferred Care combined.)	\$20 Copay	70% after deductible
Inpatient Other than Serious Mental Illness or Biologically Based Mental Illness (Limited to 30 days per member per calendar year. Preferred Care and Non-Preferred Care combined.)	\$0 Copay per admission	70% after deductible
Outpatient Other than Serious Mental Illness or Biologically Based Mental Illness (Limited to 20 visits per member per calendar year. Preferred Care and Non-Preferred Care combined.)	\$20 Copay	70% after deductible
ALCOHOL/DRUG ABUSE SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Detoxification (Limited to 7 days per member per admission; 4 admissions per member per lifetime. Preferred Care and Non-Preferred Care combined.)	\$0 Copay per admission	70% after deductible
Outpatient Detoxification	\$20 Copay	70% after deductible
Inpatient Rehabilitation (Limited to 30 days per member per calendar year; 90 days per member per lifetime. Preferred Care and Non-Preferred Care combined.)	\$0 Copay per admission	70% after deductible
Outpatient Rehabilitation (Limited to 60 visits per member per calendar year; 120 visits per member per lifetime. Preferred Care and Non-Preferred Care combined.)	\$20 Copay	70% 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 Care and Non-Preferred Care combined.)	\$0 Copay per admission	70% after deductible
Home Health Care (Limited to 60 visits per member per calendar year. One visit per day up to four hours per visit. Preferred Care and Non-Preferred Care combined.)	\$20 Copay	70% after deductible
Infusion Therapy (Provided in the home or physician's office)	\$20 Copay	70% after deductible; Aetna pays up to \$50 per visit after deductible for nursing services and supplies.
Infusion Therapy (Provided in an outpatient hospital department or freestanding facility)	\$0 Copay	70% after deductible; Aetna pays up to \$50 per visit after deductible for nursing services and supplies.
Hospice Care - Inpatient (Limited to \$10,000 per member per lifetime – combined Inpatient and Outpatient. Preferred Care and Non-Preferred Care combined.)	\$0 Copay per admission	70% after deductible
Hospice Care - Outpatient (Limited to \$10,000 per member per lifetime – combined Inpatient and Outpatient. Preferred Care and Non-Preferred Care combined.)	\$20 Copay	70% after deductible
Outpatient Physical and Occupational Therapy (Physical and Occupational Therapy limited to 30 visits [combined] per member per calendar year. Preferred Care and Non-Preferred Care combined.)	\$20 Copay	70% after deductible
Outpatient Speech Therapy (Limited to 30 visits per member per calendar year. Preferred Care and Non-Preferred Care combined.)	\$20 Copay	70% after deductible
Spinal Manipulation Therapy (Chiropractic) (Limited to 20 visits per member per calendar year. Preferred Care and Non-Preferred Care combined.)	\$20 Copay	70% after deductible
Durable Medical Equipment (Limited to \$2,500 per member calendar year maximum. Preferred Care and Non-Preferred Care combined.)	50%	50% after deductible



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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.	70% after deductible
Voluntary Sterilization (Including tubal ligation and vasectomy.)	Member cost sharing is based on the type of service performed and the place rendered.	70% after deductible
PHARMACY - PRESCRIPTION DRUG BENEFITS	PARTICIPATING PHARMACIES	NON-PARTICIPATING PHARMACIES
Prescription Drug Calendar Year Deductible	Not Applicable	Not Applicable
Retail Up to a 30-day supply	\$10 Copay for generic drugs, \$25 Copay for formulary brand-name drugs, and \$50 Copay for non-formulary brand-name drugs	80% of submitted cost after \$10 Copay for generic drugs, \$25 Copay for formulary brand-name drugs, and \$50 Copay for non-formulary brand-name drugs
Mail Order 31-90 day supply	\$20 Copay for generic drugs, \$50 Copay for formulary brand-name drugs, and \$100 Copay for non-formulary brand-name drugs	Not Covered
Self-Injectables (Excluding Insulin)	90% plan coinsurance/ 10% member coinsurance for formulary and non-formulary drugs	Not Covered
No Mandatory Generic (No MG) – Member is responsible to pay the applicable copay and/or coinsurance.		
Plan includes: Diabetic supplies, contraceptive drugs and devices obtainable from a pharmacy.		
Precertification included and 90 day Transition of Care (TOC) for Precertification included.		

* The dollar amount copayments indicate what the member is required to pay and the percentage copayments indicate what Aetna is required to pay.

** Payment for Non-Preferred facility care is determined based upon Aetna's Allowable Fee Schedule. Payment for plans 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.

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.**

- (1) All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents;
- (2) Charges related to any eye surgery mainly to correct refractive errors;
- (3) Cosmetic surgery, including breast reduction;
- (4) Custodial care;
- (5) Dental care and x-rays;
- (6) Donor egg retrieval;
- (7) Experimental and investigational procedures;

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- (8) Hearing aids;
- (9) Immunizations for travel or work;
- (10) 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;
- (11) Nonmedically necessary services or supplies;
- (12) Orthotics;
- (13) Over-the-counter medications and supplies;
- (14) Reversal of sterilization;
- (15) Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs;
- (16) Special duty nursing; and
- (17) Treatment of those services for or related to treatment of obesity or for diet or weight control.

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 90 days prior to the enrollment date.

Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 90 day period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days 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 90 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 the 90 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 90 day 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 1-888-80-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 not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits vary by location. 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.

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



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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 pre-certification 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.

Plans are provided by Aetna Life Insurance Company.

For more information about Aetna plans, refer to www.aetna.com. Information is subject to change.