

**PLAN DESIGN AND BENEFITS - PA PPO HSA Compatible Plan 2.3**

<b>PLAN FEATURES</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Deductible</b> (per plan year)		\$2,500 Individual \$5,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. All covered expenses, including prescription drugs and self-injectables, accumulate toward both the preferred and non-preferred Deductible. Member cost sharing for preventive care is excluded from charges to meet the Deductible. The Individual Deductible can only be met when a member is enrolled for self only coverage with no dependent coverage. The Family Deductible can be met by a combination of family members or by any single individual within the family. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the plan year. Deductible Credit and Deductible Carryover do not apply.		
<b>Plan Coinsurance</b> *	100%	100%
Applies to all expenses unless otherwise stated.		
<b>Payment Limit</b> (per plan year, includes deductible)		\$3,000 Individual \$6,000 Family
All covered medical and prescription drug expenses, except amounts over Recognized Charge and failure to pre-certify penalties, accumulate toward both the Preferred and Non-Preferred Payment Limit. The Individual Payment Limit can only be met when a member is enrolled for self only coverage with no dependent coverage. The Family Payment Limit can be met by a combination of family members or by any single individual within the family. Once the Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the plan year.		
<b>Lifetime Maximum</b> \$2,000,000 per member's lifetime, Preferred and Non-Preferred care combined.		
<b>Payment for Non-Preferred Care</b>	Not Applicable	Recognized Charge **
<b>Primary Care Physician Selection</b>	Not Applicable	Not Applicable
<b>Certification Requirements -</b> 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.		
<b>Referral Requirement</b>	Not Applicable	Not Applicable
<b>PHYSICIAN SERVICES</b>		
	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Office Visits to Non-Specialist</b>	100% after deductible	100% 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.		
<b>Specialist Office Visits</b>	100% after deductible	100% after deductible
<b>Maternity OB Visits</b>	100% after deductible	100% after deductible
<b>Allergy Treatment</b>	100% after deductible	100% after deductible
<b>Allergy Testing</b>	100% after deductible	100% after deductible
<b>PREVENTIVE CARE</b>		
	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Routine Adult Physical Exams/ Immunizations</b> (Limited to 1 exam every 12 months for members age 18 and older. Preferred Care and Non-Preferred Care combined.)	100%; deductible waived	100%; deductible waived
<b>Well Child Exams / Immunizations</b> (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.)	100%; deductible waived	100%; deductible waived



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<b>PREVENTIVE CARE (CONTINUED)</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Routine Gynecological Care Exams</b> (Includes pap smear and related lab fees. Limited to one exam and pap smear per plan year. Preferred Care and Non-Preferred Care combined.)	100%; deductible waived	100%; deductible waived
<b>Routine Mammograms</b> (Limited to one mammogram per plan year for females age 40 and over. Preferred Care and Non-Preferred Care combined.)	100%; deductible waived	100%; deductible waived
<b>Routine Digital Rectal Exam / Prostate-Specific Antigen Test</b> (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.	Member cost sharing is based on the type of service performed and the place rendered.
<b>Colorectal Cancer Screening</b> (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.	Member cost sharing is based on the type of service performed and the place rendered.
<b>Routine Eye Exams at Specialist</b> (Limited to one routine exam per 24 months. Preferred Care and Non-Preferred Care combined. No referral required.)	100%; deductible waived	100%; deductible waived
<b>Vision Corrective Lenses/ Contact Lenses Allowance</b>	\$100 reimbursement payable once for 24-month period (deductible waived) Preferred Care and Non-Preferred Care combined.	
<b>Routine Hearing Exams</b> Covered only as part of a routine physical exam.	Paid as part of a routine physical exam.	100%; deductible waived
<b>DIAGNOSTIC PROCEDURES</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Outpatient Diagnostic Laboratory and X-ray (except for Complex Imaging Services)</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 member cost sharing.)	100% after deductible	100% after deductible
<b>Outpatient Diagnostic X-ray for Complex Imaging Services</b> (Includes MRA/MRS, MRI, PET and CAT Scans)	100% after deductible	100% after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Urgent Care Provider</b>	100% after deductible	100% after deductible
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered	Not Covered
<b>Emergency Room</b>	100% after deductible	Paid as Preferred Care.
<b>Non-Emergency care in Emergency Room</b>	Not Covered	Not Covered
<b>Ambulance</b>	100% after deductible	Paid as Preferred Care.



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<b>HOSPITAL CARE</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Inpatient Coverage</b> Including maternity (prenatal, delivery and postpartum) & transplants (If transplant is performed through an Institute of Excellence <sup>®</sup> facility, benefits would be paid at the preferred level. If procedure is not performed through Institutes of Excellence <sup>®</sup> facility, benefits would be paid at the non-preferred level.)	100% after deductible	100% after deductible
<b>Outpatient Surgery</b>	100% after deductible	100% after deductible
<b>MENTAL HEALTH SERVICES</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Inpatient Serious Mental Illness or Biologically Based Mental Illness</b> (Limited to 30 days per member per plan year. Preferred Care and Non-Preferred Care combined.)	100% after deductible	100% after deductible
<b>Outpatient Serious Mental Illness or Biologically Based Mental Illness</b> (Limited to 60 visits per member per plan year. Preferred Care and Non-Preferred Care combined.)	100% after deductible	100% after deductible
<b>Inpatient Other than Serious Mental Illness or Biologically Based Mental Illness</b> (Limited to 30 days per member per plan year. Preferred Care and Non-Preferred Care combined.)	100% after deductible	100% after deductible
<b>Outpatient Other than Serious Mental Illness or Biologically Based Mental Illness</b> (Limited to 20 visits per member per plan year. Preferred Care and Non-Preferred Care combined.)	100% after deductible	100% after deductible
<b>ALCOHOL/DRUG ABUSE SERVICES</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Inpatient Detoxification</b> (Limited to 7 days per member per admission; 4 admissions per member per lifetime. Preferred Care and Non-Preferred Care combined.)	100% after deductible	100% after deductible
<b>Outpatient Detoxification</b>	100% after deductible	100% after deductible
<b>Inpatient Rehabilitation</b> (Limited to 30 days per member per plan year; 90 days per member per lifetime. Preferred Care and Non-Preferred Care combined.)	100% after deductible	100% after deductible
<b>Outpatient Rehabilitation</b> (Limited to 60 visits per member per plan year; 120 visits per member per lifetime. Preferred Care and Non-Preferred Care combined.)	100% after deductible	100% after deductible



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<b>OTHER SERVICES AND PLAN DETAILS</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Convalescent Facility (Skilled Nursing Facility)</b> (Limited to 120 days per member per plan year. Preferred Care and Non-Preferred Care combined.)	100% after deductible	100% after deductible
<b>Home Health Care</b> (Limited to 60 visits per member per plan year. One visit per day up to four hours per visit. Preferred Care and Non-Preferred Care combined.)	100% after deductible	100% after deductible
<b>Infusion Therapy</b> (Provided in the home or physician's office)	100% after deductible	100% after deductible; Aetna pays up to \$50 per visit after deductible for nursing services and supplies.
<b>Infusion Therapy</b> (Provided in an outpatient hospital department or freestanding facility)	100% after deductible	100% after deductible; Aetna pays up to \$50 per visit after deductible for nursing services and supplies.
<b>Hospice Care - Inpatient</b> (Limited to \$10,000 per member per lifetime – combined Inpatient and Outpatient. Preferred Care and Non-Preferred Care combined.)	100% after deductible	100% after deductible
<b>Hospice Care - Outpatient</b> (Limited to \$10,000 per member per lifetime – combined Inpatient and Outpatient. Preferred Care and Non-Preferred Care combined.)	100% after deductible	100% after deductible
<b>Outpatient Physical and Occupational Therapy</b> (Physical and Occupational Therapy limited to 30 visits [combined] per member per plan year. Preferred Care and Non-Preferred Care combined.)	100% after deductible	100% after deductible
<b>Outpatient Speech Therapy</b> (Limited to 30 visits per member per plan year. Preferred Care and Non-Preferred Care combined.)	100% after deductible	100% after deductible
<b>Spinal Manipulation Therapy (Chiropractic)</b> (Limited to 20 visits per member per plan year. Preferred Care and Non-Preferred Care combined.)	100% after deductible	100% after deductible
<b>Durable Medical Equipment</b> (Limited to \$2,500 per member plan year maximum. Preferred Care and Non-Preferred Care combined.)	100% after deductible	100% after deductible

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<b>FAMILY PLANNING</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Infertility Treatment</b> (Covered only for the diagnosis and treatment of the underlying medical condition.)	100% after deductible	100% after deductible
<b>Voluntary Sterilization</b> (Including tubal ligation and vasectomy.)	100% after deductible	100% after deductible
<b>PHARMACY - PRESCRIPTION DRUG BENEFITS</b>	<b>PARTICIPATING PHARMACIES</b>	<b>NON-PARTICIPATING PHARMACIES</b>
<b>Prescription Drug Plan Year Deductible</b> (Must be satisfied before any prescription drug benefits are paid. Preferred Care and Non-Preferred Care combined.)	Integrated with Medical Deductible	Integrated with Medical Deductible
<b>Retail</b> Up to a 30-day supply	\$15 Copay after deductible for generic drugs, \$40 Copay after deductible for brand-name formulary drugs, and \$60 Copay after deductible for brand-name non-formulary drugs	80% of submitted cost after \$15 Copay after deductible for generic drugs, \$40 Copay after deductible for brand-name formulary drugs, and \$60 Copay after deductible for brand-name non-formulary drugs
<b>Mail Order</b> 31-90 day supply	\$30 Copay after deductible for generic drugs, \$80 Copay after deductible for brand-name formulary drugs, and \$120 Copay after deductible for brand-name non-formulary drugs	Not Covered
<b>Self-Injectables (Excluding Insulin)</b>	90% plan coinsurance/ 10% member coinsurance after deductible, for formulary and non-formulary drugs	Not Covered
<b>No Mandatory Generic (No MG) - Member is responsible to pay the applicable copay or coinsurance.</b>		
Plan includes: Diabetic supplies, contraceptive drugs and devices obtainable from a pharmacy.		
<b>Precertification included and 90 day Transition of Care (TOC) for Precertification included.</b>		

\* 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;

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- (4) Custodial care;
- (5) Dental care and x-rays;
- (6) Donor egg retrieval;
- (7) Experimental and investigational procedures;
- (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.

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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.

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](http://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](http://www.aetna.com). Information is subject to change.