

**PLAN DESIGN AND BENEFITS - PA Indemnity Plan 1.3**

<b>PLAN FEATURES</b>	<b>COST SHARE</b>
<b>Deductible</b> (per calendar year)	\$1,000 Individual \$3,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Member cost-sharing for certain services, including preventive care, maternity post partum health care visits and phenyl-free enteral formula, are excluded from charges to meet the Deductible. Once the Family Deductible is met, all family members will be considered as having met their 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.	
<b>Plan Coinsurance *</b>	70%
Applies to all expenses unless otherwise stated.	
<b>Payment Limit</b> (per calendar year, excludes deductible)	\$2,000 Individual \$6,000 Family
All covered expenses, except amounts over Recognized Charge and failure to pre-certify penalty, accumulate toward the Payment Limit. Once the Family Payment Limit is met, all family members will be considered as having met their 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.	
<b>Lifetime Maximum</b>	\$1,000,000
<b>Provider Payment</b>	Recognized Charge **
<b>Primary Care Physician Selection</b>	Not Applicable
<b>Certification Requirements-</b> Certification for certain types of 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
<b>PHYSICIAN SERVICES</b>	<b>COST SHARE</b>
<b>Office Visits to Non-Specialist</b>	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 and in-office surgery.	
<b>Specialist Office Visits</b>	70% after deductible
<b>Maternity OB Visits</b>	70% after deductible
<b>Allergy Treatment</b>	70% after deductible
<b>Allergy Testing</b>	70% after deductible
<b>PREVENTIVE CARE</b>	<b>COST SHARE</b>
<b>Routine Adult Physical Exams/ Immunizations</b> (Limited to 1 exam every 12 months for members age 18 and older.)	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.)	100%; deductible waived
<b>Routine Gynecological Care Exams</b> (Includes pap smear and related lab fees. Limited to one annual exam and pap smear.)	100%; deductible waived
<b>Routine Mammograms</b> No age or frequency limits.	100%; deductible waived

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<b>PREVENTIVE CARE (CONTINUED)</b>	<b>COST SHARE</b>
<b>Routine Digital Rectal Exam / Prostate Specific Antigen Test</b> For covered males age 40 and over. Frequency schedule applies.	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.	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. No referral required.)	100%; deductible waived
<b>Vision Corrective Lenses/ Contact Lenses Allowance</b>	\$100 reimbursement payable once for 24-month period (deductible waived)
<b>Routine Hearing Exams at Specialist</b>	Not Covered
<b>DIAGNOSTIC PROCEDURES</b>	<b>COST SHARE</b>
<b>Outpatient Diagnostic Laboratory and X-ray (including 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 member coinsurance.)	70% after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>COST SHARE</b>
<b>Urgent Care Provider</b>	70% after deductible
<b>Non-Urgent use of Urgent Care Provider</b>	Not Covered
<b>Emergency Room</b>	70% after deductible
<b>Non-Emergency care in an Emergency Room</b>	Not Covered
<b>Ambulance</b>	70% after deductible
<b>HOSPITAL CARE</b>	<b>COST SHARE</b>
<b>Inpatient Coverage</b> (Including transplants and maternity - prenatal, delivery and postpartum) Inpatient hospital deductible applied per admission. 3x hospital deductible limit per calendar year; waived if readmitted to a hospital within 10 days of discharge.	70% after \$250 per confinement deductible after calendar year deductible
<b>Outpatient Surgery</b>	70% after deductible
<b>MENTAL HEALTH SERVICES</b>	<b>COST SHARE</b>
<b>Inpatient Serious Mental Illness or Biologically Based Mental Illness</b> (Limited to 30 days per member per calendar year.)	70% after \$250 per confinement deductible after calendar year deductible
<b>Outpatient Serious Mental Illness or Biologically Based Mental Illness</b> (Limited to 60 visits per member per calendar year.)	70% after deductible
<b>Inpatient Other than Serious Mental Illness or Biologically Based Mental Illness</b> (Limited to 30 days per member per calendar year.)	70% after \$250 per confinement deductible after calendar year deductible
<b>Outpatient Other than Serious Mental Illness or Biologically Based Mental Illness</b> (Limited to 20 visits per member per calendar year.)	70% after deductible



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<b>ALCOHOL/DRUG ABUSE SERVICES</b>		<b>COST SHARE</b>
<b>Inpatient Detoxification</b> (Limited to 7 days per admission, 4 admissions per lifetime.)		70% after \$250 per confinement deductible after calendar year deductible
<b>Outpatient Detoxification</b> (Limited to unlimited visits per member per calendar year.)		70% after deductible
<b>Inpatient Rehabilitation</b> (Limited to 30 days per member per calendar year, 90 days per member per lifetime.)		70% after \$250 per confinement deductible after calendar year deductible
<b>Outpatient Rehabilitation</b> (Limited to 60 visits per member per calendar year, 120 visits per member per lifetime.)		70% after deductible
<b>OTHER SERVICES</b>		<b>COST SHARE</b>
<b>Convalescent Facility (Skilled Nursing Facility)</b> (Limited to 120 days per member per calendar year.)		70% after deductible
<b>Home Health Care</b> (Limited to 60 visits per member per calendar year; 1 visit equals a period of 4 hours or less.)		70% after deductible
<b>Hospice Care - Inpatient</b> (Limited to \$10,000 per member per lifetime, combined Inpatient and Outpatient.)		70% after deductible
<b>Hospice Care - Outpatient</b> (Limited to \$10,000 per member per lifetime, combined Inpatient and Outpatient.)		70% after deductible
<b>Private Duty Nursing - Outpatient</b>		Not Covered
<b>Outpatient Physical and Occupational Therapy</b> (Physical and Occupational Therapy limited to 30 visits [combined] per member per calendar year.)		70% after deductible
<b>Outpatient Speech Therapy</b> (Limited to 30 visits per member per calendar year.)		70% after deductible
<b>Spinal Manipulation Therapy (Chiropractic)</b> (Limited to 20 visits per member per calendar year.)		70% after deductible
<b>Durable Medical Equipment</b> (Limited to \$2,500 per member calendar year maximum.)		50% after deductible
<b>FAMILY PLANNING</b>		<b>COST SHARE</b>
<b>Infertility Treatment</b> (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 of service rendered.
<b>Voluntary Sterilization</b> (Including tubal ligation and vasectomy.)		Member cost sharing is based on the type of service performed and the place rendered.

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<b>PHARMACY - PRESCRIPTION DRUG BENEFITS</b>	<b>COST SHARE</b>
<b>Prescription Drug Calendar Year Deductible</b> (Must be satisfied before any prescription drug benefits are paid.)	Integrated with Medical Deductible
<b>Prescription Drugs (Including Self-Injectables)</b>	70% after deductible
<b>First Step Rx Discount Program applies.</b>	
Plan includes: contraceptive drugs and devices obtainable from a pharmacy and diabetic supplies obtainable from a pharmacy.	

\* 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 care is determined based upon the lowest of: the provider's usual charge for furnishing it; or the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made. These charges are referred to in your plan as "reasonable" or "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;
- (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.

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#### **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.

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). Member is responsible for obtaining precertification for certain services. Precertification requirements may vary.

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.