Aetna Life Insurance Company

PA Small Group PPO
Plan Effective Date: 10/1/2010

PLAN DESIGN AND BENEFITS - PA PPO COST-SHARING 1.4 ($1,500 Ded)

PLAN FEATURES	NETWORK CARE	OUT-OF-NETWORK CARE
Deductible (per calendar year)	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. All covered expenses accumulate separately toward the Network and Out-of-Network Deductible. The Network Deductible applies to the following benefits: Inpatient Hospital Care (including maternity); Outpatient Surgery; Inpatient Serious Mental Illness; Inpatient Non-Serious Mental Illness; Inpatient Detoxification; Inpatient Rehabilitation; Skilled Nursing Facility; Inpatient Hospice and Transplants. The Out-of-Network Deductible applies to all out-of-network benefits unless state mandated. 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.		
Plan Coinsurance *	100%	50%
Applies to all expenses unless otherwise stated.		
Maximum Out-of-Pocket Limit (per plan year, includes deductible)	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family
All covered expenses, except amounts over Recognized Charge, failure to pre-certify penalties and member cost-sharing for prescription drugs, apply toward the Network and Out-of-Network Maximum Out-of-Pocket Limit. All covered expenses accumulate separately toward the Network and Out-of-Network Maximum Out-of-Pocket Limit. Once Family Maximum Out-of-Pocket Limit is met, all family members will be considered as having met their Maximum Out-of-Pocket Limit for the remainder of the plan year. No one family member may contribute more than the Individual Maximum Out-of-Pocket Limit to the Family Maximum Out-of-Pocket Limit.		
Lifetime Maximum	Unlimited	Unlimited
Payment for Out-of-Network Care	Not Applicable	Professional: 105% of Medicare** Facility: 140% of Medicare**
Primary Care Physician Selection	Not Applicable	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network 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	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Office Visits to Non-Specialist	$30 Copay, deductible waived	50% 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	$50 Copay, deductible waived	50% after deductible
Maternity OB Visits	$50 Copay for Initial Visit Only, deductible waived	50% after deductible
Allergy Testing (given by a physician)	Same as applicable office visit member cost sharing.	50% after deductible
Allergy Injections (not given by a physician)	$0 Copay, deductible waived	50% after deductible
PREVENTIVE CARE	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Routine Adult Physical Exams/ Immunizations (Limited to 1 exam every 12 months for members age 18 and older. Network and Out-of-Network combined.)	$0 Copay, deductible waived	50% after deductible

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PREVENTIVE CARE (CONTINUED)	NETWORK CARE	OUT-OF-NETWORK CARE
Well Child Exams / Immunizations (Provides coverage for 7 exams in the first 12 months of life; 3 exams in the second 12 months of life; 3 exams in the third 12 months of life; 1 exam per 12 months thereafter. Network and Out-of-Network combined.)	$0 Copay, deductible waived	50% after deductible, except deductible waived for immunizations
Routine Gynecological Care Exams (Includes pap smear and related lab fees. Limited to one annual exam and pap smear. Network and Out-of-Network combined.)	$0 Copay, deductible waived	50%, deductible waived
Routine Mammograms (Limited to one annual mammogram for females age 40 and over. Network and Out-of-Network combined.)	$0 Copay, deductible waived	50% after deductible
Routine Digital Rectal Exam / Prostate-Specific Antigen Test (For covered males age 40 and over. Frequency schedule applies. Network and Out-of-Network combined.)	$0 Copay, deductible waived	50% after deductible
Colorectal Cancer Screening (For all members age 50 and over. Frequency schedule applies. Network and Out-of-Network combined.)	$0 Copay, deductible waived	50% after deductible
Routine Eye Exams at Specialist (Limited to one routine exam per 24 months. Network and Out-of-Network combined. No referral required.)	$0 Copay, deductible waived	50% after deductible
Vision Corrective Lenses/ Contact Lenses Allowance	$100 reimbursement payable once for 24-month period (deductible waived) Network and Out-of-Network combined.	
Routine Hearing Exams Covered only as part of a routine physical exam.	Paid as part of a routine physical exam.	50% after deductible
DIAGNOSTIC PROCEDURES	**NETWORK CARE**	**OUT-OF-NETWORK 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.)	$50 Copay, deductible waived	50% after deductible
Outpatient Diagnostic X-ray for Complex Imaging Services (Includes MRA/MRS, MRI, PET and CAT Scans)	$200 Copay, deductible waived	50% after deductible

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EMERGENCY MEDICAL CARE	NETWORK CARE	OUT-OF-NETWORK CARE
Urgent Care Provider	$200 Copay, deductible waived	50% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room (Copay waived if admitted.)	$200 Copay, deductible waived	Paid as Network Care
Non-Emergency care in Emergency Room	Not Covered	Not Covered
Emergency Ambulance	$0 Copay, deductible waived	Paid as Network Care
Non-Emergency Ambulance	$0 Copay, deductible waived	50% after deductible
HOSPITAL CARE	**NETWORK CARE**	**OUT-OF-NETWORK 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 network level. If procedure is not performed through Institutes of Excellence® facility, benefits would be paid at the out-of-network level.)	$0 Copay per admission after deductible	50% after deductible
Outpatient Surgery	$0 Copay after deductible	50% after deductible
MENTAL HEALTH SERVICES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Inpatient Serious Mental Illness (Limited to 30 days per member per calendar year. Network and Out-of-Network combined.)	$0 Copay per admission after deductible	50% after deductible
Outpatient Serious Mental Illness (Limited to 60 visits per member per calendar year. Network and Out-of-Network combined.)	$50 Copay, deductible waived	50% after deductible
Inpatient Non-Serious Mental Illness (Limited to 30 days per member per calendar year. Network and Out-of-Network combined.)	$0 Copay per admission after deductible	50% after deductible
Outpatient Non-Serious Mental Illness (Limited to 20 visits per member per calendar year. Network and Out-of-Network combined.)	$50 Copay, deductible waived	50% after deductible
ALCOHOL/DRUG ABUSE SERVICES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Inpatient Detoxification (Limited to 7 days per member per admission; 4 admissions per member per lifetime. Network and Out-of-Network combined.)	$0 Copay per admission after deductible	50% after deductible
Outpatient Detoxification	$50 Copay, deductible waived	50% after deductible
Inpatient Rehabilitation (Limited to 30 days per member per calendar year; 90 days per member per lifetime. Network and Out-of-Network combined.)	$0 Copay per admission after deductible	50% after deductible
Outpatient Rehabilitation (Limited to 60 visits per member per calendar year; 120 visits per member per lifetime. Network and Out-of-Network combined.)	$50 Copay, deductible waived	50% after deductible

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OTHER SERVICES AND PLAN DETAILS	NETWORK CARE	OUT-OF-NETWORK CARE
Convalescent Facility (Skilled Nursing Facility) (Limited to 120 days per member per calendar year. Network and Out-of-Network combined.)	$0 Copay per admission after deductible	50% after deductible
Home Health Care (Limited to 60 visits per member per calendar year. One visit per day up to four hours per visit. Network and Out-of-Network combined.)	$50 Copay, deductible waived	50% after deductible
Infusion Therapy (Provided in the home or physician's office)	$50 Copay, deductible waived	50% after deductible
Infusion Therapy (Provided in an outpatient hospital department or freestanding facility)	$0 Copay after deductible	50% after deductible
Hospice Care - Inpatient	$0 Copay per admission after deductible	50% after deductible
Hospice Care - Outpatient	$50 Copay, deductible waived	50% after deductible
Outpatient Physical and Occupational Therapy (Physical and Occupational Therapy limited to 30 visits [combined] per member per calendar year. Network and Out-of-Network combined.)	$50 Copay, deductible waived	50% after deductible
Outpatient Speech Therapy (Limited to 30 visits per member per calendar year. Network and Out-of-Network combined.)	$50 Copay, deductible waived	50% after deductible
Spinal Manipulation Therapy (Chiropractic) (Limited to 20 visits per member per calendar year. Network and Out-of-Network combined.)	$50 Copay, deductible waived	50% after deductible
Durable Medical Equipment (Limited to $2,500 per member calendar year maximum. Network and Out-of-Network combined.)	50%, deductible waived	50% after deductible
FAMILY PLANNING	**NETWORK CARE**	**OUT-OF-NETWORK 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.	50% after deductible
Voluntary Sterilization (Including tubal ligation and vasectomy.)	Member cost sharing is based on the type of service performed and the place rendered.	50% after deductible

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PHARMACY - PRESCRIPTION DRUG BENEFITS	NETWORK PHARMACIES	OUT-OF-NETWORK PHARMACIES
Prescription Drug Calendar Year Deductible	Not Applicable	Not Applicable
Retail Up to a 30-day supply	$15 Copay for generic drugs, $40 Copay for formulary brand-name drugs, and $70 Copay for non-formulary brand-name drugs	80% of submitted cost after $15 Copay for generic drugs, $40 Copay for formulary brand-name drugs, and $70 Copay for non-formulary brand-name drugs
Mail Order 31-90 day supply	$30 Copay for generic drugs, $80 Copay for formulary brand-name drugs, and $140 Copay for non-formulary brand-name drugs	Not Covered
Specialty CareRx[SM] Drugs	90% plan coinsurance/ 10% member coinsurance for formulary and non-formulary drugs	Not Covered
Specialty CareRx - First Prescription for a specialty drug must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy®. Subsequent fills must be through Aetna Specialty Pharmacy®.		
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.

** You may choose providers in our network (physicians and facilities) or may visit an out-of-network provider. Typically, you will pay substantially more money out of your own pocket if you choose to use an out-of-network doctor. The out-of-network provider will be paid based on Aetna's "recognized charge." This is not the same as the billed charge from the doctor.

Aetna pays a percentage of the recognized charge, as defined in Your plan. The recognized charge for out-of-network hospitals, doctors and other out-of-network health care providers is a percentage (100 percent or above) of the rate that Medicare pays them.

You may have to pay the difference between the out-of-network provider's billed charge and Aetna's recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the doctor or hospital bills you above Aetna's recognized charge does not count toward your deductible or out-of-pocket maximums.

This benefit applies when you choose to get care out of network. When you have no choice in the doctors you see (for example, an emergency room visit after a car accident), your deductible and coinsurance for the in-network level of benefits will be applied, and you should contact Aetna if your doctor asks you to pay more.

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 no 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.

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 creditable 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 under the age of 19. 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 network provider is coordinating care, the network 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.