



**PLAN DESIGN AND BENEFITS - PA PPO HSA COMPATIBLE 1.4 (\$3,000 Ded)**

<b>PLAN FEATURES</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Deductible</b> (per plan year)	\$3,000 Individual \$6,000 Family	\$6,000 Individual \$12,000 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. 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> *	90%	50%
Applies to all expenses unless otherwise stated.		
<b>Maximum Out-of-Pocket Limit</b> (per plan year, includes deductible)	\$5,000 Individual \$10,000 Family	\$10,000 Individual \$20,000 Family
All covered medical and prescription drug expenses, except amounts over Recognized Charge and failure to pre-certify penalties, accumulate separately toward the Network and Out-of-Network Maximum Out-of-Pocket Limit. The Individual Maximum Out-of-Pocket Limit can only be met when a member is enrolled for self only coverage with no dependent coverage. The Family Maximum Out-of-Pocket Limit can be met by a combination of family members or by any single individual within the family. Once the 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.		
<b>Lifetime Maximum</b>	Unlimited	Unlimited
<b>Payment for Out-of-Network Care</b>	Not Applicable	Professional: 105% of Medicare** Facility: 140% of Medicare**
<b>Primary Care Physician Selection</b>	Not Applicable	Not Applicable
<b>Certification Requirements -</b> 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.		
<b>Referral Requirement</b>	Not Applicable	Not Applicable
<b>PHYSICIAN SERVICES</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Office Visits to Non-Specialist</b>	\$40 Copay after deductible	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.		
<b>Specialist Office Visits</b>	\$60 Copay after deductible	50% after deductible
<b>Maternity OB Visits</b>	90% after deductible	50% after deductible
<b>Allergy Testing</b> (given by a physician)	Same as applicable office visit member cost sharing.	50% after deductible
<b>Allergy Injections</b> (not given by a physician)	90% after deductible	50% after deductible
<b>PREVENTIVE CARE</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Routine Adult Physical Exams/ Immunizations</b> (Limited to 1 exam every 12 months for members age 18 and older. Network and Out-of-Network combined.)	\$0 Copay, deductible waived	50%, deductible waived



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<b>PREVENTIVE CARE (CONTINUED)</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Well Child Exams / Immunizations</b> (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%, deductible waived
<b>Routine Gynecological Care Exams</b> (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
<b>Routine Mammograms</b> (Limited to one mammogram per plan year for females age 40 and over. Network and Out-of-Network combined.)	\$0 Copay, deductible waived	50%, deductible waived
<b>Routine Digital Rectal Exam / Prostate-Specific Antigen Test</b> (For covered males age 40 and over. Frequency schedule applies. Network and Out-of-Network combined.)	\$0 Copay, deductible waived	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. Network and Out-of-Network combined.)	\$0 Copay, deductible waived	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. Network and Out-of-Network combined. No referral required.)	\$0 Copay, deductible waived	50%, deductible waived
<b>Vision Corrective Lenses/ Contact Lenses Allowance</b>	\$100 reimbursement payable once for 24-month period (deductible waived) Network and Out-of-Network combined.	
<b>Routine Hearing Exams</b> Covered only as part of a routine physical exam.	Paid as part of a routine physical exam.	Paid as part of a routine physical exam.
<b>DIAGNOSTIC PROCEDURES</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK 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.)	\$60 Copay after deductible	50% after deductible
<b>Outpatient Diagnostic X-ray for Complex Imaging Services</b> (Includes MRA/MRS, MRI, PET and CAT Scans)	\$200 Copay after deductible	50% after deductible



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<b>EMERGENCY MEDICAL CARE</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Urgent Care Provider</b>	70% after deductible	50% after deductible
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered	Not Covered
<b>Emergency Room</b>	70% after deductible	Paid as Network Care
<b>Non-Emergency care in Emergency Room</b>	Not Covered	Not Covered
<b>Emergency Ambulance</b>	90% after deductible	Paid as Network Care
<b>Non-Emergency Ambulance</b>	90% after deductible	50% after deductible
<b>HOSPITAL CARE</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Inpatient Coverage</b> 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.)	90% after deductible	50% after deductible
<b>Outpatient Surgery</b>	90% after deductible	50% after deductible
<b>MENTAL HEALTH SERVICES</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Inpatient Serious Mental Illness</b> (Limited to 30 days per member per plan year. Network and Out-of-Network combined.)	90% after deductible	50% after deductible
<b>Outpatient Serious Mental Illness</b> (Limited to 60 visits per member per plan year. Network and Out-of-Network combined.)	\$60 Copay after deductible	50% after deductible
<b>Inpatient Non-Serious Mental Illness</b> (Limited to 30 days per member per plan year. Network and Out-of-Network combined.)	90% after deductible	50% after deductible
<b>Outpatient Non-Serious Mental Illness</b> (Limited to 20 visits per member per plan year. Network and Out-of-Network combined.)	\$60 Copay after deductible	50% after deductible
<b>ALCOHOL/DRUG ABUSE SERVICES</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Inpatient Detoxification</b> (Limited to 7 days per member per admission; 4 admissions per member per lifetime. Network and Out-of-Network combined.)	90% after deductible	50% after deductible
<b>Outpatient Detoxification</b>	\$60 Copay after deductible	50% after deductible
<b>Inpatient Rehabilitation</b> (Limited to 30 days per member per plan year; 90 days per member per lifetime. Network and Out-of-Network combined.)	90% after deductible	50% after deductible
<b>Outpatient Rehabilitation</b> (Limited to 60 visits per member per plan year; 120 visits per member per lifetime. Network and Out-of-Network combined.)	\$60 Copay after deductible	50% after deductible



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<b>OTHER SERVICES AND PLAN DETAILS</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Convalescent Facility (Skilled Nursing Facility)</b> (Limited to 120 days per member per plan year. Network and Out-of-Network combined.)	90% after deductible	50% 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. Network and Out-of-Network combined.)	\$60 Copay after deductible	50% after deductible
<b>Infusion Therapy</b> (Provided in the home or physician's office)	\$60 Copay after deductible	50% after deductible
<b>Infusion Therapy</b> (Provided in an outpatient hospital department or freestanding facility)	90% after deductible	50% after deductible
<b>Hospice Care - Inpatient</b>	90% after deductible	50% after deductible
<b>Hospice Care - Outpatient</b>	\$60 Copay after deductible	50% after deductible
<b>Outpatient Physical and Occupational Therapy</b> (Physical and Occupational Therapy limited to 30 visits [combined] per member per plan year. Network and Out-of-Network combined.)	\$60 Copay after deductible	50% after deductible
<b>Outpatient Speech Therapy</b> (Limited to 30 visits per member per plan year. Network and Out-of-Network combined.)	\$60 Copay after deductible	50% after deductible
<b>Spinal Manipulation Therapy (Chiropractic)</b> (Limited to 20 visits per member per plan year. Network and Out-of-Network combined.)	\$60 Copay after deductible	50% after deductible
<b>Durable Medical Equipment</b> (Limited to \$2,500 per member plan year maximum. Network and Out-of-Network combined.)	50% after deductible	50% after deductible
<b>FAMILY PLANNING</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</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 rendered.	50% after deductible
<b>Voluntary Sterilization</b> (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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<b>PHARMACY - PRESCRIPTION DRUG BENEFITS</b>	<b>NETWORK PHARMACIES</b>	<b>OUT-OF-NETWORK PHARMACIES</b>
<b>Prescription Drug Deductible</b>	Integrated with Medical Deductible	Integrated with Medical Deductible
<b>Prescription Drug Out-of-Pocket Maximum</b>	Integrated with Medical Maximum Out-of-Pocket Limit	Integrated with Medical Maximum Out-of-Pocket Limit
<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 \$70 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 \$70 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 \$140 Copay after deductible for brand-name non-formulary drugs	Not Covered
<b>Specialty CareRx<sup>SM</sup> Drugs</b>	90% plan coinsurance/ 10% member coinsurance after deductible for formulary and non-formulary drugs	Not Covered
<b>Specialty CareRx</b> - First Prescription for a specialty drug must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy <sup>®</sup> . 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 and/or coinsurance.		
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.

\*\* 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.



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**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.

**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.



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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.

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](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.