aetna℠

Open Access® Managed Choice® POS HSA 3.5 (04/12)
PROVIDED BY AETNA LIFE INSURANCE COMPANY - INSURED

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE*
Deductible (per calendar year)	$2,500 Individual $5,000 Family	$3,000 Individual $6,000 Family

Unless otherwise indicated, the Deductible must be met prior to benefits being payable.
All covered expenses, including prescription drugs, accumulate toward both the preferred and non-preferred Deductible.
Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. There is no Individual Deductible to satisfy within the Family Deductible.

Member Coinsurance Applies to all expenses unless otherwise stated.	20%	40%
Payment Limit (per calendar year, excludes deductible)	$1,000 Individual $2,000 Family	$1,500 Individual $3,000 Family

All covered expenses, including prescription drugs, accumulate toward both the preferred and non-preferred Payment Limit.

Certain member cost sharing may not apply toward the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage and prescription drug copays, excluding any penalty amounts, may be used to satisfy the Payment Limit.
Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year. There is no Individual Payment Limit to satisfy within the Family Payment Limit.

Lifetime Maximum	Unlimited	
Primary Care Physician Selection	Optional	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, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.

Payment for Out-of-Network Care*	Not Applicable	Professional: 100% of Medicare Facility: 100% of Medicare
Referral Requirement	None	None

PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE*
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months age 18 and over.	Covered 100%; deductible waived	40% after deductible
Routine Well Child Exams/Immunizations 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. Includes immunizations.	Covered 100%; deductible waived	40% after deductible
Routine Gynecological Care Exams Includes Pap smear, HPV screening, and related lab fees. One routine exam every 12 months.	Covered 100%; deductible waived	40% after deductible
Routine Mammograms One baseline mammogram for covered females age 35 but less than 40; one mammogram per calendar year for covered females age 40 and over.	Covered 100%; deductible waived	40% after deductible
Routine Digital Rectal Exam / Prostate-specific Antigen Test For covered males age 40 and over.	Covered 100%; deductible waived	40% after deductible
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%; deductible waived	40% after deductible
Routine Eye Exams 1 exam every 24 months	Covered 100%; deductible waived	Not Covered

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PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE*
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	20% after deductible	40% after deductible
Specialist Office Visits	20% after deductible	40% after deductible
E-visit to PCP & Specialist An e-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor. Register at www.relayhealth.com	20% after deductible	40% after deductible
Walk-in Clinics Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.	20% after deductible	40% after deductible
Allergy Testing	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Allergy Injections	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**	**NON-PREFERRED CARE***
Outpatient Diagnostic X-ray and Laboratory	20% after deductible	40% after deductible
Outpatient Diagnostic Complex Imaging Including but not limited to MRI, MRA, PET and CT Scans. Precertification required.	20% after deductible	40% after deductible
EMERGENCY MEDICAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE***
Urgent Care Provider	20% after deductible	40% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	20% after deductible	Same as preferred care
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	20% after deductible	Same as preferred care
HOSPITAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE***
Inpatient Coverage	20% after deductible	40% after deductible
Inpatient Maternity Coverage	20% after deductible	40% after deductible
Outpatient Hospital Expenses (including surgery) Includes Free Standing Surgery Center	20% after deductible	40% after deductible; $400 maximum benefit per surgery
MENTAL HEALTH SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE***
Inpatient	Covered same as Inpatient Hospital services; after deductible	Covered same as Inpatient Hospital services; after deductible
Outpatient	Covered same as Specialist Office visit; after deductible	Covered same as Specialist Office visit; after deductible

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ALCOHOL/DRUG ABUSE SERVICES	PREFERRED CARE	NON-PREFERRED CARE*
Inpatient	Covered same as Inpatient Hospital services; after deductible	Covered same as Inpatient Hospital services; after deductible
Outpatient	Covered same as Specialist Office visit; after deductible	Covered same as Specialist Office visit; after deductible
OTHER SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE***
Convalescent Facility Limited to 60 days per calendar year.	20% after deductible	40% after deductible
Home Health Care Limited to 100 visits per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.	20% after deductible	40% after deductible
Private Duty Nursing	Not Covered	Not Covered
Hospice Care - Inpatient	20% after deductible	40% after deductible
Hospice Care - Outpatient Each visiting nurse care or private duty nursing care shift of 4 hours or less counts as one home health visit. Each such shift of over 4 hours and up to 8 hours counts as two home health care visits.	20% after deductible	40% after deductible
Outpatient Speech Therapy Limited to 20 visits per calendar year	20% after deductible	40% after deductible
Outpatient Physical, Occupational & Chiropractic Therapy Limited to 25 visits per calendar year	20% after deductible	40% after deductible
Durable Medical Equipment Limited to $2,000 per calendar year	20% after deductible	40% after deductible
Diabetic Supplies	Covered under pharmacy	Covered under pharmacy
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	20% (payable as any other covered expense) after deductible	40% (payable as any other covered expense) after deductible
Transplants	20% Preferred coverage is provided at an IOE contracted facility only; after deductible	40% Non-Preferred coverage is provided at a Non-IOE facility; after deductible
FAMILY PLANNING	**PREFERRED CARE**	**NON-PREFERRED CARE***
Infertility Treatment Diagnosis and treatment of the underlying medical condition.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Voluntary Sterilization Including tubal ligation and vasectomy.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible

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PHARMACY	PREFERRED CARE	NON-PREFERRED CARE*
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Retail	Covered 100% after combined medical/Rx plan deductible and $15 copay for generic drugs, $20 copay for formulary brand-name drugs, and $35 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	40% of submitted costs after combined medical/Rx plan deductible for all drugs up to a 30 day supply.
Mail Order	Covered 100% after combined medical/Rx plan deductible and $30 copay for generic drugs, $40 copay for formulary brand-name drugs, and $70 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not applicable
Specialty CareRx ℠ (Including self injectables, infused and oral specialty drugs. Excludes insulin.)	20% after combined medical/Rx plan deductible for formulary and non-formulary drugs	Not Covered
Preventive Medications - Deductible is waived for certain preventive medications. A full list of these drugs is available on Aetna Navigator™ or from your employer.		
Specialty CareRx ℠ **-** First prescriptions for specialty drugs may be filled at a retail pharmacy or Aetna Specialty Pharmacy®. Subsequent fills must be filled through Aetna Specialty Pharmacy®		
No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only.		
Plan Includes: Performance Enhancing Medication, Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs, Diabetic supplies.		
Precert for Growth Hormones included. Expanded Precert included with 90 day Transition of Care for new business.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth up to age 26.	
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Full Postponement	

This plan imposes a pre-existing condition exclusion, which may be waived in some circumstances and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to this plan, you may 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, care, or treatment was recommended or received or for which the individual took prescribed drugs within 90 days. Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, 90 days ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 180 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 180 days (90 days for individual coverage) 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 Aetna Member Services at 1-888-982-3862 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 up to age 19. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment, and the pre-existing condition exclusion will be applied from the individual's effective date of coverage.

For this plan, "participating providers" refers to the Open Access® Managed Choice® POS participating providers. For any questions or concerns about accessing and obtaining services from Open Access® Managed Choice® POS providers, please call Member Services at 1-888-98-AETNA (1-888-982-3862) or go to www.aetna.com.

*We cover the cost of services based on whether doctors are "in-network" or "out-of-network". We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

Aetna pays a percentage of the recognized charge, as defined in the member's plan. The member 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 bills the member above Aetna's recognized charge does not count toward the member's deductible or out-of-pocket maximums.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out-of-network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

For out-of-network hospitals and other out-of-network facilities, Aetna pays a percentage as defined in the member's plan of the "reasonable" charge as determined by Aetna. The member may have to pay the difference between the out-of-network facility's bill and the amount that Aetna pays, plus any coinsurance and deductibles due under the plan.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount. When you choose out-of-network care, Aetna "recognizes" an amount based on what Medicare pays for these services. The government sets the Medicare rate.

Your doctor sets his or her own rate to charge you. It may be higher - sometimes much higher - than what your Aetna plan "recognizes". Your doctor may bill you for the dollar amount that Aetna doesn't "recognize". You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums.

To learn more about how we pay out-of-network benefits visit Aetna.com. Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site.

This applies when you choose to get care out-of-network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in-network. You pay cost sharing and deductibles for your in-network level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

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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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

The following is a 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 by your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents
- Cosmetic surgery, including breast reduction
- Custodial care
- Dental care and dental X-rays
- Donor egg retrieval
- Durable medical Equipment
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial
- Hearing aids
- Home births
- Immunizations for travel or work, except where medically necessary or indicated
- Implantable drugs and certain injectable drugs including injectable infertility drugs
- Infertility services, including 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
- Long-term rehabilitation therapy
- Non-medically necessary services or supplies

- Orthotics except diabetic orthotics
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling or prescription drugs
- Special duty nursing
- Therapy or rehabilitation other than those listed as covered
- Treatment of behavioral disorders
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions

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. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc, that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits, and other amounts that they may receive from wholesalers, manufacturers, suppliers, and distributors.

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

Translation of the material into another language may be available. Please call Member Services at 1-888-98-AETNA (1-888-982-3862).

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al 1-888-98-AETNA (1-888-982-3862).

Plan features and availability may vary by location and group size.