

# Medical plan options

FOR BUSINESSES WITH 2 TO 50 ELIGIBLE EMPLOYEES



Virginia

Plans effective April 1, 2008

†Health benefits and health insurance plans are offered, underwritten and/or administered by Aetna Health Inc., 151 Farmington Avenue, Hartford, CT 06156; Aetna Health Insurance Company; and/or Aetna Life Insurance Company (Aetna).

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We want you to know<sup>®</sup>



**Aetna<sup>‡</sup> Small Group Medical Plans**

**HMO NO-REFERRAL PLAN OPTIONS**

Plan Options	VA HMO NO-REFERRAL 1.3 <sup>+,*,3</sup>	VA HMO NO-REFERRAL 2.3 <sup>+,*,3</sup>	VA HMO NO-REFERRAL 3.3 <sup>+,*,3</sup>	VA HMO NO-REFERRAL 4.3 <sup>+,*,3</sup>
Member Benefits	In-Network No Referral Needed	In-Network No Referral Needed	In-Network No Referral Needed	In-Network No Referral Needed
Member Coinsurance	N/A	N/A	N/A	N/A
Calendar Year Deductible	N/A	N/A	N/A	N/A
Calendar Year Out-of-Pocket Maximum <sup>1</sup> (Prescription drugs, including self-injectables, do not apply toward the Out-of-Pocket Maximum.)	\$1,500 per member \$3,000 family	\$2,000 per member \$4,000 family	\$2,500 per member \$5,000 family	\$2,500 per member \$5,000 family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Well-Baby/Child Exams (Age and frequency schedules apply.)	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
Adult Physical Exams (Limited to one exam per calendar year.)	\$10 Copay	\$15 Copay	\$20 Copay	\$25 Copay
Routine GYN Exams (Limited to a routine exam, pap smear and other appropriate tests using any FDA-approved gynecologic cytology screening technologies, once every 365 days.)	\$20 Copay	\$30 Copay	\$40 Copay	\$50 Copay
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; and one mammogram per calendar year for ages 40 and over.)	\$20 Copay	\$30 Copay	\$40 Copay	\$50 Copay
Primary Physician Office Visit	\$10 Copay	\$15 Copay	\$20 Copay	\$25 Copay
Specialist Office Visit	\$20 Copay	\$30 Copay	\$40 Copay	\$50 Copay
Outpatient Services — Lab	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
Outpatient Services — X-ray	\$20 Copay	\$30 Copay	\$40 Copay	\$50 Copay
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$100 Copay	\$100 Copay	\$100 Copay	\$100 Copay
Chiropractic Services (20 visits per calendar year.)	\$20 Copay	\$30 Copay	\$40 Copay	\$50 Copay
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year.)	\$20 Copay	\$30 Copay	\$40 Copay	\$50 Copay
Outpatient Speech Therapy (30 visits per calendar year.)	\$20 Copay	\$30 Copay	\$40 Copay	\$50 Copay
Durable Medical Equipment (\$2,500 Calendar Year Maximum.)	50%	50%	50%	50%
Inpatient Hospital	\$250 Copay per admission	\$200 Copay per day, 5 day copay maximum per admission	\$250 Copay per day, 5 day copay maximum per admission	\$300 Copay per day, 5 day copay maximum per admission
Outpatient Surgery	\$150 Copay	\$150 Copay	\$150 Copay	\$200 Copay
Emergency Room (Copay waived if admitted.)	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay
Urgent Care	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay
Mental Health — Inpatient (Biological: Unlimited days. Non-Biological: Max. of 30 days per calendar year. Combined with Inpatient Substance Abuse Rehab.)	\$250 Copay per admission	\$200 Copay per day, 5 day copay maximum per admission	\$250 Copay per day, 5 day copay maximum per admission	\$300 Copay per day, 5 day copay maximum per admission
Substance Abuse — Inpatient (Biological: Unlimited days. Non-Biological: Max. of 30 days per calendar year. Combined with Inpatient Mental Health.)	\$250 Copay per admission	\$200 Copay per day, 5 day copay maximum per admission	\$250 Copay per day, 5 day copay maximum per admission	\$300 Copay per day, 5 day copay maximum per admission
Routine Eye Exam (Age and frequency schedule apply.)	\$20 Copay	\$30 Copay	\$40 Copay	\$50 Copay
Aetna Vision <sup>SM</sup> Discount Program	Included	Included	Included	Included
<b>Prescription Drugs</b>				
Prescription Drugs — Calendar Year Out-of-Pocket Maximum <sup>1</sup>	\$3,000 per member \$6,000 family	\$3,000 per member \$6,000 family	\$3,000 per member \$6,000 family	\$3,000 per member \$6,000 family
Prescription Drugs — Retail: 30-day supply	Option 1: \$15/\$35/\$50 Option 2: \$10/\$25/\$50	Option 1: \$15/\$35/\$50 Option 2: \$10/\$25/\$50	Option 1: \$15/\$35/\$50 Option 2: \$10/\$25/\$50	Option 1: \$15/\$35/\$50
Prescription Drugs — Mail Order: 31-90 day supply	Option 1: \$30/\$70/\$100 Option 2: \$20/\$50/\$100	Option 1: \$30/\$70/\$100 Option 2: \$20/\$50/\$100	Option 1: \$30/\$70/\$100 Option 2: \$20/\$50/\$100	Option 1: \$30/\$70/\$100
Prescription Drug Deductible	N/A	N/A	N/A	N/A
Contraceptives and Diabetic Supplies	Included	Included	Included	Included
90 Day Transition of Coverage (TOC) for Prior Authorization <sup>2</sup>	Included	Included	Included	Included
Self-Injectables (Excluding Insulin) Up to 90-day supply	20%	20%	20%	20%
*Optional Features:	Morbid Obesity	Morbid Obesity	Morbid Obesity	Morbid Obesity

<sup>+</sup>This is a partial description of benefits available; for more information, refer to the specific plan design summary.

<sup>1</sup>Once the family out-of-pocket maximum is met, all family members will be considered as having met their out-of-pocket maximum for the remainder of the calendar year. No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum. The family prescription out-of-pocket maximum can be met in the same way for covered prescription drugs. Covered prescription drugs, including self-injectables, apply towards the Prescription Drug Out-of-Pocket Maximum.

<sup>2</sup>"Transition of Coverage for Prior Authorizations" helps members of new groups to transition to Aetna by providing a 90 calendar day opportunity, beginning on the group's initial effective date, during which time prior authorization requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. Members who have claims paid for a drug requiring prior authorization during the Transition of Coverage period may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization for this drug.

<sup>3</sup>"No-Referral" Provision: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefit from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to pre-certify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 12–13. Please refer to Aetna's Producer World website at [www.aetna.com](http://www.aetna.com) for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

**COST-SHARING HMO NO-REFERRAL PLAN OPTION**

Plan Options	VA COST-SHARING NO-REFERRAL HMO 1.3 <sup>+,*,4</sup>
Member Benefits	In-Network No Referral Needed
Member Coinsurance	20% after deductible
Calendar Year Deductible <sup>1</sup>	\$300 per member \$600 family
Calendar Year Out-of-Pocket Maximum <sup>2</sup> (Prescription drugs, including self-injectables, do not apply toward the Out-of-Pocket Maximum.)	\$2,500 per member \$5,000 family
Lifetime Maximum Benefit	Unlimited
Well-Baby/Child Exams (Age and frequency schedules apply.)	\$0 Copay, deductible waived
Adult Physical Exams (Limited to one exam per calendar year.)	\$15 Copay, deductible waived
Routine GYN Exams (Limited to a routine exam, pap smear and other appropriate tests using any FDA-approved gynecologic cytology screening technologies, once every 365 days.)	\$30 Copay, deductible waived
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; and one mammogram per calendar year for ages 40 and over.)	\$30 Copay, deductible waived
Primary Physician Office Visit	\$15 Copay, deductible waived
Specialist Office Visit	\$30 Copay, deductible waived
Outpatient Services — Lab	\$0 Copay after deductible
Outpatient Services — X-ray	\$30 Copay after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$100 Copay after deductible
Chiropractic Services (20 visits per calendar year.)	\$30 Copay after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year.)	\$30 Copay after deductible
Outpatient Speech Therapy (30 visits per calendar year.)	\$30 Copay after deductible
Durable Medical Equipment (\$2,500 Calendar Year Maximum.)	50% after deductible
Inpatient Hospital	20% after deductible
Outpatient Surgery	20% after deductible
Emergency Room	20% after deductible
Urgent Care	\$50 Copay after deductible
Mental Health — Inpatient (Biological: Unlimited days. Non-Biological: Max. of 30 days per calendar year. Combined with Inpatient Substance Abuse Rehab.)	20% after deductible
Substance Abuse — Inpatient (Biological: Unlimited days. Non-Biological: Max. of 30 days per calendar year. Combined with Inpatient Mental Health.)	20% after deductible
Routine Eye Exam (Age and frequency schedule apply.)	\$30 Copay, deductible waived
Aetna Vision <sup>SM</sup> Discount Program	Included
<b>Prescription Drugs</b>	
Prescription Drugs — Calendar Year Out-of-Pocket Maximum <sup>2</sup>	\$3,000 per member \$6,000 family
Prescription Drugs — Retail: 30-day supply	Option 1: \$15/\$35/\$50 Option 2: \$10/\$25/\$50
Prescription Drugs — Mail Order: 31-90 day supply	Option 1: \$30/\$70/\$100 Option 2: \$20/\$50/\$100
Prescription Drug Deductible	N/A
Contraceptives and Diabetic Supplies	Included
90 Day Transition of Coverage (TOC) for Prior Authorization <sup>3</sup>	Included
Self-Injectables (Excluding Insulin) Up to 90-day supply	20%
*Optional Features:	Morbid Obesity

<sup>+</sup>This is a partial description of benefits available; for more information, refer to the specific plan design summary.

<sup>1</sup>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.

<sup>2</sup>Once the family out-of-pocket maximum is met, all family members will be considered as having met their out-of-pocket maximum for the remainder of the calendar year. No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum. The family prescription out-of-pocket maximum can be met in the same way for covered prescription drugs. Covered prescription drugs, including self-injectables, apply towards the Prescription Drug Out-of-Pocket Maximum.

<sup>3</sup>“Transition of Coverage for Prior Authorizations” helps members of new groups to transition to Aetna by providing a 90 calendar day opportunity, beginning on the group’s initial effective date, during which time prior authorization requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. Members who have claims paid for a drug requiring prior authorization during the Transition of Coverage period may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization for this drug.

<sup>4</sup>“No-Referral” Provision: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefit from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to pre-certify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 12–13. Please refer to Aetna’s Producer World website at [www.aetna.com](http://www.aetna.com) for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

POS NO-REFERRAL PLAN OPTIONS

Plan Options	VA POS NO-REFERRAL 1.3+*,4		VA POS NO-REFERRAL 2.3+*,4	
Member Benefits	In-Network No Referral Needed	Out-of-Network <sup>5</sup> No Referral Needed	In-Network No Referral Needed	Out-of-Network <sup>5</sup> No Referral Needed
Member Coinsurance	N/A	30% after deductible	N/A	30% after deductible
Calendar Year Deductible <sup>1</sup>	N/A	\$500 per member \$1,000 family	N/A	\$750 per member \$1,500 family
Calendar Year Out-of-Pocket Maximum <sup>2</sup> (Deductible applies to the Out-of-Pocket Maximum. Prescription drugs, including self-injectables, do not apply toward the Out-of-Pocket Maximum.)	\$1,500 per member \$3,000 family	\$3,500 per member \$7,000 family	\$2,000 per member \$4,000 family	\$3,500 per member \$7,000 family
Lifetime Maximum Benefit	Unlimited	\$2,000,000	Unlimited	\$2,000,000
Well-Baby/Child Exams (Age and frequency schedules apply.)	\$0 Copay	0%; deductible waived	\$0 Copay	0%; deductible waived
Adult Physical Exams (Limited to one exam per calendar year. In-network and out-of-network combined.)	\$10 Copay	30% after deductible	\$20 Copay	30% after deductible
Routine GYN Exams (Limited to a routine exam, pap smear and other appropriate tests using any FDA-approved gynecologic cytology screening technologies, once every 365 days. In-network and out-of-network combined.)	\$20 Copay	30% after deductible	\$40 Copay	30% after deductible
Routine Mammograms (In-Network: Limited to one baseline mammogram for ages 35 through 39; and one annual mammogram for ages 40 and over. Out-of-Network: Limited to one baseline mammogram for ages 35-39; one mammogram every two years ages 40 – 49; and one annual mammogram for age 50+. In-network and out-of-network combined.)	\$20 Copay	30% after deductible	\$40 Copay	30% after deductible
Primary Physician Office Visit	\$10 Copay	30% after deductible	\$20 Copay	30% after deductible
Specialist Office Visit	\$20 Copay	30% after deductible	\$40 Copay	30% after deductible
Outpatient Services — Lab	\$0 Copay	30% after deductible	\$0 Copay	30% after deductible
Outpatient Services — X-ray	\$20 Copay	30% after deductible	\$40 Copay	30% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$100 Copay	30% after deductible	\$100 Copay	30% after deductible
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	\$20 Copay	30% after deductible	\$40 Copay	30% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year. In-network and out-of-network combined.)	\$20 Copay	30% after deductible	\$40 Copay	30% after deductible
Outpatient Speech Therapy (30 visits per calendar year. In-network and out-of-network combined.)	\$20 Copay	30% after deductible	\$40 Copay	30% after deductible
Durable Medical Equipment (\$2,500 Calendar Year Maximum. In-network and out-of-network combined.)	50%	50% after deductible	50%	50% after deductible
Inpatient Hospital	\$250 Copay per admission	30% after deductible	\$250 Copay per day, 5 day copay maximum per admission	\$250 Copay per day, 5 day copay maximum per admission, plus 30% after deductible
Outpatient Surgery	\$150 Copay	\$150 Copay plus 30% after deductible	\$150 Copay	\$150 Copay plus 30% after deductible
Emergency Room (Copay waived if admitted.)	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay
Urgent Care	\$50 Copay	30% after deductible	\$50 Copay	30% after deductible
Mental Health — Inpatient (Biological: Unlimited days. Non-Biological: Max of 30 days per calendar year. Combined with Inpatient Substance Abuse Rehab. In-network and out-of-network combined.)	\$250 Copay per admission	30% after deductible	\$250 Copay per day, 5 day copay maximum per admission	\$250 Copay per day, 5 day copay maximum per admission, plus 30% after deductible
Substance Abuse — Inpatient (Biological: Unlimited days. Non-Biological: Max of 30 days per calendar year. Combined with Inpatient Mental Health. In-network and out-of-network combined.)	\$250 Copay per admission	30% after deductible	\$250 Copay per day, 5 day copay maximum per admission	\$250 Copay per day, 5 day copay maximum per admission, plus 30% after deductible
Routine Eye Exam (Age and frequency schedule apply.)	\$20 Copay	Not Covered	\$40 Copay	Not Covered
Aetna Vision <sup>SM</sup> Discount Program	Included	Not Covered	Included	Not Covered
<b>Prescription Drugs</b>				
Prescription Drugs — Calendar Year Out-of-Pocket Maximum <sup>2</sup>	\$3,000 per member \$6,000 family	Not Covered	\$3,000 per member \$6,000 family	Not Covered
Prescription Drugs — Retail: 30-day supply	Option 1: \$15/\$35/\$50 Option 2: \$10/\$25/\$50	Not Covered	Option 1: \$15/\$35/\$50 Option 2: \$10/\$25/\$50	Not Covered
Prescription Drugs — Mail Order: 31-90 day supply	Option 1: \$30/\$70/\$100 Option 2: \$20/\$50/\$100	Not Covered	Option 1: \$30/\$70/\$100 Option 2: \$20/\$50/\$100	Not Covered
Prescription Drug Deductible	N/A	N/A	N/A	N/A
Contraceptives and Diabetic Supplies	Included	Not Covered	Included	Not Covered
90 Day Transition of Coverage (TOC) for Prior Authorization <sup>3</sup>	Included	Not Covered	Included	Not Covered
Self-Injectables (Excluding Insulin) Up to 90-day supply	20%	Not Covered	20%	Not Covered
*Optional Features:	Morbid Obesity		Morbid Obesity	

\*This is a partial description of benefits available; for more information, refer to the specific plan design summary.

<sup>1</sup>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.

<sup>2</sup>Once the family out-of-pocket maximum is met, all family members will be considered as having met their out-of-pocket maximum for the remainder of the calendar year. No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum. The family prescription out-of-pocket maximum can be met in the same way for covered prescription drugs. Covered prescription drugs, including self-injectables, apply towards the Prescription Drug Out-of-Pocket Maximum.

<sup>3</sup>“Transition of Coverage for Prior Authorizations” helps members of new groups to transition to Aetna by providing a 90 calendar day opportunity, beginning on the group’s initial effective date, during which time prior authorization requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. Members who have claims paid for a drug requiring prior authorization during the Transition of Coverage period may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization for this drug.

<sup>4</sup>“No-Referral” Provision: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefit from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist.

<sup>5</sup>Non-Participating Provider payments for facility charges are determined based upon Aetna’s Allowable Fee Schedule. Non-Participating Provider payments for other charges are determined based upon the negotiated charge that would apply if such services or supplies were received from a Participating Provider. These charges are referred to in plan documents as “recognized” charges.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to pre-certify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 12–13. Please refer to Aetna’s Producer World website at [www.aetna.com](http://www.aetna.com) for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.”

PPO PLAN OPTIONS

Plan Options	VA PPO 1.3+*		VA PPO 2.3+*	
	In-Network No Referral Needed	Out-of-Network <sup>4</sup> No Referral Needed	In-Network No Referral Needed	Out-of-Network <sup>4</sup> No Referral Needed
Member Benefits	In-Network No Referral Needed	Out-of-Network <sup>4</sup> No Referral Needed	In-Network No Referral Needed	Out-of-Network <sup>4</sup> No Referral Needed
Member Coinsurance	N/A	30% after deductible	10%	30% after deductible
Calendar Year Deductible <sup>1</sup>	N/A	\$500 per member \$1,000 family	N/A	\$750 per member \$1,500 family
Calendar Year Out-of-Pocket Maximum <sup>2</sup> (Deductible applies to the Out-of-Pocket Maximum. Prescription drugs, including self-injectables, do not apply toward the Out-of-Pocket Maximum.)	\$1,000 per member \$2,000 family	\$3,500 per member \$7,000 family	\$1,500 per member \$3,000 family	\$3,500 per member \$7,000 family
Lifetime Maximum Benefit	Unlimited	\$2,000,000	Unlimited	\$2,000,000
Well-Baby/Child Exams (7 exams in the first 12 months of life; 2 exams in the 13th – 24th months of life; 1 exam per 12 months thereafter. In-network and out-of-network combined.)	\$0 Copay	0%; deductible waived	\$0 Copay	0%; deductible waived
Adult Physical Exams (Limited to one exam per 12 months. In-network and out-of-network combined.)	\$10 Copay	30% after deductible	\$15 Copay	30% after deductible
Routine GYN Exams (Limited to a routine exam, pap smear and other appropriate tests using any FDA-approved gynecologic cytology screening technologies, once every calendar year. In-network and out-of-network combined.)	\$20 Copay	30% after deductible	\$30 Copay	30% after deductible
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; and one mammogram per calendar year for ages 40 and over. In-network and out-of-network combined.)	\$20 Copay	30% after deductible	\$30 Copay	30% after deductible
Primary Physician Office Visit	\$10 Copay	30% after deductible	\$15 Copay	30% after deductible
Specialist Office Visit	\$20 Copay	30% after deductible	\$30 Copay	30% after deductible
Outpatient Services — Lab	\$0 Copay	30% after deductible	\$0 Copay	30% after deductible
Outpatient Services — X-ray	\$20 Copay	30% after deductible	\$30 Copay	30% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$100 Copay	30% after deductible	\$100 Copay	30% after deductible
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	\$20 Copay	30% after deductible	\$30 Copay	30% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year. In-network and out-of-network combined.)	\$20 Copay	30% after deductible	\$30 Copay	30% after deductible
Outpatient Speech Therapy (30 visits per calendar year. In-network and out-of-network combined.)	\$20 Copay	30% after deductible	\$30 Copay	30% after deductible
Durable Medical Equipment (\$2,500 Calendar Year Maximum. In-network and out-of-network combined.)	50%	50% after deductible	50%	50% after deductible
Inpatient Hospital	\$250 Copay per admission	30% after deductible	\$200 Copay per day, 5 day copay maximum per admission, plus 10%	\$200 Copay per day, 5 day copay maximum per admission, plus 30% after deductible
Outpatient Surgery	\$150 Copay	\$150 Copay plus 30% after deductible	\$150 Copay	\$150 Copay plus 30% after deductible
Emergency Room (Copay waived if admitted.)	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay
Urgent Care	\$50 Copay	30% after deductible	\$50 Copay	30% after deductible
Mental Health — Inpatient (Biological: Unlimited days. Non-Biological: Max of 30 days per calendar year. In-network and out-of-network combined.)	\$250 Copay per admission	30% after deductible	\$200 Copay per day, 5 day copay maximum per admission, plus 10%	\$200 Copay per day, 5 day copay maximum per admission, plus 30% after deductible
Substance Abuse — Inpatient (Unlimited days per calendar year.)	\$250 Copay per admission	30% after deductible	\$200 Copay per day, 5 day copay maximum per admission, plus 10%	\$200 Copay per day, 5 day copay maximum per admission, plus 30% after deductible
Routine Eye Exam (One exam per 24 months. In-network and out-of-network combined.)	\$20 Copay	30% after deductible	\$30 Copay	30% after deductible
Aetna Vision <sup>SM</sup> Discount Program	Included	Not Covered	Included	Not Covered
<b>Prescription Drugs</b>				
Prescription Drugs — Calendar Year Out-of-Pocket Maximum <sup>2</sup>	\$3,000 per member \$6,000 family (In-network and out-of-network combined.)		\$3,000 per member \$6,000 family (In-network and out-of-network combined.)	
Prescription Drugs — Retail: 30-day supply	Option 1: \$15/\$35/\$50 Option 2: \$10/\$25/\$50	Option 1: \$15/\$35/\$50 plus 20% Option 2: \$10/\$25/\$50 plus 20%	Option 1: \$15/\$35/\$50 Option 2: \$10/\$25/\$50	Option 1: \$15/\$35/\$50 plus 20% Option 2: \$10/\$25/\$50 plus 20%
Prescription Drugs — Mail Order: 31-90 day supply	Option 1: \$30/\$70/\$100 Option 2: \$20/\$50/\$100	Not Covered	Option 1: \$30/\$70/\$100 Option 2: \$20/\$50/\$100	Not Covered
Prescription Drug Deductible	N/A	N/A	N/A	N/A
Contraceptives and Diabetic Supplies	Included	Included	Included	Included
90 Day Transition of Coverage (TOC) for Prior Authorization <sup>3</sup>	Included	Included	Included	Included
Self-Injectables (Excluding Insulin) Up to 90-day supply	20%	Not Covered	20%	Not Covered
*Optional Features:	Morbid Obesity		Morbid Obesity	

\*This is a partial description of benefits available; for more information, refer to the specific plan design summary.

<sup>1</sup>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.

<sup>2</sup>Once the family out-of-pocket maximum is met, all family members will be considered as having met their out-of-pocket maximum for the remainder of the calendar year. No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum. The family prescription out-of-pocket maximum can be met in the same way for covered prescription drugs. Covered prescription drugs, including self-injectables, apply towards the Prescription Drug Out-of-Pocket Maximum.

<sup>3</sup>“Transition of Coverage for Prior Authorizations” helps members of new groups to transition to Aetna by providing a 90 calendar day opportunity, beginning on the group’s initial effective date, during which time prior authorization requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. Members who have claims paid for a drug requiring prior authorization during the Transition of Coverage period may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization for this drug.

<sup>4</sup>Non-Participating Provider payments for facility charges are determined based upon Aetna’s Allowable Fee Schedule. Non-Participating Provider payments for other charges are determined based upon the negotiated charge that would apply if such services or supplies were received from a Participating Provider. These charges are referred to in plan documents as “recognized” charges.

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PPO PLAN OPTIONS

Plan Options	VA PPO 3.3+*		VA PPO 4.3+*	
	In-Network No Referral Needed	Out-of-Network <sup>4</sup> No Referral Needed	In-Network No Referral Needed	Out-of-Network <sup>4</sup> No Referral Needed
Member Benefits	In-Network No Referral Needed	Out-of-Network <sup>4</sup> No Referral Needed	In-Network No Referral Needed	Out-of-Network <sup>4</sup> No Referral Needed
Member Coinsurance	20%	50% after deductible	20%	50% after deductible
Calendar Year Deductible <sup>1</sup>	N/A	\$1,000 per member \$2,000 family	N/A	\$3,000 per member \$6,000 family
Calendar Year Out-of-Pocket Maximum <sup>2</sup> (Deductible applies to the Out-of-Pocket Maximum. Prescription drugs, including self-injectables, do not apply toward the Out-of-Pocket Maximum.)	\$2,500 per member \$5,000 family	\$5,000 per member \$10,000 family	\$2,500 per member \$5,000 family	\$5,000 per member \$10,000 family
Lifetime Maximum Benefit	Unlimited	\$2,000,000	Unlimited	\$2,000,000
Well-Baby/Child Exams (7 exams in the first 12 months of life; 2 exams in the 13th – 24th months of life; 1 exam per 12 months thereafter. In-network and out-of-network combined.)	\$0 Copay	0%; deductible waived	\$0 Copay	0%; deductible waived
Adult Physical Exams (Limited to one exam per 12 months. In-network and out-of-network combined.)	\$20 Copay	50% after deductible	\$25 Copay	50% after deductible
Routine GYN Exams (Limited to a routine exam, pap smear and other appropriate tests using any FDA-approved gynecologic cytology screening technologies, once every calendar year. In-network and out-of-network combined.)	\$40 Copay	50% after deductible	\$50 Copay	50% after deductible
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; and one mammogram per calendar year for ages 40 and over. In-network and out-of-network combined.)	\$40 Copay	50% after deductible	\$50 Copay	50% after deductible
Primary Physician Office Visit	\$20 Copay	50% after deductible	\$25 Copay	50% after deductible
Specialist Office Visit	\$40 Copay	50% after deductible	\$50 Copay	50% after deductible
Outpatient Services — Lab	\$0 Copay	50% after deductible	\$0 Copay	50% after deductible
Outpatient Services — X-ray	\$40 Copay	50% after deductible	\$50 Copay	50% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$100 Copay	50% after deductible	\$100 Copay	50% after deductible
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	\$40 Copay	50% after deductible	\$50 Copay	50% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year. In-network and out-of-network combined.)	\$40 Copay	50% after deductible	\$50 Copay	50% after deductible
Outpatient Speech Therapy (30 visits per calendar year. In-network and out-of-network combined.)	\$40 Copay	50% after deductible	\$50 Copay	50% after deductible
Durable Medical Equipment (\$2,500 Calendar Year Maximum. In-network and out-of-network combined.)	50%	50% after deductible	50%	50% after deductible
Inpatient Hospital	\$300 Copay per day, 5 day copay maximum per admission, plus 20%	\$300 Copay per day, 5 day copay maximum per admission, plus 50% after deductible	\$400 Copay per day, 5 day copay maximum per admission, plus 20%	\$400 Copay per day, 5 day copay maximum per admission, plus 50% after deductible
Outpatient Surgery	\$150 Copay	\$150 Copay plus 50% after deductible	\$200 Copay	\$200 Copay plus 50% after deductible
Emergency Room (Copay waived if admitted.)	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay
Urgent Care	\$50 Copay	50% after deductible	\$50 Copay	50% after deductible
Mental Health — Inpatient (Biological: Unlimited days. Non-Biological: Max of 30 days per calendar year. In-network and out-of-network combined.)	\$300 Copay per day, 5 day copay maximum per admission, plus 20%	\$300 Copay per day, 5 day copay maximum per admission, plus 50% after deductible	\$400 Copay per day, 5 day copay maximum per admission, plus 20%	\$400 Copay per day, 5 day copay maximum per admission, plus 50% after deductible
Substance Abuse — Inpatient (Unlimited days per calendar year.)	\$300 Copay per day, 5 day copay maximum per admission, plus 20%	\$300 Copay per day, 5 day copay maximum per admission, plus 50% after deductible	\$400 Copay per day, 5 day copay maximum per admission, plus 20%	\$400 Copay per day, 5 day copay maximum per admission, plus 50% after deductible
Routine Eye Exam (One exam per 24 months. In-network and out-of-network combined.)	\$40 Copay	50% after deductible	\$50 Copay	50% after deductible
Aetna Vision <sup>SM</sup> Discount Program	Included	Not Covered	Included	Not Covered
<b>Prescription Drugs</b>				
Prescription Drugs — Calendar Year Out-of-Pocket Maximum <sup>2</sup>	\$3,000 per member \$6,000 family (In-network and out-of-network combined.)		\$3,000 per member \$6,000 family (In-network and out-of-network combined.)	
Prescription Drugs — Retail: 30-day supply	Option 1: \$15/\$35/\$50 Option 2: \$10/\$25/\$50	Option 1: \$15/\$35/\$50 plus 20% Option 2: \$10/\$25/\$50 plus 20%	\$20/\$40/\$70	\$20/\$40/\$70 plus 20%
Prescription Drugs — Mail Order: 31-90 day supply	Option 1: \$30/\$70/\$100 Option 2: \$20/\$50/\$100	Not Covered	\$40/\$80/\$140	Not Covered
Prescription Drug Deductible	N/A	N/A	N/A	N/A
Contraceptives and Diabetic Supplies	Included	Included	Included	Included
90 Day Transition of Coverage (TOC) for Prior Authorization <sup>3</sup>	Included	Included	Included	Included
Self-Injectables (Excluding Insulin) Up to 90-day supply	20%	Not Covered	20%	Not Covered
*Optional Features:	Morbid Obesity		Morbid Obesity	

\*This is a partial description of benefits available; for more information, refer to the specific plan design summary.

<sup>1</sup>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.

<sup>2</sup>Once the family out-of-pocket maximum is met, all family members will be considered as having met their out-of-pocket maximum for the remainder of the calendar year. No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum. The family prescription out-of-pocket maximum can be met in the same way for covered prescription drugs. Covered prescription drugs, including self-injectables, apply towards the Prescription Drug Out-of-Pocket Maximum.

<sup>3</sup>“Transition of Coverage for Prior Authorizations” helps members of new groups to transition to Aetna by providing a 90 calendar day opportunity, beginning on the group’s initial effective date, during which time prior authorization requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. Members who have claims paid for a drug requiring prior authorization during the Transition of Coverage period may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization for this drug.

<sup>4</sup>Non-Participating Provider payments for facility charges are determined based upon Aetna’s Allowable Fee Schedule. Non-Participating Provider payments for other charges are determined based upon the negotiated charge that would apply if such services or supplies were received from a Participating Provider. These charges are referred to in plan documents as “recognized” charges.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to pre-certify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 12–13. Please refer to Aetna’s Producer World website at [www.aetna.com](http://www.aetna.com) for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

**COST-SHARING PPO PLAN OPTIONS**

Plan Options	VA COST-SHARING PPO PLAN 1.3+*		VA COST-SHARING PPO PLAN 2.3+*	
Member Benefits	In-Network No Referral Needed	Out-of-Network <sup>4</sup> No Referral Needed	In-Network No Referral Needed	Out-of-Network <sup>4</sup> No Referral Needed
Member Coinsurance	10% after deductible	50% after deductible	10% after deductible	50% after deductible
Calendar Year Deductible <sup>1</sup>	\$300 per member \$600 family	\$5,000 per member \$10,000 family	\$400 per member \$800 family	\$5,000 per member \$10,000 family
Calendar Year Out-of-Pocket Maximum <sup>2</sup> (Deductible applies to the Out-of-Pocket Maximum. Prescription drugs, including self-injectables, do not apply toward the Out-of-Pocket Maximum.)	\$1,000 per member \$2,000 family	\$15,000 per member \$30,000 family	\$1,500 per member \$3,000 family	\$15,000 per member \$30,000 family
Lifetime Maximum Benefit	Unlimited	\$1,000,000	Unlimited	\$1,000,000
Well-Baby/Child Exams (7 exams in the first 12 months of life; 2 exams in the 13th – 24th months of life; 1 exam per 12 months thereafter. In-network and out-of-network combined.)	\$0 Copay, deductible waived	0%; deductible waived	\$0 Copay, deductible waived	0%; deductible waived
Adult Physical Exams (Limited to one exam per 12 months. In-network and out-of-network combined.)	\$10 Copay, deductible waived	50% after deductible	\$15 Copay, deductible waived	50% after deductible
Routine GYN Exams (Limited to a routine exam, pap smear and other appropriate tests using any FDA-approved gynecologic cytology screening technologies, once every calendar year. In-network and out-of-network combined.)	\$20 Copay, deductible waived	50% after deductible	\$30 Copay, deductible waived	50% after deductible
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; and one mammogram per calendar year for ages 40 and over. In-network and out-of-network combined.)	\$20 Copay, deductible waived	50% after deductible	\$30 Copay, deductible waived	50% after deductible
Primary Physician Office Visit	\$10 Copay, deductible waived	50% after deductible	\$15 Copay, deductible waived	50% after deductible
Specialist Office Visit	\$20 Copay, deductible waived	50% after deductible	\$30 Copay, deductible waived	50% after deductible
Outpatient Services — Lab	\$0 Copay, deductible waived	50% after deductible	\$0 Copay, deductible waived	50% after deductible
Outpatient Services — X-ray	\$20 Copay, deductible waived	50% after deductible	\$30 Copay, deductible waived	50% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$100 Copay, deductible waived	50% after deductible	\$100 Copay, deductible waived	50% after deductible
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	\$20 Copay after deductible	50% after deductible	\$30 Copay after deductible	50% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year. In-network and out-of-network combined.)	\$20 Copay after deductible	50% after deductible	\$30 Copay after deductible	50% after deductible
Outpatient Speech Therapy (30 visits per calendar year. In-network and out-of-network combined.)	\$20 Copay after deductible	50% after deductible	\$30 Copay after deductible	50% after deductible
Durable Medical Equipment (\$2,500 Calendar Year Maximum. In-network and out-of-network combined.)	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Inpatient Hospital	10% after deductible	50% after deductible	10% after deductible	50% after deductible
Outpatient Surgery	\$150 Copay after deductible	\$150 Copay plus 50% after deductible	\$150 Copay after deductible	\$150 Copay plus 50% after deductible
Emergency Room (Copay waived if admitted.)	\$150 Copay after deductible	\$150 Copay after deductible	\$150 Copay after deductible	\$150 Copay after deductible
Urgent Care	\$50 Copay after deductible	50% after deductible	\$50 Copay after deductible	50% after deductible
Mental Health — Inpatient (Biological: Unlimited days. Non-Biological: Max of 30 days per calendar year. In-network and out-of-network combined.)	10% after deductible	50% after deductible	10% after deductible	50% after deductible
Substance Abuse — Inpatient (Unlimited days per calendar year.)	10% after deductible	50% after deductible	10% after deductible	50% after deductible
Routine Eye Exam (One exam per 24 months. In-network and out-of-network combined.)	\$20 Copay, deductible waived	50% after deductible	\$30 Copay, deductible waived	50% after deductible
Aetna Vision <sup>SM</sup> Discount Program	Included	Not Covered	Included	Not Covered
Prescription Drugs	\$3,000 per member \$6,000 family (In-network and out-of-network combined.)		\$3,000 per member \$6,000 family (In-network and out-of-network combined.)	
Prescription Drugs — Calendar Year Out-of-Pocket Maximum <sup>2</sup>	\$3,000 per member \$6,000 family (In-network and out-of-network combined.)		\$3,000 per member \$6,000 family (In-network and out-of-network combined.)	
Prescription Drugs — Retail: 30-day supply	Option 1: \$15/\$35/\$50 Option 2: \$10/\$25/\$50	Option 1: \$15/\$35/\$50 plus 20% Option 2: \$10/\$25/\$50 plus 20%	Option 1: \$15/\$35/\$50 Option 2: \$10/\$25/\$50	Option 1: \$15/\$35/\$50 plus 20% Option 2: \$10/\$25/\$50 plus 20%
Prescription Drugs — Mail Order: 31-90 day supply	Option 1: \$30/\$70/\$100 Option 2: \$20/\$50/\$100	Not Covered	Option 1: \$30/\$70/\$100 Option 2: \$20/\$50/\$100	Not Covered
Prescription Drug Deductible	N/A	N/A	N/A	N/A
Contraceptives and Diabetic Supplies	Included	Included	Included	Included
90 Day Transition of Coverage (TOC) for Prior Authorization <sup>3</sup>	Included	Included	Included	Included
Self-Injectables (Excluding Insulin) Up to 90-day supply	20%	Not Covered	20%	Not Covered
*Optional Features:	Morbid Obesity		Morbid Obesity	

\*This is a partial description of benefits available; for more information, refer to the specific plan design summary.

<sup>1</sup>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.

<sup>2</sup>Once the family out-of-pocket maximum is met, all family members will be considered as having met their out-of-pocket maximum for the remainder of the calendar year. No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum. The family prescription out-of-pocket maximum can be met in the same way for covered prescription drugs. Covered prescription drugs, including self-injectables, apply towards the Prescription Drug Out-of-Pocket Maximum.

<sup>3</sup>“Transition of Coverage for Prior Authorizations” helps members of new groups to transition to Aetna by providing a 90 calendar day opportunity, beginning on the group’s initial effective date, during which time prior authorization requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. Members who have claims paid for a drug requiring prior authorization during the Transition of Coverage period may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization for this drug.

<sup>4</sup>Non-Participating Provider payments for facility charges are determined based upon Aetna’s Allowable Fee Schedule. Non-Participating Provider payments for other charges are determined based upon the negotiated charge that would apply if such services or supplies were received from a Participating Provider. These charges are referred to in plan documents as “recognized” charges.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to pre-certify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 12–13. Please refer to Aetna’s Producer World website at [www.aetna.com](http://www.aetna.com) for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

**COST-SHARING PPO PLAN OPTIONS**

Plan Options	VA COST-SHARING PPO PLAN 3.3+*		VA COST-SHARING PPO PLAN 4.3+*	
	In-Network No Referral Needed	Out-of-Network <sup>4</sup> No Referral Needed	In-Network No Referral Needed	Out-of-Network <sup>4</sup> No Referral Needed
Member Benefits	In-Network No Referral Needed	Out-of-Network <sup>4</sup> No Referral Needed	In-Network No Referral Needed	Out-of-Network <sup>4</sup> No Referral Needed
Member Coinsurance	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Calendar Year Deductible <sup>1</sup>	\$500 per member \$1,000 family	\$5,000 per member \$10,000 family	\$750 per member \$1,500 family	\$5,000 per member \$10,000 family
Calendar Year Out-of-Pocket Maximum <sup>2</sup> (Deductible applies to the Out-of-Pocket Maximum. Prescription drugs, including self-injectables, do not apply toward the Out-of-Pocket Maximum.)	\$2,500 per member \$5,000 family	\$15,000 per member \$30,000 family	\$2,500 per member \$5,000 family	\$15,000 per member \$30,000 family
Lifetime Maximum Benefit	Unlimited	\$1,000,000	Unlimited	\$1,000,000
Well-Baby/Child Exams (7 exams in the first 12 months of life; 2 exams in the 13th – 24th months of life; 1 exam per 12 months thereafter. In-network and out-of-network combined.)	\$0 Copay, deductible waived	0%; deductible waived	\$0 Copay, deductible waived	0%; deductible waived
Adult Physical Exams (Limited to one exam per 12 months. In-network and out-of-network combined.)	\$20 Copay, deductible waived	50% after deductible	\$25 Copay, deductible waived	50% after deductible
Routine GYN Exams (Limited to a routine exam, pap smear and other appropriate tests using any FDA-approved gynecologic cytology screening technologies, once every calendar year. In-network and out-of-network combined.)	\$40 Copay, deductible waived	50% after deductible	\$50 Copay, deductible waived	50% after deductible
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; and one mammogram per calendar year for ages 40 and over. In-network and out-of-network combined.)	\$40 Copay, deductible waived	50% after deductible	\$50 Copay, deductible waived	50% after deductible
Primary Physician Office Visit	\$20 Copay, deductible waived	50% after deductible	\$25 Copay, deductible waived	50% after deductible
Specialist Office Visit	\$40 Copay, deductible waived	50% after deductible	\$50 Copay, deductible waived	50% after deductible
Outpatient Services — Lab	\$0 Copay, deductible waived	50% after deductible	\$0 Copay, deductible waived	50% after deductible
Outpatient Services — X-ray	\$40 Copay, deductible waived	50% after deductible	\$50 Copay, deductible waived	50% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$100 Copay, deductible waived	50% after deductible	\$100 Copay, deductible waived	50% after deductible
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	\$40 Copay after deductible	50% after deductible	\$50 Copay after deductible	50% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year. In-network and out-of-network combined.)	\$40 Copay after deductible	50% after deductible	\$50 Copay after deductible	50% after deductible
Outpatient Speech Therapy (30 visits per calendar year. In-network and out-of-network combined.)	\$40 Copay after deductible	50% after deductible	\$50 Copay after deductible	50% after deductible
Durable Medical Equipment (\$2,500 Calendar Year Maximum. In-network and out-of-network combined.)	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Inpatient Hospital	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient Surgery	\$150 Copay after deductible	\$150 Copay plus 50% after deductible	\$200 Copay after deductible	\$200 Copay plus 50% after deductible
Emergency Room (Copay waived if admitted.)	\$150 Copay after deductible	\$150 Copay after deductible	\$150 Copay after deductible	\$150 Copay after deductible
Urgent Care	\$50 Copay after deductible	50% after deductible	\$50 Copay after deductible	50% after deductible
Mental Health — Inpatient (Biological: Unlimited days. Non-Biological: Max of 30 days per calendar year. In-network and out-of-network combined.)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Substance Abuse — Inpatient (Unlimited days per calendar year.)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Routine Eye Exam (One exam per 24 months. In-network and out-of-network combined.)	\$40 Copay, deductible waived	50% after deductible	\$50 Copay, deductible waived	50% after deductible
Aetna Vision <sup>SM</sup> Discount Program	Included	Not Covered	Included	Not Covered
Prescription Drugs				
Prescription Drugs — Calendar Year Out-of-Pocket Maximum <sup>2</sup>	\$3,000 per member \$6,000 family (In-network and out-of-network combined.)		\$3,000 per member \$6,000 family (In-network and out-of-network combined.)	
Prescription Drugs — Retail: 30-day supply	Option 1: \$15/\$35/\$50 Option 2: \$10/\$25/\$50	Option 1: \$15/\$35/\$50 plus 20% Option 2: \$10/\$25/\$50 plus 20%	\$20/\$40/\$70	\$20/\$40/\$70 plus 20%
Prescription Drugs — Mail Order: 31-90 day supply	Option 1: \$30/\$70/\$100 Option 2: \$20/\$50/\$100	Not Covered	\$40/\$80/\$140	Not Covered
Prescription Drug Deductible	N/A	N/A	N/A	N/A
Contraceptives and Diabetic Supplies	Included	Included	Included	Included
90 Day Transition of Coverage (TOC) for Prior Authorization <sup>3</sup>	Included	Included	Included	Included
Self-Injectables (Excluding Insulin) Up to 90-day supply	20%	Not Covered	20%	Not Covered
*Optional Features:	Morbid Obesity		Morbid Obesity	

\*This is a partial description of benefits available; for more information, refer to the specific plan design summary.

<sup>1</sup>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.

<sup>2</sup>Once the family out-of-pocket maximum is met, all family members will be considered as having met their out-of-pocket maximum for the remainder of the calendar year. No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum. The family prescription out-of-pocket maximum can be met in the same way for covered prescription drugs. Covered prescription drugs, including self-injectables, apply towards the Prescription Drug Out-of-Pocket Maximum.

<sup>3</sup>“Transition of Coverage for Prior Authorizations” helps members of new groups to transition to Aetna by providing a 90 calendar day opportunity, beginning on the group’s initial effective date, during which time prior authorization requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. Members who have claims paid for a drug requiring prior authorization during the Transition of Coverage period may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization for this drug.

<sup>4</sup>Non-Participating Provider payments for facility charges are determined based upon Aetna’s Allowable Fee Schedule. Non-Participating Provider payments for other charges are determined based upon the negotiated charge that would apply if such services or supplies were received from a Participating Provider. These charges are referred to in plan documents as “recognized” charges. Some benefits are subject to limitations or visit maximums. Members or Providers may be required to pre-certify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 12–13. Please refer to Aetna’s Producer World website at [www.aetna.com](http://www.aetna.com) for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

CONSUMER DIRECTED — HMO NO-REFERRAL HSA COMPATIBLE PLAN OPTIONS

Plan Options	VA HMO NO-REFERRAL HSA COMPATIBLE PLAN 1.3 <sup>+,*,4</sup>	VA HMO NO-REFERRAL HSA COMPATIBLE PLAN 2.3 <sup>+,*,4</sup>
Member Benefits	In-Network No Referral Needed	In-Network No Referral Needed
Member Coinsurance	0% after deductible	N/A
Plan Year Deductible <sup>1</sup> (All covered expenses, except in-network preventive services, apply to the deductible.)	\$1,200 Individual \$2,400 Family	\$1,200 Individual \$2,400 Family
Plan Year Out-of-Pocket Maximum <sup>2</sup> (All amounts paid as deductible, copayment and coinsurance for covered services and supplies apply toward the Out-of-Pocket Maximum.)	\$2,400 Individual \$4,800 Family	\$2,400 Individual \$4,800 Family
Lifetime Maximum Benefit	Unlimited	Unlimited
Well-Baby/Child Exams (Age and frequency schedules apply.)	0%, deductible waived	\$0 Copay, deductible waived
Adult Physical Exams (Limited to one exam per plan year.)	0%, deductible waived	\$0 Copay, deductible waived
Routine GYN Exams (Limited to a routine exam, pap smear and other appropriate tests using any FDA-approved gynecologic cytology screening technologies, once every 365 days.)	0%, deductible waived	\$0 Copay, deductible waived
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; and one mammogram per plan year for ages 40 and over.)	0%, deductible waived	\$0 Copay, deductible waived
Primary Physician Office Visit	0% after deductible	\$20 Copay after deductible
Specialist Office Visit	0% after deductible	\$40 Copay after deductible
Outpatient Services — Lab	0% after deductible	\$0 Copay after deductible
Outpatient Services — X-ray	0% after deductible	\$40 Copay after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	0% after deductible	\$100 Copay after deductible
Chiropractic Services (20 visits per plan year.)	0% after deductible	\$40 Copay after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per plan year.)	0% after deductible	\$40 Copay after deductible
Outpatient Speech Therapy (30 visits per plan year.)	0% after deductible	\$40 Copay after deductible
Durable Medical Equipment (\$2,500 Plan Year Maximum)	0% after deductible	50% after deductible
Inpatient Hospital	0% after deductible	\$250 per admission after deductible
Outpatient Surgery	0% after deductible	\$100 Copay after deductible
Emergency Room (Copay waived if admitted.)	0% after deductible	\$100 Copay after deductible
Urgent Care	0% after deductible	\$40 Copay after deductible
Mental Health — Inpatient (Biological: Unlimited days. Non-Biological: Max of 30 days per plan year. Combined with Inpatient Substance Abuse Rehab.)	0% after deductible	\$250 per admission after deductible
Substance Abuse — Inpatient (Biological: Unlimited days. Non-Biological: Max of 30 days per plan year. Combined with Inpatient Mental Health.)	0% after deductible	\$250 per admission after deductible
Routine Eye Exam (Age and frequency schedules apply.)	0%, deductible waived	\$0 Copay, deductible waived
Aetna Vision <sup>SM</sup> Discount Program	Included	Included
<b>Prescription Drugs</b>		
Prescription Drugs — Plan Year Out-of-Pocket Maximum <sup>1</sup>	Integrated medical/pharmacy out-of-pocket maximum	Integrated medical/pharmacy out-of-pocket maximum
Prescription Drugs — Retail: 30-day supply	\$15/\$35/\$50 after integrated deductible	\$15/\$35/\$50 after integrated deductible
Prescription Drugs — Mail Order: 31-90 day supply	\$30/\$70/\$100 after integrated deductible	\$30/\$70/\$100 after integrated deductible
Prescription Drug Deductible <sup>1</sup>	Integrated medical/pharmacy deductible	Integrated medical/pharmacy deductible
Contraceptives and Diabetic Supplies	Included	Included
90 Day Transition of Coverage (TOC) for Prior Authorization <sup>3</sup>	Included	Included
Self-Injectables (Excluding Insulin) Up to 90-day supply	20% after integrated deductible	20% after integrated deductible
*Optional Features:	Morbid Obesity	Morbid Obesity

\*This is a partial description of benefits available; for more information, refer to the specific plan design summary.

<sup>1</sup>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.

<sup>2</sup>The Individual Out-of-Pocket Maximum can only be met when a member is enrolled for self-only coverage with no dependent coverage. The Family Out-of-Pocket Maximum can be met by a combination of family members or by any single individual within the family. Once the Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the plan year.

<sup>3</sup>“Transition of Coverage for Prior Authorizations” helps members of new groups to transition to Aetna by providing a 90 calendar day opportunity, beginning on the group’s initial effective date, during which time prior authorization requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. Members who have claims paid for a drug requiring prior authorization during the Transition of Coverage period may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization for this drug.

<sup>4</sup>“No-Referral” Provision: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefit from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to pre-certify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 12–13. Please refer to Aetna’s Producer World website at [www.aetna.com](http://www.aetna.com) for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

**CONSUMER DIRECTED — PPO HSA COMPATIBLE PLAN OPTION**

Plan Options	VA PPO HSA COMPATIBLE PLAN 1.3 <sup>+,*</sup>	
<b>Member Benefits</b>	In-Network No Referral Needed	Out-of-Network <sup>4</sup> No Referral Needed
<b>Member Coinsurance</b>	0% after deductible	20% after deductible
<b>Plan Year Deductible<sup>1</sup></b> (All covered expenses, except in-network preventive services and out-of-network routine well baby exams/immunizations, apply to the deductible.)	\$1,500 Individual/\$3,000 Family (In-network and out-of-network combined.)	
<b>Plan Year Out-of-Pocket Maximum<sup>2</sup></b> (All amounts paid as deductible, copayment and coinsurance for covered services and supplies, apply toward the Out-of-Pocket Maximum.)	\$3,000 Individual/\$6,000 Family (In-network and out-of-network combined.)	
<b>Lifetime Maximum Benefit</b>	Unlimited	\$2,000,000
<b>Well-Baby/Child Exams</b> (7 exams in the first 12 months of life; 2 exams in the 13th – 24th months of life; 1 exam per 12 months thereafter. In-network and out-of-network combined.)	\$0 Copay, deductible waived	0%; deductible waived
<b>Adult Physical Exams</b> (Limited to one exam per 12 months. In-network and out-of-network combined.)	\$0 Copay, deductible waived	20% after deductible
<b>Routine GYN Exams</b> (Limited to a routine exam, pap smear and other appropriate tests using any FDA-approved gynecologic cytology screening technologies, once every plan year. In-network and out-of-network combined.)	\$0 Copay, deductible waived	20% after deductible
<b>Routine Mammograms</b> (Limited to one baseline mammogram for ages 35 through 39; and one mammogram per plan year for ages 40 and over. In-network and out-of-network combined.)	\$0 Copay, deductible waived	20% after deductible
<b>Primary Physician Office Visit</b>	\$20 Copay after deductible	20% after deductible
<b>Specialist Office Visit</b>	\$40 Copay after deductible	20% after deductible
<b>Outpatient Services — Lab</b>	\$0 Copay after deductible	20% after deductible
<b>Outpatient Services — X-ray</b>	\$0 Copay after deductible	20% after deductible
<b>Outpatient Complex Imaging</b> (MRA/MRS, MRI, PET and CAT Scans)	\$0 Copay after deductible	20% after deductible
<b>Chiropractic Services</b> (20 visits per plan year. In-network and out-of-network combined.)	\$40 Copay after deductible	20% after deductible
<b>Outpatient Physical/Occupational Therapy</b> (Physical and occupational therapy combined, 30 visits per plan year. In-network and out-of-network combined.)	\$40 Copay after deductible	20% after deductible
<b>Outpatient Speech Therapy</b> (30 visits per plan year. In-network and out-of-network combined.)	\$40 Copay after deductible	20% after deductible
<b>Durable Medical Equipment</b> (\$2,500 Plan Year Maximum. In-network and out-of-network combined.)	50% after deductible	50% after deductible
<b>Inpatient Hospital</b>	\$250 per admission after deductible	\$250 Copay per admission plus 20% after deductible
<b>Outpatient Surgery</b>	\$100 Copay after deductible	\$100 Copay plus 20% after deductible
<b>Emergency Room</b> (Copay waived if admitted.)	\$100 Copay after deductible	\$100 Copay after deductible
<b>Urgent Care</b>	\$40 Copay after deductible	20% after deductible
<b>Mental Health — Inpatient</b> (Biological: Unlimited days. Non-Biological: Max. of 30 days per plan year. In-network and out-of-network combined.)	\$250 per admission after deductible	\$250 Copay per admission plus 20% after deductible
<b>Substance Abuse — Inpatient</b> (Unlimited days per plan year.)	\$250 per admission after deductible	\$250 Copay per admission plus 20% after deductible
<b>Routine Eye Exam</b> (One exam per 24 months. In-network and out-of-network combined.)	\$0 Copay, deductible waived	20% after deductible
<b>Aetna Vision<sup>SM</sup> Discount Program</b>	Included	Not Covered
<b>Prescription Drugs</b>		
<b>Prescription Drugs — Plan Year Out-of-Pocket Maximum<sup>2</sup></b>	Integrated medical/pharmacy out-of-pocket maximum	
<b>Prescription Drugs — Retail: 30-day supply</b>	\$15/\$35/\$50 after integrated deductible	\$15/\$35/\$50 plus 20% after integrated deductible
<b>Prescription Drugs — Mail Order: 31-90 day supply</b>	\$30/\$70/\$100 after integrated deductible	Not Covered
<b>Prescription Drug Deductible<sup>1</sup></b>	Integrated medical/pharmacy deductible	
<b>Contraceptives and Diabetic Supplies</b>	Included	Included
<b>90 Day Transition of Coverage (TOC) for Prior Authorization<sup>3</sup></b>	Included	Included
<b>Self-Injectables (Excluding Insulin) Up to 90-day supply</b>	20% after integrated deductible	Not Covered
<b>*Optional Features:</b>	Morbid Obesity	

\*This is a partial description of benefits available; for more information, refer to the specific plan design summary.

<sup>1</sup>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.

<sup>2</sup>The Individual Out-of-Pocket Maximum can only be met when a member is enrolled for self-only coverage with no dependent coverage. The Family Out-of-Pocket Maximum can be met by a combination of family members or by any single individual within the family. Once the Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the plan year.

<sup>3</sup>“Transition of Coverage for Prior Authorizations” helps members of new groups to transition to Aetna by providing a 90 calendar day opportunity, beginning on the group’s initial effective date, during which time prior authorization requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. Members who have claims paid for a drug requiring prior authorization during the Transition of Coverage period may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization for this drug.

<sup>4</sup>Non-Participating Provider payments for facility charges are determined based upon Aetna’s Allowable Fee Schedule. Non-Participating Provider payments for other charges are determined based upon the negotiated charge that would apply if such services or supplies were received from a Participating Provider. These charges are referred to in plan documents as “recognized” charges. Some benefits are subject to limitations or visit maximums. Members or Providers may be required to pre-certify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 12–13. Please refer to Aetna’s Producer World website at [www.aetna.com](http://www.aetna.com) for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

CONSUMER DIRECTED — HEALTH NETWORK OPTION — HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

Plan Options	VA HEALTH NETWORK OPTION AHF HRA 1.3 <sup>+,*,4</sup>	
Member Benefits	In-Network No Referral Needed	Out-of-Network <sup>5</sup> No Referral Needed
HealthFund Amount (Per plan year. Fund changes between tiers requires a life status change qualifying event.)	\$500 Individual/\$1,000 Family (In-network and out-of-network combined.)	
HealthFund Coinsurance (Percentage at which the Fund will reimburse.)	100%	
HealthFund Administration	The Fund will be used to pay for the member's responsibility, including the deductible and coinsurance. Once the deductible is met, the underlying medical plan provides coverage and if a Fund balance still exists, the Fund will pay the member's responsibility (i.e., the member's share of copay or coinsurance) until the Plan Year Out-of-Pocket Maximum has been reached or the Fund has been exhausted, whichever comes first. Preventive services, prescription drug benefit and self-injectables will be subject to the medical and pharmacy plan provisions and will not be eligible for reimbursement by the Fund.	
HealthFund Rollover	Any remaining HealthFund benefit amount at the end of the plan year is rolled over into next year's HealthFund benefit amount.	
Member Coinsurance	0% after deductible	20% after deductible
Plan Year Deductible <sup>1</sup>	\$2,000 Individual/\$4,000 Family (In-network and out-of-network combined. All covered expenses, except in-network preventive services, out-of-network routine well baby exams/immunizations, and prescription drug benefits, including self-injectables, apply to the deductible.)	
Plan Year Out-of-Pocket Maximum <sup>2</sup>	\$4,000 Individual/\$8,000 Family (In-network and out-of-network combined. All amounts paid as deductible, copayment and coinsurance for covered services and supplies, except prescription drug benefits and self-injectables, apply toward the Out-of-Pocket Maximum.)	
Lifetime Maximum Benefit	Unlimited	\$2,000,000
Well-Baby/Child Exams (Age and frequency schedules apply.)	\$0 Copay, deductible waived	0%; deductible waived
Adult Physical Exams (Limited to one exam per 12 months. In-network and out-of-network combined.)	\$0 Copay, deductible waived	20% after deductible
Routine GYN Exams (Limited to a routine exam, pap smear and other appropriate tests using any FDA-approved gynecologic cytology screening technologies, once every 365 days. In-network and out-of-network combined.)	\$0 Copay, deductible waived	20% after deductible
Routine Mammograms (In-Network: Limited to one baseline mammogram for ages 35 through 39; and one mammogram per plan year for ages 40 and over. Out-of-Network: Limited to one baseline mammogram for ages 35-39; one mammogram every two years ages 40 – 49; and one mammogram per plan year for age 50 +. In-network and out-of-network combined.)	\$0 Copay, deductible waived	20% after deductible
Primary Physician Office Visit	\$20 Copay after deductible	20% after deductible
Specialist Office Visit	\$40 Copay after deductible	20% after deductible
Outpatient Services — Lab	\$0 Copay after deductible	20% after deductible
Outpatient Services — X-ray	\$0 Copay after deductible	20% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$0 Copay after deductible	20% after deductible
Chiropractic Services (20 visits per plan year. In-network and out-of-network combined.)	\$40 Copay after deductible	20% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per plan year. In-network and out-of-network combined.)	\$40 Copay after deductible	20% after deductible
Outpatient Speech Therapy (30 visits per plan year. In-network and out-of-network combined.)	\$40 Copay after deductible	20% after deductible
Durable Medical Equipment (\$2,500 Plan Year Maximum. In-network and out-of-network combined.)	50% after deductible	50% after deductible
Inpatient Hospital	\$300 Copay per admission after deductible	\$300 Copay per admission plus 20% after deductible
Outpatient Surgery	\$100 Copay after deductible	\$100 Copay plus 20% after deductible
Emergency Room (Copay waived if admitted.)	\$100 Copay after deductible	\$100 Copay after deductible
Urgent Care	\$40 Copay after deductible	20% after deductible
Mental Health — Inpatient (Biological: Unlimited days. Non-Biological: Max. of 30 days per plan year. Combined with Inpatient Substance Abuse Rehab. In-network and out-of-network combined.)	\$300 Copay per admission after deductible	\$300 Copay per admission plus 20% after deductible
Substance Abuse — Inpatient (Biological: Unlimited days. Non-Biological: Max. of 30 days per plan year. Combined with Inpatient Mental Health. In-network and out-of-network combined.)	\$300 Copay per admission after deductible	\$300 Copay per admission plus 20% after deductible
Routine Eye Exam (One exam per 24 months. In-network and out-of-network combined.)	\$0 Copay; deductible waived	20% after deductible
Aetna Vision <sup>SM</sup> Discount Program	Included	Not Covered
<b>Prescription Drugs</b>		
Prescription Drugs — Plan Year Out-of-Pocket Maximum <sup>2</sup>	N/A	N/A
Prescription Drugs — Retail: 30-day supply	\$15/\$35/\$50	Not Covered
Prescription Drugs — Mail Order: 31-90 day supply	\$30/\$70/\$100	Not Covered
Prescription Drug Deductible	N/A	N/A
Contraceptives and Diabetic Supplies	Included	Not Covered
90 Day Transition of Coverage (TOC) for Prior Authorization <sup>3</sup>	Included	Not Covered
Self-Injectables (Excluding Insulin) Up to 90-day supply	20%	Not Covered
*Optional Features:	Morbid Obesity	

<sup>1</sup>This is a partial description of benefits available; for more information, refer to the specific plan design summary.

<sup>2</sup>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.

<sup>3</sup>The Individual Out-of-Pocket Maximum can only be met when a member is enrolled for self-only coverage with no dependent coverage. The Family Out-of-Pocket Maximum can be met by a combination of family members or by any single individual within the family. Once the Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the plan year.

<sup>4</sup>"Transition of Coverage for Prior Authorizations" helps members of new groups to transition to Aetna by providing a 90 calendar day opportunity, beginning on the group's initial effective date, during which time prior authorization requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. Members who have claims paid for a drug requiring prior authorization during the Transition of Coverage period may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization for this drug.

<sup>5</sup>"No-Referral" Provision: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefit from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist.

<sup>6</sup>Non-Participating Provider payments for facility charges are determined based upon Aetna's Allowable Fee Schedule. Non-Participating Provider payments for other charges are determined based upon the negotiated charge that would apply if such services or supplies were received from a Participating Provider. These charges are referred to in plan documents as "recognized" charges.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to pre-certify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 12–13. Please refer to Aetna's Producer World website at [www.aetna.com](http://www.aetna.com) for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

CONSUMER DIRECTED — PPO HEALTHFUND PLAN OPTION

Plan Options	VA PPO HEALTHFUND PLAN 1.3+*	
Member Benefits	In-Network No Referral Needed	Out-of-Network <sup>4</sup> No Referral Needed
HealthFund Amount (Per plan year. Fund changes between tiers requires a life status change qualifying event.)	\$500 Individual/\$1,000 Family (In-network and out-of-network combined.)	
HealthFund Coinsurance (Percentage at which the Fund will reimburse.)	100%	
HealthFund Administration	The Fund will be used to pay for the member's responsibility, including the deductible and coinsurance. Once the deductible is met, the underlying medical plan provides coverage and if a Fund balance still exists, the Fund will pay the member's responsibility (i.e., the member's share of copay or coinsurance) until the Plan Year Out-of-Pocket Maximum has been reached or the Fund has been exhausted, whichever comes first. Preventive services, prescription drug benefit and self-injectables will be subject to the medical and pharmacy plan provisions and will not be eligible for reimbursement by the Fund.	
HealthFund Rollover	Any remaining HealthFund benefit amount at the end of the plan year is rolled over into next year's HealthFund benefit amount.	
Member Coinsurance	0% after deductible	20% after deductible
Plan Year Deductible <sup>1</sup>	\$2,000 Individual/\$4,000 Family (In-network and out-of-network combined. All covered expenses, except in-network preventive services, out-of-network routine well baby exams/immunizations, and prescription drug benefits, including self-injectables, apply to the deductible.)	
Plan Year Out-of-Pocket Maximum <sup>2</sup>	\$4,000 Individual/\$8,000 Family (In-network and out-of-network combined. All amounts paid as deductible, copayment and coinsurance for covered services and supplies, except prescription drug benefits and self-injectables, apply toward the Out-of-Pocket Maximum.)	
Lifetime Maximum Benefit	Unlimited	\$2,000,000
Well-Baby/Child Exams (7 exams in the first 12 months of life; 2 exams in the 13th – 24th months of life; 1 exam per 12 months thereafter. In-network and out-of-network combined.)	\$0 Copay, deductible waived	0%; deductible waived
Adult Physical Exams (Limited to one exam per 12 months. In-network and out-of-network combined.)	\$0 Copay, deductible waived	20% after deductible
Routine GYN Exams (Limited to a routine exam, pap smear and other appropriate tests using any FDA-approved gynecologic cytology screening technologies, once every plan year. In-network and out-of-network combined.)	\$0 Copay, deductible waived	20% after deductible
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; and one mammogram per plan year for ages 40 and over. In-network and out-of-network combined.)	\$0 Copay, deductible waived	20% after deductible
Primary Physician Office Visit	\$20 Copay after deductible	20% after deductible
Specialist Office Visit	\$40 Copay after deductible	20% after deductible
Outpatient Services — Lab	\$0 Copay after deductible	20% after deductible
Outpatient Services — X-ray	\$0 Copay after deductible	20% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$0 Copay after deductible	20% after deductible
Chiropractic Services (20 visits per plan year. In-network and out-of-network combined.)	\$40 Copay after deductible	20% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per plan year. In-network and out-of-network combined.)	\$40 Copay after deductible	20% after deductible
Outpatient Speech Therapy (30 visits per plan year. In-network and out-of-network combined.)	\$40 Copay after deductible	20% after deductible
Durable Medical Equipment (\$2,500 Plan Year Maximum. In-network and out-of-network combined.)	50% after deductible	50% after deductible
Inpatient Hospital	\$300 Copay per admission after deductible	\$300 Copay per admission plus 20% after deductible
Outpatient Surgery	\$100 Copay after deductible	\$100 Copay plus 20% after deductible
Emergency Room (Copay waived if admitted.)	\$100 Copay after deductible	\$100 Copay after deductible
Urgent Care	\$40 Copay after deductible	20% after deductible
Mental Health — Inpatient (Biological: Unlimited days. Non-Biological: Max. of 30 days per plan year. In-network and out-of-network combined.)	\$300 Copay per admission after deductible	\$300 Copay per admission plus 20% after deductible
Substance Abuse — Inpatient (Unlimited days per plan year.)	\$300 Copay per admission after deductible	\$300 Copay per admission plus 20% after deductible
Routine Eye Exam (One exam per 24 months. In-network and out-of-network combined.)	\$0 Copay; deductible waived	20% after deductible
Aetna Vision <sup>SM</sup> Discount Program	Included	Not Covered
<b>Prescription Drugs</b>		
Prescription Drugs — Plan Year Out-of-Pocket Maximum <sup>2</sup>		N/A
Prescription Drugs — Retail: 30-day supply	\$15/\$35/\$50	\$15/\$35/\$50 plus 20%
Prescription Drugs — Mail Order: 31-90 day supply	\$30/\$70/\$100	Not Covered
Prescription Drug Deductible		N/A
Contraceptives and Diabetic Supplies	Included	Included
90 Day Transition of Coverage (TOC) for Prior Authorization <sup>3</sup>	Included	Included
Self-Injectables (Excluding Insulin) Up to 90-day supply	20%	Not Covered
*Optional Features:		Morbid Obesity

\*This is a partial description of benefits available; for more information, refer to the specific plan design summary.

<sup>1</sup>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.

<sup>2</sup>The Individual Out-of-Pocket Maximum can only be met when a member is enrolled for self-only coverage with no dependent coverage. The Family Out-of-Pocket Maximum can be met by a combination of family members or by any single individual within the family. Once the Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the plan year.

<sup>3</sup>"Transition of Coverage for Prior Authorizations" helps members of new groups to transition to Aetna by providing a 90 calendar day opportunity, beginning on the group's initial effective date, during which time prior authorization requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. Members who have claims paid for a drug requiring prior authorization during the Transition of Coverage period may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization for this drug.

<sup>4</sup>Non-Participating Provider payments for facility charges are determined based upon Aetna's Allowable Fee Schedule. Non-Participating Provider payments for other charges are determined based upon the negotiated charge that would apply if such services or supplies were received from a Participating Provider. These charges are referred to in plan documents as "recognized" charges. Some benefits are subject to limitations or visit maximums. Members or Providers may be required to pre-certify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 12–13. Please refer to Aetna's Producer World website at [www.aetna.com](http://www.aetna.com) for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

**INDEMNITY PLAN OPTION**

Plan Options	VA INDEMNITY 1.2*.*
Member Benefits	Out-of-Network <sup>4</sup> No Referral Needed
Member Coinsurance	30% after deductible
Calendar Year Deductible <sup>1</sup>	\$400 per member \$800 family
Calendar Year Out-of-Pocket Maximum <sup>2</sup> (Deductible applies to the Out-of-Pocket Maximum. Prescription drugs, including self-injectables, do not apply toward the Out-of-Pocket Maximum.)	\$3,000 per member \$6,000 family
Lifetime Maximum Benefit	\$2,000,000
Well-Baby/Child Exams (7 exams in the first 12 months of life; 2 exams in the 13th – 24th months of life; 1 exam per 12 months thereafter.)	0%; deductible waived
Adult Physical Exams (Limited to one exam per calendar year.)	30%; deductible waived
Routine GYN Exams (Limited to a routine exam, pap smear and other appropriate tests using any FDA-approved gynecologic cytology screening technologies, once every calendar year.)	30%; deductible waived
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; and one mammogram per calendar year for ages 40 and over.)	30%; deductible waived
Primary Physician Office Visit	30% after deductible
Specialist Office Visit	30% after deductible
Outpatient Services — Lab	30% after deductible
Outpatient Services — X-ray	30% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	30% after deductible
Chiropractic Services (20 visits per calendar year.)	30% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year.)	30% after deductible
Outpatient Speech Therapy (30 visits per calendar year.)	30% after deductible
Durable Medical Equipment (\$2,500 Calendar Year Maximum.)	50% after deductible
Inpatient Hospital	\$200 Copay per day, up to 5 days per admission, plus 30% after deductible
Outpatient Surgery	\$150 Copay plus 30% after deductible
Emergency Room (Copay waived if admitted.)	\$100 Copay after deductible
Urgent Care	30% after deductible
Mental Health — Inpatient (Biological: Unlimited days. Non-Biological: Max. of 30 days per calendar year.)	\$200 Copay per day, up to 5 days per admission, plus 30% after deductible
Substance Abuse — Inpatient (Unlimited days per calendar year.)	\$200 Copay per day, up to 5 days per admission, plus 30% after deductible
Routine Eye Exam (One exam per 24 months.)	30%; deductible waived
Aetna Vision <sup>SM</sup> Discount Program	Included
<b>Prescription Drugs</b>	
Prescription Drugs — Calendar Year Out-of-Pocket Maximum <sup>2</sup>	\$3,000 per member \$6,000 family
Prescription Drugs — Retail: 30-day supply	\$15/\$35/\$50
Prescription Drugs — Mail Order: 31-90 day supply	\$30/\$70/\$100
Prescription Drug Deductible	N/A
Contraceptives and Diabetic Supplies	Included
90 Day Transition of Coverage (TOC) for Prior Authorization <sup>3</sup>	Included
Self-Injectables (Excluding Insulin) Up to 90-day supply	20%
*Optional Features:	Morbid Obesity

\*This is a partial description of benefits available; for more information, refer to the specific plan design summary.

<sup>1</sup>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.

<sup>2</sup>Once the family out-of-pocket maximum is met, all family members will be considered as having met their out-of-pocket maximum for the remainder of the calendar year. No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum. The family prescription out-of-pocket maximum can be met in the same way for covered prescription drugs. Covered prescription drugs, including self-injectables, apply towards the Prescription Drug Out-of-Pocket Maximum.

<sup>3</sup>“Transition of Coverage for Prior Authorizations” helps members of new groups to transition to Aetna by providing a 90 calendar day opportunity, beginning on the group’s initial effective date, during which time prior authorization requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. Members who have claims paid for a drug requiring prior authorization during the Transition of Coverage period may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization for this drug.

<sup>4</sup>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.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to pre-certify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 12–13. Please refer to Aetna’s Producer World website at [www.aetna.com](http://www.aetna.com) for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

## Limitations and exclusions

### Aetna HMO/POS plans

These plans do not cover all health care expenses and include 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, the plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates.
- Cosmetic surgery.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval.
- Experimental and investigational procedures (except for coverage for medically necessary routine patient care costs for Members participating in a cancer clinical trial).
- Hearing aids.
- Immunizations for travel or work.
- 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.
- Non-medically necessary services or supplies.
- Orthotics.
- Over-the-counter medications and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered in the plan documents.

### Aetna PPO plans

These plans do not cover all health care expenses and include 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, plan documents may contain exceptions to this list based on state mandates.

- All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents.
- Charges related to any eye surgery mainly to correct refractive errors.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and X-rays.
- Donor egg retrieval.
- Experimental and investigational procedures.
- Hearing aids.
- Immunizations for travel or work.



- 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 plan documents.
- Non-medically necessary services or supplies.
- Orthotics.
- Over-the-counter medications and supplies.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling.
- Special duty nursing.

#### **Aetna PPO plans: Pre-existing conditions exclusion provision**

These plans impose a pre-existing conditions exclusion, which may be waived in some circumstances (that is, creditable coverage) and may not be applicable. A pre-existing conditions exclusion means that if the member has a medical condition before coming to the plan, the member 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 180 days.

Generally, this period ends the day before coverage becomes effective. However, if the member was in a waiting period for coverage, the 180-day period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days from the first day of coverage, or if the member was in a waiting period, from the first day of the waiting period.

If the member had prior creditable coverage within 90 days immediately before the date enrolled under the plan, then the pre-existing conditions exclusion in the plan, if any, will be waived.

If the member had no prior creditable coverage within the 90 days prior to the enrollment date (either because the member had no prior coverage or because there was more than a 90-day gap from the date the prior coverage terminated to the enrollment date), we will apply the plan's pre-existing conditions exclusion.

In order to reduce or possibly eliminate the exclusion period based on creditable coverage, the member should provide us a copy of any Certificates of Creditable Coverage. Please contact Aetna Member Services at 1-888-80-AETNA for assistance in obtaining a Certificate of Creditable Coverage from the prior carrier or with any questions on the information noted above.

The pre-existing conditions 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.

**For more information  
about any of these plans  
or to receive a quote,  
please contact your  
Small Group Account  
Executive or Small Group  
Sales Support Center at  
1-866-71-AETNA.**

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