



PLAN DESIGN AND BENEFITS  
 ADMINISTERED BY AETNA HEALTH INC. - SELF FUNDED

PLAN FEATURES	PARTICIPATING PROVIDERS / REFERRED
<b>Deductible (per plan year)</b>	None Individual None Family
<b>Member Coinsurance</b>	Covered 100%
<b>Out-of-Pocket Maximum (per plan year)</b>	\$0 Individual \$0 Family
Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. Only those participating providers/referred out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles and copays (except any penalty amounts and pharmacy cost sharing) may be used to satisfy the Out-of-Pocket Maximum. Once 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.	
<b>Lifetime Maximum</b>	Unlimited except where otherwise indicated.
<b>Primary Care Physician Selection</b>	Required
<b>Referral Requirements</b>	Required for all non-emergency, non-urgent and non-Primary Care physician services, except direct access services.
PREVENTIVE CARE	PARTICIPATING PROVIDERS / REFERRED
<b>Routine Adult Physical Exams/ Immunizations (Age and frequency schedules apply)</b>	\$10 copay
<b>Well Child Exams / Immunizations (Age and frequency schedules apply)</b>	\$10 copay
<b>Routine Gynecological Care Exams</b> Includes routine tests and related lab fees. One routine exam per 365 days.	\$10 copay
<b>Routine Mammograms</b> One baseline mammogram for females age 35 - 39; and one annual	\$15 copay mammogram for females age 40 and over.
<b>Routine Digital Rectal Exams / Prostate Specific Antigen Test</b> For males age 40 and over.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
<b>Colorectal Cancer Screening</b> For all members 50 and over. Frequency schedule applies.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
<b>Routine Eye Exam</b> Age/Frequency Schedule may apply.	\$15 copay
<b>Routine Hearing Screening</b>	Subject to Routine Physical Exam cost sharing.
PHYSICIAN SERVICES	PARTICIPATING PROVIDERS / REFERRED
<b>Office Visits to member's selected Primary Care Physician</b>	Office Hours : \$10 copay After Office Hours/Home : \$25 copay
<b>Specialist Office Visits</b> Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.	\$20 copay
<b>Maternity OB Visits</b>	\$20 copay; for initial visit only, thereafter covered 100%
<b>Allergy Treatment - \$5 copay for allergy injections</b>	
<b>Allergy Testing</b>	Same as applicable participating provider office visit member cost sharing
DIAGNOSTIC PROCEDURES	PARTICIPATING PROVIDERS / REFERRED
<b>Diagnostic Laboratory</b> If performed as a part of a physician's office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit cost sharing.	\$5 copay



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<b>Diagnostic X-ray</b>	\$15 copay (\$25 complex imaging)
Outpatient hospital or other Outpatient facility	
<b>EMERGENCY MEDICAL CARE</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>
<b>Urgent Care</b>	\$20 copay
<b>Non-Urgent use of Urgent Care Provider</b>	Not Covered
<b>Emergency Room</b>	\$135 copay
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered
<b>Ambulance</b>	\$50 per trip copay
<b>HOSPITAL CARE</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>
<b>Inpatient Coverage</b>	\$100 per day for the first 2 days per admission, thereafter coverage is provided at 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
<b>Inpatient Maternity Coverage</b>	\$100 per day for the first 2 days per admission, thereafter coverage is provided at 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
<b>Outpatient Surgery</b>	\$75 Copay/\$30 copay for Surgi Center
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
<b>MENTAL HEALTH SERVICES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>
<b>Inpatient Serious Mental Illness</b>	Covered same as Inpatient Hospital Coverage
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
<b>Inpatient Non-Serious Mental Illness</b>	Covered 80% Limited to (30) days per plan year.
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
<b>Outpatient Serious Mental Illness</b>	Covered same as Specialist Office visits cost sharing
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
<b>Outpatient Non-Serious Mental Illness</b>	\$20 Copay Limited 30 visits per plan year
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
<b>ALCOHOL/DRUG ABUSE SERVICES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>
<b>Inpatient Detoxification</b>	\$100 per day for the first 2 days per admission, thereafter coverage is provided at 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
<b>Outpatient Detoxification</b>	\$20 per visit copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
<b>Inpatient Rehabilitation -- Need smu approval &amp; sys support</b>	\$100 per day for the first 2 days per admission, thereafter coverage is provided at 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
<b>Outpatient Rehabilitation</b>	\$20 per visit copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
<b>OTHER SERVICES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>
<b>Skilled Nursing Facility</b>	Coverd 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
<b>Home Health Care</b>	Covered 100%



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<b>Hospice Care - Inpatient</b>	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
<b>Hospice Care - Outpatient</b>	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
<b>Private Duty Nursing</b>	Not Covered unless pre-authorized
<b>Outpatient Rehabilitation Therapy</b> (Includes speech, physical and occupational therapy)	Covered 80% for 45 visits per condition separate 45 visit per condition limit for Speech therapy
<b>Hearing Aids for children to age 18</b>	<b>Covered 80% (same as DME but not subject to limit</b>
<b>Subluxation</b>	\$20 per visit copay
<b>Durable Medical Equipment</b>	Covered 80% up to \$5,000 maximum benefit
<b>Diabetic Supplies</b>	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies
<b>Vision Eyewear</b>	Not Covered

<b>Transplants -- SMU Approval Needed ? Is this the plan sponsors intent?No companion coverage</b>	\$100 per day for the first 2 days per admission, thereafter coverage is provided at 100% Coverage is provided at an Institute of Excellence
<b>Bariatric</b> (need confirmation of Plan Sponsor's Intent) The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	\$100 per day for the first 2 days per admission, thereafter

<b>FAMILY PLANNING</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>
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<b>Infertility Treatment</b> Diagnosis and treatment of the underlying	Member cost sharing is based on the type of service
<b>Comprehensive Infertility Services</b>	Applicable copay applies

Coverage includes Artificial Insemination (limited to six courses of treatment per member's lifetime) and Ovulation Induction  
**Limited \$30,000 Combined Lifetime**

ART coverage includes In-Vitro Fertilization (IVF), Zygote Intra-Fallopian Transfer (ZIFT), Gamete Intra-Fallopian Transfer  
**Voluntary Sterilization** Subject to applicable service type member cost sharing  
 All covered pharmacy expenses accumulate toward the pharmacy plan year maximum.

**GENERAL PROVISIONS**

**Dependents Eligibility -- 21 EOY Students 24 EOM**  
**Members may directly access participating providers for certain services as outlined in the plan documents.**

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan



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documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on the plan design or rider(s) purchased.



State of Delaware  
Effective date: 07-01-2008  
HMO - Asc

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