



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

PLAN FEATURES	PARTICIPATING PROVIDERS / REFERRED
Deductible (per plan year)	None Individual None Family
Member Coinsurance	Covered 100%
Out-of-Pocket Maximum (per plan year)	\$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.	
Lifetime Maximum	Unlimited except where otherwise indicated.
Primary Care Physician Selection	Required
Referral Requirements	Required for all non-emergency, non-urgent and non-Primary Care physician services, except direct access services.
PREVENTIVE CARE	PARTICIPATING PROVIDERS / REFERRED
Routine Adult Physical Exams/ Immunizations (Age and frequency schedules apply)	\$10 copay
Well Child Exams / Immunizations (Age and frequency schedules apply)	\$10 copay
Routine Gynecological Care Exams Includes routine tests and related lab fees. One routine exam per 365 days.	\$10 copay
Routine Mammograms One baseline mammogram for females age 35 - 39; and one annual	\$15 copay mammogram for females age 40 and over.
Routine Digital Rectal Exams / Prostate Specific Antigen Test 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.
Colorectal Cancer Screening 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.
Routine Eye Exam Age/Frequency Schedule may apply.	\$15 copay
Routine Hearing Screening	Subject to Routine Physical Exam cost sharing.
PHYSICIAN SERVICES	PARTICIPATING PROVIDERS / REFERRED
Office Visits to member's selected Primary Care Physician	Office Hours : \$10 copay After Office Hours/Home : \$25 copay
Specialist Office Visits Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.	\$20 copay
Maternity OB Visits	\$20 copay; for initial visit only, thereafter covered 100%
Allergy Treatment - \$5 copay for allergy injections	
Allergy Testing	Same as applicable participating provider office visit member cost sharing
DIAGNOSTIC PROCEDURES	PARTICIPATING PROVIDERS / REFERRED
Diagnostic Laboratory 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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Diagnostic X-ray	\$15 copay (\$25 complex imaging)
Outpatient hospital or other Outpatient facility	
EMERGENCY MEDICAL CARE	PARTICIPATING PROVIDERS / REFERRED
Urgent Care	\$35 copay
Non-Urgent use of Urgent Care Provider	Not Covered
Emergency Room	\$135 copay
Non-Emergency Care in an Emergency Room	Not Covered
Ambulance	\$50 per trip copay
HOSPITAL CARE	PARTICIPATING PROVIDERS / REFERRED
Inpatient Coverage	\$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.	
Inpatient Maternity Coverage	\$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.	
Outpatient Surgery	\$75 Copay/\$30 copay for Surgi Center
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
MENTAL HEALTH SERVICES	PARTICIPATING PROVIDERS / REFERRED
Inpatient Serious Mental Illness	Covered same as Inpatient Hospital Coverage
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Inpatient Non-Serious Mental Illness	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.	
Outpatient Serious Mental Illness	Covered same as Specialist Office visits cost sharing
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
Outpatient Non-Serious Mental Illness	\$20 Copay Limited 30 visits per plan year
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
ALCOHOL/DRUG ABUSE SERVICES	PARTICIPATING PROVIDERS / REFERRED
Inpatient Detoxification	\$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.	
Outpatient Detoxification	\$20 per visit copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
Inpatient Rehabilitation -- Need smu approval & sys support	\$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.	
Outpatient Rehabilitation	\$20 per visit copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
OTHER SERVICES	PARTICIPATING PROVIDERS / REFERRED
Skilled Nursing Facility	Coverd 100%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Home Health Care	Covered 100%



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

Transplants -- SMU Approval Needed ? Is this the plan sponsors intent?No companion coverage	\$100 per day for the first 2 days per admission, thereafter coverage is provided at 100% Coverage is provided at an Institute of Excellence
Bariatric (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

FAMILY PLANNING	PARTICIPATING PROVIDERS / REFERRED
Infertility Treatment Diagnosis and treatment of the underlying	Member cost sharing is based on the type of service
Comprehensive Infertility Services	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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~~This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on the plan design or rider(s) purchased.~~



State of Delaware
Proposed effective date: 07-01-2007
HMO - Asc

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