aetna®

# PLAN DESIGN

Customer Name: PA National plans 1-3 7/10/14

Proposed Effective Date: 08-01-2014

Policy Period: 0

Data Source ID: D6713 - 1 - PA

Option: 1

Plan: Open POS Plus Plan

Location(s): Pennsylvania

Specialty Networks Included: None Quoted

Organization Name: Aetna

**PLAN DESIGN & BENEFITS**
**PROVIDED BY AETNA LIFE INSURANCE COMPANY**

| FUND FEATURES | |
|---|---|
| **HealthFund Amount** | $300 Employee<br>$600 Family |
| Amount contributed to the Fund by the employer<br>Fund amount reflected is on a per calendar year basis. The fund received may be prorated based on your effective date of coverage. | |
| **Fund Coinsurance** | 100% |
| Percentage at which the Fund will reimburse | |
| **Fund Administration** | The Fund will be used to pay for your member responsibility, including your 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 your member responsibility (i.e. your share of coinsurance) until the Out of Pocket Maximum has been reached or the Fund has been exhausted, whichever comes first. Services covered at 100% with no deductible will be paid by the plan and not by the Fund. |
| **Employee Termination from Your HealthFund** | Any remaining HealthFund benefit amount is forfeited (or terminated) when the employee's healthFund coverage terminates. |
| **Fund Rollover** | Any remaining HealthFund benefit amount at end of the plan year is rolled over into next years HealthFund benefit amount. |
| **Eligible Fund Expenses** | Fund covers same expenses as the medical plan. Expenses above the Reasonable & Customary limit, any plan limits, and any non covered expenses are not eligible for reimbursement under the Fund. |
| **Fund Payment/Assignment** | Network Providers: Automatic Assignment to provider.<br>Non-Network Providers: Member may assign payment to provider. |
| **Pro-ration for New Employees** | Monthly |
| **Pro-ration for Family Status Change** | No pro-ration. Change to new tier based on new employee status. |
| **Prescription Drug Plan** | Prescription Drug expenses are integrated with the medical plan (i.e., subject to medical Deductible and applied towards medical Out-of-Pocket Limit) and with the Fund (i.e., eligible for reimbursement from the Fund). |

| PLAN FEATURES | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Deductible** (per calendar year) | $2,000 Individual<br>$4,000 Family | $5,000 Individual<br>$10,000 Family |
| All covered expenses accumulate separately toward the preferred or non-preferred Deductible.<br>Unless otherwise indicated, the deductible must be met prior to benefits being payable.<br>Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible.<br>Pharmacy expenses apply towards the Deductible.<br>Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. There is no Individual Deductible to satisfy within the Family Deductible. | | |
| **Member Coinsurance** | 10% | 30% |
| Applies to all expenses unless otherwise stated. | | |
| **Payment Limit** (per calendar year) | $4,000 Individual<br>$8,000 Family | $10,000 Individual<br>$20,000 Family |
| All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit.<br>Certain member cost sharing elements may not apply toward the Payment Limit.<br>Pharmacy expenses apply towards the Payment Limit.<br>Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit.<br>There is no Individual Payment Limit to satisfy within the Family Payment Limit. Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit. | | |

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| **Lifetime Maximum**<br>Unlimited except where otherwise indicated. | | |
| **Payment for Non-Preferred** | Not Applicable | Professional: 105% of Medicare<br>Facility: 140% of Medicare |
| **Primary Care Physician Selection** | Optional | Not Applicable |
| **Certification Requirements -**<br>Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence. | | |
| **Referral Requirement** | None | None |
| **PREVENTIVE CARE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Routine Adult Physical Exams/ Immunizations**<br>1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older. | Covered 100%; deductible waived | 20%; after deductible |
| **Routine Well Child Exams/Immunizations**<br>7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 22. | Covered 100%; deductible waived | 20%; deductible waived |
| **Routine Gynecological Care Exams**<br>Includes routine tests and related lab fees. | Covered 100%; deductible waived | 20%; deductible waived |
| **Routine Mammograms** | Covered 100%; deductible waived | 20%; after deductible |
| **Women's Health**<br>Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling.<br>Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply. | Covered 100%; deductible waived | 20%; after deductible |
| **Routine Digital Rectal Exam**<br>Recommended: For covered males age 40 and over. | Covered 100%; deductible waived | 20%; after deductible |
| **Prostate-specific Antigen Test**<br>Recommended: For covered males age 40 and over. | Covered 100%; deductible waived | 20%; after deductible |
| **Colorectal Cancer Screening**<br>Recommended: For all members age 50 and over. | Covered under Routine Adult Exams | Covered under Routine Adult Exams |
| **Routine Eye Exams**<br>1 routine exam per 12 months. | Covered 100%; deductible waived | 20%; after deductible |
| **Routine Hearing Screenings** | Covered 100%; deductible waived | 20%; after deductible |
| **PHYSICIAN SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Office Visits to PCP**<br>Includes services of an internist, general physician, family practitioner or pediatrician. | 10%; after deductible | 20%; after deductible |
| **Specialist Office Visits** | 10%; after deductible | 20%; after deductible |
| **Pre-Natal Maternity** | Covered 100%; deductible waived | Covered according to standard claim practice. |
| **E-visit to PCP**<br>An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through our authorized internet E-visit service vendor. | 10%; after deductible | 20%; after deductible |
| **E-visit to Specialist**<br>An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through our authorized internet E-visit service vendor. | 10%; after deductible | 20%; after deductible |

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| **Walk-in Clinics** | 10%; after deductible | 20%; after deductible |
| Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic. | | |
| **Allergy Testing** | Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible | Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible |
| **Allergy Injections** | Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible | Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible |
| **Audiometric Hearing Exams**<br>1 routine exam per 24 months. | Covered 100%; deductible waived | 20%; after deductible |
| **DIAGNOSTIC PROCEDURES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Diagnostic X-ray** | 10%; after deductible | 30%; after deductible |
| If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing. | | |
| **Diagnostic Laboratory** | 10%; after deductible | 30%; after deductible |
| If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing. | | |
| **Diagnostic Outpatient Complex Imaging** | 10%; after deductible | 30%; after deductible |
| **EMERGENCY MEDICAL CARE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Urgent Care Provider** | 10%; after deductible | 20%; after deductible |
| **Non-Urgent Use of Urgent Care Provider** | Not Covered | Not Covered |
| **Emergency Room** | 10%; after deductible | Same as preferred care. |
| **Non-Emergency Care in an Emergency Room** | Not Covered | Not Covered |
| **Emergency Use of Ambulance** | 10%; after deductible | Same as preferred care. |
| **Non-Emergency Use of Ambulance** | Not Covered | Not Covered |
| **HOSPITAL CARE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient Coverage** | 10%; after deductible | 30%; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | | |
| **Inpatient Maternity Coverage** (includes delivery and postpartum care) | 10%; after deductible | 30%; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | | |
| **Outpatient Hospital Expenses** | 10%; after deductible | 30%; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. | | |
| **Outpatient Surgery** | 10%; after deductible | 30%; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. | | |
| **Outpatient Surgery - Freestanding Facility** | 10%; after deductible | 30%; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. | | |
| **MENTAL HEALTH SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient** | 10%; after deductible | 30%; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | | |

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| **Outpatient** | 10%; after deductible | 20%; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. | | |
| **ALCOHOL/DRUG ABUSE SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient** | 10%; after deductible | 30%; after deductible |
| Member cost sharing is based on the type of service performed and the place of service where it is rendered | | |
| **Residential Treatment Facility** | 10%; after deductible | 30%; after deductible |
| **Outpatient** | 10%; after deductible | 20%; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. | | |
| **OTHER SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Convalescent Facility** | 10%; after deductible | 30%; after deductible |
| Limited to 120 days per calendar year.<br>The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | | |
| **Home Health Care** | 10%; after deductible | 20%; after deductible |
| Limited to 120 visits per calendar year.<br>Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit. | | |
| **Hospice Care - Inpatient** | 10%; after deductible | 30%; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | | |
| **Hospice Care - Outpatient** | 10%; after deductible | 30%; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. | | |
| **Private Duty Nursing** - Outpatient | 10%; after deductible | 30%; after deductible |
| Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift. | | |
| **Outpatient Short-Term Rehabilitation** | 10%; after deductible | 20%; after deductible |
| Includes Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year. | | |
| **Autism Behavioral Therapy** | Refer to MBH Outpatient Mental Health | Refer to MBH Outpatient Mental Health |
| Covered same as any other Outpatient Mental Health benefit | | |
| **Autism Applied Behavior Analysis** | Refer to MBH Outpatient Mental Health | Refer to MBH Outpatient Mental Health |
| Covered same as any other Outpatient Mental Health benefit with no age or visit limitations. | | |
| **Autism Physical Therapy** | 10%; after deductible | 20%; after deductible |
| **Autism Occupational Therapy** | 10%; after deductible | 20%; after deductible |
| **Autism Speech Therapy** | 10%; after deductible | 20%; after deductible |
| **Spinal Manipulation Therapy** | 10%; after deductible | 20%; after deductible |
| Limited to 20 visits per calendar year. | | |
| **Durable Medical Equipment** | 10%; after deductible | 30%; after deductible |
| **Diabetic Supplies** -- (if not covered under Pharmacy benefit) | Covered same as any other medical expense. | Covered same as any other medical expense. |
| **Contraceptive drugs and devices not obtainable at a pharmacy** | Covered 100%; deductible waived | Covered same as any other expense. |
| **Generic FDA-approved Women's Contraceptives** | Covered 100%; deductible waived | Not Covered |
| **Transplants** | 10%; after deductible<br>Preferred coverage is provided at an IOE contracted facility only. | 30%; after deductible<br>Non-Preferred coverage is provided at a Non-IOE facility. |
| **Bariatric Surgery** | 10%; after deductible | 30%; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | | |
| **Out of Area Dependents** | Coverage provided at the non-preferred benefit level of the plan. | |

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| FAMILY PLANNING | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Infertility Treatment** | Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible | Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible |
| Diagnosis and treatment of the underlying medical condition. | | |
| **Comprehensive Infertility Services** | Not Covered | Not Covered |
| **Advanced Reproductive Technology (ART)** | Not Covered | Not Covered |
| **Vasectomy** | Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible | Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible. |
| **Tubal Ligation** | Covered 100%; deductible waived | Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible. |
| **PHARMACY** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Pharmacy Plan Type** | Open Formulary; with mid-year changes | |
| **Retail** | $15 copay for generic drugs, $25 copay for formulary brand-name drugs, and $40 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies. | 20% of submitted cost after the applicable preferred copay |
| **Mail Order** | $30 copay for generic drugs, $50 copay for formulary brand-name drugs, and $80 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®. | Not Applicable |
| **Aetna Specialty CareRx** | 20% for formulary and non-formulary drugs | |
| First prescription fill at any retail drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®. | | |
| **Choose Generics with Dispense as Written (DAW) override** - The member pays the applicable copay only, if the physician requires brand. If the member requests brand when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price. | | |
| **Plan Includes:** Diabetic supplies.<br>Performance Enhancing Drugs limited to 4 tablets per month.<br>Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).<br>Precert for growth hormones included. Expanded Precert included with 90 day Transition of Care.<br>Step Therapy included with 90 day Transition of Care.<br>Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network. | | |
| **GENERAL PROVISIONS** | | |
| **Dependents Eligibility** | Spouse, children from birth to age 26 regardless of student status. | |
| **Pre-existing Conditions Exclusion** | On effective date: Waived<br>After effective date: Waived | |

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

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

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

**This managed care plan may not cover all of your health care expenses. Read your contract carefully to determine which health care services are covered. To contact the plan if you are a member, call the number on your ID card; all others, call 1-888-982-3862.**

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

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.
The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental X-rays.
• Donor egg retrieval.
• Durable medical Equipment
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Hearing aids
• Home births
• Immunizations for travel or work, except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Orthotics except diabetic orthotics.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Treatment of behavioral disorders.
• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

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

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

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**
Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com.**