

Medical plan options

FOR BUSINESSES WITH 2 TO 50 ELIGIBLE EMPLOYEES



Washington, D.C.

Plans effective February 1, 2008

*Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. and/or Aetna Life Insurance Company (Aetna).

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HMO NO-REFERRAL PLAN OPTIONS

Plan Options	DC HMO NO-REFERRAL 1.2 ^{+,**}	DC HMO NO-REFERRAL 2.2 ^{+,**}	DC HMO NO-REFERRAL 3.2 ^{+,**}
MEMBER BENEFITS	In-Network No Referral Needed	In-Network No Referral Needed	In-Network No Referral Needed
Member Coinsurance	N/A	N/A	N/A
Calendar Year Deductible	N/A	N/A	N/A
Calendar Year 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	\$1,000 per member \$2,000 family	\$1,500 per member \$3,000 family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Well-Baby/Child and Adult Physical Exams (Age and frequency schedules apply.)	\$10 Copay	\$15 Copay	\$20 Copay
Routine GYN Exams (Limited to one exam and Pap smear per 365 days.)	\$20 Copay	\$35 Copay	\$40 Copay
Routine Mammograms (Limited to one mammogram per calendar year)	\$0 Copay	\$0 Copay	\$0 Copay
Primary Physician Office Visit	\$10 Copay	\$15 Copay	\$20 Copay
Specialist Office Visit	\$20 Copay	\$35 Copay	\$40 Copay
Outpatient Services – Lab	\$0 Copay	\$0 Copay	\$0 Copay
Outpatient Services – X-ray	\$20 Copay	\$35 Copay	\$40 Copay
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$100 Copay	\$100 Copay	\$100 Copay
Chiropractic Services (20 visits per calendar year)	\$20 Copay	\$35 Copay	\$40 Copay
Outpatient Physical, Occupational, Speech Therapy (Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment.)	\$20 Copay	\$35 Copay	\$40 Copay
Durable Medical Equipment (\$2,500 Calendar Year Maximum.)	50%	50%	50%
Inpatient Hospital	\$0 Copay per admission	\$250 Copay per admission	\$250 Copay per day, 5 day copay maximum per admission
Outpatient Surgery	\$0 Copay	\$100 Copay	\$100 Copay
Emergency Room (Copay waived if admitted.)	\$100 Copay	\$100 Copay	\$100 Copay
Urgent Care	\$20 Copay	\$35 Copay	\$40 Copay
Mental Health – Inpatient (Max. of 60 days per calendar year)	\$0 Copay per admission	\$250 Copay per admission	\$250 Copay per day, 5 day copay maximum
Substance Abuse – Inpatient (Detox: Max of 12 days per calendar year; Rehab: Max of 60 days per calendar year)	\$0 Copay per admission	\$250 Copay per admission	\$250 Copay per day, 5 day copay maximum per admission
Routine Eye Exam (Age and frequency schedules apply.)	\$20 Copay	\$35 Copay	\$40 Copay
Aetna Vision SM Discounts Program	Included	Included	Included
PRESCRIPTION DRUGS			
Prescription Drug – Calendar Year Out-of-Pocket Maximum*	\$3,000 per member \$6,000 family	\$3,000 per member \$6,000 family	\$3,000 per member \$6,000 family
Prescription Drug – Retail: 30-day supply	\$10/\$20/\$30	\$15/\$35/\$50	\$20/\$40/\$60
Prescription Drug – Mail Order: 31-90 day supply	\$20/\$40/\$60	\$30/\$70/\$100	\$40/\$80/\$120
Calendar Year Deductible – Prescription Drugs	N/A	N/A	N/A
Contraceptives and Diabetic Supplies	Included	Included	Included
Self-Injectables (Excluding Insulin) Up to 90-day supply	20%	20%	20%

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

*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 pharmacy out-of-pocket maximum can be met in the same way for covered prescription drugs, including self-injectables.

**“No Referral” Provision: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefits 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 precertify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 11–12. Please refer to Aetna’s Producer World® website at 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	DC POS 1.2 NO-REFERRAL ^{***}		DC POS 2.2 NO-REFERRAL ^{***}	
	In-Network No Referral Needed	Out-of-Network ^{***} No Referral Needed	In-Network No Referral Needed	Out-of-Network ^{***} No Referral Needed
MEMBER BENEFITS				
Member Coinsurance	N/A	30% after deductible	N/A	30% after deductible
Calendar Year Deductible*	N/A	\$500 per member \$1,000 family	N/A	\$750 per member \$1,500 family
Calendar Year Out-of-Pocket Maximum* (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	\$2,000 per member \$4,000 family	\$1,500 per member \$3,000 family	\$3,000 per member \$6,000 family
Lifetime Maximum Benefit	Unlimited	\$2,000,000	Unlimited	\$2,000,000
Well-Baby/Child and Adult Physical Exams (Age and frequency schedules apply. In-network and out-of-network combined.)	\$10 Copay	30% after deductible	\$20 Copay	30% after deductible
Routine GYN Exams (Limited to one exam and Pap smear per 365 days. In-network and out-of-network combined.)	\$20 Copay	0%; deductible waived	\$40 Copay	0%; deductible waived
Routine Mammograms (Limited to one mammogram per calendar year. In-network and out-of-network combined.)	\$0 Copay	0%; deductible waived	\$0 Copay	0%; deductible waived
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, Speech Therapy (Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment. 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	\$100 Copay	\$100 Copay, plus 30% after deductible	\$100 Copay	\$100 Copay, plus 30% after deductible
Emergency Room (Copay waived if admitted.)	\$100 Copay	\$100 Copay	\$100 Copay	\$100 Copay
Urgent Care	\$20 Copay	30% after deductible	\$40 Copay	30% after deductible
Mental Health – Inpatient (Max. of 60 days per calendar year. 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 (Detox: Max of 12 days per calendar year; Rehab: Max of 60 days per calendar year. 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 schedules apply.)	\$20 Copay	Not Covered	\$40 Copay	Not Covered
Aetna Vision SM Discounts Program	Included	Not Covered	Included	Not Covered
PRESCRIPTION DRUGS				
Prescription Drug – Calendar Year Out-of-Pocket Maximum*	\$3,000 per member \$6,000 family	Not Covered	\$3,000 per member \$6,000 family	Not Covered
Prescription Drug – Retail: 30-day supply	\$10/\$20/\$30	Not Covered	\$20/\$40/\$60	Not Covered
Prescription Drug – Mail Order: 31-90 day supply	\$20/\$40/\$60	Not Covered	\$40/\$80/\$120	Not Covered
Calendar Year Deductible – Prescription Drugs	N/A	N/A	N/A	N/A
Contraceptives and Diabetic Supplies	Included	Not Covered	Included	Not Covered
Self-Injectables (Excluding Insulin) Up to 90-day supply	20%	Not Covered	20%	Not Covered

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

*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. 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 pharmacy out-of-pocket maximum can be met in the same way for covered prescription drugs, including self-injectables.

**“No Referral” Provision: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefits 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.

***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 precertify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 11–12. Please refer to Aetna’s Producer World® website at 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	DC PPO 1.2 ⁺		DC PPO 2.2 ⁺	
MEMBER BENEFITS	In-Network No Referral Needed	Out-of-Network** No Referral Needed	In-Network No Referral Needed	Out-of-Network** No Referral Needed
Member Coinsurance	N/A	30% after deductible	N/A	30% after deductible
Calendar Year Deductible*	N/A	\$500 per member \$1,000 family	N/A	\$750 per member \$1,500 family
Calendar Year Out-of-Pocket Maximum* (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	\$2,000 per member \$4,000 family	\$1,000 per member \$2,000 family	\$2,000 per member \$4,000 family
Lifetime Maximum Benefit	Unlimited	\$2,000,000	Unlimited	\$2,000,000
Well-Baby/Child and Adult Physical Exams (Age and frequency schedules apply. In-network and out-of-network combined.)	\$10 Copay	30% after deductible	\$15 Copay	30% after deductible
Routine GYN Exams (Limited to one exam and Pap smear per calendar year. In-network and out-of-network combined.)	\$0 Copay	0%; deductible waived	\$0 Copay	0%; deductible waived
Routine Mammograms (Limited to one mammogram per calendar year. In-network and out-of-network combined.)	\$0 Copay	0%; deductible waived	\$0 Copay	0%; deductible waived
Primary Physician Office Visit	\$10 Copay	30% after deductible	\$15 Copay	30% after deductible
Specialist Office Visit	\$20 Copay	30% after deductible	\$35 Copay	30% after deductible
Outpatient Services – Lab	\$20 Copay	30% after deductible	\$35 Copay	30% after deductible
Outpatient Services – X-ray	\$20 Copay	30% after deductible	\$35 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	\$35 Copay	30% after deductible
Outpatient Physical, Occupational, Speech Therapy (Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment. In-network and out-of-network combined.)	\$20 Copay	30% after deductible	\$35 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	\$0 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	\$0 Copay	30% after deductible	\$100 Copay	\$100 Copay, plus 30% after deductible
Emergency Room (Copay waived if admitted.)	\$100 Copay	\$100 Copay	\$100 Copay	\$100 Copay
Urgent Care	\$20 Copay	30% after deductible	\$35 Copay	30% after deductible
Mental Health – Inpatient (Max. of 60 days per calendar year. In-network and out-of-network combined.)	\$0 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 (Detox: Max of 12 days per calendar year; Rehab: Max of 60 days per calendar year. In-network and out-of-network combined.)	\$0 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 (One exam per 24 months. In-network and out-of-network combined.)	\$20 Copay	30% after deductible	\$35 Copay	30% after deductible
Aetna Vision SM Discounts Program	Included	Not Covered	Included	Not Covered
PRESCRIPTION DRUGS				
Prescription Drug – Calendar Year Out-of-Pocket Maximum*	\$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 Drug – Retail: 30-day supply	\$10/\$20/\$30	\$10/\$20/\$30 plus 20%	\$15/\$35/\$50	\$15/\$35/\$50 plus 20%
Prescription Drug – Mail Order: 31-90 day supply	\$20/\$40/\$60	Not Covered	\$30/\$70/\$100	Not Covered
Calendar Year Deductible – Prescription Drugs	N/A		N/A	
Contraceptives and Diabetic Supplies	Included	Included	Included	Included
Self-Injectables (Excluding Insulin) Up to 90-day supply	20%	Not Covered	20%	Not Covered

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

*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. 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 pharmacy out-of-pocket maximum can be met in the same way for covered prescription drugs, including self-injectables.

**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 precertify or obtain prior approval for certain services.

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PPO PLAN OPTIONS

Plan Options	DC PPO 3.2+	
MEMBER BENEFITS	In-Network No Referral Needed	Out-of-Network** No Referral Needed
Member Coinsurance	N/A	30% after deductible
Calendar Year Deductible*	N/A	\$1,000 per member \$2,000 family
Calendar Year Out-of-Pocket Maximum* (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	\$3,000 per member \$6,000 family
Lifetime Maximum Benefit	Unlimited	\$2,000,000
Well-Baby/Child and Adult Physical Exams (Age and frequency schedules apply. In-network and out-of-network combined.)	\$20 Copay	30% after deductible
Routine GYN Exams (Limited to one exam and Pap smear per calendar year. In-network and out-of-network combined.)	\$0 Copay	0%; deductible waived
Routine Mammograms (Limited to one mammogram per calendar year. In-network and out-of-network combined.)	\$0 Copay	0%; deductible waived
Primary Physician Office Visit	\$20 Copay	30% after deductible
Specialist Office Visit	\$40 Copay	30% after deductible
Outpatient Services – Lab	\$40 Copay	30% after deductible
Outpatient Services – X-ray	\$40 Copay	30% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$100 Copay	30% after deductible
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	\$40 Copay	30% after deductible
Outpatient Physical, Occupational, Speech Therapy (Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment. In-network and out-of-network combined.)	\$40 Copay	30% after deductible
Durable Medical Equipment (\$2,500 Calendar Year Maximum. In-network and out-of-network combined.)	50%	50% after deductible
Inpatient Hospital	\$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	\$100 Copay	\$100 Copay, plus 30% after deductible
Emergency Room (Copay waived if admitted.)	\$100 Copay	\$100 Copay
Urgent Care	\$40 Copay	30% after deductible
Mental Health – Inpatient (Max. of 60 days per calendar year. In-network and out-of-network combined.)	\$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 (Detox: Max of 12 days per calendar year; Rehab: Max of 60 days per calendar year. In-network and out-of-network combined.)	\$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 (One exam per 24 months. In-network and out-of-network combined.)	\$40 Copay	30% after deductible
Aetna Vision SM Discounts Program	Included	Not Covered
PRESCRIPTION DRUGS		
Prescription Drug – Calendar Year Out-of-Pocket Maximum*	\$3,000 per member/\$6,000 family In-network and out-of-network combined	
Prescription Drug – Retail: 30-day supply	\$20/\$40/\$60	\$20/\$40/\$60 plus 20%
Prescription Drug – Mail Order: 31-90 day supply	\$40/\$80/\$120	Not Covered
Calendar Year Deductible – Prescription Drugs	N/A	
Contraceptives and Diabetic Supplies	Included	Included
Self-Injectables (Excluding Insulin) Up to 90-day supply	20%	Not Covered

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

*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. 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 pharmacy out-of-pocket maximum can be met in the same way for covered prescription drugs, including self-injectables.

**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 precertify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 11–12. Please refer to Aetna's Producer World® website at 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 HSA-COMPATIBLE OPTIONS

Plan Options	DC HMO HSA-COMPATIBLE NO-REFERRAL PLAN 1.2 ^{+,**}	DC HMO HSA-COMPATIBLE NO-REFERRAL PLAN 2.2 ^{+,**}	DC HMO HSA-COMPATIBLE NO-REFERRAL PLAN 3.2 ^{+,**}
MEMBER BENEFITS	In-Network No Referral Needed	In-Network No Referral Needed	In-Network No Referral Needed
Member Coinsurance	0% after deductible	0% after deductible	0% after deductible
Calendar Year Deductible – Medical and Prescription Drugs* (All covered prescription drug and medical expenses, except in-network preventive care services, apply to the deductible.)	\$1,200 individual \$2,400 family	\$2,000 individual \$4,000 family	\$2,000 individual \$4,000 family
Calendar Year Out-of-Pocket Maximum* (All amounts paid as deductible, copayments, or coinsurance for covered services and supplies apply toward the Out-of-Pocket Maximum.)	\$2,400 individual \$4,800 family	\$4,000 individual \$8,000 family	\$4,000 individual \$8,000 family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Well-Baby/Child and Adult Physical Exams (Age and frequency schedules apply.)	0%; deductible waived	0%; deductible waived	0%; deductible waived
Routine GYN Exams (Limited to one exam and Pap smear per 365 days.)	0%; deductible waived	0%; deductible waived	0%; deductible waived
Routine Mammograms (Limited to one mammogram per calendar year)	0%; deductible waived	0%; deductible waived	0%; deductible waived
Primary Physician Office Visit	0% after deductible	0% after deductible	\$20 Copay after deductible
Specialist Office Visit	0% after deductible	0% after deductible	\$30 Copay after deductible
Outpatient Services – Lab	0% after deductible	0% after deductible	0% after deductible
Outpatient Services – X-ray	0% after deductible	0% after deductible	\$30 Copay after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	0% after deductible	0% after deductible	\$100 Copay after deductible
Chiropractic Services (20 visits per calendar year)	0% after deductible	0% after deductible	\$30 Copay after deductible
Outpatient Physical, Occupational, Speech Therapy (Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment.)	0% after deductible	0% after deductible	\$30 Copay after deductible
Durable Medical Equipment (\$2,500 Calendar Year Maximum.)	0% after deductible	0% after deductible	0% after deductible
Inpatient Hospital	0% after deductible	0% after deductible	\$250 Copay per admission after deductible
Outpatient Surgery	0% after deductible	0% after deductible	\$100 Copay after deductible
Emergency Room (Copay waived if admitted.)	0% after deductible	0% after deductible	\$100 Copay after deductible
Urgent Care	0% after deductible	0% after deductible	\$30 Copay after deductible
Mental Health – Inpatient (Max. of 60 days per calendar year)	0% after deductible	0% after deductible	\$250 Copay per admission after deductible
Substance Abuse – Inpatient (Detox: Max of 12 days per calendar year; Rehab: Max of 60 days per calendar year)	0% after deductible	0% after deductible	\$250 Copay per admission after deductible
Routine Eye Exam (Age and frequency schedules apply.)	0%; deductible waived	0%; deductible waived	\$30 Copay; deductible waived
Aetna Vision SM Discounts Program	Included	Included	Included
PRESCRIPTION DRUGS			
Prescription Drug – Calendar Year Out-of-Pocket Maximum*	Integrated medical/pharmacy out-of-pocket maximum	Integrated medical/pharmacy out-of-pocket maximum	Integrated medical/pharmacy out-of-pocket maximum
Prescription Drug – Retail: 30-day supply	\$10/\$15/\$30 after integrated deductible	\$10/\$15/\$30 after integrated deductible	\$10/\$15/\$30 after integrated deductible
Prescription Drug – Mail Order: 31-90 day supply	\$20/\$30/\$60 after integrated deductible	\$20/\$30/\$60 after integrated deductible	\$20/\$30/\$60 after integrated deductible
Calendar Year Deductible – Prescription Drugs*	Integrated medical/pharmacy deductible	Integrated medical/pharmacy deductible	Integrated medical/pharmacy deductible
Contraceptives and Diabetic Supplies	Included	Included	Included
Self-Injectables (Excluding Insulin) Up to 90-day supply	20% after integrated deductible	20% after integrated deductible	20% after integrated deductible

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

*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 calendar year. 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 calendar year.

**"No Referral" Provision: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefits 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 precertify or obtain prior approval for certain services.

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CONSUMER DIRECTED — POS HSA-COMPATIBLE OPTIONS

Plan Options	DC POS HSA-COMPATIBLE NO-REFERRAL PLAN 1.2 ^{+,***}		DC POS HSA-COMPATIBLE NO-REFERRAL PLAN 2.2 ^{+,***}	
	In-Network No Referral Needed	Out-of-Network ^{***} No Referral Needed	In-Network No Referral Needed	Out-of-Network ^{***} No Referral Needed
MEMBER BENEFITS				
Member Coinsurance	0% after deductible	20% after deductible	0% after deductible	20% after deductible
Calendar Year Deductible – Medical and Prescription Drugs* (All covered prescription drug and medical expenses, except in-network and certain out-of-network preventive care services, apply to the deductible.)	\$1,200 individual/\$2,400 family In-network and out-of-network combined		\$1,200 individual/\$2,400 family In-network and out-of-network combined	
Calendar Year Out-of-Pocket Maximum* (All amounts paid as deductible, copayments, or coinsurance for covered services and supplies apply toward the Out-of-Pocket Maximum.)	\$2,400 individual/\$4,800 family In-network and out-of-network combined		\$2,400 individual/\$4,800 family In-network and out-of-network combined	
Lifetime Maximum Benefit	Unlimited	\$2,000,000	Unlimited	\$2,000,000
Well-Baby/Child and Adult Physical Exams (Age and frequency schedules apply. In-network and out-of-network combined.)	0%; deductible waived	20% after deductible	0%; deductible waived	20% after deductible
Routine GYN Exams (Limited to one exam and Pap smear per 365 days. In-network and out-of-network combined.)	0%; deductible waived	0%; deductible waived	0%; deductible waived	0%; deductible waived
Routine Mammograms (Limited to one mammogram per calendar year. In-network and out-of-network combined.)	0%; deductible waived	0%; deductible waived	0%; deductible waived	0%; deductible waived
Primary Physician Office Visit	0% after deductible	20% after deductible	\$20 Copay after deductible	20% after deductible
Specialist Office Visit	0% after deductible	20% after deductible	\$30 Copay after deductible	20% after deductible
Outpatient Services – Lab	0% after deductible	20% after deductible	0% after deductible	20% after deductible
Outpatient Services – X-ray	0% after deductible	20% after deductible	\$30 Copay after deductible	20% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	0% after deductible	20% after deductible	\$100 Copay after deductible	20% after deductible
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	0% after deductible	20% after deductible	\$30 Copay after deductible	20% after deductible
Outpatient Physical, Occupational, Speech Therapy (Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment. In-network and out-of-network combined.)	0% after deductible	20% after deductible	\$30 Copay after deductible	20% after deductible
Durable Medical Equipment (\$2,500 Calendar Year Maximum. In-network and out-of-network combined.)	0% after deductible	20% after deductible	0% after deductible	20% after deductible
Inpatient Hospital	0% after deductible	20% after deductible	\$250 Copay per admission after deductible	20% after deductible
Outpatient Surgery	0% after deductible	20% after deductible	\$100 Copay after deductible	20% after deductible
Emergency Room (Copay waived if admitted.)	0% after deductible	0% after deductible	\$100 Copay after deductible	\$100 Copay after deductible
Urgent Care	0% after deductible	20% after deductible	\$30 Copay after deductible	20% after deductible
Mental Health – Inpatient (Max. of 60 days per calendar year. In-network and out-of-network combined.)	0% after deductible	20% after deductible	\$250 Copay per admission after deductible	20% after deductible
Substance Abuse – Inpatient (Detox: Max of 12 days per calendar year; Rehab: Max of 60 days per calendar year. In-network and out-of-network combined.)	0% after deductible	20% after deductible	\$250 Copay per admission after deductible	20% after deductible
Routine Eye Exam (Age and frequency schedules apply.)	0%; deductible waived	Not Covered	\$30 Copay; deductible waived	Not Covered
Aetna VisionSM Discounts Program	Included	Not Covered	Included	Not Covered
PRESCRIPTION DRUGS				
Prescription Drug – Calendar Year Out-of-Pocket Maximum*	Integrated medical/pharmacy out-of-pocket maximum	Not Covered	Integrated medical/pharmacy out-of-pocket maximum	Not Covered
Prescription Drug – Retail: 30-day supply	\$10/\$15/\$30 after integrated deductible	Not Covered	\$10/\$15/\$30 after integrated deductible	Not Covered
Prescription Drug – Mail Order: 31-90 day supply	\$20/\$30/\$60 after integrated deductible	Not Covered	\$20/\$30/\$60 after integrated deductible	Not Covered
Calendar Year Deductible – Prescription Drugs*	Integrated medical/pharmacy deductible	Not Covered	Integrated medical/pharmacy deductible	Not Covered
Contraceptives and Diabetic Supplies	Included	Not Covered	Included	Not Covered
Self-Injectables (Excluding Insulin) Up to 90-day supply	20% after integrated deductible	Not Covered	20% after integrated deductible	Not Covered

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

*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 calendar year. 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 calendar year.

***No Referral Provision: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefits 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.

***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 precertify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 11–12. Please refer to Aetna's Producer World® website at 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 OPTIONS

Plan Options	DC PPO HSA-COMPATIBLE PLAN 1.2 ⁺		DC PPO HSA-COMPATIBLE PLAN 2.2 ⁺	
	In-Network No Referral Needed	Out-of-Network** No Referral Needed	In-Network No Referral Needed	Out-of-Network** No Referral Needed
Member Coinsurance	0% after deductible	20% after deductible	10% after deductible	30% after deductible
Calendar Year Deductible - Medical and Prescription Drugs* (All covered prescription drug and medical expenses, except in-network and certain out-of-network preventive care services, apply to the deductible.)	\$1,200 individual/\$2,400 family In-network and out-of-network combined		\$2,000 individual/\$4,000 family In-network and out-of-network combined	
Calendar Year Out-of-Pocket Maximum* (All amounts paid as deductible, copayments, or coinsurance for covered services and supplies apply toward the Out-of-Pocket Maximum.)	\$2,400 individual/\$4,800 family In-network and out-of-network combined		\$4,000 individual/\$8,000 family In-network and out-of-network combined	
Lifetime Maximum Benefit	Unlimited	\$2,000,000	Unlimited	\$2,000,000
Well-Baby/Child and Adult Physical Exams (Age and frequency schedules apply. In-network and out-of-network combined.)	0%; deductible waived	20% after deductible	0%; deductible waived	30% after deductible
Routine GYN Exams (Limited to one exam and Pap smear per calendar year. In-network and out-of-network combined.)	0%; deductible waived	0%; deductible waived	0%; deductible waived	0%; deductible waived
Routine Mammograms (Limited to one mammogram per calendar year. In-network and out-of-network combined.)	0%; deductible waived	0%; deductible waived	0%; deductible waived	0%; deductible waived
Primary Physician Office Visit	\$20 Copay after deductible	20% after deductible	10% after deductible	30% after deductible
Specialist Office Visit	\$30 Copay after deductible	20% after deductible	10% after deductible	30% after deductible
Outpatient Services – Lab	0% after deductible	20% after deductible	10% after deductible	30% after deductible
Outpatient Services – X-ray	0% after deductible	20% after deductible	10% after deductible	30% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$100 Copay after deductible	\$100 Copay plus 20% after deductible	10% after deductible	30% after deductible
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	\$30 Copay after deductible	20% after deductible	10% after deductible	30% after deductible
Outpatient Physical, Occupational, Speech Therapy (Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment. In-network and out-of-network combined.)	\$30 Copay after deductible	20% after deductible	10% after deductible	30% 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	\$250 Copay per admission after deductible	\$250 Copay per admission plus 20% after deductible	10% after deductible	30% after deductible
Outpatient Surgery	\$100 Copay after deductible	\$100 Copay plus 20% after deductible	10% after deductible	30% after deductible
Emergency Room (Copay waived if admitted.)	\$100 Copay after deductible	\$100 Copay after deductible	10% after deductible	10% after deductible
Urgent Care	\$30 Copay after deductible	20% after deductible	10% after deductible	30% after deductible
Mental Health – Inpatient (Max. of 60 days per calendar year. In-network and out-of-network combined.)	\$250 Copay per admission after deductible	\$250 Copay per admission plus 20% after deductible	10% after deductible	30% after deductible
Substance Abuse – Inpatient (Detox: Max of 12 days per calendar year; Rehab: Max of 60 days per calendar year. In-network and out-of-network combined.)	\$250 Copay per admission after deductible	\$250 Copay per admission plus 20% after deductible	10% after deductible	30% after deductible
Routine Eye Exam (One exam per 24 months. In-network and out-of-network combined.)	0%; deductible waived	20% after deductible	0%; deductible waived	30% after deductible
Aetna Vision SM Discounts Program	Included	Not Covered	Included	Not Covered
PRESCRIPTION DRUGS				
Prescription Drug – Calendar Year Out-of-Pocket Maximum*	Integrated medical/pharmacy out-of-pocket maximum		Integrated medical/pharmacy out-of-pocket maximum	
Prescription Drug – Retail: 30-day supply	\$10/\$20/\$30 after integrated deductible	\$10/\$20/\$30 plus 20% after integrated deductible	\$10/\$20/\$30 after integrated deductible	\$10/\$20/\$30 plus 20% after integrated deductible
Prescription Drug – Mail Order: 31-90 day supply	\$20/\$40/\$60 after integrated deductible	Not Covered	\$20/\$40/\$60 after integrated deductible	Not Covered
Calendar Year Deductible – Prescription Drugs*	Integrated medical/pharmacy deductible		Integrated medical/pharmacy deductible	
Contraceptives and Diabetic Supplies	Included	Included	Included	Included
Self-Injectables (Excluding Insulin) Up to 90-day supply	20% after integrated deductible	Not Covered	20% after integrated deductible	Not Covered

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

*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 calendar year. 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 calendar year.

**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 precertify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 11–12. Please refer to Aetna's Producer World® website at 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 OPTIONS

Plan Options	DC PPO HSA-COMPATIBLE PLAN 3.2+	
MEMBER BENEFITS	In-Network No Referral Needed	Out-of-Network** No Referral Needed
Member Coinsurance	20% after deductible	40% after deductible
Calendar Year Deductible - Medical and Prescription Drugs* (All covered prescription drug and medical expenses, except in-network and certain out-of-network preventive care services, apply to the deductible.)	\$1,500 individual/\$3,000 family In-network and out-of-network combined	
Calendar Year Out-of-Pocket Maximum* (All amounts paid as deductible, copayments, or 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	
Lifetime Maximum Benefit	Unlimited	\$2,000,000
Well-Baby/Child and Adult Physical Exams (Age and frequency schedules apply. In-network and out-of-network combined.)	0%; deductible waived	40% after deductible
Routine GYN Exams (Limited to one exam and Pap smear per calendar year. In-network and out-of-network combined.)	0%; deductible waived	0%; deductible waived
Routine Mammograms (Limited to one mammogram per calendar year. In-network and out-of-network combined.)	0%; deductible waived	0%; deductible waived
Primary Physician Office Visit	20% after deductible	40% after deductible
Specialist Office Visit	20% after deductible	40% after deductible
Outpatient Services – Lab	20% after deductible	40% after deductible
Outpatient Services – X-ray	20% after deductible	40% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	20% after deductible	40% after deductible
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	20% after deductible	40% after deductible
Outpatient Physical, Occupational, Speech Therapy (Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment. In-network and out-of-network combined.)	20% after deductible	40% after deductible
Durable Medical Equipment (\$2,500 Calendar Year Maximum. In-network and out-of-network combined.)	50% after deductible	50% after deductible
Inpatient Hospital	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
Emergency Room	20% after deductible	20% after deductible
Urgent Care	20% after deductible	40% after deductible
Mental Health – Inpatient (Max. of 60 days per calendar year. In-network and out-of-network combined.)	20% after deductible	40% after deductible
Substance Abuse – Inpatient (Detox: Max of 12 days per calendar year; Rehab: Max of 60 days per calendar year. In-network and out-of-network combined.)	20% after deductible	40% after deductible
Routine Eye Exam (One exam per 24 months. In-network and out-of-network combined.)	0%; deductible waived	40% after deductible
Aetna Vision SM Discounts Program	Included	Not Covered
PRESCRIPTION DRUGS		
Prescription Drug – Calendar Year Out-of-Pocket Maximum*	Integrated medical/pharmacy out-of-pocket maximum	
Prescription Drug – Retail: 30-day supply	20% after integrated deductible	40% after integrated deductible
Prescription Drug – Mail Order: 31-90 day supply	20% after integrated deductible	Not Covered
Calendar Year Deductible – Prescription Drugs*	Integrated medical/pharmacy deductible	
Contraceptives and Diabetic Supplies	Included	Included
Self-Injectables (Excluding Insulin) Up to 90-day supply	20% after integrated deductible	Not Covered

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

*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 calendar year. 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 calendar year.

**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 precertify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 11–12. Please refer to Aetna's Producer World® website at 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 AHF HRA

Plan Options	DC HEALTH NETWORK OPTION AHF HRA 1.2+***	
MEMBER BENEFITS	In-Network No Referral Needed	Out-of-Network*** 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*	\$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 OB/GYN, out-of-network mammography and prescription drug benefits, including self-injectables, apply to the deductible.	
Plan Year Out-of-Pocket Maximum*	\$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 and Adult Physical Exams (Age and frequency schedules apply. In-network and out-of-network combined.)	0%; deductible waived	20% after deductible
Routine GYN Exams (Limited to one exam and Pap smear per 365 days. In-network and out-of-network combined.)	0%; deductible waived	0%; deductible waived
Routine Mammograms (Limited to one mammogram per 365 days. In-network and out-of-network combined.)	0%; deductible waived	0%; deductible waived
Primary Physician Office Visit	\$20 Copay after deductible	20% after deductible
Specialist Office Visit	\$30 Copay after deductible	20% after deductible
Outpatient Services – Lab	0% after deductible	20% after deductible
Outpatient Services – X-ray	0% after deductible	20% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$100 Copay after deductible	\$100 Copay plus 20% after deductible
Chiropractic Services (20 visits per plan year. In-network and out-of-network combined.)	\$30 Copay after deductible	20% after deductible
Outpatient Physical, Occupational, Speech Therapy (Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment. In-network and out-of-network combined.)	\$30 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	\$30 Copay after deductible	20% after deductible
Mental Health – Inpatient (Max. of 60 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 (Detox: Max of 12 days per plan year; Rehab: Max of 60 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
Routine Eye Exam (One exam per 24 months. In-network and out-of-network combined.)	0%; deductible waived	20% after deductible
Aetna Vision SM Discounts Program	Included	Not Covered
PRESCRIPTION DRUGS		
Prescription Drug – Plan Year Out-of-Pocket Maximum*	N/A	
Prescription Drug – Retail: 30-day supply	\$15/\$35/\$50	Not Covered
Prescription Drug – Mail Order: 31-90 day supply	\$30/\$70/\$100	Not Covered
Plan Year Deductible – Prescription Drugs*	N/A	
Contraceptives and Diabetic Supplies	Included	Not Covered
Self-Injectables (Excluding Insulin) Up to 90-day supply	20%	Not Covered

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

*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. 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.

***"No Referral" Provision: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefits 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.

***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 precertify or obtain prior approval for certain services.

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CONSUMER DIRECTED — HMO AND PPO COST-SHARING PLANS

Plan Options	DC HMO COST SHARING NO-REFERRAL PLAN 1.2 ^{***}	DC PPO COST SHARING NO-REFERRAL PLAN 1.2 [*]	
MEMBER BENEFITS	In-Network No Referral Needed	In-Network No Referral Needed	Out-of-Network ^{***} No Referral Needed
Member Coinsurance	N/A	N/A	20% after deductible
Calendar Year Deductible*	\$1,200 per member \$2,400 family	\$1,200 per member \$2,400 family	\$1,200 per member \$2,400 family
Calendar Year Out-of-Pocket Maximum* (Deductible applies to the Out-of-Pocket Maximum. Prescription drugs, including self-injectables, do not apply toward the Out-of-Pocket Maximum.)	\$2,400 per member \$4,800 family	\$2,400 per member \$4,800 family	\$2,400 per member \$4,800 family
Lifetime Maximum Benefit	Unlimited	Unlimited	\$2,000,000
Well-Baby/Child and Adult Physical Exams (Age and frequency schedules apply.)	\$20 Copay; deductible waived	\$0 Copay; deductible waived	20% after deductible
Routine GYN Exams (HMO Cost-Sharing: Limited to one exam and Pap smear per 365 days. PPO Cost-Sharing: Limited to one exam and Pap smear per calendar year. In-network and out-of-network combined.)	\$30 Copay; deductible waived	\$0 Copay; deductible waived	0%; deductible waived
Routine Mammograms (Limited to one mammogram per calendar year. In-network and out-of-network combined.)	\$0 Copay; deductible waived	\$0 Copay; deductible waived	0%; deductible waived
Primary Physician Office Visit	\$20 Copay after deductible	\$20 Copay after deductible	20% after deductible
Specialist Office Visit	\$30 Copay after deductible	\$30 Copay after deductible	20% after deductible
Outpatient Services – Lab	\$0 Copay; deductible waived	\$0 Copay after deductible	20% after deductible
Outpatient Services – X-ray	\$30 Copay after deductible	\$0 Copay after deductible	20% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$100 Copay after deductible	\$100 Copay after deductible	\$100 Copay plus 20% after deductible
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	\$30 Copay after deductible	\$30 Copay after deductible	20% after deductible
Outpatient Physical, Occupational, Speech Therapy (Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment. In-network and out-of-network combined.)	\$30 Copay after deductible	\$30 Copay after deductible	20% 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
Inpatient Hospital	\$300 Copay per admission after deductible	\$300 Copay per admission after deductible	\$300 Copay per admission, plus 20% after deductible
Outpatient Surgery	\$100 Copay after deductible	\$100 Copay after deductible	\$100 Copay, plus 20% after deductible
Emergency Room (Copay waived if admitted.)	\$100 Copay after deductible	\$100 Copay after deductible	\$100 Copay after deductible
Urgent Care	\$30 Copay after deductible	\$30 Copay after deductible	20% after deductible
Mental Health – Inpatient (Max. of 60 days per calendar year In-network and out-of-network combined.)	\$300 Copay per admission after deductible	\$300 Copay per admission after deductible	\$300 Copay per admission, plus 20% after deductible
Substance Abuse – Inpatient (Detox: Max of 12 days per calendar year; Rehab: Max of 60 days per calendar year. In-network and out-of-network combined.)	\$300 Copay per admission after deductible	\$300 Copay per admission after deductible	\$300 Copay per admission, plus 20% after deductible
Routine Eye Exam (Age and frequency schedules apply.)	\$30 Copay; deductible waived	0%; deductible waived	20% after deductible
Aetna Vision SM Discounts Program	Included	Included	Not Covered
PRESCRIPTION DRUGS			
Prescription Drug – Calendar Year Out-of-Pocket Maximum*	\$3,000 per member \$6,000 family	\$3,000 per member/\$6,000 family In-network and out-of-network combined	
Prescription Drug – Retail: 30-day supply	\$15/\$35/\$50	\$15/\$35/\$50	\$15/\$35/\$50 plus 20%
Prescription Drug – Mail Order: 31-90 day supply	\$30/\$70/\$100	\$30/\$70/\$100	Not Covered
Calendar Year Deductible – Prescription Drugs*	N/A	N/A	
Contraceptives and Diabetic Supplies	Included	Included	Included
Self-Injectables (Excluding Insulin) Up to 90-day supply	20%	20%	Not Covered

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

*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. 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 pharmacy out-of-pocket maximum can be met in the same way for covered prescription drugs, including self-injectables.

**“No Referral” Provision: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefits 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.

***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 precertify or obtain prior approval for certain services.

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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.
- Nonmedically 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.
- 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 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.

- Nonmedically 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.
- Treatment of those services for or related to treatment of obesity or for diet or weight control.

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.

Notes

Notes

**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.**

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits vary by location. 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.

Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group. In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

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.

Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to www.aetna.com.