

PLAN DESIGN AND BENEFITS - MD HMO PLAN 1.3

PLAN FEATURES	PARTICIPATING PROVIDERS
Deductible (per plan year)	Not Applicable
Member Coinsurance	Not Applicable
Out-of-Pocket Maximum - Medical (per plan year)	\$2,000 Individual \$4,000 Family
Once the Family Medical Out-of-Pocket Maximum is met, all family members will be considered as having met their Medical Out-of-Pocket Maximum for the remainder of the plan year. No one family member may contribute more than the individual Medical Out-of-Pocket Maximum amount to the family Medical Out-of-Pocket Maximum.	
Lifetime Maximum	Unlimited
Primary Care Physician Selection	Recommended. Until a primary care physician is selected, benefits will be limited to coverage for Emergency Services.
Referral Requirement	Required for all non-emergency, non-urgent and non-Primary Care Physician services, except direct access services.
PHYSICIAN SERVICES	PARTICIPATING PROVIDERS
Primary Care Physician Visits	\$25 Copay
Specialist Office Visits (Includes newborn hearing screening, which is limited to one screening and one confirming screening for newborns.)	\$40 Copay
Maternity / OB Visits	\$25 Copay for initial visit only
Allergy Treatment by Primary Care Physician	Applicable office visit copay
Allergy Testing by Specialist Physician	\$40 Copay
PREVENTIVE CARE	PARTICIPATING PROVIDERS
Routine Adult Physical Exams / Immunizations (Limited to one exam per plan year.)	\$0 Copay
Well Child Exams / Immunizations (Limited to Children ages 0 - 13. Age and frequency schedules may apply.)	\$0 Copay
Routine Gynecological Exams (Includes Pap smear and related lab fees. Limited to one routine exam and pap smear every 365 days.)	\$0 Copay
Routine Mammograms (No age or frequency limits.)	\$0 Copay
Routine Digital Rectal Exams / Prostate Specific Antigen Test (For covered males age 40 and over. Age and frequency schedules may apply.)	Member cost sharing is based on the type of service performed and the place rendered
Colorectal Cancer Screening (For all members age 50 and over. Frequency schedule applies.)	Member cost sharing is based on the type of service performed and the place rendered
Routine Eye Exams at Specialist (Limited to one routine exam per 24 months.)	\$0 Copay
Routine Hearing Screening at PCP	Covered as part of a routine physical exam

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DIAGNOSTIC PROCEDURES		PARTICIPATING PROVIDERS
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.)		\$0 Copay
Diagnostic X-ray - Outpatient hospital or other outpatient facility		\$40 Copay or 50% of the cost of the service, whichever is less
EMERGENCY / URGENT MEDICAL CARE		PARTICIPATING PROVIDERS
Urgent Care Provider		\$40 Copay
Emergency Room (Copay waived if admitted.)		\$100 Copay
Ambulance		\$0 Copay
HOSPITAL CARE		PARTICIPATING PROVIDERS
Inpatient Coverage (Including maternity & transplants.)		\$150 Copay per day, 5 day copay maximum per admission
Outpatient Surgery - Provided in an outpatient hospital department or a freestanding surgical facility		\$40 Copay
MENTAL HEALTH SERVICES		PARTICIPATING PROVIDERS
Inpatient (Limited to 60 days per member per plan year, combined with Inpatient Drug and/or Alcohol Rehabilitation.)		\$150 Copay per day, 5 day copay maximum per admission
Outpatient (Office visits for medication management reimbursed as physical illness.)		30%
ALCOHOL / DRUG ABUSE SERVICES		PARTICIPATING PROVIDERS
Inpatient Detoxification		\$150 Copay per day, 5 day copay maximum per admission
Outpatient Detoxification (Office visits for medication management reimbursed as physical illness.)		30%
Inpatient Rehabilitation (Limited to 60 days per member per plan year, combined with Inpatient Mental Health.)		\$150 Copay per day, 5 day copay maximum per admission
Outpatient Rehabilitation (Office visits for medication management reimbursed as physical illness.)		30%
OTHER SERVICES		PARTICIPATING PROVIDERS
Skilled Nursing Facility (Limited to 100 days per member per plan year.)		\$40 Copay per day
Home Health Care		\$40 Copay per visit
Inpatient Hospice Care		\$150 Copay per day, 5 day copay maximum per admission
Outpatient Hospice Care		\$40 Copay per visit

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OTHER SERVICES (CONTINUED)	PARTICIPATING PROVIDERS
Outpatient Rehabilitation Therapy (Includes speech, physical and occupational therapy. Limited to 30 visits per therapy per condition per plan year.)	\$40 Copay per visit
Chiropractic Care (Subluxation) (Limited to 20 visits per condition per plan year.)	\$40 Copay per visit
Durable Medical Equipment	\$0 Copay
Hearing Aids (Limited to Children ages 0 to 18. \$1,400 benefit maximum per hearing aid per hearing-impaired ear every 36 months.)	\$0 Copay
FAMILY PLANNING	PARTICIPATING PROVIDERS
Infertility Treatment (Limited to diagnosis and treatment for certain covered infertility services, excluding ovum transplants, IVF, GIFT, ZIFT, cryogenic or other preservation techniques or other similar procedures.)	50%
Voluntary Sterilization (Including tubal ligation and vasectomy.)	Member cost sharing is based on the type of service performed and the place rendered
PHARMACY - PRESCRIPTION DRUG BENEFITS	PARTICIPATING PHARMACIES
Plan Year Deductible - Prescription Drug	Not Applicable
Plan Year Out-of-Pocket Maximum - Prescription Drug	Not Applicable
Prescription Drugs: 30-day supply	\$10 Copay for generic drugs, \$25 Copay for preferred brand-name drugs, and \$50 Copay for non-preferred brand-name drugs
Maintenance Prescription Drugs: 90-day supply	\$20 Copay for generic drugs, \$50 Copay for preferred brand-name drugs, and \$100 Copay for non-preferred brand-name drugs
Self-Injectables (Excluding Insulin): 30-day supply	\$200 Copay
Self-Injectables (Excluding Insulin): 90-day supply	\$400 Copay
No Mandatory Generic (No MG) - Member is responsible to pay the applicable copay.	
Plan includes: Diabetic supplies, contraceptive drugs and devices obtainable from a pharmacy.	
Pre-certification included.	

What's Not Covered

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. Some benefits listed as excluded may be available on an optional basis to the contract-holder and may be covered when purchased in addition to the medical plan by the contract-holder. Check with your employer for information on additional coverages.

Services and supplies that are generally not covered include, but are not limited to:

- (1) Surgery or related services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies;
- (2) Private duty nursing, unless authorized by the plan;
- (3) Personal Care services and Domiciliary Care services not stated herein;
- (4) Non-replacement fees for blood and blood products;

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- (5) Unless otherwise specified in covered services, dental work or treatment which includes Hospital or professional care in connection with:
- The operation or treatment for the fitting or wearing of dentures,
 - Orthodontic care or malocclusion,
 - Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the treatment is received within 6 months of the accident,
 - Dental implants;
- (6) Experimental services;
- (7) Immunizations related to foreign travel;
- (8) Insulin pumps;
- (9) The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, unless included as a covered benefit;
- (10) Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports, or exams for their prescription or fitting, unless these services are determined to be Medically Necessary;
- (11) Inpatient admissions primarily for physical therapy, unless authorized by the plan;
- (12) Treatment of sexual dysfunction not related to organic disease;
- (13) Services to reverse a voluntary sterilization procedure;
- (14) In vitro fertilization, ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures;
- (15) Practitioner, Hospital, or clinical services related to radial keratotomy, myopic keratomileusis, and surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error;
- (16) Treatment for mental health or substance abuse not authorized by the plan through its managed care system, or a mental health or substance abuse condition determined by the plan through its managed care system to be untreatable;
- (17) Medical or surgical treatment or regimen for reducing or controlling weight;
- (18) Nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy;
- (19) Services that are not Medically Necessary.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Schedule of Benefits, Certificate of Coverage, Evidence of Coverage, Group Agreement, Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. The availability of a plan or program may vary by geographic service area. Some benefits are subject to limitations or visit maximums. Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.

If your plan covers outpatient prescription drugs, your plan may include a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally not limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step-therapy, please refer to Aetna's website at Aetna.com, or the Aetna Medication Formulary Guide.

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Many drugs, including many of those listed on the formulary, are subject to rebate arrangements between Aetna and the manufacturer of the drugs. Rebates received by Aetna from drug manufacturers are not reflected in the cost paid by a member for a prescription drug. In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage.

Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna, Inc., that is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated charge with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services.

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group subsidiary companies.

While this information is believed to be accurate as of the print date, it is subject to change.