



**PLAN DESIGN AND BENEFITS  
 PROVIDED BY AETNA HEALTH INC. - FULL RISK**

<b>PLAN FEATURES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>
<b>Deductible</b> (per calendar year)  Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Member cost sharing for certain services including member cost sharing for prescription drugs as indicated in the plan, are excluded from charges to meet the Deductible. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.	\$1,000 Individual \$2,000 Family
<b>Out-of-Pocket Maximum</b> (per calendar year)  Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. Only those participating providers/referred out of pocket expenses resulting from the application of coinsurance percentage and copays (except any penalty amounts and pharmacy cost sharing) may be used to satisfy the Out-of-Pocket Maximum. Once Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.	\$3,000 Individual \$6,000 Family
<b>Lifetime Maximum</b>	Unlimited unless otherwise indicated.
<b>Primary Care Physician Selection</b>	Required
<b>Referral Requirements</b>	Required for all non-emergency, non-urgent and non-Primary Care Physician services, except direct access services
<b>PREVENTIVE CARE</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>
<b>Routine Adult Physical Exams / Immunizations</b> (Age and frequency schedules apply)	\$40 copay; deductible waived
<b>Well Child Exams / Immunizations</b> (Age and frequency schedules apply)	\$40 copay; deductible waived
<b>Routine Gynecological Care Exams</b> (Coverage includes pap smears and related lab fees for females 18 and older) One exam per calendar year.	\$50 copay; deductible waived
<b>Routine Mammograms</b> One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over	\$50 copay; deductible waived
<b>Routine Digital Rectal Exams / Prostate Specific Antigen Test</b> For males age 40 and over	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
<b>Colorectal Cancer Screening</b> For all members 50 and over. Frequency schedule applies	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
<b>Routine Eye Exam</b> Age/Frequency Schedule may apply. Direct access to participating providers without a referral.	\$50 copay; deductible waived



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<b>Routine Hearing Screening</b>	Subject to Routine Physical Exam cost sharing
<b>PHYSICIAN SERVICES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>
<b>Primary Care Physician Visits</b>	Office Hours: \$40 copay; deductible waived After Office Hours/Home: \$45 copay
<b>Specialist Office Visits</b>	\$50 copay; deductible waived
<b>Maternity OB Visits</b>	\$50 copay for initial visit only, thereafter covered 100%
<b>Allergy Treatment</b>	Same as applicable participating provider office visit member cost sharing
<b>Allergy Testing</b>	Same as applicable participating provider office visit member cost sharing
<b>DIAGNOSTIC PROCEDURES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>
<b>Diagnostic Laboratory</b>	\$50 copay 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.
<b>Diagnostic X-ray</b>	\$50 copay Outpatient hospital or other Outpatient facility (except for Complex Imaging Services)
<b>Diagnostic X-ray for Complex Imaging Services</b>	\$50 copay
<b>EMERGENCY MEDICAL CARE</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>
<b>Urgent Care</b>	\$75 copay
<b>Non-Urgent use of Urgent Care Provider</b>	Not Covered
<b>Emergency Room</b>	\$150 copay; deductible waived
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered
<b>Emergency Use of Ambulance</b>	Covered 100%
<b>Non-Emergency Use of Ambulance</b>	Not Covered
<b>HOSPITAL CARE</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>
<b>Inpatient Coverage</b>	30% per admission The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.
<b>Inpatient Maternity Coverage</b>	30% per admission The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.
<b>Outpatient Surgery</b>	30% per visit The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.
<b>MENTAL HEALTH SERVICES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>
<b>Inpatient Biologically Based Mental Illness</b>	30% per admission The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.
<b>Inpatient Non-Biologically Based Mental Illness</b>	30% per admission Limited to 30 days per calendar year Limit is a combined maximum with Inpatient Non-Biologically Based Rehabilitation benefit. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.
<b>Outpatient Biologically Based Mental Illness</b>	Visits 1-5 Covered 100%; subsequent visits \$50 copay per visit The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.
<b>Outpatient Non-Biologically Based Mental Illness</b>	Visits 1-5 : Covered 100% Visits 6-20 : \$50 per visit copay Limited to 20 visits per calendar year Limit is a combined maximum with Outpatient Non-Biologically Based Rehabilitation benefit. The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.
<b>ALCOHOL/DRUG ABUSE SERVICES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>
<b>Inpatient Detoxification</b>	30% per admission The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.
<b>Outpatient Detoxification</b>	\$50 copay The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.



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<b>Inpatient Rehabilitation</b>	30% per admission
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
<b>Inpatient Non-Biologically Based Rehabilitation</b>	30% per admission
Limited to 60 days per calendar year	
Limit is a combined maximum with Inpatient Non-Biologically Based Mental Illness benefit	
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
<b>Outpatient Biologically Based Rehabilitation</b>	Visits 1-5 : Covered 100%
	Visits 6-60 : \$50 copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
<b>Outpatient Non-Biologically Based Rehabilitation</b>	Visits 1-5 : Covered 100%
	Visits 6-60 : \$50 copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
<b>OTHER SERVICES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>
<b>Early Intervention Services (Birth to age 3)</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Includes speech, language, occupational, physical therapies and assistive technology services and devices for dependents certified as eligible, up to \$5,000 per calendar year, which cannot be applied to any lifetime maximums under the plan.	
<b>Skilled Nursing Facility</b>	30% per admission
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
<b>Home Health Care</b>	Covered 100%
<b>Hospice Care - Inpatient</b>	30% per admission
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
<b>Hospice Care - Outpatient</b>	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
<b>Private Duty Nursing</b>	Not Covered
<b>Outpatient Rehabilitation Therapy</b> (Includes speech, physical and occupational therapy)	\$50 copay
Treatment over a 90-day consecutive period per incident of illness or injury beginning with the first day of treatment.	
<b>Subluxation</b>	\$35 copay
Limited to 20 visits per calendar year	
<b>Durable Medical Equipment</b>	Covered 100%
<b>Diabetic Supplies</b>	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.
<b>Dental</b>	Not Covered
<b>Vision Eyewear</b>	Not Covered
<b>Transplants</b>	30% per admission
Coverage is provided at an IOE contracted facility only	
<b>Bariatric Surgery</b>	Not Covered
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
<b>FAMILY PLANNING</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>
<b>Infertility Treatment</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Diagnosis and treatment of the underlying medical condition.	
<b>Comprehensive Infertility Services</b>	Not Covered
Coverage includes Artificial Insemination and Ovulation Induction	
<b>Advanced Reproductive Technology (ART)</b>	Not Covered
ART coverage includes In-Vitro Fertilization (IVF), Zygote Intra-Fallopian Transfer (ZIFT), Gamete Intra-Fallopian Transfer (GIFT), cryopreserved embryo transfers, Intra-Cytoplasmic Sperm Injection (ICSI) or ovum microsurgery.	



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**Voluntary Sterilization** Subject to applicable service type member cost sharing  
 Including tubal ligation and vasectomy.

**PHARMACY - PRESCRIPTION DRUG BENEFITS PARTICIPATING PROVIDERS / REFERRED**

**Retail** \$20 copay for formulary generic drugs, \$40 copay for formulary brand-name drugs, and \$70 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.

**Mail Order** \$40 copay for formulary generic drugs, \$80 copay for formulary brand-name drugs, and \$140 copay for non-formulary brand-name and generic drugs up to a 31-90 day supply from Aetna Rx Home Delivery®

**Pharmacy Managed Self Injectables (PMSI)**  
 First prescription fill at any retail or mail order drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®

**No Mandatory Generic (NO MG)** - Member is responsible to pay the applicable copay only.

**Plan Includes** : Contraceptive drugs and devices obtainable from a pharmacy.  
 Precert included  
 Step Therapy included

**Exclusions and Limitations**

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The Aetna companies that offer, underwrite or administer benefits include Aetna Health Inc.. While this material is believed to be accurate as of the print date, it is subject to change.

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased.



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- 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.
- 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
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- 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 your plan documents.
- Nonmedically 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.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered in the plan documents.

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 any results or outcomes. Consult the plan document (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 limitations 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. With the exception of Aetna Rx Home Delivery, all 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.

Aetna Pharmacy Management refers to an internal business unit of Aetna Health Management, LLC. 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 [www.aetna.com](http://www.aetna.com), or the Aetna Medication Formulary Guide. 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.



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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.

Certain primary care providers are affiliated with integrated delivery systems or other provider groups (such as independent practice associations and physician-hospital organizations), and members who select these providers will generally be referred to specialists and hospitals within those systems or groups. However, if a system or group does not include a provider qualified to meet member's medical needs, member may request to have services provided by a non-system or non-group providers. Member's request will be reviewed and will require prior authorization from the system or group and/or Aetna to be a covered benefit.

Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage.

Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification), inpatient and outpatient rehabilitation). When the Member obtains covered services from participating providers, the provider will obtain precertification. If the Member obtains covered services from a nonparticipating provider, the Member must obtain the precertification. Precertification requirements may vary. Members may refer to their plan documents for a complete list of medical services that require precertification. Certain benefits like comprehensive infertility and advanced reproductive technology (ART) services, if covered under your plan, are subject to a select network of participating providers, from which you will be required to seek care to receive covered benefits.

Members or providers may be required to precertify, or obtain prior approval of coverage for certain services such as non-emergency inpatient hospital care. Certain benefits like comprehensive infertility and advanced reproduction technology (ART) services, if covered under your plan, are subject to a select network of participating providers, from which you will be required to seek care to receive covered benefits.

For the Commonwealth of Virginia one or more of the following policy numbers may apply:



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GR-67603-5; GR-9; GR-29; GR-27;  
GR-7; GR-89296; GR-89297; GR-700-W; GR-70-W; GR-96124; GR-96125;  
HMO/VA GACS-AMEND-1 07/99; HMO/VA RIDER-ART-1 07/99;  
HMO/VA COC-1 07/99; HMO/VA RIDER-DEN 1 07/99; HMO/VA GA-1 07/99;  
HMO/VA2 RIDER-HEAR 1 01/00; HMO/VA AMEND-INF-1 07/99;  
HMO/VA RIDER-SBF-1 07/99;  
HMO/VA SERVAGREE-1 07/99;  
HMO/VA AMEND-STNT-1 07/99; HMO/VA ENDORSE-RXENH-1 (07/99);  
HMO/VA RIDER-VIS 1 07/99; HMO/VA ENDORSE-SEC125-1 07/99;  
HMO/VA INDOC-1 01/98; HMO/VA INDHISB-1 01/98;  
HMO/VA INDLOS-1 01/98; HMO/VA RIDER-RX-2000 (3/99);  
HMO/VA2 RIDER-UAW-1 (01/00); HMO/VA RIDER-DENTAL-1 03/00;  
CHI/VA OPT-POS-MAND-1 07/00;  
CHI/VA SBQNET-1 01/00; HMO/VA RIDER-MH/SA-1 07/00;  
HMO/VA SELFREF (10/00);  
CHI/VA UCR-AMEND-1 06/01; CVA-HMO-SOB-1 07/01; CVA SOB-QPOS-1 07/01;  
CHI/VA GP-1 10/01; CHI/VA INSCT-1-[A-K] (10/01); CHI/VA SBQPOS-1 10/01;  
HMO/VA AMEND-URGENT-1 0/01; HMO/VA SUPSVSEND-4 01/02;  
HMO/VA MOP-AMEND-1 01/02; HMO/VA GA-1 01/02; CHI/VA UCR-AMEND-2 04/02;  
CHI/VA GP-1 04/02; HMO/VA COC-AMEND-3 07/02; HMO/VA SB-1 07/02;  
HMO/VA NAMEAMEND-1 05/02; HMO/VA Amendment to GA ELR-1 05/02;  
HMO/VA RxExThera-1 07/02  
HMO/VA RIDER-RX-2003-1 (8/02)  
HMO/VA SB-1 10/02  
HMO/VA AMEND COB (8/02)  
HMO/VA COC-CONVERSION-AMEND 01/03  
HMO/VA INDCOC-ELIGIBILITY-AMEND 01/03  
HMO AMD-COMPL-APPL-11/02-VA  
HMO/VA IND AMEND COB (02/03)  
HMO VA TRANSPLANT-AMEND-1 (10-03)