

PLAN DESIGN AND BENEFITS – HMO Open Access 802

PLAN FEATURES	PARTICIPATING PROVIDERS
<b>Deductible</b> (per calendar year)	Not Applicable
All covered expenses accumulate separately toward the participating and non-participating Deductible. 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 the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.	
<b>Member Coinsurance</b>	Not applicable
<b>Out-of-Pocket Maximum</b> (per calendar year, excludes deductible)	\$3,000 Individual \$6,000 Family
Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. All covered expenses accumulate separately toward the participating and non-participating Out-of-Pocket Maximum. 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.	
<b>Lifetime Maximum</b>	\$5,000,000 per lifetime
<b>Payment for services from a Non-Participating Provider</b>	Not applicable
<b>Primary Care Physician Selection</b>	Not Required
<b>Precertification Requirement-</b> certain non-participating provider services require precertification or benefits will be reduced. Refer to your plan documents for a complete list of services that require precertification.	
<b>Referral Requirement</b>	None
PHYSICIAN SERVICES	PARTICIPATING PROVIDERS
<b>Primary Care Physician Visits</b>	Office Hours \$20 copay; After Office Hours/Home: \$25 copay
<b>Specialist Office Visits</b>	\$50 copay
<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
PREVENTIVE CARE	PARTICIPATING PROVIDERS
<b>Routine Adult Physical Exams / Immunizations</b> Age and frequency schedules apply.	\$20 copay
<b>Well Child Exams / Immunizations</b> Age and frequency schedules apply.	\$20 copay
<b>Routine Gynecological Exams</b> One routine exam per calendar year. Includes Pap smear and related lab fees.	\$20 copay
<b>Routine Mammograms</b> One mammogram for females age 35 and over.	\$20 copay
<b>Routine Digital Rectal Exams /Prostate Specific Antigen Test</b> Age/Frequency Schedule may apply.	Member cost sharing is based on the type of service performed and the place rendered.



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<b>Routine (or Preventive) Colorectal Cancer Screening</b> Sigmoidoscopy and Double Contrast Barium Enema (DCBE) - 1 every 5 years for all members age 50 and over Colonoscopy - 1 every 10 years for all members age 50 and over Fecal Occult Blood Testing (FOBT) - 1 every year for all members age 50 and over.	\$20 copay
<b>Routine Eye Exams at Specialist</b> Age/Frequency Schedule may apply.	\$50 copay
<b>Routine Hearing Screening at PCP</b> Covered only as part of a physical exam.	Subject to Routine Physical Exam cost sharing.
<b>DIAGNOSTIC PROCEDURES</b>	<b>PARTICIPATING PROVIDERS</b>
<b>Diagnostic Laboratory</b> – (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 member cost sharing.)	\$0 copay
<b>Diagnostic X-ray except for Complex Imaging Services</b> – outpatient hospital or other outpatient facility	\$50 copay
<b>Diagnostic X-ray for Complex Imaging Services</b> (including but not limited to MRI, MRA, PET and CT Scans)	\$300 copay
<b>EMERGENCY MEDICAL CARE</b>	<b>PARTICIPATING PROVIDERS</b>
<b>Urgent Care Provider</b>	\$75 copay
<b>Non-Urgent use of Urgent Care Provider</b>	Not Covered
<b>Emergency Room</b>	\$150 copay
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered
<b>Ambulance</b>	\$200 copay
<b>HOSPITAL CARE</b>	<b>PARTICIPATING PROVIDERS</b>
<b>Inpatient Coverage</b> (including maternity and transplants. Transplant Coverage is provided at an IOE contracted facility only)	\$500 per day for the first 4 days per admission, thereafter coverage is provided at 100%,
<b>Outpatient Surgery</b>	\$500 copay
<b>MENTAL HEALTH SERVICES</b>	<b>PARTICIPATING PROVIDERS</b>
<b>Inpatient</b> Limited to 30 days per member per calendar year	\$500 per day for the first 4 days per admission, thereafter coverage is provided at 100%,
<b>Outpatient</b> Limited to 20 visits per member per calendar year	\$50 copay
<b>ALCOHOL/DRUG ABUSE SERVICES</b>	<b>PARTICIPATING PROVIDERS</b>
<b>Inpatient Detoxification</b>	\$500 per day for the first 4 days per admission, thereafter coverage is provided at 100%,
<b>Outpatient Detoxification</b>	\$50 copay
<b>Inpatient Rehabilitation</b> Limited to 30 days per member per calendar year	\$500 per day for the first 4 days per admission, thereafter coverage is provided at 100%,
<b>Outpatient Rehabilitation</b> Limited to 20 visits per member per calendar year	\$50 copay



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OTHER SERVICES	PARTICIPATING PROVIDERS
<b>Skilled Nursing Facility</b> Limited to 30 days per member per calendar year	\$500 per day for the first 4 days per admission, thereafter coverage is provided at 100%,
<b>Home Health Care</b> Limited to 60 visits per member per calendar year; 1 visit equals a period of 4 hours or less.	\$50 copay
<b>Hospice Care – Inpatient</b>	\$500 per day for the first 4 days per admission, thereafter coverage is provided at 100%,
<b>Hospice Care – Outpatient</b>	\$50 copay
<b>Infusion Therapy</b> Provided in the home or physician's office	\$50 copay
<b>Infusion Therapy</b> Provided in an outpatient hospital department or freestanding facility	\$50 copay
<b>Outpatient Rehabilitation Therapy</b> Includes speech, physical and occupational therapy. Limited to 30 visits per calendar year.	\$50 copay
<b>Subluxation (Chiropractic)</b> Limited to 20 visits per member per calendar year.	\$50 copay
<b>Durable Medical Equipment</b> Maximum benefit \$2000 per member per calendar year.	30%
<b>Diabetic Supplies</b>	Prescription drug copay
FAMILY PLANNING	PARTICIPATING PROVIDERS
<b>Infertility Treatment</b> Coverage for only the diagnosis and surgical treatment of the underlying medical cause.	Member cost sharing is based on the type of service performed and the place rendered.
<b>Voluntary Sterilization</b> 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
<b>Retail</b> Up to a 30 day supply at participating pharmacies.	\$10 copay for generic formulary drugs, \$35 copay for brand-name formulary drugs, and \$50 copay for generic and brand-name non-formulary drugs
<b>Mail Order</b> 31- 90 day supply at participating pharmacies.	\$20 copay for generic formulary drugs, \$70 copay for brand-name formulary drugs, and \$100 copay for generic and brand-name non-formulary drugs
<b>Self-Injectables</b>	20%, not to exceed \$100 for formulary and non-formulary drugs
No Mandatory Generic (No MG) – Member is responsible to pay the applicable copay only. Plan includes contraceptive drugs and devices obtainable from a pharmacy and diabetic supplies. Precertification included.	

\*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 your plan documents as "recognized" charges.



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### 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. 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.**

- 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.
- Home births.
- 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, counseling, and prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered in the plan documents.
- Treatment of behavioral disorders.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

This plan imposes a pre-existing conditions exclusion, which may be waived in some circumstances (that is, creditable coverage) and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to our plan, you 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 your coverage becomes effective. However, if you were in a waiting period for coverage, 180 day lookback period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period.

If you had prior credible coverage within 63 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.

If you had no prior creditable coverage within the 63 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 63 day gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion.



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Florida Small Group HMO Open Access  
Plan Effective Date: 01/01/2008

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In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any Certificates of Creditable Coverage you have. Please contact your Aetna Member Services representative at 1-888-702-3862 if you need assistance in obtaining a Certificate of Creditable Coverage from your prior carrier or if you have any questions on the information noted above.

The pre-existing condition 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.

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 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 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. 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. 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 of subsidiary companies.

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

Health Benefit Plans are provided by Aetna Health Inc.