



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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
<b>Deductible</b> (per calendar year)	\$300 Individual \$900 Family	\$1,000 Individual \$3,000 Family
<p>All covered expenses accumulate separately toward the preferred or non-preferred Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Deductible amount.</p>		
<b>Member Coinsurance</b>	Covered 100%	30%
Applies to all expenses unless otherwise stated.		
<b>Payment Limit</b> (per calendar year)	\$1,200 Individual \$3,600 Family	\$10,000 Individual \$30,000 Family
<p>All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses apply towards the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Payment Limit amount.</p>		
<b>Lifetime Maximum</b>	Unlimited except where otherwise indicated.	
<b>Payment for Non-Preferred Care**</b>	Not Applicable	Professional: Prevailing Charges Facility: 140% of Medicare
<p>*We cover the cost of care differently based on whether health care providers, such as doctors and hospitals, are "in network" or "out of network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this out-of-network care. As an example, you may choose a doctor in our network. You may choose to visit an out-of-network doctor. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital. When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount. This amount is based on "reasonable" or "prevailing" charges. We get this data from an external database. Exactly how much Aetna "recognizes" depends on the plan you or your employer picks. Your out-of-network doctor sets the rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna plan "recognizes" or "allows." Your doctor may bill you for the dollar amount that Aetna doesn't recognize. You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the recognized charge counts toward your deductible or maximum out-of-pocket. To learn more about how we pay out-of-network benefits visit Aetna.com. Type "how Aetna pays" in the search box. You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to <a href="http://www.aetna.com">www.aetna.com</a> and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site. This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.</p>		
<b>Primary Care Physician Selection</b>	Required	Not Applicable



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<b>Certification Requirements -</b>		
Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is \$400 per occurrence.		
<b>Referral Requirement</b>	Required	None
<b>PREVENTIVE CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Routine Adult Physical Exams/ Immunizations</b>	Covered 100%; deductible waived	30%; after deductible
1 exam per calendar year up to age 65, 1 exam per calendar year age 65 and older		
<b>Routine Well Child Exams/Immunizations</b>	Covered 100%; deductible waived	Covered 100%; deductible waived
7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per calendar year thereafter to age 22.		
<b>Routine Gynecological Care Exams</b>	Covered 100%; deductible waived	30%; after deductible
2 exams per calendar year. Includes routine tests and related lab fees.		
<b>Routine Mammograms</b>	Covered 100%; deductible waived	30%; after deductible
<b>Women's Health</b>	Covered 100%; deductible waived	30%; after deductible
Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		
<b>Routine Digital Rectal Exam</b>	Covered 100%; deductible waived	30%; after deductible
<b>Prostate-specific Antigen Test</b>	Covered 100%; deductible waived	30%; after deductible
<b>Colorectal Cancer Screening</b>	Covered 100%; deductible waived	Covered under Routine Adult Exams
Recommended: For all members age 50 and over.		
<b>Routine Eye Exams</b>	Covered 100%; deductible waived	30%; after deductible
1 routine exam per 24 months.		
<b>Routine Hearing Screening</b>	Covered 100%; deductible waived	30%; after deductible
<b>PHYSICIAN SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Office Visits to PCP</b>	\$20 copay; deductible waived	30%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
<b>Specialist Office Visits</b>	\$30 copay; deductible waived	30%; after deductible
<b>Audiometric Hearing Exam</b>	Not Covered	Not Covered
<b>Pre-Natal Maternity</b>	Covered 100%; deductible waived	30%; after deductible
<b>Walk-in Clinics</b>	\$20 copay; deductible waived	30%; after deductible
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.		
<b>Allergy Testing</b>	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
<b>Allergy Injections</b>	Your cost sharing is based on the type of service and where it is performed; Covered 100% when an office visit charge is not applicable.	Your cost sharing is based on the type of service and where it is performed



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<b>DIAGNOSTIC PROCEDURES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Diagnostic X-ray</b> If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	\$30 copay; deductible waived	30%; after deductible
<b>Diagnostic Laboratory</b> If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	Covered 100%; deductible waived	30%; after deductible
<b>Diagnostic Outpatient Complex Imaging</b> If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	\$30 copay; deductible waived	30%; after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Urgent Care Provider</b>	\$25 copay; deductible waived	30%; after deductible
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered	Not Covered
<b>Emergency Room</b> Copay waived if admitted	\$35 copay; deductible waived	Same as in-network care
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered	Not Covered
<b>Emergency Use of Ambulance</b>	Covered 100%; deductible waived	Same as in-network care
<b>Non-Emergency Use of Ambulance</b>	Not Covered	Not Covered
<b>HOSPITAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient Coverage</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	30%; after deductible
<b>Inpatient Maternity Coverage</b> (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	30%; after deductible
<b>Outpatient Hospital Expenses</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; deductible waived	30%; after deductible
<b>Outpatient Surgery - Hospital</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	30%; after deductible
<b>Outpatient Surgery - Freestanding Facility</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	30%; after deductible
<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	30%; after deductible
<b>Outpatient</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	\$30 copay; deductible waived	30%; after deductible
<b>Crisis Intervention Services</b>	\$30 copay; deductible waived	30%; after deductible
<b>SUBSTANCE ABUSE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	30%; after deductible
<b>Residential Treatment Facility</b>	Covered 100%; after deductible	30%; after deductible
<b>Outpatient</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	\$30 copay; deductible waived	30%; after deductible



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OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
<b>Skilled Nursing Facility</b>	Covered 100%; after deductible	30%; after deductible Limited to 240 days per calendar year
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
<b>Home Health Care</b>	Covered 100%; deductible waived	25%; deductible waived
<b>Hospice Care - Inpatient</b>	Covered 100%; deductible waived	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
<b>Hospice Care - Outpatient</b>	Covered 100%; deductible waived	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
<b>Private Duty Nursing - Outpatient</b>	Not Covered	Not Covered
<b>Spinal Manipulation Therapy</b>	\$30 copay; deductible waived	30%; after deductible
<b>Outpatient Short-Term Rehabilitation</b>	\$30 copay; deductible waived	30%; after deductible
Includes Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year. Unlimited for Early Intervention Services from birth to age 3.		
<b>Autism Behavioral Therapy</b>	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Covered same as any other Outpatient Mental Health benefit		
<b>Autism Applied Behavior Analysis</b>	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Covered same as any other Outpatient Mental Health benefit		
<b>Autism Physical Therapy</b>	\$30 copay; deductible waived	30%; after deductible
<b>Autism Occupational Therapy</b>	\$30 copay; deductible waived	30%; after deductible
<b>Autism Speech Therapy</b>	\$30 copay; deductible waived	30%; after deductible
<b>Hearing Aids</b>	Not Covered	Not Covered
<b>Durable Medical Equipment</b>	Covered 100%; deductible waived	30%; after deductible
<b>Diabetic Supplies</b>	Covered same as any other expense.	Covered same as any other expense.
<b>Fertility Drugs (oral and injectable)</b>	Covered 100%; deductible waived	30%; after deductible
Physician charges included (oral and injectable fertility drugs obtained at a pharmacy are covered under the Rx plan).		
<b>Contraceptive drugs and devices not obtainable at a pharmacy</b>	Covered 100%; deductible waived	Covered same as any other expense.
<b>Generic FDA-approved Women's Contraceptives</b>	Covered 100%; deductible waived	Covered same as any other expense.
<b>Vision Eyewear</b>	Not Covered	Not Covered
<b>Transplants</b>	Covered 100%; after deductible Preferred coverage is provided at an IOE contracted facility only.	30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
<b>Bariatric Surgery</b>	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
<b>Out of Area Dependents</b>	Coverage provided at the non-preferred benefit level of the plan if in-network provider is not available.	
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
<b>Infertility Treatment</b>	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Diagnosis and treatment of the underlying medical condition only.		



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<b>Comprehensive Infertility Services</b>	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Coverage includes artificial insemination and ovulation induction limited to six courses of treatment combined, per member lifetime. Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law.		
<b>Advanced Reproductive Technology (ART)</b>	Not Covered	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery		
<b>Vasectomy</b>	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
<b>Tubal Ligation</b>	Covered 100%; deductible waived	30%; after deductible
<b>PHARMACY</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Pharmacy Plan Type</b>	Aetna Premier Open Formulary	
<b>Generic Drugs</b>		
<b>Retail</b>	\$20 copay	30% of submitted cost; after applicable copay Not Applicable
<b>Mail Order</b>	\$20 copay	
<b>Brand-Name Drugs</b>		
<b>Retail</b>	\$30 copay	30% of submitted cost; after applicable copay Not Applicable
<b>Mail Order</b>	\$30 copay	
<b>Pharmacy Day Supply and Requirements</b>		
<b>Retail</b>	Up to a 30 day supply	
<b>Mail Order</b>	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
<b>Premier Specialty</b>	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred Aetna Specialty Pharmacy network.	
<b>Plan Includes:</b> Diabetic supplies and medication covered at PCP cost sharing and Contraceptive drugs and devices obtainable from a pharmacy. Performance Enhancing Drugs limited to 4 tablets per month. Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited). Oral chemotherapy drugs covered 100% Premier Pre-certification included Premier Step Therapy included One transition fill allowed within 90 days of member's effective date Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.		
<b>Prescription Drug Calendar Year</b>	\$100 Individual	\$100 Individual
<b>Deductible</b> (must be satisfied before any drug benefits are paid)		
	\$100 Family	\$100 Family
All covered pharmacy expenses accumulate toward both the preferred and non-preferred pharmacy deductible. Unless otherwise indicated, the pharmacy deductible must be met prior to pharmacy benefits being payable. Once family pharmacy deductible is met, all family members will be considered as having met their pharmacy deductible for the remainder of the calendar year		

**GENERAL PROVISIONS**



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**Dependents Eligibility**

Spouse, children from birth to age 26 regardless of student status.

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

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

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

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.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids
- Home births
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- 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/enhancement, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- 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.



Consolidated  
Proposed Effective Date: 01-01-2017  
Open Access<sup>®</sup> Managed Choice<sup>®</sup> POS - New York

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

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

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

Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862**.

Plan features and availability may vary by location and group size.  
For more information about Aetna plans, refer to **www.aetna.com**.  
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