



Aetna Health Inc and Aetna Health Insurance Company

**PLAN DESIGN AND BENEFITS - CPOS \$1,000 80/60 \$25/\$50
(No Referrals Required)**

| PLAN FEATURES | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS |
|---|--|--|
| Deductible (per calendar year) | \$1,000 Individual 2 Individuals per Family | \$1,000 Individual 2 Individuals per Family |
| <p>Unless otherwise indicated, the Deductible must be met prior to benefits being payable. 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 and self-injectables, as indicated in the plan, are excluded from charges to meet the Deductible.</p> <p>Once 2 individual members of a family each satisfy their Deductible amount separately, all family members will be considered as having met their Deductible for the remainder of the calendar year.</p> | | |
| Member Coinsurance | 20% | 40% |
| Out-of-Pocket Maximum (per calendar year, excludes deductible) | \$4,000 Individual 2 Individuals per Family | \$8,000 Individual 2 Individuals per Family |
| <p>All covered expenses accumulate separately toward the Participating and Non-Participating Out-of-Pocket Maximum.</p> <p>Once 2 individual members of a family each satisfy their Out-of-Pocket Maximum separately, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.</p> <p>Only those out-of-pocket expenses resulting from the application of coinsurance percentage (except any Deductibles, Copays, Prescription Drugs (including self-injectables), payments for Mental Disorders, Substance Abuse, ER/Urgent Care, DME, Amounts Over Allowable and Failure to Pre-Certify Penalty Amounts) may be used to satisfy the Out-of-Pocket Maximum.</p> | | |
| Lifetime Maximum (per member lifetime, Preferred and Non-Preferred combined) | \$2,000,000 | \$2,000,000 |
| Payment for services from a Non-Participating Provider | Not Applicable | Recognized Charge* |
| Primary Care Physician Selection | Not Required | Not Applicable |
| <p>Precertification Requirement 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.</p> | | |
| Referral Requirement | Not Required | Not Applicable |
| PHYSICIAN SERVICES | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS |
| Primary Care Physician Visits | \$25 copay; deductible waived | 40% after deductible |
| Specialist Office Visits | \$50 copay; deductible waived | 40% after deductible |
| Maternity OB Visits | 20% after deductible | 40% after deductible |
| Allergy Testing & Treatment | \$50 copay; deductible waived | 40% after deductible |



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| PREVENTIVE CARE | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS |
|--|--|--|
| Routine Adult Physical Exams / Immunizations Age and frequency schedules may apply Preferred and Non Preferred Combined | \$25 copay; deductible waived | 40% after deductible |
| Well Child Exams / Immunizations Age and frequency schedules may apply | \$25 copay; deductible waived | 40% after deductible |
| Routine Gynecological Exams Includes Pap smear and related lab fees One routine exam(s) per 365 days. | \$25 copay; deductible waived | 40% after deductible |
| Routine Mammograms One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over. | \$50 copay; deductible waived | 40% after deductible |
| Routine Digital Rectal Exams / Prostate Specific Antigen Test For covered males age 40 and over. | Member cost sharing is based on the type of service performed and the place rendered | 40% after deductible |
| 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 | 40% after deductible |
| Routine Vision and Hearing Screening | Covered as part of a routine physical exam | Covered as part of a routine physical exam |
| DIAGNOSTIC PROCEDURES | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS |
| Diagnostic Laboratory and X-ray 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. | \$50 copay; deductible waived | 40% after deductible |
| Complex Imaging Services Precertification required. Including, but not limited to, MRI, MRA, PET and CT Scans and any other outpatient diagnostic imaging service costing over \$500. | 30% after deductible | 50% after deductible |
| EMERGENCY MEDICAL CARE | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS |
| Urgent Care Provider | \$50 copay; deductible waived | \$50 copay; deductible waived |
| Non-Urgent use of Urgent Care Provider | No benefit is provided | No benefit is provided |
| Emergency Room Copay waived if admitted | \$250 copay; deductible waived | Refer to participating provider benefit |
| Non-Emergency care in an Emergency Room | No benefit is provided | No benefit is provided |
| Emergency Ambulance | 20% after deductible | Refer to participating provider benefit |



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| HOSPITAL CARE | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS |
|---|--------------------------------|---|
| Inpatient Coverage Including maternity & transplants. Transplant coverage is provided at an IOE or NME contracted facility only. | 20% after deductible | 40% after deductible |
| Outpatient Surgery - OP Hospital Provided in an outpatient hospital department | 30% after deductible | 50% after deductible |
| Outpatient Surgery - Freestanding Provided in a freestanding surgical facility | 20% after deductible | 40% after deductible |
| MENTAL HEALTH SERVICES | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS |
| Inpatient Limited to 15 days per member per calendar year. Participating and Non-Participating combined. | 20% after deductible | 50% after deductible |
| Outpatient Limited to 20 visits per member per calendar year. Participating and Non-Participating combined. | \$50 copay; deductible waived | 50% after deductible |
| ALCOHOL/DRUG ABUSE SERVICES | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS |
| Inpatient Detoxification Limited to 3 days per admission, 2 admissions per member per calendar year. Participating and Non-Participating combined. | 20% after deductible | No benefit is provided |
| Outpatient Detoxification | No benefit is provided | No benefit is provided |
| OTHER SERVICES | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS |
| Skilled Nursing Facility Limited to 30 days per member per calendar year. Participating and Non-Participating combined. | 20% after deductible | 40% after deductible |
| Home Health Care | 20% after deductible | 40% after deductible |
| Infusion Therapy Provided in the home or physician's office | 20% after deductible | 40% after deductible Maximum Aetna payment of \$50 per visit after deductible. |
| Infusion Therapy Provided in an outpatient hospital department or freestanding facility | 30% after deductible | 40% after deductible Maximum Aetna payment of \$50 per visit after deductible. |
| Inpatient Hospice Care Limited to 30 days per member per calendar year. Participating and Non-Participating combined. | 20% after deductible | 40% after deductible |



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| Outpatient Hospice Care Limited to 60 days per member per calendar year. Participating and Non-Participating combined. | 20% after deductible | 40% after deductible |
| Private Duty Nursing | No benefit is provided | No benefit is provided |
| Outpatient Speech Therapy Limited to 20 visits per member per calendar year. Participating and Non-Participating combined. | 20% after deductible | 40% after deductible |
| Outpatient Physical and Occupational Therapy Limited to 20 visits per member per calendar year. Participating and Non-Participating combined. | 20% after deductible | 40% after deductible |
| Chiropractic | \$50 copay after deductible Limited to 20 visits per calendar year | 40% after deductible No visit limit |
| Durable Medical Equipment Maximum benefit of \$2,500 per member per calendar year. Participating and Non-Participating combined. | 50% after deductible | 50% after deductible |
| FAMILY PLANNING | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS |
| Infertility Treatment 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 | 40% after deductible |
| Voluntary Sterilization Including tubal ligation and vasectomy | Member cost sharing is based on the type of service performed and the place rendered | 40% after deductible |
| PHARMACY - PRESCRIPTION DRUG BENEFITS | PARTICIPATING PHARMACIES | NON-PARTICIPATING PHARMACIES |
| Retail Up to a 30-day supply at participating pharmacies, includes insulin. | \$20 copay for generic formulary drugs, \$40 copay for brand name formulary drugs, and \$60 copay for generic and brand name non-formulary drugs | No benefit is provided |
| Mail Order 31-90 day supply at participating pharmacies, includes insulin. | \$40 copay for generic formulary drugs, \$80 copay for brand name formulary drugs, and \$120 copay for generic and brand name non-formulary drugs | No benefit is provided |



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| Self-Injectables (retail and mail order, excludes insulin, does not accumulate toward out of pocket payment maximum) | 20%; deductible waived for formulary and non-formulary drugs | No benefit is provided |
| Mandatory Generic with DAW override - The member pays the applicable copay only, if the physician requires brand. If the member requests brand when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price. | | |
| Plan includes: Contraceptive drugs and devices obtainable from a pharmacy and diabetic supplies obtainable from a pharmacy and lifestyle/performance enhancing drugs (6 pills per month). | | |
| Precertification included and 90 day Transition of Care (TOC) for Precertification included. | | |

*Non-Participating Provider payments for facility charges are determined based upon Aetna's Allowable Fee Schedule, which is subject to change. 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.

What's No benefit is provided

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 No benefit is provided. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased.

- All medical or 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
- Blood and blood byproducts, except as administered on an inpatient or emergency care basis
- Cosmetic surgery
- Custodial care
- Dental care and 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
- Implantable drugs and certain injectible drugs including injectible 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
- Nonmedically necessary services or supplies
- Orthotics, except diabetic orthotics
- Over-the-counter medications (except as provided in a hospital) and supplies
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs
- Special duty nursing



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- 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 co morbid conditions

**Arizona Members are covered for all indicated or medically necessary immunizations.

Pre-existing Conditions Exclusion Provision

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 conditions 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 six months.

Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six month period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 12 months 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 less than six months of creditable coverage immediately before the date you enrolled, your plan's pre-existing conditions exclusion period will be reduced by the amount (that is, number of days) of that prior coverage.

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 1-888-802-3862 for PPO and 1-888-702-3862 for HMO/CPOS 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 under age 18, 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.

In Arizona, benefits are provided by Aetna Health of Arizona Inc. and Corporate Health Insurance Company.

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 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



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