PLAN DESIGN AND BENEFITS - CT Open Access Managed Choice (OA MC) 2-10/10

PLAN FEATURES	NETWORK CARE	OUT-OF-NETWORK CARE
Deductible (per calendar year)	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. All covered expenses accumulate separately toward the network and out-of-network 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. No one family member may contribute more than the Individual Deductible amount to the Family 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.		
Member Coinsurance (applies to all expenses unless otherwise stated)	10% after deductible	30% after deductible
Maximum Out-of-Pocket Limit (per calendar year, excludes deductible)	$2,000 Individual $4,000 Family	$5,000 Individual $10,000 Family
All covered expenses accumulate separately toward the network and out-of-network Maximum Out-of-Pocket Limit. Certain member cost sharing elements may not apply toward the Maximum Out-of-Pocket Limit. Only those out-of-network expenses resulting from the application of coinsurance percentage (except any penalty amounts) may be used to satisfy the Maximum Out-of-Pocket Limit. Once the Family Maximum Out-of-Pocket Limit is met, all family members will be considered as having met their Maximum Out-of-Pocket Limit for the remainder of the calendar year. No one family member may contribute more than the Individual Maximum Out-of-Pocket Limit amount to the Family Maximum Out-of-Pocket Limit.		
Lifetime Maximum	Unlimited	Unlimited
Payment for Out-of-Network Care	Not Applicable	Professional: 110% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Not Applicable	Not Applicable
Certification Requirements Certification for certain types of Out-of-Network 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, and Hospice Care is required. Benefits will be reduced by 50% up to a maximum of $400 per service or supply if Certification is not obtained.		
Referral Requirement	None	None
PHYSICIAN SERVICES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Office Visits to Primary Care Physician Includes services of an internist, general physician, family practitioner or pediatrician for routine care as well as diagnosis and treatment of an illness or injury	$25 copay; deductible waived	30% after deductible
Specialist Office Visits	$35 copay; deductible waived	30% after deductible
Maternity OB Visits	$35 copay; deductible waived for initial visit only; thereafter covered 10% after deductible	30% after deductible
Surgery (in office)	10% after deductible	30% after deductible
Allergy Testing (given by a physician)	$35 copay; deductible waived	30% after deductible
Allergy Injections (not given by a physician)	$35 copay; deductible waived	30% after deductible

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PREVENTIVE CARE	NETWORK CARE	OUT-OF-NETWORK CARE
Routine Adult Physical Exams / Immunizations Ages 19-65: One exam every 24 months Ages 65 and over: One exam every 12 months Network and Out-of-Network combined	$0 copay; deductible waived	30% after deductible
Well Child Exams / Immunizations 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 12 months thereafter to age 18 Network and Out-of-Network combined	$0 copay; deductible waived	30% after deductible
Routine Gynecological Exams One routine exam per calendar year Network and Out-of-Network combined	$0 copay; deductible waived	30% after deductible
Routine Mammograms One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over Network and Out-of-Network combined	$0 copay; deductible waived	30% after deductible
Routine Digital Rectal Exam / Prostate-Specific Antigen Test One exam every 12 months for all males ages 50 and over & males under 50 who are symptomatic and/or whose biological father/brother has been diagnosed with prostate cancer Network and Out-of-Network combined	$0 copay; deductible waived	30% after deductible
Routine (or Preventive) Colorectal Cancer Screening For all members age 50 and over. 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 Network and Out-of-Network combined	$0 copay; deductible waived	30% after deductible
Routine Eye Exams at Specialist One routine exam per 24 months Network and Out-of-Network combined	$0 copay; deductible waived	30% after deductible
Routine Hearing Exams	Not Covered	Not Covered

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DIAGNOSTIC PROCEDURES	NETWORK CARE	OUT-OF-NETWORK CARE
Outpatient Diagnostic Laboratory and X-ray except for Complex Imaging Services 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. If performed in the outpatient hospital department, payable under outpatient hospital benefit.	10% after deductible	30% after deductible
Outpatient Diagnostic X-ray for Complex Imaging Services Including, but not limited to, MRI, MRA, PET and CT Scans	10% after deductible	30% after deductible
EMERGENCY MEDICAL CARE	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Urgent Care Provider	$75 copay; deductible waived	30% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	$150 copay; deductible waived	Paid as Network Care
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Emergency Ambulance	10% after deductible	Paid as Network Care
Non-Emergency Ambulance	10% after deductible	30% after deductible
HOSPITAL CARE	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Inpatient Coverage Including maternity & transplants If transplant is performed through an Institute of Excellence™ facility, benefits would be paid at the network level. If procedure is not performed through an Institute of Excellence™ facility, benefits would be paid at the out-of-network level	10% after deductible	30% after deductible
Outpatient Surgery Provided in an outpatient hospital department or a freestanding surgical facility	10% after deductible	30% after deductible
Outpatient Hospital Services other than Surgery Including, but not limited to, lab, x-ray, physical therapy, speech therapy, occupational therapy, spinal manipulation, dialysis, radiation therapy and infusion therapy	10% after deductible	30% after deductible
MENTAL HEALTH SERVICES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Inpatient	10% after deductible	30% after deductible
Outpatient	$35 copay; deductible waived	30% after deductible
ALCOHOL/DRUG ABUSE SERVICES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Inpatient Detoxification	10% after deductible	30% after deductible
Outpatient Detoxification	$35 copay; deductible waived	30% after deductible
Inpatient Rehabilitation	10% after deductible	30% after deductible
Outpatient Rehabilitation	$35 copay; deductible waived	30% after deductible

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OTHER SERVICES AND PLAN DETAILS	NETWORK CARE	OUT-OF-NETWORK CARE
Skilled Nursing Facility Limited to 30 days per member per calendar year Network and Out-of-Network combined	10% after deductible	30% after deductible
Home Health Care Limited to 80 visits per member per calendar year Network and Out-of-Network combined; 1 visit equals a period of 4 hours or less	10%; deductible waived	25%; deductible waived
Inpatient Hospice Care	10% after deductible	30% after deductible
Outpatient Hospice Care	10% after deductible	30% after deductible
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Outpatient Short-Term Rehabilitation Includes speech, physical and occupational therapy (if provided in the outpatient hospital department, paid under the outpatient hospital benefit) Limited to 20 combined visits per member per calendar year Network and Out-of-Network combined	10% after deductible	30% after deductible
Outpatient Spinal Manipulation Therapy (Chiropractic) (if provided in the outpatient hospital department, paid under the outpatient hospital benefit) Limited to 20 visits per member per calendar year Network and Out-of-Network combined	$35 copay; deductible waived	30% after deductible
Durable Medical Equipment Maximum benefit of $1,000 per member per calendar year Network and Out-of-Network combined	50% after deductible	50% after deductible
Diabetic Supplies not obtainable at a pharmacy	Covered same as any other medical expense	Covered same as any other medical expense
Contraceptive drugs and devices not obtainable at a pharmacy Includes coverage for contraceptive visits	Covered same as any other medical expense	Covered same as any other medical expense

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FAMILY PLANNING	NETWORK CARE	OUT-OF-NETWORK CARE
Infertility Treatment Covered only for the diagnosis and treatment of the underlying medical condition	Member cost sharing is based on the type of service performed and the place rendered	30% after deductible
Comprehensive Infertility Services For a covered person who is under age 40 and unable to conceive or produce conception, or sustain a successful pregnancy during a one year period. Coverage includes the following: • 3 courses of treatment for Artificial Insemination (AI) per lifetime • 4 courses of treatment of Ovulation Induction (OI) per lifetime	Member cost sharing is based on the type of service performed and the place rendered	30% after deductible
Advanced Reproductive Technology (ART) For a covered person who is under age 40 and unable to conceive or produce conception, or sustain a successful pregnancy during a one year period. Coverage includes the following: • 2 cycles with not more than 2 embryos per cycle of ART treatments (IVF, GIFT, ZIFT, low tubal ovum transfer) combined per lifetime	Member cost sharing is based on the type of service performed and the place rendered	30% after deductible
Voluntary Sterilization Including tubal ligation and vasectomy	10% after deductible	30% after deductible
PHARMACY-PRESCRIPTION DRUG BENEFITS	**PARTICIPATING PHARMACIES**	**NON-PARTICIPATING PHARMACIES**
Retail Up to a 30-day supply	$10 copay for generic drugs, $25 copay for brand name formulary drugs, and $40 copay for brand name non-formulary drugs	20% of submitted cost after $10 per prescription deductible for generic drugs,$25 per prescription deductible for brand name formulary drugs, and $40 per prescription deductible for brand name non-formulary drugs
Mail Order 31-90 day supply	$20 copay for generic drugs, $50 copay for brand name formulary drugs, and $80 copay for brand name non-formulary drugs	Not Covered
Specialty CareRx^{SM} Drugs	20% for generic, brand name formulary and brand name non-formulary drugs	20% for generic, brand name formulary and brand name non-formulary drugs
Mandatory Generic (MG) - If the member or the physician requests brand when generic is available, the member pays the applicable copay or coinsurance 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.		
Precertification and Step Therapy included and 90 day Transition of Care (TOC) for Precertification and Step Therapy included.		

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You may choose providers in our network (physicians and facilities) or may visit an out-of-network provider. Typically, you will pay substantially more money out of your own pocket if you choose to use an out-of-network doctor or hospital. The out-of-network provider will be paid based on Aetna's “recognized charge.” This is not the same as the billed charge from the doctor.

Aetna pays a percentage of the recognized charge, as defined in your plan. The recognized charge for out-of-network hospitals, doctors and other out-of-network health care providers is a percentage (100 percent or above) of the rate that Medicare pays them.

You may have to pay the difference between the out-of-network provider's billed charge and Aetna’s recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the doctor or hospital bills you above Aetna’s recognized charge does not count toward your deductible or out-of-pocket maximums.

This benefit applies when you *choose* to get care out of network. When you have no choice in the doctors you see (for example, an emergency room visit after a car accident), your deductible and coinsurance for the in-network level of benefits will be applied, and you should contact Aetna if your doctor asks you to pay more. Generally, you are not responsible for any outstanding balance billed by your doctors in an emergency situation.

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 or hospital services no specifically covered in, or which are limited or excluded in the plan documents;
- Charges related to any eye surgery mainly to correct refractive errors;
- Cosmetic surgery, including breast reduction;
- Custodial care;
- Dental care and x-rays;
- Donor egg retrieval;
- Experimental and investigational procedures;
- Immunizations for travel or work;
- Nonmedically necessary services or supplies;
- Orthotics;
- Over-the-counter medications and supplies;
- Reversal of sterilization;
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs;
- Special duty nursing; and
- Treatment of those services for or related to treatment of obesity or for diet or weight control.

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This material is for informational purposes only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Plan features and availability may vary by location and group size. Not all heath services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. With the exception of Aetna Rx Home Delivery, Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services.

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's preferred provider is coordinating care, the preferred provider will obtain the precertification. Precertification requirements may vary.

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. 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. 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.

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

Plans are provided by Aetna Life Insurance Company.

For more information about Aetna plans, refer to www.aetna.com.

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