

Medical plan options

FOR BUSINESSES WITH 2 TO 50 ELIGIBLE EMPLOYEES



Pennsylvania

†Health benefits and health insurance plans/policies are offered, underwritten or administered by Aetna Health Inc., Aetna Health Insurance Company and/or Aetna Life Insurance Company (Aetna).

We want you to know[®]



Pennsylvania Aetna⁺ Small Group Medical Plans — POS PLAN OPTIONS

Plan Options	PA POS 7.3 ⁺	
Member Benefits	In-Network PCP Coordinated	Out-of-Network* No Referral Needed
Plan Coinsurance	N/A	50% after deductible
Calendar Year Deductible**	N/A	\$2,500 per member \$7,500 family
Calendar Year Out-of-Pocket Maximum*** (Deductible and prescription drugs, including self-injectables, do not apply toward the Out-of-Pocket Maximum.)	\$2,500 per member \$5,000 family	\$10,000 per member \$30,000 family
Lifetime Maximum Benefit	Unlimited	\$1,000,000
Preventive Care		
Well Baby/Child and Adult Physical Exams (Age and frequency schedules apply. In-network and out-of-network combined.)	\$0 copay	50%, deductible waived
Routine GYN Exams (Limited to one exam and Pap smear per 365 days. In-network and out-of-network combined.)	\$0 copay	50%, deductible waived
Routine Mammograms (One annual mammogram for females age 40 and over. In-network and out-of-network combined.)	\$0 copay	50% after deductible
Routine Eye Exam (One exam per 24 months. In-network and out-of-network combined.)	\$0 copay	50% after deductible
Glasses and Contact Lens Reimbursement	\$100/24 month period. In-network and out-of-network combined.	
Aetna Vision SM Discounts Program	Included	Not Covered
Primary Physician Office Visit	\$40 copay	50% after deductible
Specialist Office Visit	\$50 copay	50% after deductible
Outpatient Services – Lab	\$0 copay	50% after deductible
Outpatient Services – X-ray	\$50 copay	50% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$150 copay	50% after deductible
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	\$50 copay	50% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year. In-network and out-of-network combined.)	\$50 copay	50% after deductible
Outpatient Speech Therapy (30 visits per calendar year. In-network and out-of-network combined.)	\$50 copay	50% after deductible
Durable Medical Equipment (\$2,500 Calendar Year Maximum. In-network and out-of-network combined.)	50%	50% after deductible
Inpatient Hospital	\$500 copay per day, 5 day copay maximum per admission	50% after deductible
Outpatient Surgery	\$500 copay	50% after deductible
Emergency Room (Copay waived if admitted.)	\$150 copay	\$150 copay
Mental Health – Inpatient (Limited to 30 days per calendar year. In-network and out-of-network combined.)	\$500 copay per day, 5 day copay maximum per admission	50% after deductible
Substance Abuse – Inpatient (In-Network: Detox.: Unlimited days per calendar year; Rehab.: 30 days per calendar year; 90 days per lifetime. Out-of-Network: Detox.: 7 days per admission, 4 admissions per lifetime. In-network and out-of-network combined. Rehab.: 30 days per calendar year; 90 days per lifetime. In-network and out-of-network combined.)	\$500 copay per day, 5 day copay maximum per admission	50% after deductible
Prescription Drug Deductible	N/A	N/A
Prescription Drugs – Retail: 30-day supply	Option 1: \$20/\$40/\$70 Option 2: \$15 for Generic Drugs; Brand-name drugs are not covered. Members may access Aetna’s negotiated discount for brand-name drugs at participating pharmacies. (Option 2 is not available with the No-Referral plan.)	Not Covered
Prescription Drugs – Mail Order: 31-90-day supply	Option 1: \$40/\$80/\$140 Option 2: \$30 for Generic Drugs; Brand-name drugs are not covered. Members may access Aetna’s negotiated discount for brand-name drugs at participating pharmacies. (Option 2 is not available with the No-Referral plan.)	Not Covered
Contraceptives and Diabetic Supplies	Included	Not Covered
90 Day Transition of Coverage (TOC) for Prior Authorization and Step Therapy [†]	Option 1: Included for Prior Authorization and Step Therapy. Option 2: Included for Prior Authorization. Step Therapy Not Applicable.	Not Covered
Self-Injectables (Excluding Insulin)	Option 1: 90% Option 2: No coverage provided. Members may access Aetna’s negotiated discount for formulary and non-formulary drugs at participating pharmacies.	Not Covered
Optional Features ^{††}	No Referral Option: PA POS No-Referral 7.3 (Offered Only with RX Option 1).	

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

**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 plan documents as “recognized” charges.

***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.

††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. No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum.

†Transition of Coverage for Prior Authorizations and Step Therapy helps members of new groups to transition to Aetna by providing a 90 calendar day opportunity, beginning on the group’s initial effective date, during which time prior authorization and step therapy requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization and step therapy edits will apply to all drugs requiring prior authorization and step therapy as listed in the formulary guide. Members, who have claims paid for a drug requiring prior authorization and step therapy during the Transition of Coverage period, may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization or approval for a medical exception for this drug.

†††“No Referral” Provision: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefits from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 15–16. Please refer to Aetna’s Producer World[®] web site at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

Pennsylvania Aetna Small Group Medical Plans — POS PLAN OPTIONS

Plan Options	PA POS 1.3 ⁺		PA POS 2.3 ⁺	
Member Benefits	In-Network PCP Coordinated	Out-of-Network* No Referral Needed	In-Network PCP Coordinated	Out-of-Network* No Referral Needed
Plan Coinsurance	N/A	50% after deductible	N/A	60% after deductible
Calendar Year Deductible**	N/A	\$2,000 per member \$6,000 family	N/A	\$1,500 per member \$4,500 family
Calendar Year Out-of-Pocket Maximum*** (Deductible and prescription drugs, including self-injectables, do not apply toward the Out-of-Pocket Maximum.)	\$2,500 per member \$5,000 family	\$10,000 per member \$30,000 family	\$2,500 per member \$5,000 family	\$10,000 per member \$30,000 family
Lifetime Maximum Benefit	Unlimited	\$1,000,000	Unlimited	\$1,000,000
Preventive Care				
Well Baby/Child and Adult Physical Exams (Age and frequency schedules apply. In-network and out-of-network combined.)	\$0 copay	50%, deductible waived	\$0 copay	60%, deductible waived
Routine GYN Exams (Limited to one exam and Pap smear per 365 days. In-network and out-of-network combined.)	\$0 copay	50%, deductible waived	\$0 copay	60%, deductible waived
Routine Mammograms (One annual mammogram for females age 40 and over. In-network and out-of-network combined.)	\$0 copay	50% after deductible	\$0 copay	60% after deductible
Routine Eye Exam (One exam per 24 months. In-network and out-of-network combined.)	\$0 copay	50% after deductible	\$0 copay	60% after deductible
Glasses and Contact Lens Reimbursement	\$100/24 month period. In-network and out-of-network combined.		\$100/24 month period. In-network and out-of-network combined.	
Aetna VisionSM Discounts Program	Included	Not Covered	Included	Not Covered
Primary Physician Office Visit	\$30 copay	50% after deductible	\$20 copay	60% after deductible
Specialist Office Visit	\$50 copay	50% after deductible	\$40 copay	60% after deductible
Outpatient Services – Lab	\$0 copay	50% after deductible	\$0 copay	60% after deductible
Outpatient Services – X-ray	\$50 copay	50% after deductible	\$40 copay	60% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$150 copay	50% after deductible	\$150 copay	60% after deductible
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	\$50 copay	50% after deductible	\$40 copay	60% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year. In-network and out-of-network combined.)	\$50 copay	50% after deductible	\$40 copay	60% after deductible
Outpatient Speech Therapy (30 visits per calendar year. In-network and out-of-network combined.)	\$50 copay	50% after deductible	\$40 copay	60% after deductible
Durable Medical Equipment (\$2,500 Calendar Year Maximum. In-network and out-of-network combined.)	50%	50% after deductible	50%	50% after deductible
Inpatient Hospital	\$300 copay per day, 5 day copay maximum per admission	50% after deductible	\$200 copay per day, 5 day copay maximum per admission	60% after deductible
Outpatient Surgery	\$300 copay	50% after deductible	\$200 copay	60% after deductible
Emergency Room (Copay waived if admitted.)	\$150 copay	\$150 copay	\$150 copay	\$150 copay
Mental Health – Inpatient (Limited to 30 days per calendar year. In-network and out-of-network combined.)	\$300 copay per day, 5 day copay maximum per admission	50% after deductible	\$200 copay per day, 5 day copay maximum per admission	60% after deductible
Substance Abuse – Inpatient (In-Network: Detox.: Unlimited days per calendar year; Rehab.: 30 days per calendar year; 90 days per lifetime. Out-of-Network: Detox.: 7 days per admission, 4 admissions per lifetime. In-network and out-of-network combined. Rehab.: 30 days per calendar year; 90 days per lifetime. In-network and out-of-network combined.)	\$300 copay per day, 5 day copay maximum per admission	50% after deductible	\$200 copay per day, 5 day copay maximum per admission	60% after deductible
Prescription Drug Deductible	N/A	N/A	N/A	N/A
Prescription Drugs – Retail: 30-day supply	Option 1: \$15/\$35/\$60 Option 2: \$20/\$40/\$70	Not Covered	Option 1: \$15/\$30/\$50 Option 2: \$20/\$40/\$70	Not Covered
Prescription Drugs – Mail Order: 31-90-day supply	Option 1: \$30/\$70/\$120 Option 2: \$40/\$80/\$140	Not Covered	Option 1: \$30/\$60/\$100 Option 2: \$40/\$80/\$140	Not Covered
Contraceptives and Diabetic Supplies	Included	Not Covered	Included	Not Covered
90 Day Transition of Coverage (TOC) for Prior Authorization and Step Therapy[†]	Included	Not Covered	Included	Not Covered
Self-Injectables (Excluding Insulin)	90%	Not Covered	90%	Not Covered
Optional Features^{††}	No Referral Option: PA POS No-Referral 1.3		No Referral Option: PA POS No-Referral 2.3	

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

*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 plan documents as "recognized" charges.

**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.

***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. No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum.

[†]Transition of Coverage for Prior Authorizations and Step Therapy helps members of new groups to transition to Aetna by providing a 90 calendar day opportunity, beginning on the group's initial effective date, during which time prior authorization and step therapy requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization and step therapy edits will apply to all drugs requiring prior authorization and step therapy as listed in the formulary guide. Members, who have claims paid for a drug requiring prior authorization and step therapy during the Transition of Coverage period, may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization or approval for a medical exception for this drug.

^{††}"No Referral" Provision: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefits from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 15–16. Please refer to Aetna's Producer World® web site at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

Pennsylvania Aetna Small Group Medical Plans — POS PLAN OPTIONS

Plan Options	PA POS 3.3 ⁺		PA POS 4.3 ⁺	
Member Benefits	In-Network PCP Coordinated	Out-of-Network* No Referral Needed	In-Network PCP Coordinated	Out-of-Network* No Referral Needed
Plan Coinsurance	N/A	70% after deductible	N/A	80% after deductible
Calendar Year Deductible**	N/A	\$1,000 per member \$3,000 family	N/A	\$500 per member \$1,500 family
Calendar Year Out-of-Pocket Maximum*** (Deductible and prescription drugs, including self-injectables, do not apply toward the Out-of-Pocket Maximum.)	\$2,500 per member \$5,000 family	\$5,000 per member \$15,000 family	\$2,500 per member \$5,000 family	\$5,000 per member \$15,000 family
Lifetime Maximum Benefit	Unlimited	\$1,000,000	Unlimited	\$1,000,000
Preventive Care				
Well Baby/Child and Adult Physical Exams (Age and frequency schedules apply. In-network and out-of-network combined.)	\$0 copay	70%, deductible waived	\$0 copay	80%, deductible waived
Routine GYN Exams (Limited to one exam and Pap smear per 365 days. In-network and out-of-network combined.)	\$0 copay	70%, deductible waived	\$0 copay	80%, deductible waived
Routine Mammograms (One annual mammogram for females age 40 and over. In-network and out-of-network combined.)	\$0 copay	70% after deductible	\$0 copay	80% after deductible
Routine Eye Exam (One exam per 24 months. In-network and out-of-network combined.)	\$0 copay	70% after deductible	\$0 copay	80% after deductible
Glasses and Contact Lens Reimbursement	\$100/24 month period. In-network and out-of-network combined.		\$100/24 month period. In-network and out-of-network combined.	
Aetna Vision SM Discounts Program	Included	Not Covered	Included	Not Covered
Primary Physician Office Visit	\$15 copay	70% after deductible	\$10 copay	80% after deductible
Specialist Office Visit	\$30 copay	70% after deductible	\$20 copay	80% after deductible
Outpatient Services – Lab	\$0 copay	70% after deductible	\$0 copay	80% after deductible
Outpatient Services – X-ray	\$30 copay	70% after deductible	\$20 copay	80% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$150 copay	70% after deductible	\$150 copay	80% after deductible
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	\$30 copay	70% after deductible	\$20 copay	80% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year. In-network and out-of-network combined.)	\$30 copay	70% after deductible	\$20 copay	80% after deductible
Outpatient Speech Therapy (30 visits per calendar year. In-network and out-of-network combined.)	\$30 copay	70% after deductible	\$20 copay	80% after deductible
Durable Medical Equipment (\$2,500 Calendar Year Maximum. In-network and out-of-network combined.)	50%	50% after deductible	50%	50% after deductible
Inpatient Hospital	\$150 copay per day, 5 day copay maximum per admission	70% after deductible	\$0 copay per admission	80% after deductible
Outpatient Surgery	\$150 copay	70% after deductible	\$0 copay	80% after deductible
Emergency Room (Copay waived if admitted.)	\$150 copay	\$150 copay	\$150 copay	\$150 copay
Mental Health – Inpatient (Limited to 30 days per calendar year. In-network and out-of-network combined.)	\$150 copay per day, 5 day copay maximum per admission	70% after deductible	\$0 copay per admission	80% after deductible
Substance Abuse – Inpatient (In-Network: Detox.: Unlimited days per calendar year; Rehab.: 30 days per calendar year; 90 days per lifetime. Out-of-Network: Detox.: 7 days per admission, 4 admissions per lifetime. In-network and out-of-network combined. Rehab.: 30 days per calendar year; 90 days per lifetime. In-network and out-of-network combined.)	\$150 copay per day, 5 day copay maximum per admission	70% after deductible	\$0 copay per admission	80% after deductible
Prescription Drug Deductible	N/A	N/A	N/A	N/A
Prescription Drugs – Retail: 30-day supply	Option 1: \$10/\$25/\$50 Option 2: \$20/\$40/\$70	Not Covered	Option 1: \$5/\$20/\$40 Option 2: \$20/\$40/\$70	Not Covered
Prescription Drugs – Mail Order: 31-90-day supply	Option 1: \$20/\$50/\$100 Option 2: \$40/\$80/\$140	Not Covered	Option 1: \$10/\$40/\$80 Option 2: \$40/\$80/\$140	Not Covered
Contraceptives and Diabetic Supplies	Included	Not Covered	Included	Not Covered
90 Day Transition of Coverage (TOC) for Prior Authorization and Step Therapy [†]	Included	Not Covered	Included	Not Covered
Self-Injectables (Excluding Insulin)	90%	Not Covered	90%	Not Covered
Optional Features ^{††}	No Referral Option: PA POS No-Referral 3.3		No Referral Option: PA POS No-Referral 4.3	

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

*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 plan documents as "recognized" charges.

**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.

***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. No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum.

[†]Transition of Coverage for Prior Authorizations and Step Therapy helps members of new groups to transition to Aetna by providing a 90 calendar day opportunity, beginning on the group's initial effective date, during which time prior authorization and step therapy requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization and step therapy edits will apply to all drugs requiring prior authorization and step therapy as listed in the formulary guide. Members, who have claims paid for a drug requiring prior authorization and step therapy during the Transition of Coverage period, may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization or approval for a medical exception for this drug.

^{††}"No Referral" Provision: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefits from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 15–16. Please refer to Aetna's Producer World[®] web site at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

Pennsylvania Aetna Small Group Medical Plans — POS PLAN OPTIONS

Plan Options	PA POS 8.3 ⁺	
Member Benefits	In-Network PCP Coordinated	Out-of-Network* No Referral Needed
Plan Coinsurance	N/A	50% after deductible
Calendar Year Deductible**	N/A	\$5,000 per member \$15,000 family
Calendar Year Out-of-Pocket Maximum*** (Deductible and prescription drugs, including self-injectables, do not apply toward the Out-of-Pocket Maximum.)	\$5,000 per member \$10,000 family	\$10,000 per member \$30,000 family
Lifetime Maximum Benefit	Unlimited	\$250,000
Preventive Care		
Well Baby/Child and Adult Physical Exams (Age and frequency schedules apply. In-network and out-of-network combined.)	\$0 copay	50%, deductible waived
Routine GYN Exams (Limited to one exam and Pap smear per 365 days. In-network and out-of-network combined.)	\$0 copay	50%, deductible waived
Routine Mammograms (One annual mammogram for females age 40 and over. In-network and out-of-network combined.)	\$0 copay	50% after deductible
Routine Eye Exam (One exam per 24 months. In-network and out-of-network combined.)	\$0 copay	50% after deductible
Glasses and Contact Lens Reimbursement	\$100/24 month period. In-network and out-of-network combined.	
Aetna Vision SM Discounts Program	Included	Not Covered
Primary Physician Office Visit	\$50 copay	50% after deductible
Specialist Office Visit	\$75 copay	50% after deductible
Outpatient Services – Lab	\$0 copay	50% after deductible
Outpatient Services – X-ray	\$75 copay	50% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$150 copay	50% after deductible
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	\$75 copay	50% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year. In-network and out-of-network combined.)	\$75 copay	50% after deductible
Outpatient Speech Therapy (30 visits per calendar year. In-network and out-of-network combined.)	\$75 copay	50% after deductible
Durable Medical Equipment (\$2,500 Calendar Year Maximum. In-network and out-of-network combined.)	50%	50% after deductible
Inpatient Hospital	\$750 copay per day, 5 day copay maximum per admission	50% after deductible
Outpatient Surgery	\$750 copay	50% after deductible
Emergency Room (Copay waived if admitted.)	\$150 copay	\$150 copay
Mental Health – Inpatient (Limited to 30 days per calendar year. In-network and out-of-network combined.)	\$750 copay per day, 5 day copay maximum per admission	50% after deductible
Substance Abuse – Inpatient (In-Network: Detox.: Unlimited days per calendar year; Rehab.: 30 days per calendar year; 90 days per lifetime. Out-of-Network: Detox.: 7 days per admission, 4 admissions per lifetime. In-network and out-of-network combined. Rehab.: 30 days per calendar year; 90 days per lifetime. In-network and out-of-network combined.)	\$750 copay per day, 5 day copay maximum per admission	50% after deductible
Prescription Drug Deductible	N/A	N/A
Prescription Drugs – Retail: 30-day supply	Option 1: \$20/\$40/\$70 Option 2: \$15 for Generic Drugs; Brand-name drugs are not covered. Members may access Aetna’s negotiated discount for brand-name drugs at participating pharmacies. (Option 2 is not available with the No-Referral plan.)	Not Covered
Prescription Drugs – Mail Order: 31-90-day supply	Option 1: \$40/\$80/\$140 Option 2: \$30 for Generic Drugs; Brand-name drugs are not covered. Members may access Aetna’s negotiated discount for brand-name drugs at participating pharmacies. (Option 2 is not available with the No-Referral plan.)	Not Covered
Contraceptives and Diabetic Supplies	Included	Not Covered
90 Day Transition of Coverage (TOC) for Prior Authorization and Step Therapy [†]	Option 1: Included for Prior Authorization and Step Therapy. Option 2: Included for Prior Authorization. Step Therapy Not Applicable.	Not Covered
Self-Injectables (Excluding Insulin)	Option 1: 90% Option 2: No coverage provided. Members may access Aetna’s negotiated discount for formulary and non-formulary drugs at participating pharmacies.	Not Covered
Optional Features ^{††}	Not Applicable	

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

**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 plan documents as “recognized” charges.

***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.

††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. No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum.

†Transition of Coverage for Prior Authorizations and Step Therapy helps members of new groups to transition to Aetna by providing a 90 calendar day opportunity, beginning on the group’s initial effective date, during which time prior authorization and step therapy requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization and step therapy edits will apply to all drugs requiring prior authorization and step therapy as listed in the formulary guide. Members, who have claims paid for a drug requiring prior authorization and step therapy during the Transition of Coverage period, may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization or approval for a medical exception for this drug.

†††“No Referral” Provision: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefits from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 15–16. Please refer to Aetna’s Producer World® web site at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

Pennsylvania Aetna Small Group Medical Plans — POS PLAN OPTIONS

Plan Options	PA POS 5.3 ⁺		PA POS 9.3 ⁺	
Member Benefits	In-Network PCP Coordinated	Out-of-Network* No Referral Needed	In-Network PCP Coordinated	Out-of-Network* No Referral Needed
Plan Coinsurance	N/A	50% after deductible	N/A	50% after deductible
Calendar Year Deductible**	N/A	\$5,000 per member \$15,000 family	N/A	\$5,000 per member \$15,000 family
Calendar Year Out-of-Pocket Maximum*** (Deductible and prescription drugs, including self-injectables, do not apply toward the Out-of-Pocket Maximum.)	\$2,500 per member \$5,000 family	\$10,000 per member \$30,000 family	\$2,500 per member \$5,000 family	\$10,000 per member \$30,000 family
Lifetime Maximum Benefit	Unlimited	\$250,000	Unlimited	\$250,000
Preventive Care				
Well Baby/Child and Adult Physical Exams (Age and frequency schedules apply. In-network and out-of-network combined.)	\$0 copay	50%, deductible waived	\$0 copay	50%, deductible waived
Routine GYN Exams (Limited to one exam and Pap smear per 365 days. In-network and out-of-network combined.)	\$0 copay	50%, deductible waived	\$0 copay	50%, deductible waived
Routine Mammograms (One annual mammogram for females age 40 and over. In-network and out-of-network combined.)	\$0 copay	50% after deductible	\$0 copay	50% after deductible
Routine Eye Exam (One exam per 24 months. In-network and out-of-network combined.)	\$0 copay	50% after deductible	\$0 copay	50% after deductible
Glasses and Contact Lens Reimbursement	\$100/24 month period. In-network and out-of-network combined.		\$100/24 month period. In-network and out-of-network combined.	
Aetna VisionSM Discounts Program	Included	Not Covered	Included	Not Covered
Primary Physician Office Visit	\$20 copay	50% after deductible	\$15 copay	50% after deductible
Specialist Office Visit	\$40 copay	50% after deductible	\$30 copay	50% after deductible
Outpatient Services – Lab	\$0 copay	50% after deductible	\$0 copay	50% after deductible
Outpatient Services – X-ray	\$40 copay	50% after deductible	\$30 copay	50% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$150 copay	50% after deductible	\$150 copay	50% after deductible
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	\$40 copay	50% after deductible	\$30 copay	50% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year. In-network and out-of-network combined.)	\$40 copay	50% after deductible	\$30 copay	50% after deductible
Outpatient Speech Therapy (30 visits per calendar year. In-network and out-of-network combined.)	\$40 copay	50% after deductible	\$30 copay	50% after deductible
Durable Medical Equipment (\$2,500 Calendar Year Maximum. In-network and out-of-network combined.)	50%	50% after deductible	50%	50% after deductible
Inpatient Hospital	\$300 copay per day, 5 day copay maximum per admission	50% after deductible	\$200 copay per day, 5 day copay maximum per admission	50% after deductible
Outpatient Surgery	\$300 copay	50% after deductible	\$200 copay	50% after deductible
Emergency Room (Copay waived if admitted.)	\$150 copay	\$150 copay	\$150 copay	\$150 copay
Mental Health – Inpatient (Limited to 30 days per calendar year. In-network and out-of-network combined.)	\$300 copay per day, 5 day copay maximum per admission	50% after deductible	\$200 copay per day, 5 day copay maximum per admission	50% after deductible
Substance Abuse – Inpatient (In-Network: Detox.: Unlimited days per calendar year; Rehab.: 30 days per calendar year; 90 days per lifetime. Out-of-Network: Detox.: 7 days per admission, 4 admissions per lifetime. In-network and out-of-network combined. Rehab.: 30 days per calendar year; 90 days per lifetime. In-network and out-of-network combined.)	\$300 copay per day, 5 day copay maximum per admission	50% after deductible	\$200 copay per day, 5 day copay maximum per admission	50% after deductible
Prescription Drug Deductible	N/A	N/A	N/A	N/A
Prescription Drugs – Retail: 30-day supply	Option 1: \$15/\$35/\$60	Not Covered	Option 1: \$15/\$30/\$50	Not Covered
Prescription Drugs – Mail Order: 31-90-day supply	Option 1: \$30/\$70/\$120	Not Covered	Option 1: \$30/\$60/\$100	Not Covered
Contraceptives and Diabetic Supplies	Included	Not Covered	Included	Not Covered
90 Day Transition of Coverage (TOC) for Prior Authorization and Step Therapy[†]	Included	Not Covered	Included	Not Covered
Self-Injectables (Excluding Insulin)	90%	Not Covered	90%	Not Covered
Optional Features^{††}	No Referral Option: PA POS No-Referral 5.3		No Referral Option: PA POS No-Referral 9.3	

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

**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 plan documents as "recognized" charges.

***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.

***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. No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum.

[†]Transition of Coverage for Prior Authorizations and Step Therapy helps members of new groups to transition to Aetna by providing a 90 calendar day opportunity, beginning on the group's initial effective date, during which time prior authorization and step therapy requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization and step therapy edits will apply to all drugs requiring prior authorization and step therapy as listed in the formulary guide. Members, who have claims paid for a drug requiring prior authorization and step therapy during the Transition of Coverage period, may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization or approval for a medical exception for this drug.

^{††}"No Referral" Provision: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefits from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 15–16. Please refer to Aetna's Producer World[®] web site at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

Pennsylvania Aetna Small Group Medical Plans — POS PLAN OPTIONS

Plan Options	PA POS 6.3 ⁺	
Member Benefits	In-Network PCP Coordinated	Out-of-Network* No Referral Needed
Plan Coinsurance	N/A	50% after deductible
Calendar Year Deductible**	N/A	\$5,000 per member \$15,000 family
Calendar Year Out-of-Pocket Maximum*** (Deductible and prescription drugs, including self-injectables, do not apply toward the Out-of-Pocket Maximum.)	\$2,500 per member \$5,000 family	\$10,000 per member \$30,000 family
Lifetime Maximum Benefit	Unlimited	\$250,000
Preventive Care		
Well Baby/Child and Adult Physical Exams (Age and frequency schedules apply. In-network and out-of-network combined.)	\$0 copay	50%, deductible waived
Routine GYN Exams (Limited to one exam and Pap smear per 365 days. In-network and out-of-network combined.)	\$0 copay	50%, deductible waived
Routine Mammograms (One annual mammogram for females age 40 and over. In-network and out-of-network combined.)	\$0 copay	50% after deductible
Routine Eye Exam (One exam per 24 months. In-network and out-of-network combined.)	\$0 copay	50% after deductible
Glasses and Contact Lens Reimbursement	\$100/24 month period. In-network and out-of-network combined.	
Aetna Vision SM Discounts Program	Included	Not Covered
Primary Physician Office Visit	\$10 copay	50% after deductible
Specialist Office Visit	\$20 copay	50% after deductible
Outpatient Services – Lab	\$0 copay	50% after deductible
Outpatient Services – X-ray	\$20 copay	50% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$150 copay	50% after deductible
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	\$20 copay	50% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year. In-network and out-of-network combined.)	\$20 copay	50% after deductible
Outpatient Speech Therapy (30 visits per calendar year. In-network and out-of-network combined.)	\$20 copay	50% after deductible
Durable Medical Equipment (\$2,500 Calendar Year Maximum. In-network and out-of-network combined.)	50%	50% after deductible
Inpatient Hospital	\$0 copay per admission	50% after deductible
Outpatient Surgery	\$0 copay	50% after deductible
Emergency Room (Copay waived if admitted.)	\$150 copay	\$150 copay
Mental Health – Inpatient (Limited to 30 days per calendar year. In-network and out-of-network combined.)	\$0 copay per admission	50% after deductible
Substance Abuse – Inpatient (In-Network: Detox.: Unlimited days per calendar year; Rehab.: 30 days per calendar year; 90 days per lifetime. Out-of-Network: Detox.: 7 days per admission, 4 admissions per lifetime. In-network and out-of-network combined. Rehab.: 30 days per calendar year; 90 days per lifetime. In-network and out-of-network combined.)	\$0 copay per admission	50% after deductible
Prescription Drug Deductible	N/A	N/A
Prescription Drugs – Retail: 30-day supply	Option 1: \$10/\$25/\$50	Not Covered
Prescription Drugs – Mail Order: 31-90-day supply	Option 1: \$20/\$50/\$100	Not Covered
Contraceptives and Diabetic Supplies	Included	Not Covered
90 Day Transition of Coverage (TOC) for Prior Authorization and Step Therapy [†]	Included	Not Covered
Self-Injectables (Excluding Insulin)	90%	Not Covered
Optional Features ^{††}	No Referral Option: PA POS No-Referral 6.3	

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

**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 plan documents as "recognized" charges.

***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.

***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. No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum.

[†]Transition of Coverage for Prior Authorizations and Step Therapy helps members of new groups to transition to Aetna by providing a 90 calendar day opportunity, beginning on the group's initial effective date, during which time prior authorization and step therapy requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization and step therapy edits will apply to all drugs requiring prior authorization and step therapy as listed in the formulary guide. Members, who have claims paid for a drug requiring prior authorization and step therapy during the Transition of Coverage period, may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization or approval for a medical exception for this drug.

^{††}"No Referral" Provision: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefits from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 15–16. Please refer to Aetna's Producer World[®] web site at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

Pennsylvania Aetna Small Group Medical Plans — POS COST-SHARING PLAN OPTIONS

Plan Options	PA POS COST-SHARING 1.3 ⁺		PA POS COST-SHARING 2.3 ⁺	
Member Benefits	In-Network PCP Coordinated	Out-of-Network* No Referral Needed	In-Network PCP Coordinated	Out-of-Network* No Referral Needed
Plan Coinsurance	N/A	50% after deductible	N/A	50% after deductible
Calendar Year Deductible** (Deductible applies only to in-network inpatient hospital-type services/outpatient surgery and out-of-network benefits unless state mandated.)	\$2,500 per member/\$5,000 family (In-network and out-of-network combined.)		\$2,000 per member/\$4,000 family (In-network and out-of-network combined.)	
Calendar Year Out-of-Pocket Maximum*** (Deductible does apply to the Out-of-Pocket Maximum. Prescription drugs, including self-injectables, do not apply toward the Out-of-Pocket Maximum.)	\$5,000 per member/\$10,000 family (In-network and out-of-network combined.)		\$4,000 per member/\$8,000 family (In-network and out-of-network combined.)	
Lifetime Maximum Benefit	Unlimited	\$250,000	Unlimited	\$250,000
Preventive Care				
Well Baby/Child and Adult Physical Exams (Age and frequency schedules apply. In-network and out-of-network combined.)	\$0 copay, deductible waived	50%, deductible waived	\$0 copay, deductible waived	50%, deductible waived
Routine GYN Exams (Limited to one exam and Pap smear per 365 days. In-network and out-of-network combined.)	\$0 copay, deductible waived	50%, deductible waived	\$0 copay, deductible waived	50%, deductible waived
Routine Mammograms (One annual mammogram for females age 40 and over. In-network and out-of-network combined.)	\$0 copay, deductible waived	50% after deductible	\$0 copay, deductible waived	50% after deductible
Routine Eye Exam (One exam per 24 months. In-network and out-of-network combined.)	\$0 copay, deductible waived	50% after deductible	\$0 copay, deductible waived	50% after deductible
Glasses and Contact Lens Reimbursement	\$100/24 month period. In-network and out-of-network combined.		\$100/24 month period. In-network and out-of-network combined.	
Aetna VisionSM Discounts Program	Included	Not Covered	Included	Not Covered
Primary Physician Office Visit	\$40 copay, deductible waived	50% after deductible	\$30 copay, deductible waived	50% after deductible
Specialist Office Visit	\$50 copay, deductible waived	50% after deductible	\$50 copay, deductible waived	50% after deductible
Outpatient Services – Lab	\$0 copay, deductible waived	50% after deductible	\$0 copay, deductible waived	50% after deductible
Outpatient Services – X-ray	\$50 copay, deductible waived	50% after deductible	\$50 copay, deductible waived	50% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$150 copay, deductible waived	50% after deductible	\$150 copay, deductible waived	50% after deductible
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	\$50 copay, deductible waived	50% after deductible	\$50 copay, deductible waived	50% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year. In-network and out-of-network combined.)	\$50 copay, deductible waived	50% after deductible	\$50 copay, deductible waived	50% after deductible
Outpatient Speech Therapy (30 visits per calendar year. In-network and out-of-network combined.)	\$50 copay, deductible waived	50% after deductible	\$50 copay, deductible waived	50% after deductible
Durable Medical Equipment (\$2,500 Calendar Year Maximum. In-network and out-of-network combined.)	50%, deductible waived	50% after deductible	50%, deductible waived	50% after deductible
Inpatient Hospital	\$0 copay per admission after deductible	50% after deductible	\$0 copay per admission after deductible	50% after deductible
Outpatient Surgery	\$0 copay after deductible	50% after deductible	\$0 copay after deductible	50% after deductible
Emergency Room (Copay waived if admitted.)	\$150 copay, deductible waived	\$150 copay, deductible waived	\$150 copay, deductible waived	\$150 copay, deductible waived
Mental Health – Inpatient (Limited to 30 days per calendar year. In-network and out-of-network combined.)	\$0 copay per admission after deductible	50% after deductible	\$0 copay per admission after deductible	50% after deductible
Substance Abuse – Inpatient (In-Network: Detox.: Unlimited days per calendar year; Rehab.: 30 days per calendar year; 90 days per lifetime. Out-of-Network: Detox.: 7 days per admission, 4 admissions per lifetime. In-network and out-of-network combined. Rehab.: 30 days per calendar year; 90 days per lifetime. In-network and out-of-network combined.)	\$0 copay per admission after deductible	50% after deductible	\$0 copay per admission after deductible	50% after deductible
Prescription Drug Deductible	N/A	N/A	N/A	N/A
Prescription Drugs – Retail: 30-day supply	\$20/\$40/\$70	Not Covered	\$20/\$40/\$70	Not Covered
Prescription Drugs – Mail Order: 31-90-day supply	\$40/\$80/\$140	Not Covered	\$40/\$80/\$140	Not Covered
Contraceptives and Diabetic Supplies	Included	Not Covered	Included	Not Covered
90 Day Transition of Coverage (TOC) for Prior Authorization and Step Therapy[†]	Included	Not Covered	Included	Not Covered
Self-Injectables (Excluding Insulin)	90%	Not Covered	90%	Not Covered
Optional Features^{††}	Not Applicable		Not Applicable	

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

*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 plan documents as "recognized" charges.

**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.

***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. No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum.

[†]Transition of Coverage for Prior Authorizations and Step Therapy helps members of new groups to transition to Aetna by providing a 90 calendar day opportunity, beginning on the group's initial effective date, during which time prior authorization and step therapy requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization and step therapy edits will apply to all drugs requiring prior authorization and step therapy as listed in the formulary guide. Members, who have claims paid for a drug requiring prior authorization and step therapy during the Transition of Coverage period, may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization or approval for a medical exception for this drug.

^{††}"No Referral" Provision: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefits from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 15–16. Please refer to Aetna's Producer World[®] web site at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

Pennsylvania Aetna Small Group Medical Plans — POS COST-SHARING PLAN OPTIONS

Plan Options	PA POS COST-SHARING 3.3 ⁺		PA POS COST-SHARING 4.3 ⁺	
Member Benefits	In-Network PCP Coordinated	Out-of-Network* No Referral Needed	In-Network PCP Coordinated	Out-of-Network* No Referral Needed
Plan Coinsurance	N/A	50% after deductible	N/A	50% after deductible
Calendar Year Deductible** (Deductible applies only to in-network inpatient hospital-type services/outpatient surgery and out-of-network benefits unless state mandated.)	\$1,500 per member/\$3,000 family (In-network and out-of-network combined.)		\$1,000 per member/\$2,000 family (In-network and out-of-network combined.)	
Calendar Year Out-of-Pocket Maximum*** (Deductible does apply to the Out-of-Pocket Maximum. Prescription drugs, including self-injectables, do not apply toward the Out-of-Pocket Maximum.)	\$2,500 per member/\$5,000 family (In-network and out-of-network combined.)		\$2,500 per member/\$5,000 family (In-network and out-of-network combined.)	
Lifetime Maximum Benefit	Unlimited	\$250,000	Unlimited	\$250,000
Preventive Care				
Well Baby/Child and Adult Physical Exams (Age and frequency schedules apply. In-network and out-of-network combined.)	\$0 copay, deductible waived	50%, deductible waived	\$0 copay, deductible waived	50%, deductible waived
Routine GYN Exams (Limited to one exam and Pap smear per 365 days. In-network and out-of-network combined.)	\$0 copay, deductible waived	50%, deductible waived	\$0 copay, deductible waived	50%, deductible waived
Routine Mammograms (One annual mammogram for females age 40 and over. In-network and out-of-network combined.)	\$0 copay, deductible waived	50% after deductible	\$0 copay, deductible waived	50% after deductible
Routine Eye Exam (One exam per 24 months. In-network and out-of-network combined.)	\$0 copay, deductible waived	50% after deductible	\$0 copay, deductible waived	50% after deductible
Glasses and Contact Lens Reimbursement	\$100/24 month period. In-network and out-of-network combined.		\$100/24 month period. In-network and out-of-network combined.	
Aetna Vision SM Discounts Program	Included	Not Covered	Included	Not Covered
Primary Physician Office Visit	\$30 copay, deductible waived	50% after deductible	\$20 copay, deductible waived	50% after deductible
Specialist Office Visit	\$50 copay, deductible waived	50% after deductible	\$40 copay, deductible waived	50% after deductible
Outpatient Services – Lab	\$0 copay, deductible waived	50% after deductible	\$0 copay, deductible waived	50% after deductible
Outpatient Services – X-ray	\$50 copay, deductible waived	50% after deductible	\$40 copay, deductible waived	50% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$150 copay, deductible waived	50% after deductible	\$150 copay, deductible waived	50% after deductible
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	\$50 copay, deductible waived	50% after deductible	\$40 copay, deductible waived	50% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year. In-network and out-of-network combined.)	\$50 copay, deductible waived	50% after deductible	\$40 copay, deductible waived	50% after deductible
Outpatient Speech Therapy (30 visits per calendar year. In-network and out-of-network combined.)	\$50 copay, deductible waived	50% after deductible	\$40 copay, deductible waived	50% after deductible
Durable Medical Equipment (\$2,500 Calendar Year Maximum. In-network and out-of-network combined.)	50%, deductible waived	50% after deductible	50%, deductible waived	50% after deductible
Inpatient Hospital	\$0 copay per admission after deductible	50% after deductible	\$0 copay per admission after deductible	50% after deductible
Outpatient Surgery	\$0 copay after deductible	50% after deductible	\$0 copay after deductible	50% after deductible
Emergency Room (Copay waived if admitted.)	\$150 copay, deductible waived	\$150 copay, deductible waived	\$150 copay, deductible waived	\$150 copay, deductible waived
Mental Health – Inpatient (Limited to 30 days per calendar year. In-network and out-of-network combined.)	\$0 copay per admission after deductible	50% after deductible	\$0 copay per admission after deductible	50% after deductible
Substance Abuse – Inpatient (In-Network: Detox.: Unlimited days per calendar year; Rehab.: 30 days per calendar year; 90 days per lifetime. Out-of-Network: Detox.: 7 days per admission, 4 admissions per lifetime. In-network and out-of-network combined. Rehab.: 30 days per calendar year; 90 days per lifetime. In-network and out-of-network combined.)	\$0 copay per admission after deductible	50% after deductible	\$0 copay per admission after deductible	50% after deductible
Prescription Drug Deductible	N/A	N/A	N/A	N/A
Prescription Drugs – Retail: 30-day supply	\$15/\$40/\$60	Not Covered	\$15/\$40/\$60	Not Covered
Prescription Drugs – Mail Order: 31-90-day supply	\$30/\$80/\$120	Not Covered	\$30/\$80/\$120	Not Covered
Contraceptives and Diabetic Supplies	Included	Not Covered	Included	Not Covered
90 Day Transition of Coverage (TOC) for Prior Authorization and Step Therapy [†]	Included	Not Covered	Included	Not Covered
Self-Injectables (Excluding Insulin)	90%	Not Covered	90%	Not Covered
Optional Features ^{††}	Not Applicable		No Referral Option: PA POS Cost-Sharing No-Referral 4.3	

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

*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 plan documents as "recognized" charges.

**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.

***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. No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum.

[†]Transition of Coverage for Prior Authorizations and Step Therapy helps members of new groups to transition to Aetna by providing a 90 calendar day opportunity, beginning on the group's initial effective date, during which time prior authorization and step therapy requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization and step therapy edits will apply to all drugs requiring prior authorization and step therapy as listed in the formulary guide. Members, who have claims paid for a drug requiring prior authorization and step therapy during the Transition of Coverage period, may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization or approval for a medical exception for this drug.

^{††}"No Referral" Provision: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefits from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 15–16. Please refer to Aetna's Producer World[®] web site at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

Pennsylvania Aetna Small Group Medical Plans — POS COST-SHARING PLAN OPTIONS

Plan Options	PA POS COST-SHARING 5.3 ⁺	
Member Benefits	In-Network PCP Coordinated	Out-of-Network* No Referral Needed
Plan Coinsurance	N/A	50% after deductible
Calendar Year Deductible** (Deductible applies only to in-network inpatient hospital-type services/outpatient surgery and out-of-network benefits unless state mandated.)	\$500 per member/\$1,000 family (In-network and out-of-network combined.)	
Calendar Year Out-of-Pocket Maximum*** (Deductible does apply to the Out-of-Pocket Maximum. Prescription drugs, including self-injectables, do not apply toward the Out-of-Pocket Maximum.)	\$2,500 per member/\$5,000 family (In-network and out-of-network combined.)	
Lifetime Maximum Benefit	Unlimited	\$250,000
Preventive Care		
Well Baby/Child and Adult Physical Exams (Age and frequency schedules apply. In-network and out-of-network combined.)	\$0 copay, deductible waived	50%, deductible waived
Routine GYN Exams (Limited to one exam and Pap smear per 365 days. In-network and out-of-network combined.)	\$0 copay, deductible waived	50%, deductible waived
Routine Mammograms (One annual mammogram for females age 40 and over. In-network and out-of-network combined.)	\$0 copay, deductible waived	50% after deductible
Routine Eye Exam (One exam per 24 months. In-network and out-of-network combined.)	\$0 copay, deductible waived	50% after deductible
Glasses and Contact Lens Reimbursement	\$100/24 month period. In-network and out-of-network combined.	
Aetna VisionSM Discounts Program	Included	Not Covered
Primary Physician Office Visit	\$20 copay, deductible waived	50% after deductible
Specialist Office Visit	\$40 copay, deductible waived	50% after deductible
Outpatient Services – Lab	\$0 copay, deductible waived	50% after deductible
Outpatient Services – X-ray	\$40 copay, deductible waived	50% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$150 copay, deductible waived	50% after deductible
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	\$40 copay, deductible waived	50% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year. In-network and out-of-network combined.)	\$40 copay, deductible waived	50% after deductible
Outpatient Speech Therapy (30 visits per calendar year. In-network and out-of-network combined.)	\$40 copay, deductible waived	50% after deductible
Durable Medical Equipment (\$2,500 Calendar Year Maximum. In-network and out-of-network combined.)	50%, deductible waived	50% after deductible
Inpatient Hospital	\$0 copay per admission after deductible	50% after deductible
Outpatient Surgery	\$0 copay after deductible	50% after deductible
Emergency Room (Copay waived if admitted.)	\$150 copay, deductible waived	\$150 copay, deductible waived
Mental Health – Inpatient (Limited to 30 days per calendar year. In-network and out-of-network combined.)	\$0 copay per admission after deductible	50% after deductible
Substance Abuse – Inpatient (In-Network: Detox.: Unlimited days per calendar year; Rehab.: 30 days per calendar year; 90 days per lifetime. Out-of-Network: Detox.: 7 days per admission, 4 admissions per lifetime. In-network and out-of-network combined. Rehab.: 30 days per calendar year; 90 days per lifetime. In-network and out-of-network combined.)	\$0 copay per admission after deductible	50% after deductible
Prescription Drug Deductible	N/A	N/A
Prescription Drugs – Retail: 30-day supply	\$15/\$40/\$60	Not Covered
Prescription Drugs – Mail Order: 31-90-day supply	\$30/\$80/\$120	Not Covered
Contraceptives and Diabetic Supplies	Included	Not Covered
90 Day Transition of Coverage (TOC) for Prior Authorization and Step Therapy[†]	Included	Not Covered
Self-Injectables (Excluding Insulin)	90%	Not Covered
Optional Features^{††}	No Referral Option: PA POS Cost-Sharing No-Referral 5.3	

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

*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 plan documents as "recognized" charges.

**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.

***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. No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum.

[†]Transition of Coverage for Prior Authorizations and Step Therapy helps members of new groups to transition to Aetna by providing a 90 calendar day opportunity, beginning on the group's initial effective date, during which time prior authorization and step therapy requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization and step therapy edits will apply to all drugs requiring prior authorization and step therapy as listed in the formulary guide. Members, who have claims paid for a drug requiring prior authorization and step therapy during the Transition of Coverage period, may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization or approval for a medical exception for this drug.

^{††}"No Referral" Provision: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefits from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 15–16. Please refer to Aetna's Producer World[®] web site at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

Pennsylvania Aetna Small Group Medical Plans — CONSUMER DIRECTED – POS HSA COMPATIBLE PLAN OPTIONS

Plan Options	PA POS HSA COMPATIBLE NO-REFERRAL 5.3 ^{+,††}		PA POS HSA COMPATIBLE NO-REFERRAL 6.3 ^{+,††}	
	In-Network No Referral Needed	Out-of-Network* No Referral Needed	In-Network No Referral Needed	Out-of-Network* No Referral Needed
Member Benefits	In-Network No Referral Needed	Out-of-Network* No Referral Needed	In-Network No Referral Needed	Out-of-Network* No Referral Needed
Plan Coinsurance	N/A	60% after deductible	N/A	70% after deductible
Plan Year Deductible** (All covered prescription drug and medical expenses, except preventive services, apply to the deductible.)	\$2,500 Individual/\$5,000 Family (In-network and out-of-network combined.)		\$1,500 Individual/\$3,000 Family (In-network and out-of-network combined.)	
Plan Year Out-of-Pocket Maximum*** (All amounts paid as deductible, copayment and coinsurance for covered services and supplies apply toward the Out-of-Pocket Maximum.)	\$5,000 Individual/\$10,000 Family (In-network and out-of-network combined.)		\$3,000 Individual/\$6,000 Family (In-network and out-of-network combined.)	
Lifetime Maximum Benefit	Unlimited	\$1,000,000	Unlimited	\$1,000,000
Preventive Care				
Well Baby/Child and Adult Physical Exams (Age and frequency schedules apply. In-network and out-of-network combined.)	\$0 copay, deductible waived	100%, deductible waived	\$0 copay, deductible waived	100%, deductible waived
Routine GYN Exams (Limited to one exam and Pap smear per 365 days. In-network and out-of-network combined.)	\$0 copay, deductible waived	100%, deductible waived	\$0 copay, deductible waived	100%, deductible waived
Routine Mammograms (One mammogram per plan year for females age 40 and over. In-network and out-of-network combined.)	\$0 copay, deductible waived	100%, deductible waived	\$0 copay, deductible waived	100%, deductible waived
Routine Eye Exam (One exam per 24 months. In-network and out-of-network combined.)	\$0 copay, deductible waived	100%, deductible waived	\$0 copay, deductible waived	100%, deductible waived
Glasses and Contact Lens Reimbursement	\$100/24 month period. In-network and out-of-network combined.		\$100/24 month period. In-network and out-of-network combined.	
Aetna Vision SM Discounts Program	Included	Not Covered	Included	Not Covered
Primary Physician Office Visit	\$30 copay after deductible	60% after deductible	\$20 copay after deductible	70% after deductible
Specialist Office Visit	\$50 copay after deductible	60% after deductible	\$40 copay after deductible	70% after deductible
Outpatient Services – Lab	\$50 copay after deductible	60% after deductible	\$40 copay after deductible	70% after deductible
Outpatient Services – X-ray	\$50 copay after deductible	60% after deductible	\$40 copay after deductible	70% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$150 copay after deductible	60% after deductible	\$150 copay after deductible	70% after deductible
Chiropractic Services (20 visits per plan year. In-network and out-of-network combined.)	\$50 copay after deductible	60% after deductible	\$40 copay after deductible	70% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per plan year. In-network and out-of-network combined.)	\$50 copay after deductible	60% after deductible	\$40 copay after deductible	70% after deductible
Outpatient Speech Therapy (30 visits per plan year. In-network and out-of-network combined.)	\$50 copay after deductible	60% after deductible	\$40 copay after deductible	70% after deductible
Durable Medical Equipment (\$2,500 Plan Year Maximum. In-network and out-of-network combined.)	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Inpatient Hospital	\$500 copay per day, 5 day copay maximum per admission, after deductible	60% after deductible	\$300 copay per day, 5 day copay maximum per admission, after deductible	70% after deductible
Outpatient Surgery	\$500 copay after deductible	60% after deductible	\$300 copay after deductible	70% after deductible
Emergency Room (Copay waived if admitted.)	\$150 copay after deductible	\$150 copay after deductible	\$150 copay after deductible	\$150 copay after deductible
Mental Health – Inpatient (Limited to 30 days per plan year. In-network and out-of-network combined.)	\$500 copay per day, 5 day copay maximum per admission, after deductible	60% after deductible	\$300 copay per day, 5 day copay maximum per admission, after deductible	70% after deductible
Substance Abuse – Inpatient (In-Network: Detox.: Unlimited days per plan year; Rehab.: 30 days per plan year; 90 days per lifetime. Out-of-Network: Detox.: 7 days per admission, 4 admissions per lifetime. In-network and out-of-network combined. Rehab.: 30 days per plan year; 90 days per lifetime. In-network and out-of-network combined.)	\$500 copay per day, 5 day copay maximum per admission, after deductible	60% after deductible	\$300 copay per day, 5 day copay maximum per admission, after deductible	70% after deductible
Prescription Drug Deductible	Integrated with Medical Deductible	N/A	Integrated with Medical Deductible	N/A
Prescription Drugs – Retail: 30-day supply	\$15/\$40/\$60 after deductible	Not Covered	\$15/\$40/\$60 after deductible	Not Covered
Prescription Drugs – Mail Order: 31-90-day supply	\$30/\$80/\$120 after deductible	Not Covered	\$30/\$80/\$120 after deductible	Not Covered
Contraceptives and Diabetic Supplies	Included	Not Covered	Included	Not Covered
90 Day Transition of Coverage (TOC) for Prior Authorization [†]	Included	Not Covered	Included	Not Covered
Self-Injectables (Excluding Insulin)	90% after deductible	Not Covered	90% after deductible	Not Covered

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

*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 plan documents as "recognized" charges.

**The Individual Deductible can only be met when a member is enrolled for self-only coverage with no dependent coverage. The Family Deductible can be met by a combination of family members or by any single individual within the family. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the plan year.

***The Individual Out-of-Pocket Maximum can only be met when a member is enrolled for self-only coverage with no dependent coverage. The Family Out-of-Pocket Maximum can be met by a combination of family members or by any single individual within the family. 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 plan year.

[†]Transition of Coverage for Prior Authorizations helps members of new groups to transition to Aetna by providing a 90-calendar-day opportunity, beginning on the group's initial effective date, during which time prior authorization requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. Members, who have claims paid for a drug requiring prior authorization during the Transition of Coverage period, may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization for this drug.

^{††}"No Referral" Provision: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefits from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 15–16. Please refer to Aetna's Producer World[®] web site at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

Pennsylvania Aetna Small Group Medical Plans — CONSUMER DIRECTED – POS HSA COMPATIBLE PLAN OPTIONS

Plan Options	PA POS HSA COMPATIBLE NO-REFERRAL 3.3 ^{+,††}		PA POS HSA COMPATIBLE NO-REFERRAL 4.3 ^{+,††}	
	In-Network No Referral Needed	Out-of-Network* No Referral Needed	In-Network No Referral Needed	Out-of-Network* No Referral Needed
Member Benefits	In-Network No Referral Needed	Out-of-Network* No Referral Needed	In-Network No Referral Needed	Out-of-Network* No Referral Needed
Plan Coinsurance	N/A	100% after deductible	N/A	100% after deductible
Plan Year Deductible** (All covered prescription drug and medical expenses, except preventive services, apply to the deductible.)	\$2,500 Individual/\$5,000 Family (In-network and out-of-network combined.)		\$1,500 Individual/\$3,000 Family (In-network and out-of-network combined.)	
Plan Year Out-of-Pocket Maximum*** (All amounts paid as deductible, copayment and coinsurance for covered services and supplies apply toward the Out-of-Pocket Maximum.)	\$3,000 Individual/\$6,000 Family (In-network and out-of-network combined.)		\$2,000 Individual/\$4,000 Family (In-network and out-of-network combined.)	
Lifetime Maximum Benefit	Unlimited	\$1,000,000	Unlimited	\$1,000,000
Preventive Care				
Well Baby/Child and Adult Physical Exams (Age and frequency schedules apply. In-network and out-of-network combined.)	\$0 copay, deductible waived	100%, deductible waived	\$0 copay, deductible waived	100%, deductible waived
Routine GYN Exams (Limited to one exam and Pap smear per 365 days. In-network and out-of-network combined.)	\$0 copay, deductible waived	100%, deductible waived	\$0 copay, deductible waived	100%, deductible waived
Routine Mammograms (One mammogram per plan year for females age 40 and over. In-network and out-of-network combined.)	\$0 copay, deductible waived	100%, deductible waived	\$0 copay, deductible waived	100%, deductible waived
Routine Eye Exam (One exam per 24 months. In-network and out-of-network combined.)	\$0 copay, deductible waived	100%, deductible waived	\$0 copay, deductible waived	100%, deductible waived
Glasses and Contact Lens Reimbursement	\$100/24 month period. In-network and out-of-network combined.		\$100/24 month period. In-network and out-of-network combined.	
Aetna Vision SM Discounts Program	Included	Not Covered	Included	Not Covered
Primary Physician Office Visit	\$0 copay after deductible	100% after deductible	\$0 copay after deductible	100% after deductible
Specialist Office Visit	\$0 copay after deductible	100% after deductible	\$0 copay after deductible	100% after deductible
Outpatient Services – Lab	\$0 copay after deductible	100% after deductible	\$0 copay after deductible	100% after deductible
Outpatient Services – X-ray	\$0 copay after deductible	100% after deductible	\$0 copay after deductible	100% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$0 copay after deductible	100% after deductible	\$0 copay after deductible	100% after deductible
Chiropractic Services (20 visits per plan year. In-network and out-of-network combined.)	\$0 copay after deductible	100% after deductible	\$0 copay after deductible	100% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per plan year. In-network and out-of-network combined.)	\$0 copay after deductible	100% after deductible	\$0 copay after deductible	100% after deductible
Outpatient Speech Therapy (30 visits per plan year. In-network and out-of-network combined.)	\$0 copay after deductible	100% after deductible	\$0 copay after deductible	100% after deductible
Durable Medical Equipment (\$2,500 Plan Year Maximum. In-network and out-of-network combined.)	100% after deductible	100% after deductible	100% after deductible	100% after deductible
Inpatient Hospital	\$0 copay per admission after deductible	100% after deductible	\$0 copay per admission after deductible	100% after deductible
Outpatient Surgery	\$0 copay after deductible	100% after deductible	\$0 copay after deductible	100% after deductible
Emergency Room (Copay waived if admitted.)	\$0 copay after deductible	100% after deductible	\$0 copay after deductible	100% after deductible
Mental Health – Inpatient (Limited to 30 days per plan year. In-network and out-of-network combined.)	\$0 copay per admission after deductible	100% after deductible	\$0 copay per admission after deductible	100% after deductible
Substance Abuse – Inpatient (In-Network: Detox.: Unlimited days per plan year; Rehab.: 30 days per plan year; 90 days per lifetime. Out-of-Network: Detox.: 7 days per admission, 4 admissions per lifetime. In-network and out-of-network combined. Rehab.: 30 days per plan year; 90 days per lifetime. In-network and out-of-network combined.)	\$0 copay per admission after deductible	100% after deductible	\$0 copay per admission after deductible	100% after deductible
Prescription Drug Deductible	Integrated with Medical Deductible	N/A	Integrated with Medical Deductible	N/A
Prescription Drugs – Retail: 30-day supply	\$15/\$40/\$60 after deductible	Not Covered	\$15/\$40/\$60 after deductible	Not Covered
Prescription Drugs – Mail Order: 31-90-day supply	\$30/\$80/\$120 after deductible	Not Covered	\$30/\$80/\$120 after deductible	Not Covered
Contraceptives and Diabetic Supplies	Included	Not Covered	Included	Not Covered
90 Day Transition of Coverage (TOC) for Prior Authorization [†]	Included	Not Covered	Included	Not Covered
Self-Injectables (Excluding Insulin)	90% after deductible	Not Covered	90% after deductible	Not Covered

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

*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 plan documents as "recognized" charges.

**The Individual Deductible can only be met when a member is enrolled for self-only coverage with no dependent coverage. The Family Deductible can be met by a combination of family members or by any single individual within the family. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the plan year.

***The Individual Out-of-Pocket Maximum can only be met when a member is enrolled for self-only coverage with no dependent coverage. The Family Out-of-Pocket Maximum can be met by a combination of family members or by any single individual within the family. 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 plan year.

[†]Transition of Coverage for Prior Authorizations helps members of new groups to transition to Aetna by providing a 90-calendar-day opportunity, beginning on the group's initial effective date, during which time prior authorization requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. Members, who have claims paid for a drug requiring prior authorization during the Transition of Coverage period, may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization for this drug.

^{††}"No Referral" Provision: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefits from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 15–16. Please refer to Aetna's Producer World[®] web site at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

Pennsylvania Aetna Small Group Medical Plans — CONSUMER DIRECTED – HEALTH NETWORK OPTION – HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

Plan Options	PA HEALTH NETWORK OPTION AHF HRA 1.3 ^{*,††}	
Member Benefits	In-Network No Referral Needed	Out-of-Network* No Referral Needed
HealthFund Amount (Per plan year. Fund changes between tiers requires a life status change qualifying event.)	\$500 Individual/\$1,000 Family In-network and out-of-network combined.	
HealthFund Coinsurance (Percentage at which the Fund will reimburse)	100%	
HealthFund Administration	The Fund will be used to pay for the member's responsibility, including the deductible, copays and coinsurance. Once the deductible is met, the underlying medical plan provides coverage and if a Fund balance still exists, the Fund will pay the member's responsibility (i.e., the member's share of copay or coinsurance) until the Plan Year Out-of-Pocket Maximum has been reached or the Fund has been exhausted, whichever comes first. Preventive services and prescription drug benefits, including self-injectables, will be subject to the medical and pharmacy plan provisions and will not be eligible for reimbursement by the Fund.	
HealthFund Rollover	Any remaining HealthFund benefit amount at the end of the plan year is rolled over into next year's HealthFund benefit amount.	
Plan Coinsurance	80% after deductible	60% after deductible
Plan Year Deductible**	\$2,000 Individual/\$4,000 Family (In-network and out-of-network combined.) All covered expenses, except preventive services, glasses and contact lens reimbursement, prescription drug benefits — including self-injectables, maternity post partum home health visits and phenyl-free enteral formula, apply to the deductible.	
Plan Year Out-of-Pocket Maximum***	\$4,000 Individual/\$8,000 Family (In-network and out-of-network combined.) Deductible does apply to the Out-of-Pocket Maximum. Prescription drugs, including self-injectables, do not apply toward the Out-of-Pocket Maximum.	
Lifetime Maximum Benefit	Unlimited	\$1,000,000
Preventive Care		
Well Baby/Child and Adult Physical Exams (Age and frequency schedules apply. In-network and out-of-network combined.)	\$0 copay, deductible waived	100%, deductible waived
Routine GYN Exams (Limited to one exam and Pap smear per 365 days. In-network and out-of-network combined.)	\$0 copay, deductible waived	100%, deductible waived
Routine Mammograms (One mammogram per plan year for females age 40 and over. In-network and out-of-network combined.)	\$0 copay, deductible waived	100%, deductible waived
Routine Eye Exam (One exam per 24 months. In-network and out-of-network combined.)	\$0 copay, deductible waived	100%, deductible waived
Glasses and Contact Lens Reimbursement	\$100/24 month period. In-network and out-of-network combined.	
Aetna VisionSM Discounts Program	Included	Not Covered
Primary Physician Office Visit	\$20 copay after deductible	60% after deductible
Specialist Office Visit	\$40 copay after deductible	60% after deductible
Outpatient Services – Lab	\$40 copay after deductible	60% after deductible
Outpatient Services – X-ray	\$40 copay after deductible	60% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	80% after deductible	60% after deductible
Chiropractic Services (20 visits per plan year. In-network and out-of-network combined.)	\$40 copay after deductible	60% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per plan year. In-network and out-of-network combined.)	\$40 copay after deductible	60% after deductible
Outpatient Speech Therapy (30 visits per plan year. In-network and out-of-network combined.)	\$40 copay after deductible	60% after deductible
Durable Medical Equipment (\$2,500 Plan Year Maximum. In-network and out-of-network combined.)	50% after deductible	50% after deductible
Inpatient Hospital	80% after deductible	60% after deductible
Outpatient Surgery	80% after deductible	60% after deductible
Emergency Room (Copay waived if admitted.)	80% after deductible	80% after deductible
Mental Health – Inpatient (Limited to 30 days per plan year. In-network and out-of-network combined.)	80% after deductible	60% after deductible
Substance Abuse – Inpatient (In-Network: Detox.: Unlimited days per plan year; Rehab.: 30 days per plan year; 90 days per lifetime. Out-of-Network: Detox.: 7 days per admission, 4 admissions per lifetime. In-network and out-of-network combined. Rehab.: 30 days per plan year; 90 days per lifetime. In-network and out-of-network combined.)	80% after deductible	60% after deductible
Prescription Drug Deductible	N/A	N/A
Prescription Drugs – Retail: 30-day supply	\$15/\$40/\$60	Not Covered
Prescription Drugs – Mail Order: 31-90-day supply	\$30/\$80/\$120	Not Covered
Contraceptives and Diabetic Supplies	Included	Not Covered
90 Day Transition of Coverage (TOC) for Prior Authorization[†]	Included	Not Covered
Self-Injectables (Excluding Insulin)	90%	Not Covered

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

*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 plan documents as "recognized" charges.

**The Individual Deductible can only be met when a member is enrolled for self-only coverage with no dependent coverage. The Family Deductible can be met by a combination of family members or by any single individual within the family. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the plan year.

***The Individual Out-of-Pocket Maximum can only be met when a member is enrolled for self-only coverage with no dependent coverage. The Family Out-of-Pocket Maximum can be met by a combination of family members or by any single individual within the family. 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 plan year.

†Transition of Coverage for Prior Authorizations helps members of new groups to transition to Aetna by providing a 90-calendar-day opportunity, beginning on the group's initial effective date, during which time prior authorization requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. Members, who have claims paid for a drug requiring prior authorization during the Transition of Coverage period, may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization for this drug.

†† "No Referral" Provision: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefits from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 15–16. Please refer to Aetna's Producer World® web site at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

Pennsylvania Aetna Small Group Medical Plans — PPO PLAN OPTIONS

Plan Options	PA PPO 1.3 ⁺		PA PPO 2.3 ⁺	
Member Benefits	In-Network No Referral Needed	Out-of-Network* No Referral Needed	In-Network No Referral Needed	Out-of-Network* No Referral Needed
Plan Coinsurance	N/A	50% after deductible	N/A	50% after deductible
Calendar Year Deductible**	N/A	\$3,000 per member \$9,000 family	N/A	\$1,500 per member \$4,500 family
Calendar Year Out-of-Pocket Maximum*** (Deductible applies to the Out-of-Pocket Maximum. Prescription drugs and self-injectables do not apply toward the Out-of-Pocket Maximum.)	N/A	\$10,000 per member \$30,000 family	N/A	\$5,000 per member \$15,000 family
Lifetime Maximum Benefit	Unlimited	\$500,000	Unlimited	\$500,000
Preventive Care				
Well Baby/Child and Adult Physical Exams (Age and frequency schedules apply. In-network and out-of-network combined.)	\$0 copay	50% after deductible	\$0 copay	50% after deductible
Routine GYN Exams (Limited to one exam and Pap smear per calendar year. In-network and out-of-network combined.)	\$0 copay	50%, deductible waived	\$0 copay	50%, deductible waived
Routine Mammograms (One annual mammogram for females age 40 and over. In-network and out-of-network combined.)	\$0 copay	50% after deductible	\$0 copay	50% after deductible
Routine Eye Exam (One exam per 24 months. In-network and out-of-network combined.)	\$0 copay	50% after deductible	\$0 copay	50% after deductible
Glasses and Contact Lens Reimbursement	\$100/24 month period. In-network and out-of-network combined.		\$100/24 month period. In-network and out-of-network combined.	
Aetna VisionSM Discounts Program	Included	Not Covered	Included	Not Covered
Primary Physician Office Visit	\$30 copay	50% after deductible	\$20 copay	50% after deductible
Specialist Office Visit	\$50 copay	50% after deductible	\$40 copay	50% after deductible
Outpatient Services – Lab	\$50 copay	50% after deductible	\$40 copay	50% after deductible
Outpatient Services – X-ray	\$50 copay	50% after deductible	\$40 copay	50% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$150 copay	50% after deductible	\$150 copay	50% after deductible
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	\$50 copay	50% after deductible	\$40 copay	50% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year. In-network and out-of-network combined.)	\$50 copay	50% after deductible	\$40 copay	50% after deductible
Outpatient Speech Therapy (30 visits per calendar year. In-network and out-of-network combined.)	\$50 copay	50% after deductible	\$40 copay	50% after deductible
Durable Medical Equipment (\$2,500 Calendar Year Maximum. In-network and out-of-network combined.)	50%	50% after deductible	50%	50% after deductible
Inpatient Hospital	\$500 copay per day, 5 day copay maximum per admission	50% after deductible	\$250 copay per day, 5 day copay maximum per admission	50% after deductible
Outpatient Surgery	\$500 copay	50% after deductible	\$250 copay	50% after deductible
Emergency Room (Copay waived if admitted.)	\$150 copay	\$150 copay	\$150 copay	\$150 copay
Mental Health – Inpatient (Limited to 30 days per calendar year. In-network and out-of-network combined.)	\$500 copay per day, 5 day copay maximum per admission	50% after deductible	\$250 copay per day, 5 day copay maximum per admission	50% after deductible
Substance Abuse – Inpatient (Detox: 7 days per admission, 4 admissions per lifetime. In-network and out-of-network combined. Rehab.: 30 days per calendar year; 90 days per lifetime. In-network and out-of-network combined.)	\$500 copay per day, 5 day copay maximum per admission	50% after deductible	\$250 copay per day, 5 day copay maximum per admission	50% after deductible
Prescription Drug Deductible	N/A	N/A	N/A	N/A
Prescription Drugs – Retail: 30-day supply	\$20/\$40/\$70	80% after \$20/\$40/\$70	\$15/\$35/\$60	80% after \$15/\$35/\$60
Prescription Drugs – Mail Order: 31-90-day supply	\$40/\$80/\$140	Not Covered	\$30/\$70/\$120	Not Covered
Contraceptives and Diabetic Supplies	Included	Included	Included	Included
90 Day Transition of Coverage (TOC) for Prior Authorization[†]	Included	Included	Included	Included
Self-Injectables (Excluding Insulin)	90%	Not Covered	90%	Not Covered

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

*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 plan documents as "recognized" charges.

**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.

***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. No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum.

[†]Transition of Coverage for Prior Authorizations helps members of new groups to transition to Aetna by providing a 90-calendar-day opportunity, beginning on the group's initial effective date, during which time prior authorization requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. Members, who have claims paid for a drug requiring prior authorization during the Transition of Coverage period, may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization for this drug.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 15–16. Please refer to Aetna's Producer World® web site at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

Pennsylvania Aetna Small Group Medical Plans — PPO PLAN OPTIONS

Plan Options	PA PPO 3.3 ⁺	
Member Benefits	In-Network No Referral Needed	Out-of-Network* No Referral Needed
Plan Coinsurance	N/A	70% after deductible
Calendar Year Deductible**	N/A	\$500 per member \$1,500 family
Calendar Year Out-of-Pocket Maximum*** (Deductible applies to the Out-of-Pocket Maximum. Prescription drugs and self-injectables do not apply toward the Out-of-Pocket Maximum.)	N/A	\$5,000 per member \$15,000 family
Lifetime Maximum Benefit	Unlimited	\$1,000,000
Preventive Care		
Well Baby/Child and Adult Physical Exams (Age and frequency schedules apply. In-network and out-of-network combined.)	\$0 copay	70% after deductible
Routine GYN Exams (Limited to one exam and Pap smear per calendar year. In-network and out-of-network combined.)	\$0 copay	70%, deductible waived
Routine Mammograms (One annual mammogram for females age 40 and over. In-network and out-of-network combined.)	\$0 copay	70% after deductible
Routine Eye Exam (One exam per 24 months. In-network and out-of-network combined.)	\$0 copay	70% after deductible
Glasses and Contact Lens Reimbursement	\$100/24 month period. In-network and out-of-network combined.	
Aetna VisionSM Discounts Program	Included	Not Covered
Primary Physician Office Visit	\$10 copay	70% after deductible
Specialist Office Visit	\$20 copay	70% after deductible
Outpatient Services – Lab	\$20 copay	70% after deductible
Outpatient Services – X-ray	\$20 copay	70% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$150 copay	70% after deductible
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	\$20 copay	70% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year. In-network and out-of-network combined.)	\$20 copay	70% after deductible
Outpatient Speech Therapy (30 visits per calendar year. In-network and out-of-network combined.)	\$20 copay	70% after deductible
Durable Medical Equipment (\$2,500 Calendar Year Maximum. In-network and out-of-network combined.)	50%	50% after deductible
Inpatient Hospital	\$0 copay per admission	70% after deductible
Outpatient Surgery	\$0 copay	70% after deductible
Emergency Room (Copay waived if admitted.)	\$150 copay	\$150 copay
Mental Health – Inpatient (Limited to 30 days per calendar year. In-network and out-of-network combined.)	\$0 copay per admission	70% after deductible
Substance Abuse – Inpatient (Detox: 7 days per admission, 4 admissions per lifetime. In-network and out-of-network combined. Rehab.: 30 days per calendar year; 90 days per lifetime. In-network and out-of-network combined.)	\$0 copay per admission	70% after deductible
Prescription Drug Deductible	N/A	N/A
Prescription Drugs – Retail: 30-day supply	\$10/\$25/\$50	80% after \$10/\$25/\$50
Prescription Drugs – Mail Order: 31-90-day supply	\$20/\$50/\$100	Not Covered
Contraceptives and Diabetic Supplies	Included	Included
90 Day Transition of Coverage (TOC) for Prior Authorization[†]	Included	Included
Self-Injectables (Excluding Insulin)	90%	Not Covered

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

**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 plan documents as "recognized" charges.

***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.

†Transition of Coverage for Prior Authorizations helps members of new groups to transition to Aetna by providing a 90-calendar-day opportunity, beginning on the group's initial effective date, during which time prior authorization requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. Members, who have claims paid for a drug requiring prior authorization during the Transition of Coverage period, may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization for this drug.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 15–16. Please refer to Aetna's Producer World[®] web site at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

Pennsylvania Aetna Small Group Medical Plans — CONSUMER DIRECTED – PPO HSA COMPATIBLE PLAN OPTIONS

Plan Options	PA PPO HSA COMPATIBLE 1.3 ⁺		PA PPO HSA COMPATIBLE 2.3 ⁺	
Member Benefits	In-Network No Referral Needed	Out-of-Network* No Referral Needed	In-Network No Referral Needed	Out-of-Network* No Referral Needed
Plan Coinsurance	80% after deductible	60% after deductible	100% after deductible	100% after deductible
Plan Year Deductible** (All covered prescription drug and medical expenses, except preventive services, apply to the deductible.)	\$2,500 Individual/\$5,000 Family (In-network and out-of-network combined.)		\$2,500 Individual/\$5,000 Family (In-network and out-of-network combined.)	
Plan Year Out-of-Pocket Maximum*** (All amounts paid as deductible, copayment and coinsurance for covered services and supplies apply toward the Out-of-Pocket Maximum.)	\$5,000 Individual/\$10,000 Family (In-network and out-of-network combined.)		\$3,000 Individual/\$6,000 Family (In-network and out-of-network combined.)	
Lifetime Maximum Benefit	\$2,000,000 (In-network and out-of-network combined.)		\$2,000,000 (In-network and out-of-network combined.)	
Preventive Care				
Well Baby/Child and Adult Physical Exams (Age and frequency schedules apply. In-network and out-of-network combined.)	100%, deductible waived	60%, deductible waived	100%, deductible waived	100%, deductible waived
Routine GYN Exams (Limited to one exam and Pap smear per plan year. In-network and out-of-network combined.)	100%, deductible waived	60%, deductible waived	100%, deductible waived	100%, deductible waived
Routine Mammograms (One mammogram per plan year for females age 40 and over. In-network and out-of-network combined.)	100%, deductible waived	60%, deductible waived	100%, deductible waived	100%, deductible waived
Routine Eye Exam (One exam per 24 months. In-network and out-of-network combined.)	100%, deductible waived	60%, deductible waived	100%, deductible waived	100%, deductible waived
Glasses and Contact Lens Reimbursement	\$100/24 month period. In-network and out-of-network combined.		\$100/24 month period. In-network and out-of-network combined.	
Aetna VisionSM Discounts Program	Included	Not Covered	Included	Not Covered
Primary Physician Office Visit	80% after deductible	60% after deductible	100% after deductible	100% after deductible
Specialist Office Visit	80% after deductible	60% after deductible	100% after deductible	100% after deductible
Outpatient Services – Lab	80% after deductible	60% after deductible	100% after deductible	100% after deductible
Outpatient Services – X-ray	80% after deductible	60% after deductible	100% after deductible	100% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	80% after deductible	60% after deductible	100% after deductible	100% after deductible
Chiropractic Services (20 visits per plan year. In-network and out-of-network combined.)	80% after deductible	60% after deductible	100% after deductible	100% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per plan year. In-network and out-of-network combined.)	80% after deductible	60% after deductible	100% after deductible	100% after deductible
Outpatient Speech Therapy (30 visits per plan year. In-network and out-of-network combined.)	80% after deductible	60% after deductible	100% after deductible	100% after deductible
Durable Medical Equipment (\$2,500 Plan Year Maximum. In-network and out-of-network combined.)	50% after deductible	50% after deductible	100% after deductible	100% after deductible
Inpatient Hospital	80% after deductible	60% after deductible	100% after deductible	100% after deductible
Outpatient Surgery	80% after deductible	60% after deductible	100% after deductible	100% after deductible
Emergency Room (Copay waived if admitted.)	80% after deductible	80% after deductible	100% after deductible	100% after deductible
Mental Health – Inpatient (Limited to 30 days per plan year. In-network and out-of-network combined.)	80% after deductible	60% after deductible	100% after deductible	100% after deductible
Substance Abuse – Inpatient (Detox: 7 days per admission, 4 admissions per lifetime. In-network and out-of-network combined. Rehab: 30 days per plan year; 90 days per lifetime. In-network and out-of-network combined.)	80% after deductible	60% after deductible	100% after deductible	100% after deductible
Prescription Drug Deductible	Integrated with Medical Deductible		Integrated with Medical Deductible	
Prescription Drugs – Retail: 30-day supply	\$15/\$40/\$60 after deductible	80% after \$15/\$40/\$60 and deductible	\$15/\$40/\$60 after deductible	80% after \$15/\$40/\$60 and deductible
Prescription Drugs – Mail Order: 31-90-day supply	\$30/\$80/\$120 after deductible	Not Covered	\$30/\$80/\$120 after deductible	Not Covered
Contraceptives and Diabetic Supplies	Included	Included	Included	Included
90 Day Transition of Coverage (TOC) for Prior Authorization[†]	Included	Included	Included	Included
Self-Injectables (Excluding Insulin)	90% after deductible	Not Covered	90% after deductible	Not Covered

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

**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 plan documents as "recognized" charges.

***The Individual Deductible can only be met when a member is enrolled for self-only coverage with no dependent coverage. The Family Deductible can be met by a combination of family members or by any single individual within the family. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the plan year.

†Transition of Coverage for Prior Authorizations helps members of new groups to transition to Aetna by providing a 90-calendar-day opportunity, beginning on the group's initial effective date, during which time prior authorization requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. Members, who have claims paid for a drug requiring prior authorization during the Transition of Coverage period, may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization for this drug.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to pages 15–16. Please refer to Aetna's Producer World® web site at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

Limitations and exclusions

POS/Health Network Option plans

These plans do not cover all health care expenses and include 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, the 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
- 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
- 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

PPO plans

These plans do not cover all health care expenses and include 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, the 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 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
- Hearing aids
- Immunizations for travel or work
- 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
- 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
- Treatment of those services for or related to treatment of obesity or for diet or weight control

PPO pre-existing conditions exclusion provision

These plans impose a pre-existing conditions exclusion, which may be waived in some circumstances (that is, creditable coverage) and may not be applicable. A pre-existing conditions exclusion means that if the member has a medical condition before coming to the plan, the member 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 90 days prior to the enrollment date.

Generally, this period ends the day before coverage becomes effective. However, if the member was in a waiting period for coverage, the 90-day period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days from the first day of coverage, or, if the member was in a waiting period, from the first day of the waiting period.

If the member had prior credible coverage within 90-days immediately before the date enrolled under the plan, then the pre-existing conditions exclusion in the plan, if any, will be waived.

If the member had no prior creditable coverage within the 90 days prior to the enrollment date (either because the member had no prior coverage or because there was more than a 90-day gap from the date the prior coverage terminated to the enrollment date), we will apply the plan's pre-existing conditions exclusion.

In order to reduce or possibly eliminate the exclusion period based on creditable coverage, the member should provide Aetna with a copy of any Certificates of Creditable Coverage. Please contact Aetna Member Services at **1-888-80-AETNA (1-888-802-3862)** for assistance in obtaining a Certificate of Creditable Coverage from the prior carrier or with any questions on the information noted above.

The pre-existing conditions 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 managed care plan may not cover all of your health care expenses. Read your contract carefully to determine which health care services are covered. To contact the plan if you are a member, call the number on your ID card. All others, for HMO and QPOS products call: 1-888-70-AETNA (1-888-702-3862). For Health Network Option products, call 1-866-529-2517. For Traditional/PPO products call: 1-888-80-AETNA (1-888-802-3862).

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits vary by location. 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.

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

Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Discount programs provide access to discounted prices and are NOT insured benefits.

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.

Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to www.aetna.com.

