



Proposed effective date: 01-01-2011
HMO - Maine

**PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA HEALTH INC. - FULL RISK**

PLAN FEATURES	PARTICIPATING PROVIDERS / REFERRED
Deductible (per calendar year) Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Member cost sharing for certain services including member cost sharing for prescription drugs as indicated in the plan, are excluded from charges to meet the Deductible. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.	\$500 Individual \$1,000 Family
Out-of-Pocket Maximum (per calendar year) Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. Only those participating providers/referred out of pocket expenses resulting from the application of coinsurance percentage, deductibles and copays (except any penalty amounts and pharmacy cost sharing) may be used to satisfy the Out-of-Pocket Maximum. Once 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.	\$1,500 Individual \$3,000 Family
Lifetime Maximum	Unlimited unless otherwise indicated.
Primary Care Physician Selection	Required
Referral Requirements	Required for all non-emergency, non-urgent and non-Primary Care Physician services, except direct access services
PREVENTIVE CARE	PARTICIPATING PROVIDERS / REFERRED
Routine Adult Physical Exams / Immunizations 1 exam every 12 months	Covered 100%; deductible waived
Well Child Exams / Immunizations (Age and frequency schedules apply)	Covered 100%; deductible waived
Routine Gynecological Care Exams Includes Pap smear and related lab fees. One exam per calendar year.	Covered 100%; deductible waived
Routine Mammograms One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over	Covered 100%; deductible waived
Routine Digital Rectal Exams / Prostate Specific Antigen Test For males age 40 and over	Covered 100%; deductible waived
Colorectal Cancer Screening For all members 50 and over. Frequency schedule applies	Covered 100%; deductible waived
Routine Eye Exam Age/Frequency Schedule may apply. Direct access to participating providers without a referral.	Covered 100%; deductible waived
Routine Hearing Screening For covered dependent children under age 19; subject to \$1,400 non-disposable hearing aid maximum for each hearing impaired ear in any 36 month period.	Subject to Routine Physical Exam cost sharing; deductible waived



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PHYSICIAN SERVICES	PARTICIPATING PROVIDERS / REFERRED
Primary Care Physician Visits	Office Hours: \$20 copay; deductible waived After Office Hours/Home: \$25 copay; deductible waived
Specialist Office Visits	\$25 copay; deductible waived
Maternity OB Visits	\$25 copay for initial visit only, thereafter covered 100%; deductible waived
Allergy Treatment	Same as applicable participating provider office visit member cost sharing
Allergy Testing	Same as applicable participating provider office visit member cost sharing
DIAGNOSTIC PROCEDURES	PARTICIPATING PROVIDERS / REFERRED
Diagnostic Laboratory If performed as a part of a physician's office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit cost sharing.	Covered 100%; deductible waived
Diagnostic X-ray Outpatient hospital or other Outpatient facility (except for Complex Imaging Services)	Covered 100%; deductible waived
Diagnostic X-ray for Complex Imaging Services	\$50 copay; deductible waived
EMERGENCY MEDICAL CARE	PARTICIPATING PROVIDERS / REFERRED
Emergency Room	\$100 copay; deductible waived
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	Covered 100%; deductible waived
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	PARTICIPATING PROVIDERS / REFERRED
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% per admission; after deductible
Inpatient Maternity Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% per admission; after deductible
Outpatient Surgery - Hospital The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	20% per visit; after deductible
Outpatient Surgery - Freestanding Facility The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	20% per visit; after deductible
MENTAL HEALTH SERVICES	PARTICIPATING PROVIDERS / REFERRED
Inpatient Biologically Based Mental Illness The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% per admission; after deductible
Inpatient Non-Biologically Based Mental Illness The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% per admission; after deductible
Outpatient Biologically Based Mental Illness The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	\$25 copay per visit ; deductible waived
Outpatient Non-Biologically Based Mental Illness The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	\$25 copay per visit ; deductible waived
ALCOHOL/DRUG ABUSE SERVICES	PARTICIPATING PROVIDERS / REFERRED
Inpatient Detoxification The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% per admission; after deductible
Outpatient Detoxification The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	\$25 copay; deductible waived
Inpatient Rehabilitation The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% per admission; after deductible
Residential Treatment Facility	20% ; after deductible
Outpatient Rehabilitation The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	\$25 Copay; deductible waived



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OTHER SERVICES	PARTICIPATING PROVIDERS / REFERRED
Skilled Nursing Facility Limited to 100 days per calendar year The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% per admission; after deductible
Home Health Care Limited to 100 visits per calendar year Limited to 3 intermittent visit per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	20%; deductible waived
Hospice Care - Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% per admission; after deductible
Hospice Care - Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered 100%; deductible waived
Private Duty Nursing	Not Covered
Outpatient Rehabilitation Therapy (Includes speech, physical and occupational therapy) Limited to 60 visits per calendar year.	\$25 copay; deductible waived
Subluxation Limited to 36 visits per calendar year	\$25 copay; deductible waived
Hearing Aids Maximun Benefit of \$1,400 per hearing aid for each impaired ear every 36 months for members through age 18.	Covered 100%
Durable Medical Equipment	Covered 100%; deductible waived
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.
Transplants Coverage is provided at an IOE contracted facility only	20% per admission; after deductible
Bariatric Surgery The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% per admission; after deductible
FAMILY PLANNING	PARTICIPATING PROVIDERS / REFERRED
Infertility Treatment Diagnosis and treatment of the underlying medical condition.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Comprehensive Infertility Services	Not Covered
Advanced Reproductive Technology (ART) ART coverage includes In-Vitro Fertilization (IVF), Zygote Intra-Fallopian Transfer (ZIFT), Gamete Intra-Fallopian Transfer (GIFT), cryopreserved embryo transfers, Intra-Cytoplasmic Sperm Injection (ICSI) or ovum microsurgery.	Not Covered
Voluntary Sterilization Including tubal ligation and vasectomy.	Subject to applicable service type member cost sharing
PHARMACY - PRESCRIPTION DRUG BENEFITS	PARTICIPATING PROVIDERS / REFERRED
Retail (2 times retail copay for 31-90 day supply at participating pharmacies. Percentage copays will not be doubled)	\$10 copay for formulary generic drugs, \$25 copay for formulary brand-name drugs, and \$40 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.
Mail Order	\$20 copay for formulary generic drugs, \$50 copay for formulary brand-name drugs, and \$80 copay for non-formulary brand-name and generic drugs up to a 31-90 day supply from Aetna Rx Home Delivery®
Aetna Specialty CareRx First prescription fill at any retail drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®	
No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only. Precert included with 90 day Transition of Care Step Therapy included with 90 day Transition of Care Dependents Eligibility	Spouse, children from birth to age 26.



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For any service or supply that is subject to a maximum visit, day, or dollar limitation, such maximums will be reduced by any services or supplies which are covered as participating providers and non-participating providers benefits under this plan.

Exclusions and Limitations

Plans are provided by Aetna Health Inc. While this material is believed to be accurate as of the production date, it is subject to change.

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

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

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

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental x-rays.
- Donor egg retrieval.
- Durable medical equipment.
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial).
- Hearing aids.
- Home births
- Immunizations for travel or work except where medically necessary or indicated.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents. .
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- Orthotics except diabetic orthotics.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Treatment of behavioral disorders.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.



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

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

If you require language assistance from an Aetna representative, please call Member Services' multilingual hotline at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).

Si necesita asistencia linguistica de un representante de Aetna, contamos con una linea directa de Servicios a Miembros disponible en varios idiomas. Comuniquese al 1-888-982-3862 (140 idiomas disponibles. Debe solicitar un interprete). TDD 1-800-628-3323 (para personas con problemas de audicion unicamente).

Plan features and availability may vary by location and group size.

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

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