



Proposed effective date: 01-01-2011
AETNA CHOICE™ POS - Maine

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

PLAN FEATURES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Deductible (per calendar year)	\$500 Individual \$1,000 Family	\$1,000 Individual \$2,000 Family
<p>Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Applicable covered expenses accumulate toward both the participating providers and non-participating providers Deductible. Member cost sharing for certain services including member cost sharing for prescription drugs, as indicated in the plan, are excluded from charges to meet the Deductible. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.</p>		
Out-of-Pocket Maximum (per calendar year)	\$1,500 Individual \$3,000 Family	\$3,000 Individual \$6,000 Family
<p>Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. Applicable covered expenses accumulate toward both the participating providers and non-participating providers Out-of-Pocket Maximum. Only those participating providers and non-participating providers 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.</p>		
Lifetime Maximum	Unlimited unless otherwise indicated.	Unlimited unless otherwise indicated.
<p>Applicable covered expenses accumulate toward both the participating providers and non-participating providers Lifetime Maximum.</p>		
<p>Benefit Limitations -- For any service or supply that is subject to a maximum visit, day, or dollar limitation, such services or supplies accumulate toward both the participating provider and non-participating provider benefit limits under this plan.</p>		
Primary Care Physician Selection	Not Required	Not Applicable
<p>Precertification Requirement Certain non-participating providers/participating provider self referred services require precertification or benefits will be reduced. Refer to your plan documents for a complete list of services that require precertification.</p>		
Referral Requirements	None	None
PREVENTIVE CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Routine Adult Physical Exams / Immunizations (Age and frequency schedules apply)	Covered 100%; deductible waived	40% after deductible
Well Child Exams / Immunizations (Age and frequency schedules apply)	Covered 100%; deductible waived	40% for children from birth through age 6; Not Covered age 7 and over.
Routine Gynecological Care Exams Includes Pap smear and related lab fees. One exam per calendar year.	Covered 100%; deductible waived	40% after deductible
Routine Mammograms One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over	Covered 100%; deductible waived	40% after deductible
Routine Digital Rectal Exams / Prostate Specific Antigen Test For males age 40 and over	Covered 100%; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered.



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Colorectal Cancer Screening	Covered 100%; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
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For all members 50 and over. Frequency schedule applies.

Routine Eye Exam Age/Frequency Schedule may apply.	Covered 100%; deductible waived	40% after deductible
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Routine Hearing Screening	Subject to Routine Physical Exam cost sharing; deductible waived	Subject to Routine Physical Exam benefit
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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.

PHYSICIAN SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
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Office Visits to a Non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician.	Office Hours: \$20 copay; deductible waived and After Office Hours/Home: \$25 copay; deductible waived	40% after deductible
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Specialist Office Visits	\$25 copay; deductible waived	40% after deductible
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Maternity OB Visits	\$25 copay for initial visit only, thereafter covered 100% ; deductible waived	40% after deductible
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Allergy Treatment	Same as applicable participating provider office visit member cost sharing	40% after deductible
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Allergy Testing	Same as applicable participating provider office visit member cost sharing	40% after deductible
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DIAGNOSTIC PROCEDURES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
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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	40% after deductible
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Diagnostic X-ray Outpatient hospital or other Outpatient facility (except for Complex Imaging Services)	Covered 100%; deductible waived	40% after deductible
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Diagnostic X-ray for Complex Imaging Services	\$50 copay; deductible waived	40% after deductible
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EMERGENCY MEDICAL CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
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Emergency Room	\$100 copay; deductible waived	Refer to participating provider benefit.
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Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
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Emergency Use of Ambulance	Covered 100%; deductible waived	Refer to participating provider benefit.
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Non-Emergency Use of Ambulance	Not Covered	Not Covered
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HOSPITAL CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
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Inpatient Coverage	20% per admission; after deductible	40% per admission; after deductible
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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.



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Inpatient Maternity Coverage	20% per admission; after deductible	40% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Surgery	20% per visit; after deductible	40% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
MENTAL HEALTH SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Inpatient Biologically Based Mental Illness	20% per admission; after deductible	40% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Non-Biologically Based Mental Illness	20% per admission; after deductible	40% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Biologically Based Mental Illness	\$25 copay per visit ; deductible waived	40% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Non-Biologically Based Mental Illness	\$25 copay per visit ; deductible waived	40% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
ALCOHOL/DRUG ABUSE SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Inpatient Detoxification	20% per admission; after deductible	40% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Detoxification	\$25 copay; deductible waived	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Inpatient Rehabilitation	20% per admission; after deductible	40% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Residential Treatment Facility	20% ; after deductible	40% ; after deductible
Outpatient Rehabilitation	\$25 Copay; deductible waived	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
OTHER SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Skilled Nursing Facility	20% per admission; after deductible Limited to 100 days per calendar year	40% per visit; after deductible Limited to 100 days per calendar year
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Home Health Care	20%; deductible waived Limited to 100 visits per calendar year	40% per visit; after deductible 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.		
Hospice Care - Inpatient	20% per admission; after deductible	40% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	Covered 100%; deductible waived	40% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		



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Private Duty Nursing	Not Covered	Not Covered
Outpatient Rehabilitation Therapy (Includes speech, physical and occupational therapy)	\$25 copay; deductible waived Limited to 60 visits per calendar year.	40% per admission; after deductible Limited to 60 visits per calendar year.
Subluxation	\$25 copay; deductible waived Limited to 36 visits per calendar year	40% after deductible Limited to 36 visits per calendar year
Hearing Aids	Covered 100%	
Maximum benefit of \$1,400 per hearing aid for each impaired ear every 36 months for members through age 18		
Durable Medical Equipment	Covered 100%; deductible waived	40% (must precertify if over \$1,500)
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.	40%
Dental	Not Covered	Not Covered
Vision Eyewear	Not Covered	Covered same as participating provider benefit
Transplants	20% per admission; after deductible Coverage is provided at an IOE contracted facility only	40% per admission; after deductible Coverage is provided at an Non-IOE contracted facility only
Bariatric Surgery	20% per admission; after deductible	Not Covered

The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.

FAMILY PLANNING	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered. 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; after deductible.
Comprehensive Infertility Services	Not Covered	Not Covered
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
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.		
Voluntary Sterilization	Subject to applicable service type member cost sharing	Subject to applicable service type member cost sharing
Including tubal ligation and vasectomy.		

PHARMACY - PRESCRIPTION DRUG BENEFITS	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Retail	\$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.	Not Covered

(2 times retail copay for 31-90 day supply at participating pharmacies. Percentage copays will not be doubled)



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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®.	Not Covered
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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.

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

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not 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.



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- 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.

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

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

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 linguística de un representante de Aetna, contamos con una línea directa de Servicios a Miembros disponible en varios idiomas. Comuníquese al 1-888-982-3862 (140 idiomas disponibles. Debe solicitar un intérprete). TDD 1-800-628-3323 (para personas con problemas de audición únicamente).

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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