Aetna

Aetna Life Insurance Company

Florida 2-100 Open Access Managed Choice®
Plan Effective Date: 03/01/2012

PLAN DESIGN AND BENEFITS – MC OA Plan 12-3000-100

PLAN FEATURES	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Deductible (per calendar year)	$3,000 Individual $9,000 Family	$4,000 Individual $12,000 Family
All covered expenses accumulate separately toward the preferred and non-preferred 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 3 individual members of a family each satisfy their Deductible amount separately, all family members will be considered as having met their Deductible for the remainder of the calendar year.		
Member Coinsurance Applies to all expenses unless otherwise stated.	0%	30%
Out-of-Pocket Maximum (per calendar year, includes deductible)	$3,000 Individual $9,000 Family	$6,000 Individual $18,000 Family
All covered expenses accumulate separately toward the preferred and non-preferred Out-of-Pocket Maximum. Only those out-of-pocket expenses resulting from the application of coinsurance percentage and deductibles (not including any copays, Prescription Drug copays and penalty amounts) may be used to satisfy the Out of Pocket Maximum. Members must continue to pay any copays, prescription drug copayments and penalty amounts after meeting their Out-of-Pocket Maximum. Once 3 individual members of a family each satisfy their Out-of-Pocket Maximum separately, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.		
Lifetime Maximum	Unlimited	
Payment for services from a Non-Participating Provider	Not applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Not Required	Not applicable
Precertification Requirement- certain non-participating provider services require precertification or benefits will be reduced. Refer to your plan documents for a complete list of services that require precertification.		
Referral Requirement	None	None
PHYSICIAN SERVICES	**PREFERRED PROVIDERS**	**NON-PREFERRED PROVIDERS**
Primary Care Physician Visits	$30 copay; deductible waived	30%, deductible applies
Specialist Office Visits	$60 copay; deductible waived	30%, deductible applies
Maternity OB Visits	0%, deductible applies	30%, deductible applies
Primary Care Physician E-Visits An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor.	$30 copay; deductible waived	30%, deductible applies
Specialist E-Visits An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor.	$30 copay; deductible waived	30%, deductible applies
Walk-in Clinics Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor an outpatient department of a hospital, shall be considered a Walk-in Clinic.	$30 copay; deductible waived	30%, deductible applies
Allergy Treatment	0%, deductible applies	30%, deductible applies
Allergy Testing	Same as applicable participating provider office visit member cost sharing.	30%, deductible applies

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PREVENTIVE CARE	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Routine Adult Physical Exams / Immunizations One exam every 12 months	$0 copay; deductible waived	30%, deductible applies
Well Child Exams / Immunizations 7 exams 1st 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 18.	$0 copay; deductible waived	30%, deductible applies
Routine Gynecological Care Exams Includes Pap smear and related lab fees. Frequency schedule applies.	$0 copay; deductible waived	30%, deductible applies
Routine Mammograms One baseline exam ages 35-39, one per calendar year age 40 and over, or as directed by a physician.	$0 copay; deductible waived	30%, deductible applies
Routine Digital Rectal Exam / Prostate Specific Antigen Test For covered males age 40 and over, frequency schedule applies.	$0 copay; deductible waived	30%, deductible applies
Routine (or Preventive) Colorectal Cancer Screening Sigmoidoscopy and Double Contrast Barium Enema (DCBE) - 1 every 5 years for all members age 50 and over; Colonoscopy - 1 every 10 years for all members age 50 and over; Fecal Occult Blood Testing (FOBT) - 1 every year for all members age 50 and over.	$0 copay; deductible waived	30%, deductible applies
Routine Eye Exams at Specialist 1 exam every 24 months	$60 copay; deductible waived	Not Covered
Routine Hearing Screening at PCP Covered only as part of a physical exam.	Subject to Routine Physical Exam cost sharing.	30%, deductible applies
DIAGNOSTIC PROCEDURES	**PREFERRED PROVIDERS**	**NON-PREFERRED PROVIDERS**
Outpatient 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 member cost sharing.)	$0 copay; deductible waived	30%, deductible applies
Diagnostic X-ray except for Complex Imaging Services – outpatient hospital or other outpatient facility	$60 copay; deductible waived	30%, deductible applies
Diagnostic X-ray for Complex Imaging Services (including but not limited to MRI, MRA, PET and CT Scans)	0%, deductible applies	30%, deductible applies
EMERGENCY MEDICAL CARE	**PREFERRED PROVIDERS**	**NON-PREFERRED PROVIDERS**
Urgent Care Provider	$75 copay; deductible waived	30%, deductible applies
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room copay waived if admitted	$350 copay; deductible waived	Refer to participating provider benefit.
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Ambulance	0%, deductible applies	Refer to participating provider benefit.
HOSPITAL CARE	**PREFERRED PROVIDERS**	**NON-PREFERRED PROVIDERS**
Inpatient Coverage Including maternity (prenatal, delivery and postpartum) & transplants	0%, deductible applies	30%, deductible applies
Outpatient Surgery	0%, deductible applies	30%, deductible applies
MENTAL HEALTH SERVICES	**PREFERRED PROVIDERS**	**NON-PREFERRED PROVIDERS**
Inpatient Limited to 30 days per member per calendar year. Preferred and Non-Preferred combined	0%, deductible applies	30%, deductible applies
Outpatient Limited to 20 visits per member per calendar year. Preferred and Non-Preferred combined	$60 copay; deductible waived	30%, deductible applies
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED PROVIDERS**	**NON-PREFERRED PROVIDERS**
Inpatient Detoxification	0%, deductible applies	30%, deductible applies
Outpatient Detoxification	$60 copay; deductible waived	30%, deductible applies
Inpatient Rehabilitation Limited to 30 days per member per calendar year. Preferred and Non-Preferred combined	0%, deductible applies	30%, deductible applies

Outpatient Rehabilitation Limited to 45 visits per member per calendar year. Preferred and Non-Preferred combined	$60 copay; deductible waived	30%, deductible applies
MENTAL HEALTH SERVICES (For Employer Groups subject to Federal Mental Health Parity)	**PREFERRED PROVIDERS**	**NON-PREFERRED PROVIDERS**
Inpatient	0%, deductible applies	30%, deductible applies
Outpatient	$60 copay; deductible waived	30%, deductible applies
ALCOHOL/DRUG ABUSE SERVICES (For Employer Groups subject to Federal Mental Health Parity)	**PREFERRED PROVIDERS**	**NON-PREFERRED PROVIDERS**
Inpatient Detoxification	0%, deductible applies	30%, deductible applies
Outpatient Detoxification	$60 copay; deductible waived	30%, deductible applies
Inpatient Rehabilitation	0%, deductible applies	30%, deductible applies
Outpatient Rehabilitation	$60 copay; deductible waived	30%, deductible applies
OTHER SERVICES AND PLAN DETAILS	**PREFERRED PROVIDERS**	**NON-PREFERRED PROVIDERS**
Convalescent Facility (skilled nursing facility) Limited to 60 days per member per calendar year. Preferred and Non-Preferred combined	0%, deductible applies	30%, deductible applies
Home Health Care Limited to 60 visits per member per calendar year; 1 visit equals a period of 4 hours or less. Preferred and Non-Preferred combined	$60 copay; deductible waived	30%, deductible applies
Hospice Care – Inpatient	0%, deductible applies	30%, deductible applies
Hospice Care – Outpatient	0%, deductible applies	30%, deductible applies
Infusion Therapy Provided in the home or physician's office	$60 copay; deductible waived	30%, deductible applies
Infusion Therapy Provided in an outpatient hospital department or freestanding facility	0%, deductible applies	30%, deductible applies
Outpatient Short-Term Rehabilitation Limited to 30 visits per member per calendar year. Includes speech, physical and occupational therapy. Preferred and Non-Preferred combined	$60 copay; deductible waived	30%, deductible applies
Subluxation (Chiropractic) Limited to 20 visits per member per calendar year. Preferred and Non-Preferred combined	$60 copay; deductible waived	30%, deductible applies
Durable Medical Equipment Maximum benefit of $2,000 per member per calendar year. Preferred and Non-Preferred combined	0%, deductible applies	30%, deductible applies
Diabetic Supplies not obtainable at a pharmacy	Prescription drug copay	30%, deductible applies
FAMILY PLANNING	**PREFERRED PROVIDERS**	**NON-PREFERRED PROVIDERS**
Infertility Treatment Coverage only for the diagnosis and treatment of the underlying medical condition.	Member cost sharing is based on the type of service performed and the place rendered.	30%, deductible applies
Voluntary Sterilization Including tubal ligation and vasectomy	Member cost sharing is based on the type of service performed and the place rendered.	30%, deductible applies
PHARMACY – PRESCRIPTION DRUG BENEFITS	**PREFERRED PROVIDERS**	**NON-PREFERRED PROVIDERS**
Retail Up to a 30 day supply at participating pharmacies.	$10 copay for generic formulary drugs, $45 copay for brand-name formulary drugs, and $65 copay for non-formulary drugs	Not Covered
Mail Order Up to 90 day supply at participating pharmacies.	$20 copay for generic formulary drugs, $90 copay for brand-name formulary drugs, and $130 copay for non-formulary drugs	Not Covered
Specialty CareRx	20% copay with a minimum copay of $10 and a maximum copay of $180 per prescription.	Not Covered

Specialty CareRx - First Prescription for a specialty drug must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy®. Subsequent fills must be through Aetna Specialty Pharmacy®.

No Mandatory Generic (No MG) – Member is responsible to pay the applicable copay only. Plan includes contraceptive drugs and devices obtainable from a pharmacy and diabetic supplies. Precertification included.

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

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

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

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

What's Not Covered

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased.

• All medical 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.
• Over-the-counter medications and supplies.
• 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.
• 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.

For members age 19 or over this plan imposes a pre-existing conditions exclusion, which may be waived in some circumstances (that is, creditable coverage) and may not be applicable to you. A pre-existing conditions exclusion means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis or treatment was recommended or received or for which the individual took prescribed drugs within 180 days.

Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 180 day lookback period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period.

If you had prior creditable coverage within the 365 day period immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.

If you had less than 365 days of creditable coverage immediately before the date you enrolled, your plan's pre-existing conditions exclusion period will be reduced by the amount (that is, number of days) of that prior coverage.

If you had no prior creditable coverage within the 63 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 63 day gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion.

In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any Certificates of Creditable Coverage you have. Please contact your Aetna Member Services representative at 1-888-802-3862 if you need assistance in obtaining a Certificate of Creditable Coverage from your prior carrier or if you have any questions on the information noted above.

The pre-existing condition exclusion does not apply to pregnancy nor to a child under the age of 19. 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 material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan.

Some benefits are subject to limitations or visit maximums. Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.

If your plan covers outpatient prescription drugs, your plan may include a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally not limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step-therapy, please refer to Aetna's website at Aetna.com, or the Aetna Medication Formulary Guide. Many drugs, including many of those listed on the formulary, are subject to rebate arrangements between Aetna and the manufacturer of the drugs. Rebates received by Aetna from drug manufacturers are not reflected in the cost paid by a member for a prescription drug. In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage.

Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna Inc., that is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated charge with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services.

Plans are provided by Aetna Life Insurance Company.

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

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