



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

<b>PLAN FEATURES</b>	<b>IN-NETWORK</b>
<b>Deductible</b> (per calendar year)	None Individual  None Family
<b>Out-of-Pocket Maximum</b> (per calendar year)	\$3,500 Individual  \$9,400 Family
Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. In-network expenses include coinsurance, deductible and copays. Pharmacy expenses do not apply towards the Out-of-Pocket-Maximum.	
<b>Lifetime Maximum</b>	Unlimited except where otherwise indicated.
<b>Primary Care Physician Selection</b>	Not Required
<b>Referral Requirement</b>	None
<b>PREVENTIVE CARE</b>	<b>IN-NETWORK</b>
<b>Routine Adult Physical Exams/ Immunizations</b> 1 exam every 12 months for members age 21 and older.	Covered 100%
<b>Routine Well Child Exams/Immunizations</b> (Age and frequency schedules apply)	Covered 100%
<b>Routine Gynecological Care Exams</b> 1 exam per 12 months Includes Pap smear and related lab fees.	Covered 100%
<b>Routine Mammograms</b> Recommended: one baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	Covered 100%
<b>Routine Digital Rectal Exams / Prostate Specific Antigen Test</b> Recommended for males age 40 and over.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
<b>Colorectal Cancer Screening</b>  For all members age 50 and over. Frequency schedule applies.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
<b>Routine Eye Exams</b>	Covered 100% 1 routine exam per 24 months.
<b>Routine Hearing Screening</b>	Subject to Routine Physical Exam benefit.
<b>PHYSICIAN SERVICES</b>	<b>IN-NETWORK</b>
<b>Primary Care Physician Visits</b> Includes services of an internist, general physician, family practitioner or pediatrician.	Office Hours: \$10 copay; After Office Hours/Home: \$15 copay
<b>Specialist Office Visits</b>	\$20 copay
<b>Prenatal OB Care</b>	\$20 copay for initial visit only, thereafter covered 100%
<b>Allergy Treatment</b>	Covered 100%
<b>Allergy Testing</b>	Covered 100%
<b>DIAGNOSTIC PROCEDURES</b>	<b>IN-NETWORK</b>
<b>Diagnostic Laboratory</b> If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	Covered 100%
<b>Diagnostic X-ray</b> Outpatient hospital or other Outpatient facility (other than Complex Imaging Services)	Covered 100%
<b>Diagnostic X-ray for Complex Imaging Services</b>	Covered 100%



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<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>
<b>Urgent Care Provider</b>	\$20 copay
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered
<b>Emergency Room</b>	\$50 copay
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered
<b>Emergency Use of Ambulance</b>	Covered 100%
<b>Non-Emergency Use of Ambulance</b>	Not Covered
<b>HOSPITAL CARE</b>	<b>IN-NETWORK</b>
<b>Inpatient Coverage</b>	\$100 copay per admission The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.
<b>Inpatient Maternity Coverage</b>	\$100 copay per admission The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.
<b>Outpatient Hospital</b>	\$50 copay per visit The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.
<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK</b>
<b>Inpatient Mental Illness</b>	\$100 copay per admission The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.
<b>Outpatient Mental Illness</b>	\$10 copay per visit The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.
<b>ALCOHOL/DRUG ABUSE SERVICES</b>	<b>IN-NETWORK</b>
<b>Inpatient Detoxification</b>	\$100 copay per admission The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.
<b>Outpatient Detoxification</b>	\$10 copay per visit
<b>Inpatient Rehabilitation</b>	\$100 copay per admission The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.
<b>Residential Treatment Facility</b>	\$100 copay per admission
<b>Outpatient Rehabilitation</b>	\$10 copay per visit The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.
<b>OTHER SERVICES</b>	<b>IN-NETWORK</b>
<b>Skilled Nursing Facility</b>	\$100 copay per admission Limited to 60 days; per calendar year The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.
<b>Home Health Care</b>	Covered 100% Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.
<b>Hospice Care - Inpatient</b>	Covered 100% The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.
<b>Hospice Care - Outpatient</b>	Covered 100% The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.
<b>Private Duty Nursing</b>	Not Covered
<b>Outpatient Rehabilitation Therapy</b>	\$20 copay per visit Includes speech, physical, occupational therapy
<b>Spinal Manipulation Therapy</b>	\$20 copay per visit Limited to 20 visits; per calendar year
<b>Durable Medical Equipment</b>	Covered 50%
<b>Diabetic Supplies</b>	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.
<b>Vision Eyewear</b>	\$100 once per 24 month period
<b>Transplants</b>	\$100 copay per admission



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Preferred coverage is provided at an IOE contracted facility only.

<b>Bariatric Surgery</b>	\$100 copay per admission
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
<b>FAMILY PLANNING</b>	<b>IN-NETWORK</b>

<b>Infertility Treatment</b>	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.	

<b>Comprehensive Infertility Services</b>	Not covered
Comprehensive Infertility includes Artificial Insemination and Ovulation Induction.	

<b>Advanced Reproductive Technology (ART)</b>	Covered 50%
ART coverage includes: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery.	
Limited to 3 courses of treatment in member's lifetime. Maximum applies to all procedures covered by any Aetna plan except where prohibited by law.	

<b>Voluntary Sterilization</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Including tubal ligation and vasectomy.	

<b>PRESCRIPTION DRUG BENEFITS</b>	<b>IN-NETWORK</b>
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<b>Retail</b>	\$20 copay for formulary generic drugs, \$40 copay for formulary brand-name drugs, and \$55 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.
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<b>Mail Order</b>	\$8 copay for formulary generic drugs, \$18 copay for formulary brand-name drugs, and \$33 copay for non-formulary brand-name and generic drugs up to a 30 day supply from Aetna Rx Home Delivery <sup>®</sup> .
	\$16 copay for formulary generic drugs, \$36 copay for formulary brand-name drugs, and \$66 copay for non-formulary brand-name and generic drugs up to a 31-90 day supply from Aetna Rx Home Delivery <sup>®</sup> .

**Aetna Specialty CareRx<sup>SM</sup>**  
 First prescription fill at any retail drug facility. Subsequent fills must be through Aetna Specialty Pharmacy<sup>®</sup>.  
**No Mandatory Generic (NO MG)** - The member pays the applicable copay only.  
**Plan Includes:** Contraceptive drugs and devices obtainable from a pharmacy and Performance Enhancing Medication.  
 Oral fertility drugs included.  
 Precert included  
 Step Therapy included

<b>GENERAL PROVISIONS</b>	<b>IN-NETWORK</b>
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<b>Dependents Eligibility</b>	Spouse, children from birth to age 26 regardless of student status.
<b>Pre-existing Conditions Exclusion</b>	On effective date: Waived After effective date: Waived

**Exclusions and Limitations**

**Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. Each insurer has sole financial responsibility for its own products.**

This material is for information only. 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.



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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.

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 and Aetna Specialty Pharmacy refer to Aetna Rx Home Delivery, LLC and Aetna Specialty Pharmacy, LLC, respectively. Aetna Rx Home Delivery and Aetna Specialty Pharmacy are licensed pharmacy subsidiaries of Aetna Inc. that operate through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery and Aetna Specialty Pharmacy 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 pharmacies' 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.



DC GOVERNMENT/HMO/ACTIVE  
Proposed Effective Date: 01-01-2012  
Aetna Open Access<sup>®</sup> HMO - Washington DC

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**If you require language assistance from an Aetna representative, please call the Member Services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).**

**Si requiere la asistencia de un representante de Aetna que hable su idioma, por favor llame al número de Servicios al Miembro que aparece en su tarjeta de identificación y se le comunicará con la línea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intérprete). TDD-1-800-628-3323 (sólo para las personas con impedimentos auditivos).**

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

For more information about Aetna plans, refer to **[www.aetna.com](http://www.aetna.com)**. While this material is believed to be accurate as of the production date, it is subject to change.

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