

# Take charge of your health. We're here to help.

AETNA ADVANTAGE PLANS FOR  
INDIVIDUALS, FAMILIES AND THE  
SELF-EMPLOYED IN MARYLAND



We want you to know<sup>®</sup>

 Aetna<sup>®</sup>

# Aetna Advantage plan choices

**Our health insurance plans are designed to offer you quality coverage at an excellent value. Coverage can include prescription drugs, doctor visits, hospitalization and preventive care services.**

Generally speaking, the lower your “premiums,” or monthly payments, the higher your “deductible,” which is the amount you pay out of pocket before the plan begins paying for expenses.

You’ll pay less by using “in-network” doctors, hospitals, pharmacies and other health care providers who participate in Aetna’s nationwide network than by using “out-of-network” doctors.

## About HSAs

Many of our high-deductible plans are Health Savings Account (HSA) Compatible, offering you lower premiums and tax advantaged savings. An HSA is a personal account that lets you pay for qualified medical expenses with tax advantaged funds. You or an eligible family member make contributions to your HSA tax-free, and those dollars earn interest tax-free. Then, when you make withdrawals from your account to pay for qualified health care expenses, they’re tax-free, too.

## It’s easy to establish a Health Savings Account...

Simply enroll in an Aetna HSA Compatible High Deductible Health Plan and you will automatically have an HSA opened through Bank of America. You will also receive a debit card and a welcome package with additional information to get you started.

If you do not wish to set up an HSA, you can opt out by calling Bank of America – or the account will be automatically canceled after 90 days if the debit card is not activated or if you do not enroll online.

**Aetna Advantage Plans for Individuals, Families and the Self-Employed are underwritten by Aetna Life Insurance Company (Aetna) directly and/or through an out-of-state blanket trust. In some states, individuals may qualify as a business group of one and may be eligible for guaranteed issue, small group health plans.** These plans are medically underwritten and you may be declined coverage in accordance with your health condition.

## Why choose an Aetna HealthFund HSA?

- No set-up fees
- No monthly administration fee
- No withdrawal forms required
- Convenient access to HSA funds via debit card or online
- Track HSA activity through Aetna Navigator®

## Is your doctor in the Aetna network?

Which local physicians, hospitals, pharmacies and eyewear providers participate in the nationwide Aetna Advantage Plan network?

## Get more from your Aetna plan

### Cover just your children

Aetna Advantage Plans are also available for children only, which means you can enroll your child even if no other family member enrolls. Coverage includes immunizations, well-child visits, emergency room and dental preventive services (if a dental plan is selected).

Note: when an HSA Compatible plan is selected for child only enrollment, an HSA account is not available for the child.

### Add Dental PPO Max

With the Aetna Advantage Dental PPO Max insurance plan, you can obtain services from either a participating or non-participating dentist. Participating dentists have agreed to provide services at a negotiated rate for both covered services, as well as non-covered services such as cosmetic tooth whitening and orthodontic care, so you generally pay less out-of-pocket. You also have the flexibility to visit a dentist who does not participate in Aetna's network, though you will not have access to negotiated fees. Dental coverage is offered only if medical coverage is obtained.

# Plan Details

## 1) PPO High Deductible plan options

Lower premium costs...and an HSA-compatible plan that offers tax advantaged savings

### Featuring:

- 0% coinsurance in network after your deductible is met
- Lower monthly premiums, higher annual deductibles (at least \$3,000 for individuals and \$6,000 for families)
- Can be paired with a tax-advantaged Health Savings Account (HSA)

## 2) PPO Value plan options

Affordability — a balance of lower monthly premiums and quality coverage...where you want to cap the amount you'll spend on total medical expenses each year

### Featuring:

- Lower monthly premiums (that's the "Value" part)
- No deductible for generic prescription drugs

**PLUS ... THESE BENEFITS ARE INCLUDED WITH MOST OF OUR PLANS.**

- Coverage for office visits to your primary care physician and specialists
- No claim forms to fill out when you visit a network provider
- No referrals required to see a specialist
- No waiting period for routine physical exams
- 100% annual routine GYN exam coverage — no waiting period, no dollar maximum and no copay or deductible when you visit a network provider\*
- Coverage for prescription drugs
- Coverage for routine physicals including lab work and X-rays
- 100% coverage for in-network childhood immunizations

\* These benefits are not applicable to the PPO Value 7500 and PPO Value 10000 plans

**AETNA'S MARYLAND RATINGS AREAS\***

Your rates will depend on the area in which your county is located.

For more information or a quote on what your rate would be, call your broker.

**Counties**

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|                |                 |
|----------------|-----------------|
| Allegany       | Harford         |
| Anne Arundel   | Howard          |
| Baltimore      | Kent            |
| Baltimore City | Montgomery      |
| Calvert        | Prince George's |
| Caroline       | Queen Anne's    |
| Carroll        | St. Mary's      |
| Cecil          | Somerset        |
| Charles        | Talbot          |
| Dorchester     | Washington      |
| Frederick      | Wicomico        |
| Garrett        | Worcester       |



\* All products not available in all counties. Please refer to the county in which you reside for the available product.

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## PPO High Deductible 3000 (HSA Compatible)

| MEMBER BENEFITS                                                                                                                    | In-Network                                                                                                                                                                                            | Out-of-Network*                               |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| <b>Deductible</b>                                                                                                                  |                                                                                                                                                                                                       |                                               |
| Individual                                                                                                                         | \$3,000                                                                                                                                                                                               | \$6,000                                       |
| Family                                                                                                                             | \$6,000                                                                                                                                                                                               | \$12,000                                      |
| <b>Coinsurance</b><br>(Member's responsibility)                                                                                    | 0% after deductible up to out-of-pocket max.                                                                                                                                                          | 20% after deductible up to out-of-pocket max. |
|                                                                                                                                    | \$0 once out-of-pocket max. is satisfied                                                                                                                                                              |                                               |
| <b>Coinsurance Maximum</b>                                                                                                         |                                                                                                                                                                                                       |                                               |
| Individual                                                                                                                         | \$0                                                                                                                                                                                                   | \$6,500                                       |
| Family                                                                                                                             | \$0                                                                                                                                                                                                   | \$13,000                                      |
| <b>Out-of-Pocket Maximum</b>                                                                                                       |                                                                                                                                                                                                       |                                               |
| Individual                                                                                                                         | \$3,000                                                                                                                                                                                               | \$12,500                                      |
| Family                                                                                                                             | \$6,000                                                                                                                                                                                               | \$25,000                                      |
|                                                                                                                                    | Includes deductible                                                                                                                                                                                   |                                               |
| <b>Lifetime Maximum* per insured</b>                                                                                               | \$3,000,000                                                                                                                                                                                           |                                               |
| <b>Non-Specialist Office Visit</b><br><i>Unlimited visits</i><br>General Physician, Family Practitioner, Pediatrician or Internist | 0% after deductible                                                                                                                                                                                   | 20% after deductible                          |
| <b>Specialist Visit</b><br><i>Unlimited visits</i>                                                                                 | 0% after deductible                                                                                                                                                                                   | 20% after deductible                          |
| <b>Hospital Admission</b><br>(includes complications of pregnancy)                                                                 | 0% after deductible                                                                                                                                                                                   | 20% after deductible                          |
| <b>Outpatient Surgery</b>                                                                                                          | 0% after deductible                                                                                                                                                                                   | 20% after deductible                          |
| <b>Urgent Care Facility</b>                                                                                                        | 0% after deductible                                                                                                                                                                                   | 20% after deductible                          |
| <b>Emergency Room</b>                                                                                                              | \$0 copay after deductible                                                                                                                                                                            |                                               |
| <b>Annual Routine Gyn Exam</b><br><i>No waiting period, no calendar year max. Annual Pap/Mammogram</i>                             | \$0 copay deductible waived                                                                                                                                                                           | 20% after deductible                          |
| <b>Maternity</b> — Inpatient Facility Services                                                                                     | 0% after deductible                                                                                                                                                                                   | 20% after deductible                          |
|                                                                                                                                    | Inpatient Facility Services coverage after deductible for the mother and the newborn for a minimum of 48 hours for an uncomplicated vaginal delivery and 96 hours for an uncomplicated cesarean birth |                                               |
| <b>Maternity</b> — Professional Services                                                                                           | Coverage for complications of pregnancy                                                                                                                                                               |                                               |
| <b>Preventive Health — Routine Physical</b><br><i>Aetna will pay up to \$200 per exam* No waiting period</i>                       | \$20 copay deductible waived                                                                                                                                                                          | \$20 copay; 20% coinsurance after deductible  |
|                                                                                                                                    | Includes lab work and X-rays                                                                                                                                                                          |                                               |
| <b>Lab/X-Ray</b>                                                                                                                   | 0% after deductible                                                                                                                                                                                   | 20% after deductible                          |
| <b>Skilled Nursing</b> — in lieu of hospital<br><i>30 days per calendar year*</i>                                                  | 0% after deductible                                                                                                                                                                                   | 20% after deductible                          |
| <b>Physical/Occupational Therapy and Chiropractic Care</b><br><i>24 visits per calendar year*</i>                                  | 0% after deductible                                                                                                                                                                                   | 20% after deductible                          |
|                                                                                                                                    | Aetna will pay a max. of \$25 per visit*                                                                                                                                                              |                                               |
| <b>Home Health Care</b> —<br><i>in lieu of hospital 40 visits per calendar year*</i>                                               | 0% after deductible                                                                                                                                                                                   | 20% after deductible                          |
| <b>Durable Medical Equipment</b><br><i>Aetna will pay up to \$2000 per calendar year*</i>                                          | 0% after deductible                                                                                                                                                                                   | 20% after deductible                          |
| <b>PHARMACY</b>                                                                                                                    |                                                                                                                                                                                                       |                                               |
| <b>Pharmacy Deductible</b><br>per individual                                                                                       | Integrated Medical/Rx Deductible                                                                                                                                                                      | Integrated Medical/Rx Deductible              |
| <b>Generic</b><br><i>Oral Contraceptives Included</i>                                                                              | 0% after Medical/Rx Deductible                                                                                                                                                                        | 20% after Medical/Rx Deductible               |
| <b>Preferred Brand</b><br><i>Oral Contraceptives Included</i>                                                                      | 0% after Medical/Rx Deductible                                                                                                                                                                        | 20% after Medical/Rx Deductible               |
| <b>Non-Preferred Brand</b><br><i>Oral Contraceptives Included</i>                                                                  | 0% after Medical/Rx Deductible                                                                                                                                                                        | 20% after Medical/Rx Deductible               |
| <b>Calendar Year Maximum</b><br>per individual*                                                                                    | Unlimited                                                                                                                                                                                             | Unlimited                                     |

\* Maximum applies to combined in and out-of-network benefits.

\*\* Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

## PPO High Deductible 5000 (HSA Compatible)

| MEMBER BENEFITS                                                                                                                    | In-Network                                                                                                                                                                                            | Out-of-Network*                               |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| <b>Deductible</b>                                                                                                                  |                                                                                                                                                                                                       |                                               |
| Individual                                                                                                                         | \$5,000                                                                                                                                                                                               | \$10,000                                      |
| Family                                                                                                                             | \$10,000                                                                                                                                                                                              | \$20,000                                      |
| <b>Coinsurance</b><br>(Member's responsibility)                                                                                    | 0% after deductible up to out-of-pocket max.                                                                                                                                                          | 20% after deductible up to out-of-pocket max. |
|                                                                                                                                    | \$0 once out-of-pocket max. is satisfied                                                                                                                                                              |                                               |
| <b>Coinsurance Maximum</b>                                                                                                         |                                                                                                                                                                                                       |                                               |
| Individual                                                                                                                         | \$0                                                                                                                                                                                                   | \$2,500                                       |
| Family                                                                                                                             | \$0                                                                                                                                                                                                   | \$5,000                                       |
| <b>Out-of-Pocket Maximum</b>                                                                                                       |                                                                                                                                                                                                       |                                               |
| Individual                                                                                                                         | \$5,000                                                                                                                                                                                               | \$12,500                                      |
| Family                                                                                                                             | \$10,000                                                                                                                                                                                              | \$25,000                                      |
|                                                                                                                                    | Includes deductible                                                                                                                                                                                   |                                               |
| <b>Lifetime Maximum* per insured</b>                                                                                               | \$3,000,000                                                                                                                                                                                           |                                               |
| <b>Non-Specialist Office Visit</b><br><i>Unlimited visits</i><br>General Physician, Family Practitioner, Pediatrician or Internist | 0% after deductible                                                                                                                                                                                   | 20% after deductible                          |
| <b>Specialist Visit</b><br><i>Unlimited visits</i>                                                                                 | 0% after deductible                                                                                                                                                                                   | 20% after deductible                          |
| <b>Hospital Admission</b><br>(includes complications of pregnancy)                                                                 | 0% after deductible                                                                                                                                                                                   | 20% after deductible                          |
| <b>Outpatient Surgery</b>                                                                                                          | 0% after deductible                                                                                                                                                                                   | 20% after deductible                          |
| <b>Urgent Care Facility</b>                                                                                                        | 0% after deductible                                                                                                                                                                                   | 20% after deductible                          |
| <b>Emergency Room</b>                                                                                                              | \$0 copay after deductible                                                                                                                                                                            |                                               |
| <b>Annual Routine Gyn Exam</b><br><i>No waiting period, no calendar year max. Annual Pap/Mammogram</i>                             | \$0 copay deductible waived                                                                                                                                                                           | 20% after deductible                          |
| <b>Maternity</b> — Inpatient Facility Services                                                                                     | 0% after deductible                                                                                                                                                                                   | 20% after deductible                          |
|                                                                                                                                    | Inpatient Facility Services coverage after deductible for the mother and the newborn for a minimum of 48 hours for an uncomplicated vaginal delivery and 96 hours for an uncomplicated cesarean birth |                                               |
| <b>Maternity</b> — Professional Services                                                                                           | Coverage for complications of pregnancy                                                                                                                                                               |                                               |
| <b>Preventive Health — Routine Physical</b><br><i>Aetna will pay up to \$200 per exam* No waiting period</i>                       | \$25 copay deductible waived                                                                                                                                                                          | \$25 copay; 20% coinsurance after deductible  |
|                                                                                                                                    | Includes lab work and X-rays                                                                                                                                                                          |                                               |
| <b>Lab/X-Ray</b>                                                                                                                   | 0% after deductible                                                                                                                                                                                   | 20% after deductible                          |
| <b>Skilled Nursing</b> — in lieu of hospital<br><i>30 days per calendar year*</i>                                                  | 0% after deductible                                                                                                                                                                                   | 20% after deductible                          |
| <b>Physical/Occupational Therapy and Chiropractic Care</b><br><i>24 visits per calendar year*</i>                                  | 0% after deductible                                                                                                                                                                                   | 20% after deductible                          |
|                                                                                                                                    | Aetna will pay a max. of \$25 per visit*                                                                                                                                                              |                                               |
| <b>Home Health Care</b> —<br><i>in lieu of hospital 40 visits per calendar year*</i>                                               | 0% after deductible                                                                                                                                                                                   | 20% after deductible                          |
| <b>Durable Medical Equipment</b><br><i>Aetna will pay up to \$2000 per calendar year*</i>                                          | 0% after deductible                                                                                                                                                                                   | 20% after deductible                          |
| <b>PHARMACY</b>                                                                                                                    |                                                                                                                                                                                                       |                                               |
| <b>Pharmacy Deductible</b><br>per individual                                                                                       | Integrated Medical/Rx Deductible                                                                                                                                                                      | Integrated Medical/Rx Deductible              |
| <b>Generic</b><br><i>Oral Contraceptives Included</i>                                                                              | 0% after Medical/Rx Deductible                                                                                                                                                                        | 20% after Medical/Rx Deductible               |
| <b>Preferred Brand</b><br><i>Oral Contraceptives Included</i>                                                                      | 0% after Medical/Rx Deductible                                                                                                                                                                        | 20% after Medical/Rx Deductible               |
| <b>Non-Preferred Brand</b><br><i>Oral Contraceptives Included</i>                                                                  | 0% after Medical/Rx Deductible                                                                                                                                                                        | 20% after Medical/Rx Deductible               |
| <b>Calendar Year Maximum</b><br>per individual*                                                                                    | Unlimited                                                                                                                                                                                             | Unlimited                                     |

+ Payment for out-of-network facility care is determined based upon Aetna's Allowable Fee Schedule. Payment for other out-of-network facility care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider.

## PPO Value 2500

| MEMBER BENEFITS                                                                                                                    | In-Network                                                                                                                                                                                                                   | Out-of-Network*                                                                                                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Deductible</b><br>Individual<br>Family                                                                                          | \$2,500<br>\$5,000                                                                                                                                                                                                           | \$5,000<br>\$10,000                                                                                                                                                                                                        |
| <b>Coinsurance</b><br>(Member's responsibility)                                                                                    | 20% after deductible up to out-of-pocket max.                                                                                                                                                                                | 35% after deductible up to out-of-pocket max.                                                                                                                                                                              |
|                                                                                                                                    | \$0 once out-of-pocket max. is satisfied                                                                                                                                                                                     |                                                                                                                                                                                                                            |
| <b>Coinsurance Maximum</b><br>Individual<br>Family                                                                                 | \$2,500<br>\$5,000                                                                                                                                                                                                           | \$5,000<br>\$10,000                                                                                                                                                                                                        |
| <b>Out-of-Pocket Maximum</b><br>Individual<br>Family                                                                               | \$5,000<br>\$10,000                                                                                                                                                                                                          | \$10,000<br>\$20,000                                                                                                                                                                                                       |
|                                                                                                                                    | Includes deductible                                                                                                                                                                                                          |                                                                                                                                                                                                                            |
| <b>Lifetime Maximum* per insured</b>                                                                                               | \$5,000,000                                                                                                                                                                                                                  |                                                                                                                                                                                                                            |
| <b>Non-Specialist Office Visit</b><br><i>Unlimited visits</i><br>General Physician, Family Practitioner, Pediatrician or Internist | Visits 1-5 \$50 copay, deductible waived;<br>Visit 5+ member is responsible for 100% but Aetna discount applies; Aetna will pay 100% after out-of-pocket maximum is satisfied. Specialist and Non-Specialist share visit max | Visits 1-5 \$50 copay plus 20% coinsurance, deductible applies;<br>Visit 5+ member is responsible for 100% but Aetna will pay 100% after out-of-pocket maximum is satisfied. Specialist and Non-Specialist share visit max |
| <b>Specialist Visit</b><br><i>Unlimited visits</i>                                                                                 |                                                                                                                                                                                                                              |                                                                                                                                                                                                                            |
| <b>Hospital Admission</b><br>(includes complications of pregnancy)                                                                 | 40% after deductible                                                                                                                                                                                                         | 50% after deductible                                                                                                                                                                                                       |
| <b>Outpatient Surgery</b>                                                                                                          | 20% after deductible                                                                                                                                                                                                         | 35% after deductible                                                                                                                                                                                                       |
| <b>Urgent Care Facility</b>                                                                                                        | \$50 copay deductible waived                                                                                                                                                                                                 | \$50 copay; 20% coinsurance after deductible                                                                                                                                                                               |
| <b>Emergency Room</b>                                                                                                              | \$100 copay** (waived if admitted)<br>20% coinsurance after deductible                                                                                                                                                       |                                                                                                                                                                                                                            |
| <b>Annual Routine Gyn Exam</b><br><i>No waiting period, no calendar year max. Annual Pap</i>                                       | \$0 copay deductible waived                                                                                                                                                                                                  | \$50 copay; 20% coinsurance after deductible                                                                                                                                                                               |
| <b>Mammogram</b>                                                                                                                   | \$30 copay deductible waived                                                                                                                                                                                                 | \$50 copay; 20% coinsurance after deductible                                                                                                                                                                               |
| <b>Maternity — Inpatient Facility Services</b>                                                                                     | 40% after deductible                                                                                                                                                                                                         | 50% after deductible                                                                                                                                                                                                       |
|                                                                                                                                    | Inpatient Facility Services coverage after deductible for the mother and the newborn for a minimum of 48 hours for an uncomplicated vaginal delivery and 96 hours for an uncomplicated cesarean birth                        |                                                                                                                                                                                                                            |
| <b>Maternity — Professional Services</b>                                                                                           | Coverage for complications of pregnancy                                                                                                                                                                                      |                                                                                                                                                                                                                            |
| <b>Preventive Health — Routine Physical</b><br><i>Aetna will pay up to \$200 per exam*<br/>No waiting period</i>                   | \$50 copay deductible waived                                                                                                                                                                                                 | \$50 copay; 20% coinsurance after deductible                                                                                                                                                                               |
|                                                                                                                                    | Includes lab work and X-rays                                                                                                                                                                                                 |                                                                                                                                                                                                                            |
| <b>Lab/X-Ray</b>                                                                                                                   | 20% after deductible                                                                                                                                                                                                         | 35% after deductible                                                                                                                                                                                                       |
| <b>Skilled Nursing — in lieu of hospital</b><br><i>30 days per calendar year*</i>                                                  | 40% after deductible                                                                                                                                                                                                         | 50% after deductible                                                                                                                                                                                                       |
| <b>Physical/Occupational Therapy and Chiropractic Care</b><br><i>24 visits per calendar year*</i>                                  | 20% after deductible                                                                                                                                                                                                         | 35% after deductible                                                                                                                                                                                                       |
|                                                                                                                                    | Aetna will pay a max. of \$25 per visit*                                                                                                                                                                                     |                                                                                                                                                                                                                            |
| <b>Home Health Care — in lieu of hospital</b><br><i>40 visits per calendar year*</i>                                               | 20% after deductible                                                                                                                                                                                                         | 35% after deductible                                                                                                                                                                                                       |
| <b>Durable Medical Equipment</b><br><i>Aetna will pay up to \$2000 per calendar year*</i>                                          | 40% after deductible                                                                                                                                                                                                         | 50% after deductible                                                                                                                                                                                                       |
| <b>PHARMACY</b>                                                                                                                    |                                                                                                                                                                                                                              |                                                                                                                                                                                                                            |
| <b>Pharmacy Deductible</b><br>per individual                                                                                       | \$500                                                                                                                                                                                                                        | \$500                                                                                                                                                                                                                      |
|                                                                                                                                    | Does not apply to generic                                                                                                                                                                                                    |                                                                                                                                                                                                                            |
| <b>Generic Oral Contraceptives Included</b>                                                                                        | \$15 copay deductible waived                                                                                                                                                                                                 | \$15 copay plus 20% deductible waived                                                                                                                                                                                      |
| <b>Preferred Brand Oral Contraceptives Included</b>                                                                                | \$40 copay after deductible                                                                                                                                                                                                  | \$40 copay plus 20% after deductible                                                                                                                                                                                       |
| <b>Non-Preferred Brand Oral Contraceptives Included</b>                                                                            | \$60 copay after deductible                                                                                                                                                                                                  | \$60 copay plus 20% after deductible                                                                                                                                                                                       |
| <b>Calendar Year Maximum</b><br>per individual*                                                                                    | \$5,000                                                                                                                                                                                                                      | \$5,000                                                                                                                                                                                                                    |

\* Maximum applies to combined in and out-of-network benefits.

\*\* Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

## PPO Value 5000

| MEMBER BENEFITS                                                                                                                    | In-Network                                                                                                                                                                                                                   | Out-of-Network*                                                                                                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Deductible</b><br>Individual<br>Family                                                                                          | \$5,000<br>\$10,000                                                                                                                                                                                                          | \$10,000<br>\$20,000                                                                                                                                                                                                       |
| <b>Coinsurance</b><br>(Member's responsibility)                                                                                    | 20% after deductible up to out-of-pocket max.                                                                                                                                                                                | 35% after deductible up to out-of-pocket max.                                                                                                                                                                              |
|                                                                                                                                    | \$0 once out-of-pocket max. is satisfied                                                                                                                                                                                     |                                                                                                                                                                                                                            |
| <b>Coinsurance Maximum</b><br>Individual<br>Family                                                                                 | \$5,000<br>\$10,000                                                                                                                                                                                                          | \$2,500<br>\$5,000                                                                                                                                                                                                         |
| <b>Out-of-Pocket Maximum</b><br>Individual<br>Family                                                                               | \$10,000<br>\$20,000                                                                                                                                                                                                         | \$12,500<br>\$25,000                                                                                                                                                                                                       |
|                                                                                                                                    | Includes deductible                                                                                                                                                                                                          |                                                                                                                                                                                                                            |
| <b>Lifetime Maximum* per insured</b>                                                                                               | \$5,000,000                                                                                                                                                                                                                  |                                                                                                                                                                                                                            |
| <b>Non-Specialist Office Visit</b><br><i>Unlimited visits</i><br>General Physician, Family Practitioner, Pediatrician or Internist | Visits 1-5 \$50 copay, deductible waived;<br>Visit 5+ member is responsible for 100% but Aetna discount applies; Aetna will pay 100% after out-of-pocket maximum is satisfied. Specialist and Non-Specialist share visit max | Visits 1-5 \$50 copay plus 20% coinsurance, deductible applies;<br>Visit 5+ member is responsible for 100% but Aetna will pay 100% after out-of-pocket maximum is satisfied. Specialist and Non-Specialist share visit max |
| <b>Specialist Visit</b><br><i>Unlimited visits</i>                                                                                 |                                                                                                                                                                                                                              |                                                                                                                                                                                                                            |
| <b>Hospital Admission</b><br>(includes complications of pregnancy)                                                                 | 40% after deductible                                                                                                                                                                                                         | 50% after deductible                                                                                                                                                                                                       |
| <b>Outpatient Surgery</b>                                                                                                          | 20% after deductible                                                                                                                                                                                                         | 35% after deductible                                                                                                                                                                                                       |
| <b>Urgent Care Facility</b>                                                                                                        | \$50 copay deductible waived                                                                                                                                                                                                 | \$50 copay; 20% coinsurance after deductible                                                                                                                                                                               |
| <b>Emergency Room</b>                                                                                                              | \$100 copay** (waived if admitted)<br>20% after deductible                                                                                                                                                                   |                                                                                                                                                                                                                            |
| <b>Annual Routine Gyn Exam</b><br><i>No waiting period, no calendar year max. Annual Pap</i>                                       | \$0 copay deductible waived                                                                                                                                                                                                  | \$50 copay; 20% coinsurance after deductible                                                                                                                                                                               |
| <b>Mammogram</b>                                                                                                                   | \$30 copay deductible waived                                                                                                                                                                                                 | \$50 copay; 20% coinsurance after deductible                                                                                                                                                                               |
| <b>Maternity — Inpatient Facility Services</b>                                                                                     | 40% after deductible                                                                                                                                                                                                         | 50% after deductible                                                                                                                                                                                                       |
|                                                                                                                                    | Inpatient Facility Services coverage after deductible for the mother and the newborn for a minimum of 48 hours for an uncomplicated vaginal delivery and 96 hours for an uncomplicated cesarean birth                        |                                                                                                                                                                                                                            |
| <b>Maternity — Professional Services</b>                                                                                           | Coverage for complications of pregnancy                                                                                                                                                                                      |                                                                                                                                                                                                                            |
| <b>Preventive Health — Routine Physical</b><br><i>Aetna will pay up to \$200 per exam*<br/>No waiting period</i>                   | \$50 copay deductible waived                                                                                                                                                                                                 | \$50 copay; 20% coinsurance after deductible                                                                                                                                                                               |
|                                                                                                                                    | Includes lab work and X-rays                                                                                                                                                                                                 |                                                                                                                                                                                                                            |
| <b>Lab/X-Ray</b>                                                                                                                   | 20% after deductible                                                                                                                                                                                                         | 35% after deductible                                                                                                                                                                                                       |
| <b>Skilled Nursing — in lieu of hospital</b><br><i>30 days per calendar year*</i>                                                  | 40% after deductible                                                                                                                                                                                                         | 50% after deductible                                                                                                                                                                                                       |
| <b>Physical/Occupational Therapy and Chiropractic Care</b><br><i>24 visits per calendar year*</i>                                  | 20% after deductible                                                                                                                                                                                                         | 35% after deductible                                                                                                                                                                                                       |
|                                                                                                                                    | Aetna will pay a max. of \$25 per visit*                                                                                                                                                                                     |                                                                                                                                                                                                                            |
| <b>Home Health Care — in lieu of hospital</b><br><i>40 visits per calendar year*</i>                                               | 20% after deductible                                                                                                                                                                                                         | 35% after deductible                                                                                                                                                                                                       |
| <b>Durable Medical Equipment</b><br><i>Aetna will pay up to \$2000 per calendar year*</i>                                          | 40% after deductible                                                                                                                                                                                                         | 50% after deductible                                                                                                                                                                                                       |
| <b>PHARMACY</b>                                                                                                                    |                                                                                                                                                                                                                              |                                                                                                                                                                                                                            |
| <b>Pharmacy Deductible</b><br>per individual                                                                                       | \$500                                                                                                                                                                                                                        | \$500                                                                                                                                                                                                                      |
|                                                                                                                                    | Does not apply to generic                                                                                                                                                                                                    |                                                                                                                                                                                                                            |
| <b>Generic Oral Contraceptives Included</b>                                                                                        | \$15 copay deductible waived                                                                                                                                                                                                 | \$15 copay plus 20% deductible waived                                                                                                                                                                                      |
| <b>Preferred Brand Oral Contraceptives Included</b>                                                                                | \$40 copay after deductible                                                                                                                                                                                                  | \$40 copay plus 20% after deductible                                                                                                                                                                                       |
| <b>Non-Preferred Brand Oral Contraceptives Included</b>                                                                            | \$60 copay after deductible                                                                                                                                                                                                  | \$60 copay plus 20% after deductible                                                                                                                                                                                       |
| <b>Calendar Year Maximum</b><br>per individual*                                                                                    | \$5,000                                                                                                                                                                                                                      | \$5,000                                                                                                                                                                                                                    |

+ Payment for out-of-network facility covered expenses is determined based on Aetna's Market Fee Schedule. Payment for out-of-network non-facility covered expenses is determined based on the negotiated charge that would apply if such services were received from a Network Provider.

PPO Value 7500

| MEMBER BENEFITS                                                                                                                    | In-Network                                                                                                                                                                                            | Out-of-Network*                               |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| <b>Deductible</b>                                                                                                                  |                                                                                                                                                                                                       |                                               |
| Individual                                                                                                                         | \$7,500                                                                                                                                                                                               | \$10,000                                      |
| Family                                                                                                                             | \$15,000                                                                                                                                                                                              | \$20,000                                      |
| <b>Coinurance</b><br>(Member's responsibility)                                                                                     | 30% after deductible up to out-of-pocket max.                                                                                                                                                         | 40% after deductible up to out-of-pocket max. |
|                                                                                                                                    | \$0 once out-of-pocket max. is satisfied                                                                                                                                                              |                                               |
| <b>Coinurance Maximum</b>                                                                                                          |                                                                                                                                                                                                       |                                               |
| Individual                                                                                                                         | \$5,000                                                                                                                                                                                               | \$2,500                                       |
| Family                                                                                                                             | \$10,000                                                                                                                                                                                              | \$5,000                                       |
| <b>Out-of-Pocket Maximum</b>                                                                                                       |                                                                                                                                                                                                       |                                               |
| Individual                                                                                                                         | \$12,500                                                                                                                                                                                              | \$12,500                                      |
| Family                                                                                                                             | \$25,000                                                                                                                                                                                              | \$25,000                                      |
|                                                                                                                                    | Includes deductible                                                                                                                                                                                   |                                               |
| <b>Lifetime Maximum* per insured</b>                                                                                               | \$1,000,000                                                                                                                                                                                           |                                               |
| <b>Non-Specialist Office Visit</b><br><i>Unlimited visits</i><br>General Physician, Family Practitioner, Pediatrician or Internist | 30% after deductible                                                                                                                                                                                  | 40% after deductible                          |
| <b>Specialist Visit</b><br><i>Unlimited visits</i>                                                                                 | 30% after deductible                                                                                                                                                                                  | 40% after deductible                          |
| <b>Hospital Admission</b><br>(includes complications of pregnancy)                                                                 | 30% after deductible                                                                                                                                                                                  | 40% after deductible                          |
| <b>Outpatient Surgery</b>                                                                                                          | 30% after deductible                                                                                                                                                                                  | 40% after deductible                          |
| <b>Urgent Care Facility</b>                                                                                                        | \$50 copay deductible waived                                                                                                                                                                          | \$50 copay; 20% coinsurance after deductible  |
| <b>Emergency Room</b>                                                                                                              | \$100 copay** (waived if admitted) 30% coinsurance after deductible                                                                                                                                   |                                               |
| <b>Annual Routine Gyn Exam</b><br><i>No waiting period, no calendar year max. Annual Pap</i>                                       | \$30 copay deductible waived                                                                                                                                                                          | \$50 copay; 20% coinsurance after deductible  |
| <b>Mammogram</b>                                                                                                                   | \$30 copay deductible waived                                                                                                                                                                          | \$50 copay; 20% coinsurance after deductible  |
| <b>Maternity — Inpatient Facility Services</b>                                                                                     | 30% after deductible                                                                                                                                                                                  | 40% after deductible                          |
|                                                                                                                                    | Inpatient Facility Services coverage after deductible for the mother and the newborn for a minimum of 48 hours for an uncomplicated vaginal delivery and 96 hours for an uncomplicated cesarean birth |                                               |
| <b>Maternity — Professional Services</b>                                                                                           | Coverage for complications of pregnancy                                                                                                                                                               |                                               |
| <b>Preventive Health — Routine Physical</b><br><i>Aetna will pay up to \$200 per exam* No waiting period</i>                       | \$50 copay deductible waived                                                                                                                                                                          | \$50 copay; 20% coinsurance after deductible  |
|                                                                                                                                    | Includes lab work and X-rays                                                                                                                                                                          |                                               |
| <b>Lab/X-Ray</b>                                                                                                                   | 30% after deductible                                                                                                                                                                                  | 40% after deductible                          |
| <b>Skilled Nursing — in lieu of hospital 30 days per calendar year*</b>                                                            | 30% after deductible                                                                                                                                                                                  | 40% after deductible                          |
| <b>Physical/Occupational Therapy and Chiropractic Care</b><br><i>24 visits per calendar year*</i>                                  | 30% after deductible                                                                                                                                                                                  | 40% after deductible                          |
|                                                                                                                                    | Aetna will pay a max. of \$25 per visit*                                                                                                                                                              |                                               |
| <b>Home Health Care — in lieu of hospital 40 visits per calendar year*</b>                                                         | 30% after deductible                                                                                                                                                                                  | 40% after deductible                          |
| <b>Durable Medical Equipment</b><br><i>Aetna will pay up to \$2000 per calendar year*</i>                                          | 30% after deductible                                                                                                                                                                                  | 40% after deductible                          |
| <b>PHARMACY</b>                                                                                                                    |                                                                                                                                                                                                       |                                               |
| <b>Pharmacy Deductible</b><br>per individual                                                                                       | Not Applicable                                                                                                                                                                                        | Not Applicable                                |
| <b>Generic</b><br><i>Oral Contraceptives Included</i>                                                                              | \$20 copay deductible waived                                                                                                                                                                          | \$20 copay plus 20% deductible waived         |
| <b>Preferred Brand</b><br><i>Oral Contraceptives Included</i>                                                                      | Not covered<br>Aetna Discount Applies                                                                                                                                                                 | Not covered                                   |
| <b>Non-Preferred Brand</b><br><i>Oral Contraceptives Included</i>                                                                  | Not covered<br>Aetna Discount Applies                                                                                                                                                                 | Not covered                                   |
| <b>Calendar Year Maximum</b><br>per individual*                                                                                    | \$5,000                                                                                                                                                                                               | \$5,000                                       |

\* Maximum applies to combined in and out-of-network benefits.

\*\* Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

PPO Value 10000

| MEMBER BENEFITS                                                                                                                    | In-Network                                                                                                                                                                                            | Out-of-Network*                               |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| <b>Deductible</b>                                                                                                                  |                                                                                                                                                                                                       |                                               |
| Individual                                                                                                                         | \$10,000                                                                                                                                                                                              | \$10,000                                      |
| Family                                                                                                                             | \$20,000                                                                                                                                                                                              | \$20,000                                      |
| <b>Coinurance</b><br>(Member's responsibility)                                                                                     | 30% after deductible up to out-of-pocket max.                                                                                                                                                         | 40% after deductible up to out-of-pocket max. |
|                                                                                                                                    | \$0 once out-of-pocket max. is satisfied                                                                                                                                                              |                                               |
| <b>Coinurance Maximum</b>                                                                                                          |                                                                                                                                                                                                       |                                               |
| Individual                                                                                                                         | \$2,500                                                                                                                                                                                               | \$2,500                                       |
| Family                                                                                                                             | \$5,000                                                                                                                                                                                               | \$5,000                                       |
| <b>Out-of-Pocket Maximum</b>                                                                                                       |                                                                                                                                                                                                       |                                               |
| Individual                                                                                                                         | \$12,500                                                                                                                                                                                              | \$12,500                                      |
| Family                                                                                                                             | \$25,000                                                                                                                                                                                              | \$25,000                                      |
|                                                                                                                                    | Includes deductible                                                                                                                                                                                   |                                               |
| <b>Lifetime Maximum* per insured</b>                                                                                               | \$1,000,000                                                                                                                                                                                           |                                               |
| <b>Non-Specialist Office Visit</b><br><i>Unlimited visits</i><br>General Physician, Family Practitioner, Pediatrician or Internist | 30% after deductible                                                                                                                                                                                  | 40% after deductible                          |
| <b>Specialist Visit</b><br><i>Unlimited visits</i>                                                                                 | 30% after deductible                                                                                                                                                                                  | 40% after deductible                          |
| <b>Hospital Admission</b><br>(includes complications of pregnancy)                                                                 | 30% after deductible                                                                                                                                                                                  | 40% after deductible                          |
| <b>Outpatient Surgery</b>                                                                                                          | 30% after deductible                                                                                                                                                                                  | 40% after deductible                          |
| <b>Urgent Care Facility</b>                                                                                                        | \$50 copay deductible waived                                                                                                                                                                          | \$50 copay; 20% coinsurance after deductible  |
| <b>Emergency Room</b>                                                                                                              | \$100 copay** (waived if admitted) 30% coinsurance after deductible                                                                                                                                   |                                               |
| <b>Annual Routine Gyn Exam</b><br><i>No waiting period, no calendar year max. Annual Pap</i>                                       | \$30 copay deductible waived                                                                                                                                                                          | \$50 copay; 20% coinsurance after deductible  |
| <b>Mammogram</b>                                                                                                                   | \$30 copay deductible waived                                                                                                                                                                          | \$50 copay; 20% coinsurance after deductible  |
| <b>Maternity — Inpatient Facility Services</b>                                                                                     | 30% after deductible                                                                                                                                                                                  | 40% after deductible                          |
|                                                                                                                                    | Inpatient Facility Services coverage after deductible for the mother and the newborn for a minimum of 48 hours for an uncomplicated vaginal delivery and 96 hours for an uncomplicated cesarean birth |                                               |
| <b>Maternity — Professional Services</b>                                                                                           | Coverage for complications of pregnancy                                                                                                                                                               |                                               |
| <b>Preventive Health — Routine Physical</b><br><i>Aetna will pay up to \$200 per exam* No waiting period</i>                       | \$50 copay deductible waived                                                                                                                                                                          | \$50 copay; 20% coinsurance after deductible  |
|                                                                                                                                    | Includes lab work and X-rays                                                                                                                                                                          |                                               |
| <b>Lab/X-Ray</b>                                                                                                                   | 30% after deductible                                                                                                                                                                                  | 40% after deductible                          |
| <b>Skilled Nursing — in lieu of hospital 30 days per calendar year*</b>                                                            | 30% after deductible                                                                                                                                                                                  | 40% after deductible                          |
| <b>Physical/Occupational Therapy and Chiropractic Care</b><br><i>24 visits per calendar year*</i>                                  | 30% after deductible                                                                                                                                                                                  | 40% after deductible                          |
|                                                                                                                                    | Aetna will pay a max. of \$25 per visit*                                                                                                                                                              |                                               |
| <b>Home Health Care — in lieu of hospital 40 visits per calendar year*</b>                                                         | 30% after deductible                                                                                                                                                                                  | 40% after deductible                          |
| <b>Durable Medical Equipment</b><br><i>Aetna will pay up to \$2000 per calendar year*</i>                                          | 30% after deductible                                                                                                                                                                                  | 40% after deductible                          |
| <b>PHARMACY</b>                                                                                                                    |                                                                                                                                                                                                       |                                               |
| <b>Pharmacy Deductible</b><br>per individual                                                                                       | Not Applicable                                                                                                                                                                                        | Not Applicable                                |
| <b>Generic</b><br><i>Oral Contraceptives Included</i>                                                                              | \$20 copay deductible waived                                                                                                                                                                          | \$20 copay plus 20% deductible waived         |
| <b>Preferred Brand</b><br><i>Oral Contraceptives Included</i>                                                                      | Not covered<br>Aetna Discount Applies                                                                                                                                                                 | Not covered                                   |
| <b>Non-Preferred Brand</b><br><i>Oral Contraceptives Included</i>                                                                  | Not covered<br>Aetna Discount Applies                                                                                                                                                                 | Not covered                                   |
| <b>Calendar Year Maximum</b><br>per individual*                                                                                    | \$5,000                                                                                                                                                                                               | \$5,000                                       |

+ Payment for out-of-network facility covered expenses is determined based on Aetna's Market Fee Schedule. Payment for out-of-network non-facility covered expenses is determined based on the negotiated charge that would apply if such services were received from a Network Provider.

## Aetna Advantage Plan options Individual Dental PPO Max plan

| MEMBER BENEFITS                                                                        | Preferred                 | NonPreferred              |
|----------------------------------------------------------------------------------------|---------------------------|---------------------------|
| Annual Deductible per Member<br>(Does not apply to Diagnostic and Preventive Services) | \$25;<br>\$75 family max. | \$25;<br>\$75 family max. |
| Annual Maximum Benefit                                                                 | Unlimited                 | Unlimited                 |
| <b>DIAGNOSTIC SERVICES</b>                                                             |                           |                           |
| <b>Oral exams</b>                                                                      |                           |                           |
| Periodic oral exam                                                                     | 100% ded. waived          | 100% ded. waived          |
| Comprehensive oral exam                                                                | 100% ded. waived          | 100% ded. waived          |
| Problem-focused oral exam                                                              | 100% ded. waived          | 100% ded. waived          |
| <b>X-rays</b>                                                                          |                           |                           |
| Bitewing — single film                                                                 | 100% ded. waived          | 100% ded. waived          |
| Complete series                                                                        | 100% ded. waived          | 100% ded. waived          |
| <b>PREVENTIVE SERVICES</b>                                                             |                           |                           |
| Adult cleaning                                                                         | 100% ded. waived          | 100% ded. waived          |
| Child cleaning                                                                         | 100% ded. waived          | 100% ded. waived          |
| Sealants — per tooth                                                                   | Discount                  | Not covered               |
| Fluoride application — with cleaning                                                   | 100% ded. waived          | 100% ded. waived          |
| Space maintainers                                                                      | Discount                  | Not covered               |
| <b>BASIC SERVICES</b>                                                                  |                           |                           |
| Amalgam fillings — 2 surfaces                                                          | 100% after ded.           | 100% after ded.           |
| Resin fillings — 2 surfaces                                                            | Discount                  | Not covered               |
| <b>Oral Surgery</b>                                                                    |                           |                           |
| Extraction — exposed root or erupted tooth                                             | Discount                  | Not covered               |
| Extraction of impacted tooth — soft tissue                                             | Discount                  | Not covered               |
| <b>MAJOR SERVICES</b>                                                                  |                           |                           |
| Complete upper denture                                                                 | Discount                  | Not covered               |
| Partial upper denture (resin based)                                                    | Discount                  | Not covered               |
| Crown — Porcelain with noble metal                                                     | Discount                  | Not covered               |
| Pontic — Porcelain with noble metal                                                    | Discount                  | Not covered               |
| Inlay — Metallic (3 or more surfaces)                                                  | Discount                  | Not covered               |
| <b>Oral Surgery</b>                                                                    |                           |                           |
| Removal of impacted tooth — partially bony                                             | Discount                  | Not covered               |
| <b>Endodontic Services</b>                                                             |                           |                           |
| Bicuspid root canal therapy                                                            | Discount                  | Not covered               |
| Molar root canal therapy                                                               | Discount                  | Not covered               |
| <b>Periodontic Services</b>                                                            |                           |                           |
| Scaling & root planing — per quadrant                                                  | Discount                  | Not covered               |
| Osseous surgery — per quadrant                                                         | Discount                  | Not covered               |
| <b>ORTHODONTIC SERVICES</b>                                                            |                           |                           |
|                                                                                        | Discount                  | Not covered               |

**Access to negotiated discounts: members are eligible to receive non-covered services, including cosmetic services such as tooth whitening, at the PPO negotiated rate when visiting a participating PPO dentist.**

Nonpreferred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Above list of covered services is representative. A summary of exclusions is listed later in this brochure. For a full list of benefit coverage and exclusions refer to the plan documents. All products not available in all counties.

This material is for informational purposes only and is neither an offer of coverage nor dental advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract.

# Aetna special programs

Aetna Advantage plans include special programs<sup>1</sup> to complement our standard health insurance coverage. These programs include health information programs and tools, and offer you access to substantial savings on products to help you stay healthy. These programs are offered in addition to your Aetna Advantage Plan and are NOT insurance.

### Aetna Vision<sup>SM</sup> Discount Program

Aetna Vision<sup>SM</sup> discount program offers special savings on eye exams, contact lenses, frames, lenses, LASIK eye surgery, and eye care accessories.

### Aetna Natural Products and Services<sup>SM</sup> Discount Program

Eligible Aetna members and their families can access complementary health care products and services at reduced rates through the Aetna Natural Products and Services discount program. Members can save on acupuncture, chiropractic care, massage therapy and dietetic counseling as well as on over-the-counter vitamins, herbal and nutritional supplements and other health-related products.

<sup>1</sup> Availability varies by plan. Talk with your Aetna representative for details.



### Aetna Fitness<sup>SM</sup> Discount Program

Eligible Aetna members and their families can access the GlobalFit™ national network of nearly 10,000 fitness clubs, in the United States and Canada, at preferred rates\*. In addition, members can access other programs such as at-home weight loss programs, home fitness options and even one-on-one health coaching\*\* services.

### Aetna Weight Management<sup>SM</sup> Discount Program

The Weight Management<sup>SM</sup> discount program can help you achieve your weight loss goals by providing you with a sensible weight loss plan and balanced nutrition guide to fit your lifestyle. This program provides Aetna members and their eligible family members access to discounts on Jenny Craig® weight loss programs and products.

### Aetna Hearing<sup>SM</sup> Discount Program

Aetna's Hearing<sup>SM</sup> discount program help Aetna members and their families save on hearing exams, hearing services and hearing aids.

### Aetna Rx Home Delivery<sup>®</sup>

With this mail order delivery program, order prescription medications through our convenient and easy-to-use mail order pharmacy.

### Informed Health<sup>®</sup> Line

Our 24-hour toll-free number that puts you in touch with experienced registered nurses and an audio library for information on thousands of health topics.

### Aetna Navigator<sup>®</sup>

Register and log on to Aetna Navigator, Aetna's secure member website, to check claims status, contact Aetna Member Services, estimate the costs of health care services, and more. Our new Aetna Navigator Health Information Guide provides a starting point to find answers about health care, types of treatment, cost of services and more to help members make more informed decisions. Plus, members have access to their own Personal Health Record\*\*\*, a single, secure place where they can view their medical history and add other health information.

\* At some clubs, participation in this program may be restricted to new club members.

\*\* Provided by WellCall, Inc. through GlobalFit.

\*\*\* The Aetna Personal Health Record should not be used as the sole source of information about your health conditions or medical treatment.

For more information on any of these programs, please visit us online at



### WANT TO SAVE ON DENTAL EXPENSES?

Vital Savings by Aetna<sup>®</sup> is a discount program that provides you with dental savings. This is not insurance. Enrolling in the program will give you access to a network of providers who have agreed to accept discounted rates for services.

The Vital Savings by Aetna<sup>®</sup> program (the "Program") is not insurance. The Program provides Members with access to discounted fees pursuant to schedules negotiated by Aetna Life Insurance Company for the Vital Savings by Aetna<sup>®</sup> discount program. The Program does not make payments directly to the providers participating in the Program. Each Member is obligated to pay for all services or products but will receive a discount from the providers who have contracted with the Discount Medical Plan Organization to participate in the Program. Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156, is the Discount Medical Plan Organization.

Discount programs provide access to discounted prices and are NOT insured benefits.

# Things you need to know

## To qualify for an Aetna Advantage Plan, you must be:

- Under age 64 3/4 (If applying as a couple, both you and your spouse must be under 64 3/4.)
- Under age 25 for unmarried dependent children
- Legal residents in a state with products offered by the Aetna Advantage Plans
- Legal U.S. residents for at least six continuous months

## Your premium payments

*Your rates are guaranteed not to increase for 12 months from your effective date once you've been accepted for coverage. After that, your premiums may change. Final rates are subject to underwriting review.*

## Your coverage

Your coverage remains in effect as long as you pay the required premium charges on time, and as long as you maintain eligibility in the plan. Coverage will be terminated if you become ineligible due to any of the following circumstances:

- Non-payment of premiums
- Becoming a resident of a state or location in which Aetna Advantage Plans are not available
- Obtaining duplicate coverage
- For other reasons permissible by law

## EASY-PAY

### Simple Automatic Payments via Electronic Funds Transfer (EFT)

**Registration:** Complete the payment section of the Aetna Advantage Plans application. Select the EFT option to approve the automatic withdrawal of your initial premium and all subsequent premium payments.

**Invoices:** You will not receive a paper invoice when you are enrolled in EFT. Payments will appear on your bank statement as "Aetna Autodebit Coverage."

**Terminating:** To terminate EFT, you will need to provide Aetna with 10 days written notice prior to the date your next EFT payment will be deducted. Without this written notice, your bank account may be debited for the next month's premium. You will then need to contact Aetna to have funds placed back in the checking account.

**Refunds:** To process an EFT refund (placing money back in member's checking account), Aetna will require at least five days after the withdrawal was made to ensure valid payment.

**Rejected transactions:** If the EFT payment rejects for any reason, Aetna will automatically terminate the EFT and send you a letter saying you will receive paper invoices. Processing time to reinstate EFT will be 30–60 days. If an EFT payment is rejected, you will need to pay that payment by paper check or credit card.

**Timing:** Payments for Cycle 1 accounts (1st of the month effective date) will be taken from your bank account between the 3rd and the 10th of the month the premium is due. Payments for Cycle 2 accounts (15th of the month effective date) will be taken from your bank account between the 18th and 23rd of the month the premium is due.

## Levels of coverage & enrollment

- You may be enrolled in your selected plan at the premium charge.
- *You may be enrolled in your selected plan at a higher premium, based on medical underwriting.*
- You may be declined coverage based on medical underwriting.

## Medical underwriting requirements

The Aetna Advantage Plans are not guaranteed issue plans and require medical underwriting. Some individuals may qualify as federally eligible under the Health Insurance Portability Accountability Act (HIPAA) for a special guaranteed issue plan under Maryland laws and regulations.

All applicants, enrolling spouses and dependents are subject to medical underwriting to determine eligibility and appropriate premium rate level.

We offer various premium rate levels based on the medical underwriting of each applicant.

## 10-day right to review

Do not cancel your current insurance until you are notified that you have been accepted for coverage. We'll review your application to determine if you meet underwriting requirements. If you're denied, you'll be notified by mail. If you're approved, you'll be sent an Aetna Advantage Plan contract and ID card.

If, after reviewing the contract, you find that you're not satisfied for any reason, simply return the contract to us within 10 days. We will refund any premium you've paid (including any contract fees or other charges) less the cost of any services paid on behalf of you or any covered dependent.

## Duplicate coverage

If you are currently covered by another carrier, you must agree to discontinue the other coverage before or on the effective date of the Aetna Advantage Plan. Do not cancel your current insurance until you are notified that you have been accepted for coverage and are certain that you are keeping your Aetna Advantage Plan coverage.

## Limitations & exclusions

### Medical

These medical plans do not cover all health care expenses and include exclusions and limitations. You should refer to your 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). Services and supplies that are generally not covered include, but are not limited to:

- 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
- Ambulance coverage is limited to \$1,000 per trip
- Cosmetic surgery
- Custodial care
- Donor egg retrieval
- Weight control services including surgical procedures for the treatment of obesity, medical treatment, and weight control/loss programs
- Experimental and investigational procedures, (except for coverage for medically necessary routine patient care costs for Members participating in a cancer clinical trial)
- Immunizations for travel or work
- Implantable drugs and certain injectable drugs
- Non-medically 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 or counseling

## PRE-EXISTING CONDITIONS

During the first 12 months following your effective date of coverage, no coverage will be provided for the treatment of a pre-existing condition unless you have prior creditable coverage.

A preexisting condition is an illness, disease, physical condition, or injury for which medical advice, or treatment was recommended or received and/or the use of prescription drugs of any kind within six months preceding the effective date of coverage. Services or supplies for the treatment of a preexisting condition are not covered for the first 12 months after the member's effective date. If the member had continuous prior creditable coverage within the 63 days immediately preceding the signature on the application and meets certain other requirements, then the preexisting condition exclusion of 12 months may not apply.

- Special or private duty nursing
- Therapy or rehabilitation other than those listed as covered in the plan documents

## Dental

Listed below are some of the charges and services for which these dental plans do not provide coverage. For a complete list of exclusions and limitations, refer to plan documents.

- Dental Services or supplies that are primarily used to alter, improve or enhance appearance. *Negotiated rates for cosmetic procedures available when a participating dentist is accessed.*
- Experimental services, supplies or procedures
- Treatment of any jaw joint disorder, such as temporomandibular joint disorder
- Replacement of lost or stolen appliances and certain damaged appliances
- Services that Aetna defines as not necessary for the diagnosis, care or treatment of a condition involved
- All other limitations and exclusions in your plan documents

Call your broker.



**If you need this material translated into another language, please call Member Services at 1-866-565-1236.**

Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-866-565-1236.

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