



**PLAN DESIGN AND BENEFITS**  
**Arizona HMO Based Plans – HMO+ \$15/\$30/\$250**  
(QPOS - Referral Required)

PLAN FEATURES	PARTICIPATING PROVIDERS (REFERRED*)	NON-PARTICIPATING PROVIDERS or PARTICIPATING PROVIDER (SELF-REFERRAL)
<b>Deductible Amount</b>	Not Applicable	\$1,000 per Member per calendar year

The family Deductible is based on 2 family members each satisfying the per Member Deductible amount. Once 2 Members have each satisfied their individual Deductible amount, the Deductible is considered met for the remaining family members.

<b>Member Coinsurance</b>	0%	40%
<b>Maximum Out-of-Pocket Limit</b>	\$2,000 per Member per calendar year	\$3,000 per Member per calendar year

The family Maximum Out-of-Pocket Limit is based on 2 family members each satisfying the per Member Maximum Out-of-Pocket Limit. Once 2 family Members have each met their individual Maximum Out-of-Pocket Limit, the Maximum Out-of-Pocket Limit is considered met for all remaining family members.

<b>Maximum Benefit</b>	Unlimited per Member per lifetime	\$2,000,000 per Member per lifetime
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**Precertification Penalty:** Certain Non-Participating provider or participating provider self-referred services require Precertification or benefits will be reduced. Please refer to your plan documents for a complete list of services that require Precertification.

PREVENTIVE CARE	PARTICIPATING PROVIDERS (REFERRED*)	NON-PARTICIPATING PROVIDERS or PARTICIPATING PROVIDER (SELF-REFERRAL)
<b>Adult Physical Examinations</b> Age and frequency schedules apply.	\$15 copay per visit	40% after deductible per visit
<b>Well Child Physical Examinations including Immunizations</b> Age and frequency schedules apply.	\$15 copay per visit	40% after deductible per visit
<b>Routine Gynecological Exams*</b> One visit per 365 consecutive day period	\$30 copay per visit	40% after deductible per visit
<b>Mammography*</b> - One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over.	\$30 copay per visit	40% after deductible per visit
<b>Prostate Specific Antigen Test</b> For males age 40 and over.	Subject to Routine Physical Exam cost sharing	40% after deductible per visit
<b>Colorectal Cancer Screening</b> For all members age 50 and over. Frequency schedule applies.	Subject to Routine Physical Exam cost sharing	40% after deductible per visit
<b>Routine Hearing Screening</b> PCP screening only	Subject to Routine Physical Exam cost sharing	Subject to Routine Physical Exam cost sharing

PHYSICIAN SERVICES	PARTICIPATING PROVIDERS (REFERRED*)	NON-PARTICIPATING PROVIDERS or PARTICIPATING PROVIDER (SELF-REFERRAL)
<b>Primary Care Physician Services</b>	\$15 copay per visit	40% after deductible per visit
<b>Specialist Physician Services</b>	\$30 copay per visit	40% after deductible per visit
<b>Maternity OB Visits</b>	\$30 copay per visit	40% after deductible per visit
<b>Allergy Testing and Treatment</b>	\$30 copay per visit	40% after deductible per visit

DIAGNOSTIC PROCEDURES	PARTICIPATING PROVIDERS (REFERRED*)	NON-PARTICIPATING PROVIDERS or PARTICIPATING PROVIDER (SELF-REFERRAL)
<b>Diagnostic Laboratory and X-Ray Testing</b> Performed at a Hospital Outpatient Facility	Lab \$0 copay per visit; X-Ray \$30 copay per visit	40% after deductible per visit



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<b>Diagnostic X-Ray Testing (Complex Imaging Services):</b> including but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT); and Positron Emission Tomography (PET); and any other outpatient diagnostic imaging service costing over \$500).	\$100 copay per visit	50% after deductible per visit
<b>EMERGENCY MEDICAL CARE</b>	<b>PARTICIPATING PROVIDERS (REFERRED*)</b>	<b>NON-PARTICIPATING PROVIDERS or PARTICIPATING PROVIDER (SELF-REFERRAL)</b>
<b>Urgent Care Facility</b>	\$50 copay per visit	\$50 copay per visit
<b>Outpatient Emergency Services</b>	\$100 copay per visit	\$100 copay per visit
<b>Ambulance</b>	\$100 copay per trip	\$100 copay per trip
<b>HOSPITAL CARE</b>	<b>PARTICIPATING PROVIDERS (REFERRED*)</b>	<b>NON-PARTICIPATING PROVIDERS or PARTICIPATING PROVIDER (SELF-REFERRAL)</b>
<b>Acute Care</b>	\$250 per day for a maximum of 3 days per admission; thereafter coverage is provided at 100%	40% after deductible per admission
<b>Outpatient Surgery</b> Performed at a Hospital Outpatient Facility	\$250 copay per visit	50% after deductible per visit
<b>Outpatient Surgery</b> Performed at a Facility other than a Hospital Outpatient Facility	\$125 copay per visit	40% after deductible per visit
<b>Maternity Inpatient Coverage</b>	\$250 per day for a maximum of 3 days per admission; thereafter coverage is provided at 100%	40% after deductible per admission
<b>MENTAL HEALTH SERVICES</b>	<b>PARTICIPATING PROVIDERS (REFERRED*)</b>	<b>NON-PARTICIPATING PROVIDERS or PARTICIPATING PROVIDER (SELF-REFERRAL)</b>
<b>Inpatient Mental Health</b> Maximum of 15-days per calendar year.	\$250 per day for a maximum of 3 days per admission; thereafter coverage is provided at 100%	50% after deductible per admission
<b>Outpatient Mental Health</b> 20 visits per calendar year	\$30 copay per visit	50% after deductible per visit
<b>SUBSTANCE ABUSE SERVICES</b>	<b>PARTICIPATING PROVIDERS (REFERRED*)</b>	<b>NON-PARTICIPATING PROVIDERS or PARTICIPATING PROVIDER (SELF-REFERRAL)</b>
<b>Inpatient Detoxification</b> 3 days per admission, 2 admissions per lifetime.	\$250 per day for a maximum of 3 days per admission; thereafter coverage is provided at 100%	No benefit is provided
<b>Outpatient Detoxification</b>	No benefit is provided	No benefit is provided
<b>OTHER SERVICES</b>	<b>PARTICIPATING PROVIDERS (REFERRED*)</b>	<b>NON-PARTICIPATING PROVIDERS or PARTICIPATING PROVIDER (SELF-REFERRAL)</b>
<b>Skilled Nursing Facility</b> Maximum of 30-days per calendar year	\$250 per day for a maximum of 3 days per admission; thereafter coverage is provided at 100%	40% after deductible per admission
<b>Outpatient Home Health Care Visits</b>	\$0 copay	40% after deductible per visit



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<b>Hospice Care – Inpatient</b> Maximum of 30-days per calendar year	\$250 per day for a maximum of 3 days per admission; thereafter coverage is provided at 100%	40% after deductible per admission
<b>Hospice Care – Outpatient</b> 60 visits per calendar year	\$30 copay per visit	40% after deductible per visit
<b>Private Duty Nursing</b>	No benefit is provided	No benefit is provided
<b>Outpatient Therapy -Physical &amp; Occupational</b> 20 visits per incident of illness or injury beginning with the first day of treatment	\$30 copay per visit	40% after deductible per visit
<b>Outpatient Therapy – Speech</b> 20 visits per incident of illness or injury beginning with the first day of treatment	\$30 copay per visit	40% after deductible per visit
<b>Chiropractic Benefits</b>	\$30 copay per visit 20 visits per calendar year	40% after deductible per visit No visit limit
<b>Durable Medical Equipment</b> DME Out-of-Pocket maximum does not count toward the Member's medical maximum Out-of-Pocket limit; DME maximum benefit - \$2,500 per member, per calendar year	50% per item	50% after deductible per item
<b>Transplant Benefits</b> Physician/Specialists Services including office visits	IOE Facility Covered same as any hospital expense. See Acute Care for member cost sharing options.	Not covered
<b>Infertility Treatment</b> Coverage only for the diagnosis and surgical treatment of the underlying medical cause.	Subject to applicable service type member cost sharing	40% after deductible per visit
<b>Voluntary Sterilization</b> Including tubal ligation and vasectomy	Subject to applicable service type member cost sharing	40% after deductible per visit
<b>PHARMACY – PRESCRIPTION DRUG BENEFIT</b>	<b>PARTICIPATING PHARMACY PROVIDERS</b>	<b>NON-PARTICIPATING PHARMACY PROVIDERS</b>
<b>Retail</b>	\$15 copay generic formulary; \$30 copay brand formulary; \$50 copay generic and brand non-formulary; up to a 30-day supply at participating pharmacies	Not covered
<b>Mail Order</b>	\$30 copay generic formulary; \$60 copay brand formulary; \$100 copay generic and brand non-formulary; up to a 90-day supply at participating pharmacies	Not covered

No Mandatory Generic (No MG) – Member is responsible to pay the applicable copay only.  
Plan includes: Lifestyle/performance prescription drugs – 6 pills per month, contraceptive drugs and devices obtainable from a pharmacy and diabetic supplies.

For service or supply that is subject to a maximum visit, day or dollar limitation, such maximums will be reduced by any service or supplies which are covered as Self-Referral and Referred Benefits under this plan.

**SPECIAL PROGRAMS**

Certain Special programs and services may be included in your plan: Aetna Navigator™, Fitness, Healthy Outlook, Moms-to-Babies Maternity Management™, National Advantage, National Medical Excellence, Natural Alternatives, Natural Products, Vision One® and Vitamin Advantage™

**\*Members may directly access participating providers for certain services as outlined in the plan documents.**



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### What's Not Covered:

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

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

In Arizona, benefits are provided by Aetna Health of Arizona, Inc. or Corporate Health Insurance Company.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee any results or outcomes. Consult the plan documents (i.e. Schedule of Benefits, Certificate of Coverage, Evidence of Coverage, Group Agreement, Group Insurance Certificate, and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. The availability of a plan or program may vary by geographic service area. Some benefits are subject to limitations or visit maximums. Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider cannot be guaranteed, and provider network composition is subject to change. Notice of the changes shall be provided in accordance with applicable state law.

Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available at the highest copay under plans with an open formulary, or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary. They may also be subject to precertification or step-therapy. Non-



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prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received upon enrollment) are not covered, and medical exceptions are not available for them.

“Aetna” is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. Employer-funded plans are administered by Aetna Life Insurance Company or Aetna Health Administrators. While this material is believed to be accurate as of the print date, it is subject to change