

PLAN DESIGN AND BENEFITS
Arizona HMO Based Plans – HMO \$15/\$30/\$250

PLAN FEATURES	PARTICIPATING PROVIDERS (REFERRED*)
Deductible Amount	Not Applicable
Maximum Out-of-Pocket Limit	\$2,000 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.	
Maximum Benefit	Unlimited per Member per lifetime
PREVENTIVE CARE	PARTICIPATING PROVIDERS (REFERRED*)
Adult Physical Exams	\$15 copay per visit
Well- Child Physical Examinations including Immunizations	\$15 copay per visit
Routine Gynecological Exams* One visit per 365 consecutive day period.	\$30 copay per visit
Mammography* One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over	\$30 copay per visit
Prostate Specific Antigen Test For males age 40 and over.	Subject to Routine Physical Exam cost sharing
Colorectal Cancer Screening For all members age 50 and over. Frequency schedule applies	Subject to Routine Physical Exam cost sharing
Routine Hearing Screening PCP screening only	Subject to Routine Physical Exam cost sharing
PHYSICIAN SERVICES	PARTICIPATING PROVIDERS (REFERRED*)
Primary Care Physician Services	\$15 copay per visit
Specialist Physician Services	\$30 copay per visit
Maternity OB Visits	\$30 copay
Allergy Testing and Treatment	\$30 copay
DIAGNOSTIC PROCEDURES	PARTICIPATING PROVIDERS (REFERRED*)
Diagnostic Laboratory and X-Ray Testing Performed at a Hospital Outpatient Facility	Lab \$0 copay per visit; X-Ray \$30 copay per visit
Diagnostic X-Ray Testing (Complex Imaging Services): Services 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
EMERGENCY MEDICAL CARE	PARTICIPATING PROVIDERS (REFERRED*)
Urgent Care Facility	\$50 copay per visit
Outpatient Emergency Services	\$100 copay per visit
Ambulance	\$100 copay per trip
HOSPITAL CARE	PARTICIPATING PROVIDERS (REFERRED*)
Acute Care	\$250 per day for a maximum of 3 days per admission; thereafter coverage is provided at 100%

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Maternity Inpatient Coverage	\$250 per day for a maximum of 3 days per admission; thereafter coverage is provided at 100%
Outpatient Surgery Performed at a Hospital Outpatient Facility	\$250 copay per visit
Outpatient Surgery Performed at a Facility other than a Hospital Outpatient Facility	\$125 copay per visit
MENTAL HEALTH SERVICES	PARTICIPATING PROVIDERS (REFERRED*)
Inpatient Mental Health Maximum of 15-days per calendar year.	\$250 per day for a maximum of 3 days per admission; thereafter coverage is provided at 100%
Outpatient Mental Health 20 visits per calendar year	\$30 copay per visit
SUBSTANCE ABUSE SERVICES	PARTICIPATING PROVIDERS (REFERRED*)
Inpatient Detoxification 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%
Outpatient Detoxification	No benefit is provided
OTHER SERVICES	PARTICIPATING PROVIDERS (REFERRED*)
Skilled Nursing Facility Maximum of 30-days per calendar year	\$250 per day for a maximum of 3 days per admission; thereafter coverage is provided at 100%
Outpatient Home Health Care Visits	\$0 copay per visit
Hospice Care – Inpatient Maximum of 30-days per calendar year	\$250 per day for a maximum of 3 days per admission; thereafter coverage is provided at 100%
Hospice Care – Outpatient 60 visits per calendar year	\$30 copay per visit
Private Duty Nursing	Not benefit is provided unless pre-authorized by HMO
Outpatient Therapy -Physical & Occupational 20 visits per incident of illness or injury beginning with the first day of treatment	\$30 copay per visit
Outpatient Therapy – Speech 20 visits per incident of illness or injury beginning with the first day of treatment	\$30 copay per visit
Chiropractic Benefits 20 visits per calendar year	\$30 copay per visit
Durable Medical Equipment 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
Transplant Benefits Physician/Specialists Services including office visits	IOE Facility Covered same as any hospital expense. See Acute Care for member cost sharing options.
Infertility Treatment Coverage only for the diagnosis and surgical treatment of the underlying medical cause.	Subject to applicable service type member cost sharing
Voluntary Sterilization Including tubal ligation and vasectomy	Subject to applicable service type member cost sharing

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PHARMACY – PRESCRIPTION DRUG BENEFITS	PARTICIPATING PHARMACY PROVIDERS
Retail	\$15 copay generic formulary; \$30 copay brand formulary; \$50 copay generic and brand non-formulary; up to a 30-day supply at participating pharmacies
Mail Order	\$30 copay generic formulary; \$60 copay brand formulary; \$100 copay generic and brand non-formulary; up to a 90-day supply at participating pharmacies.
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-Referred 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.**

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.

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- 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 co-morbid conditions.

In Arizona, benefits are provided by Aetna Health of Arizona, Inc.

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-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.

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