Aetna

SOUDERTON AREA SCHOOL DISTRICT
Proposed effective date: 09-01-2007
HMO - Pennsylvania

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

PLAN FEATURES	PARTICIPATING PROVIDERS / REFERRED
Deductible (per calendar year)	None Individual None Family
Out-of-Pocket Maximum (per calendar year)	$1,500 Individual $3,000 Family
Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. Only those participating providers/referred out of pocket expenses resulting from the application of coinsurance percentage and copays (except any penalty amounts and pharmacy cost sharing) may be used to satisfy the Out-of Pocket Maximum. Once Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.	
Lifetime Maximum	Unlimited unless otherwise indicated.
Primary Care Physician Selection	Required
Referral Requirements	Required for all non-emergency, non-urgent and non-Primary Care Physician services, except direct access services
PREVENTIVE CARE	**PARTICIPATING PROVIDERS / REFERRED**
Routine Adult Physical Exams / Immunizations (Age and frequency schedules apply)	$2 copay
Well Child Exams / Immunizations (Age and frequency schedules apply)	$2 copay; deductible waived
Routine Gynecological Care Exams Includes Pap smear and related lab fees. One exam per calendar year.	$2 copay; deductible waived
Routine Mammograms One annual mammogram for covered females age 40 and over.	Covered 100%; deductible waived
Routine Digital Rectal Exams / Prostate Specific Antigen Test For males age 40 and over	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Colorectal Cancer Screening For all members 50 and over. Frequency schedule applies	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Routine Eye Exam Age/Frequency Schedule may apply. Direct access to participating providers without a referral.	Covered 100%
Routine Hearing Screening	Subject to Routine Physical Exam cost sharing
PHYSICIAN SERVICES	**PARTICIPATING PROVIDERS / REFERRED**
Primary Care Physician Visits	Office Hours: $2 Copay After Office Hours/Home: $5 copay
Specialist Office Visits	Covered 100%
Maternity OB Visits	Covered 100%
Allergy Treatment	Same as applicable participating provider office visit member cost sharing
Allergy Testing	Same as applicable participating provider office visit member cost sharing
DIAGNOSTIC PROCEDURES	**PARTICIPATING PROVIDERS / REFERRED**
Diagnostic Laboratory	Covered 100%
If performed as a part of a physician's office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit cost sharing.	
Diagnostic X-ray Outpatient hospital or other Outpatient facility (except for Complex Imaging Services)	Covered 100%

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Diagnostic X-ray for Complex Imaging Services	Covered 100%
EMERGENCY MEDICAL CARE	**PARTICIPATING PROVIDERS / REFERRED**
Urgent Care	$15 copay
Non-Urgent use of Urgent Care Provider	Not Covered
Emergency Room	$15 copay
Non-Emergency Care in an Emergency Room	Not Covered
Ambulance	Covered 100%
HOSPITAL CARE	**PARTICIPATING PROVIDERS / REFERRED**
Inpatient Coverage	Covered 100% per admission
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Inpatient Maternity Coverage	Covered 100% per admission
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Outpatient Surgery	Covered 100% per visit
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
MENTAL HEALTH SERVICES	**PARTICIPATING PROVIDERS / REFERRED**
Inpatient Serious Mental Illness	Covered 100% per admission
Limited to 35 days per calendar year	
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Inpatient Non-Serious Mental Illness	Covered 100% per admission
Limited to 35 days per calendar year	
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Outpatient Serious Mental Illness	Covered 100% for visits 1-2; $10 for visits 3-10; $25 for visits 11-20
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
Outpatient Non-Serious Mental Illness	Covered 100% for visits 1-2; $10 for visits 3-10; $25 for visits 11-20
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
ALCOHOL/DRUG ABUSE SERVICES	**PARTICIPATING PROVIDERS / REFERRED**
Inpatient Detoxification	Covered 100% per admission
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Outpatient Detoxification	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
Inpatient Rehabilitation	Covered 100% per admission
Limited to 30 days per calendar year	
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Outpatient Rehabilitation	Covered 100%
Limited to 60 visits per calendar year and 120 visits per lifetime	
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
OTHER SERVICES	**PARTICIPATING PROVIDERS / REFERRED**
Skilled Nursing Facility	Covered 100% per admission
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Home Health Care	Covered 100%
Hospice Care - Inpatient	Covered 100% per admission
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Hospice Care - Outpatient	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
Private Duty Nursing	Not Covered unless pre-authorized
Outpatient Rehabilitation Therapy (Includes speech, physical and occupational therapy)	Covered 100%
Treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment.	

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Subluxation	Not Covered
Durable Medical Equipment	Not Covered
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.
Dental	Not Covered
Vision Eyewear	$35 once per 24 month period
Transplants Coverage is provided at an IOE contracted facility only	Covered 100% per admission
Bariatric Surgery	Not Covered
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
FAMILY PLANNING	**PARTICIPATING PROVIDERS / REFERRED**
Infertility Treatment Diagnosis and treatment of the underlying medical condition.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Comprehensive Infertility Services Coverage includes Artificial Insemination and Ovulation Induction	Not Covered
Advanced Reproductive Technology (ART)	Not Covered
ART coverage includes In-Vitro Fertilization (IVF), Zygote Intra-Fallopian Transfer (ZIFT), Gamete Intra-Fallopian Transfer (GIFT), cryopreserved embryo transfers, Intra-Cytoplasmic Sperm Injection (ICSI) or ovum microsurgery.	
Voluntary Sterilization Including tubal ligation and vasectomy.	Subject to applicable service type member cost sharing

Exclusions and Limitations

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The Aetna companies that offer, underwrite or administer benefits include Aetna Health Inc.. While this material is believed to be accurate as of the print date, it is subject to change.

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.

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- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates.
- Cosmetic surgery.
- Custodial care.
- Dental care and dental x-rays.
- Donor egg retrieval.
- 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, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents.
- Nonmedically necessary services or supplies.
- Orthotics 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.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered in the plan documents.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

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 document (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. With the exception of Aetna Rx Home Delivery, all participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.

Aetna Pharmacy Management refers to an internal business unit of Aetna Health Management, LLC. If your plan covers outpatient prescription drugs, your plan may include a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally not limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step-therapy, please refer to Aetna's website at www.aetna.com, or the Aetna Medication Formulary Guide. Many drugs, including many of those listed on the formulary, are subject to rebate arrangements between Aetna and the manufacturer of the drugs. Rebates received by Aetna from drug manufacturers are not reflected in the cost paid by a member for a prescription drug.

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In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage. Aetna Rx Home Delivery® refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna Inc., that is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated charge with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services.

Certain primary care providers are affiliated with integrated delivery systems or other provider groups (such as independent practice associations and physician-hospital organizations), and members who select these providers will generally be referred to specialists and hospitals within those systems or groups. However, if a system or group does not include a provider qualified to meet member's medical needs, member may request to have services provided by a non-system or non-group providers. Member's request will be reviewed and will require prior authorization from the system or group and/or Aetna to be a covered benefit.

Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage.

Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification), inpatient and outpatient rehabilitation). When the Member obtains covered services from participating providers, the provider will obtain precertification. If the Member obtains covered services from a nonparticipating provider, the Member must obtain the precertification. Precertification requirements may vary. Members may refer to their plan documents for a complete list of medical services that require precertification. Certain benefits like comprehensive infertility and advanced reproductive technology (ART) services, if covered under your plan, are subject to a select network of participating providers, from which you will be required to seek care to receive covered benefits.

Members or providers may be required to precertify, or obtain prior approval of coverage for certain services such as non-emergency inpatient hospital care. Certain benefits like comprehensive infertility and advanced reproduction technology (ART) services, if covered under your plan, are subject to a select network of participating providers, from which you will be required to seek care to receive covered benefits.

If you need this material translated into another language, please call Member Services at 1-877-402-8742 usted necesita este documento en otro idioma, por favor llame a Servicios al Miembro al 1-877-402-8742.