



PLAN DESIGN AND BENEFITS - VA PPO HSA COMPATIBLE PLAN 1.3

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per plan year)		\$1,500 Individual \$3,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Member cost sharing for preventive services are excluded from charges to meet the Preferred Deductible. Member cost sharing for well child/immunizations are excluded from charges to meet the Non-Preferred Deductible. All covered expenses, including prescription drugs and self-injectables, accumulate toward the Preferred and Non-Preferred Deductible. The Individual Deductible can only be met when a member is enrolled for self only coverage with no dependent coverage. The Family Deductible can be met by a combination of family members or by any single individual within the family. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the plan year. Deductible Credit and Deductible Carryover do not apply.		
Member Coinsurance	Not Applicable	20%
Applies to all expenses unless otherwise stated.		
Payment Limit (per plan year, includes deductible)		\$3,000 Individual \$6,000 Family
All covered expenses, except amounts over Recognized Charge and failure to pre-certify penalties, apply toward the Preferred and Non-Preferred Payment Limit. All covered expenses accumulate toward the Preferred and Non-Preferred Payment Limit. The Individual Out-of-Pocket Maximum can only be met when a member is enrolled for self only coverage with no dependent coverage. The Family Out-of-Pocket Maximum can be met by a combination of family members or by any single individual within the family. Once the 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 plan year.		
Lifetime Maximum	Unlimited	\$2,000,000 per lifetime
Payment for Non-Preferred Care	Not Applicable	Recognized Charge *
Primary Care Physician Selection	Not Applicable	Not Applicable
Certification Requirements: Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, and Hospice Care is required. Benefits will be reduced by \$400 per occurrence if Certification is not obtained.		
Referral Requirement	Not Applicable	Not Applicable
PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Office Visits to Non-Specialist	\$20 Copay after deductible	20% after deductible
Includes services of an internist, general physician, family practitioner or pediatrician for routine care as well as diagnosis and treatment of an illness or injury.		
Specialist Office Visits	\$40 Copay after deductible	20% after deductible
Maternity OB Visits	\$40 Copay after deductible for Initial Visit Only	20% after deductible
Allergy Testing (given by a physician)	\$40 Copay after deductible	20% after deductible
Allergy Injections (not given by a physician)	\$0 Copay after deductible	20% after deductible
PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE
Routine Adult Physical Exams/ Immunizations (Limited to 1 exam every 12 months for members age 18 and older.)	\$0 Copay, deductible waived	20% after deductible
Well Child Exams / Immunizations (Provides coverage for 7 exams in the first 12 months of life; 2 exams in the 13th – 24th months of life; 1 exam per 12 months thereafter.)	\$0 Copay, deductible waived	0%, deductible waived



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PREVENTIVE CARE (CONTINUED)	PREFERRED CARE	NON-PREFERRED CARE
Routine Gynecological Exams (Limited to a routine exam, pap smear and other appropriate tests using any FDA-approved gynecologic cytology screening technologies, once per plan year. Preferred and Non-Preferred combined.)	\$0 Copay, deductible waived	20% after deductible
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; and one mammogram per plan year for ages 40 and over. Preferred and Non-Preferred combined.)	\$0 Copay, deductible waived	20% after deductible
Routine Digital Rectal Exams/Prostate Specific Antigen Test (For covered members age 40 and over. Age and frequency schedules may apply.)	Member cost sharing is based on the type of service performed and the place rendered.	Member cost sharing is based on the type of service performed and the place rendered.
Colorectal Cancer Screening (For all members age 50 and over. Frequency schedule applies.)	Member cost sharing is based on the type of service performed and the place rendered.	Member cost sharing is based on the type of service performed and the place rendered.
Routine Eye Exams at Specialist (Limited to one routine exam per 24 months. Preferred and Non-Preferred combined.)	\$0 Copay, deductible waived	20% after deductible
Vision Corrective Lenses/Contact Allowance	Not Covered	Not Covered
Routine Hearing Exams Covered only as part of a routine physical exam.	Paid as part of a routine physical exam.	Refer to Routine Adult Physical Exams/ Immunizations or Well Child Exams / Immunizations for applicable cost-share.
Newborn Hearing Screening (All necessary audiological examinations for newborns, including a follow-up audiological examination, recommended by the infant's PCP or Participating audiologist to confirm the existence or absence of hearing loss.)	\$40 Copay after deductible	20% after deductible
DIAGNOSTIC PROCEDURES	PREFERRED CARE	NON-PREFERRED CARE
Outpatient Diagnostic Laboratory and X-ray (except for Complex Imaging Services) - (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 member cost sharing.)	0% after deductible	20% after deductible
Outpatient Diagnostic X-ray for Complex Imaging Services (Includes MRA/MRS, MRI, PET and CAT Scans)	0% after deductible	20% after deductible



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EMERGENCY MEDICAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Urgent Care Provider	\$40 Copay after deductible	20% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room (Copay waived if admitted.)	\$100 Copay after deductible	Paid as Preferred Care
Non-Emergency care in Emergency Room	Not Covered	Not Covered
Ambulance	0% after deductible	20% after deductible
HOSPITAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Coverage Including maternity (prenatal, delivery and postpartum) & transplants. If transplant is performed through an Institute of Excellence [®] facility, benefits would be paid at the Preferred level. If procedure is not performed through Institutes of Excellence [®] facility, benefits would be paid at the Non-Preferred level.	\$250 Copay per admission after deductible	\$250 Copay per admission plus 20% after deductible
Outpatient Surgery	\$100 Copay after deductible	\$100 Copay plus 20% after deductible
MENTAL HEALTH SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Biologically Based Mental Illness (Unlimited days per member per plan year.)	\$250 Copay per admission after deductible	\$250 Copay per admission plus 20% after deductible
Outpatient Biologically Based Mental Illness (Unlimited visits per member per plan year.)	\$40 Copay after deductible	20% after deductible
Inpatient Non-Biologically Based Mental Illness (Limited to 30 days per member per plan year. Preferred and Non-Preferred combined.)	\$250 Copay per admission after deductible	\$250 Copay per admission plus 20% after deductible
Outpatient Non-Biologically Based Mental Illness (Limited to 20 visits per member per plan year. Preferred and Non-Preferred combined.)	50% after deductible	50% after deductible
ALCOHOL/DRUG ABUSE SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Detoxification (Unlimited days per member per plan year.)	\$250 Copay per admission after deductible	\$250 Copay per admission plus 20% after deductible
Outpatient Detoxification (Unlimited visits per member per plan year.)	\$40 Copay after deductible	20% after deductible
Inpatient Rehabilitation – Biologically Based (Unlimited days per member per plan year.)	\$250 Copay per admission after deductible	\$250 Copay per admission plus 20% after deductible
Inpatient Rehabilitation – Non-Biologically Based (Unlimited days per member per plan year.)	\$250 Copay per admission after deductible	\$250 Copay per admission plus 20% after deductible



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ALCOHOL/DRUG ABUSE SERVICES (CONTINUED)	PREFERRED CARE	NON-PREFERRED CARE
Outpatient Rehabilitation – Biologically Based (Unlimited visits per member per plan year.)	\$40 Copay after deductible	20% after deductible
Outpatient Rehabilitation – Non-Biologically Based (Unlimited visits per member per plan year.)	\$40 Copay after deductible	20% after deductible
OTHER SERVICES AND PLAN DETAILS	PREFERRED CARE	NON-PREFERRED CARE
Convalescent Facility (Skilled Nursing Facility) (Limited to 60 days per plan year. Preferred and Non-Preferred combined.)	\$250 Copay per admission after deductible	\$250 Copay per admission plus 20% after deductible
Home Health Care (Limited to 90 visits per member per plan year. Preferred and Non-Preferred combined.)	\$0 Copay after deductible	20% after deductible
Infusion Therapy (Provided in the home or physician's office)	\$40 Copay after deductible	20% after deductible; Aetna pays up to \$50 per visit after deductible for nursing services and supplies.
Infusion Therapy (Provided in an outpatient hospital department or freestanding facility)	\$100 Copay after deductible	\$100 Copay plus 20% after deductible; Aetna pays up to \$50 per visit after deductible for nursing services and supplies.
Hospice Care – Inpatient <i>(Preferred Care:</i> Unlimited days per member per plan year. <i>Non-Preferred Care:</i> Limited to 30 days per plan year. Preferred and Non-Preferred combined.)	\$250 Copay per admission after deductible	\$250 Copay per admission plus 20% after deductible
Hospice Care - Outpatient	\$0 Copay after deductible	20% after deductible
Outpatient Speech Therapy (Limited to 30 visits per member per plan year. Preferred and Non-Preferred combined.)	\$40 Copay after deductible	20% after deductible
Outpatient Physical and Occupational Therapy (Physical and Occupational Therapy limited to 30 visits [combined] per member per plan year. Preferred and Non-Preferred combined.)	\$40 Copay after deductible	20% after deductible
Subluxation (Chiropractic) (Limited to 20 visits per member per plan year. Preferred and Non-Preferred combined.)	\$40 Copay after deductible	20% after deductible
Durable Medical Equipment (Maximum benefit of \$2,500 per member per plan year. Preferred and Non-Preferred combined.)	50% after deductible	50% after deductible (Must pre-certify if over \$1,500.)



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FAMILY PLANNING	PREFERRED CARE	NON-PREFERRED CARE
Infertility Treatment (Covered only for the diagnosis and treatment of the underlying medical condition.)	Member cost sharing is based on the type of service performed and the place rendered.	Member cost sharing is based on the type of service performed and the place rendered.
Voluntary Sterilization (Including tubal ligation and vasectomy.)	Member cost sharing is based on the type of service performed and the place rendered.	Member cost sharing is based on the type of service performed and the place rendered.
PHARMACY - PRESCRIPTION DRUG BENEFITS	PARTICIPATING PHARMACIES	NON-PARTICIPATING PHARMACIES
Prescription Drug Plan Year Deductible (Must be satisfied before any prescription drug benefits are paid.)	Integrated with Medical Deductible	
Prescription Drug Plan Year Out-of-Pocket Maximum	Integrated with Medical Out-of-Pocket Maximum	
Retail Up to a 30-day supply	\$15 Copay after integrated deductible for generic drugs, \$35 Copay after integrated deductible for formulary brand-name drugs, and \$50 Copay after integrated deductible for non-formulary brand-name drugs	\$15 Copay plus 20% after integrated deductible for generic drugs, \$35 Copay plus 20% after integrated deductible for formulary brand-name drugs, and \$50 Copay plus 20% after integrated deductible for non-formulary brand-name drugs
Mail Order 31-90 day supply	\$30 Copay after integrated deductible for generic drugs, \$70 Copay after integrated deductible for formulary brand-name drugs, and \$100 Copay after integrated deductible for non-formulary brand-name drugs	Not Covered
Self-Injectables (Excluding Insulin) Up to 90 day supply	20% after integrated deductible for formulary and non-formulary drugs	Not Covered
No Mandatory Generic (No MG) – Member is responsible to pay the applicable copay and/or coinsurance.		
Plan includes: Diabetic supplies, contraceptive drugs and devices obtainable from a pharmacy.		
Pre-certification and 90 day Transition of Care (TOC) for Precertification included.		
ADDITIONAL EMPLOYER PLAN OPTION:		
The following optional benefit is available only if elected by your employer.		
Morbid Obesity Rider (Provides coverage for the treatment of morbid obesity through gastric by-pass surgery or such other methods as recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity.)	Member cost sharing is based on the type of service performed and the place where it is rendered.	Member cost sharing is based on the type of service performed and the place where it is rendered.

* Payment for Non-Preferred facility care is determined based upon Aetna's Allowable Fee Schedule. Payment for plans other Non-Preferred care is determined based upon the negotiated charge that would apply if such services or supplies



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were received from a Preferred Provider. These charges are referred to in your plan documents as "recognized" charges.

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.**

- (1) All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents;
- (2) Charges related to any eye surgery mainly to correct refractive errors;
- (3) Cosmetic surgery, including breast reduction;
- (4) Custodial care;
- (5) Dental care and x-rays;
- (6) Donor egg retrieval;
- (7) Experimental and investigational procedures;
- (8) Hearing aids;
- (9) Immunizations for travel or work;
- (10) 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;
- (11) Nonmedically necessary services or supplies;
- (12) Orthotics;
- (13) Over-the-counter medications and supplies;
- (14) Reversal of sterilization;
- (15) Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs; and
- (16) Special duty nursing.

Pre-Existing Conditions Exclusion Provision

This plan imposes a pre-existing conditions exclusion, which may be waived in some circumstances (that is, creditable coverage) and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis or treatment was recommended or received or for which the individual took prescribed drugs within 180 days prior to the enrollment date.

Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 180 day period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period.

If you had prior credible coverage within 90 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.

If you had no prior creditable coverage within the 90 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 90 day gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion.



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In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any Certificates of Creditable Coverage you have. Please contact your Aetna Member Services representative at 1-888-80-AETNA if you need assistance in obtaining a Certificate of Creditable Coverage from your prior carrier or if you have any questions on the information noted above.

The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment; the pre-existing exclusion will be applied from the individual's effective date of coverage.

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 results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Some benefits are subject to limitations or visit maximums. 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's preferred provider is coordinating care, the preferred provider will obtain the precertification. Precertification requirements may vary.

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 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. 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.

While this information is believed to be accurate as of the print date, it is subject to change.

Plans are provided by Aetna Life Insurance Company.