



**PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA HEALTH OF THE CAROLINAS INC. - FULL RISK**

PLAN FEATURES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Deductible (per plan year)	\$500 Individual \$1,000 Family	\$1,000 Individual \$2,000 Family
<p>Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Member cost sharing for certain services including member cost sharing for prescription drugs, as indicated in the plan, are excluded from charges to meet the Deductible. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the plan year</p>		
Out-of-Pocket Maximum (per plan year)	\$2,000 Individual \$4,000 Family	\$4,000 Individual \$8,000 Family
<p>Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. Only those participating providers and non-participating providers 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 plan year.</p>		
Lifetime Maximum	Unlimited unless otherwise indicated.	Unlimited unless otherwise indicated.
Benefit Limitations -- For any service or supply that is subject to a maximum visit, day, or dollar limitation, such services or supplies accumulate toward both the participating provider and non-participating provider benefit limits under this plan.		
Payment for Non-Preferred	Not Applicable	Professional: 105% of Medicare Facility Prevailing Charges
Primary Care Physician Selection	Not Required	Not Applicable
Precertification Requirement Certain non-participating providers/participating provider self referred services require precertification or benefits will be reduced. Refer to your plan documents for a complete list of services that require precertification.		
Referral Requirements	None	None
PREVENTIVE CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Routine Adult Physical Exams / Immunizations 1 exam every 12 months.	Covered 100%; deductible waived	Not Covered
Well Child Exams / Immunizations (Age and frequency schedules apply)	Covered 100%; deductible waived	Not Covered
Routine Gynecological Care Exams	Covered 100%; deductible waived	Not Covered (Pap smear always covered at member coinsurance; after deductible.)
Includes Pap smear and related lab fees.		
Routine Mammograms Recommended: one baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over	Covered 100%; deductible waived	30%; after deductible
Routine Digital Rectal Exams / Prostate Specific Antigen Test Recommended for males 40 and over.	Covered 100%; deductible waived	Not Covered
Colorectal Cancer Screening	Covered 100%; deductible waived	Subject to Routine Physical Exam benefit.
Routine Eye Exam	Covered 100%; deductible waived 1 exam per 12 months.	30%; after deductible 1 exam per 12 months.



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Routine Hearing Screening	Subject to Routine Physical Exam benefit.	Subject to Routine Physical Exam benefit.
PHYSICIAN SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Primary Care Physician Visits	Office Hours: \$20 copay; deductible waived After Office Hours/Home: \$25 copay; deductible waived	30%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician		
Specialist Office Visits	\$40 copay; deductible waived	30%; after deductible
Prenatal OB Care	\$40 copay; deductible waived	30%; after deductible
E-visit to PCP	\$20 office visit copay; deductible waived	30%; after deductible
An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor.		
E-visit to Specialist	\$40 office visit copay; deductible waived	30%; after deductible
An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor.		
Walk-in Clinics	\$20 office visit copay; deductible waived	30%; after deductible
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.		
Allergy Treatment	Same as applicable participating provider office visit member cost sharing	30%; after deductible
Allergy Testing	Same as applicable participating provider office visit member cost sharing	30%; after deductible
DIAGNOSTIC PROCEDURES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Diagnostic Laboratory	Covered 100%; deductible waived	30%; after deductible
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	Covered 100%; deductible waived	30%; after deductible
Outpatient hospital or other Outpatient facility (except for Complex Imaging Services)		
Diagnostic X-ray for Complex Imaging Services	20%; after deductible	30%; after deductible
EMERGENCY MEDICAL CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Urgent Care	\$40 copay; deductible waived	30%; after deductible
Non-Urgent use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	\$150 copay; deductible waived	Refer to participating provider benefit.
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	20%; after deductible	Refer to participating provider benefit.
Non-Emergency Use of Ambulance	Not Covered	Not Covered



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HOSPITAL CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Inpatient Coverage	20% per admission; after deductible	30% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Maternity Coverage	20% per admission; after deductible	30% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Surgery - Hospital	20% per visit; after deductible	30% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Surgery - Freestanding Facility	20% per visit; after deductible	30% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
MENTAL HEALTH SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Inpatient Biologically Based Mental Illness	20% per admission; after deductible	30% per admission; after deductible
Inpatient Non-Biologically Based Mental Illness	20% per admission; after deductible	30% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Biologically Based Mental Illness	\$40 per visit; deductible waived	30% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Non-Biologically Based Mental Illness	\$40 per visit; deductible waived	30% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
ALCOHOL/DRUG ABUSE SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Inpatient Detoxification	20% per admission; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Detoxification	\$40 copay per visit; deductible waived	30% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Inpatient Rehabilitation	20% per admission; after deductible	30% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Residential Treatment Facility	20%; after deductible	30%; after deductible
Outpatient Rehabilitation	\$40 per visit copay; deductible waived	30% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
OTHER SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Skilled Nursing Facility	20% per admission; after deductible Limited to 60 days per plan year	30% per admission; after deductible Limited to 60 days per plan year
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Home Health Care	20% per visit; after deductible Limited to 60 visits per plan year	30% per visit; after deductible Limited to 60 visits per plan year
Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.		



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Hospice Care - Inpatient	20% per admission; after deductible	30% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	20% per visit; after deductible	30% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Private Duty Nursing	Not Covered	Not Covered
Outpatient Rehabilitation Therapy (Includes speech, physical and occupational therapy)	\$40 copay; deductible waived	30%; after deductible
	Limited to 30 visits per plan year.	Limited to 30 visits per plan year.
Spinal Manipulation	\$20 copay per visit; deductible waived	30% per visit; after deductible
Durable Medical Equipment	20%; after deductible	30%; after deductible (must precertify if over \$1,500)
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.	30%; after deductible
Vision Eyewear	Not Covered	Covered same as participating provider benefit
Transplants	Covered same as any other expense for treatment in an approved IOE transplant facility. Services rendered by a participating Aetna facility, but not an IOE transplant facility, covered at out of network level.	Services rendered at a non-IOE transplant facility covered same as any other expense.
Bariatric Surgery	Not Covered	Not Covered
FAMILY PLANNING	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
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; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible.
Comprehensive Infertility Services Coverage includes Artificial Insemination and Ovulation Induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART) 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.	Not Covered	Not Covered
Voluntary Sterilization Including tubal ligation and vasectomy.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible.
PHARMACY - PRESCRIPTION DRUG BENEFITS	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Retail (2 times retail copay for 31-90 day supply at participating pharmacies. Percentage copays will not be doubled)	\$10 copay for formulary generic drugs, \$30 copay for formulary brand-name drugs, and \$45 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.	Not Covered



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Mail Order	\$20 copay for formulary generic drugs, \$60 copay for formulary brand-name drugs, and \$90 copay for non-formulary brand-name and generic drugs up to a 31-90 day supply from Aetna Rx Home Delivery®	Not covered
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Aetna Specialty CareRx -First prescription fill at any retail drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®

No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only.

Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy.

Oral fertility drugs included.

Dependents Eligibility

Spouse, children from birth to age 26.

Plans are provided by: Aetna Health of the Carolinas Inc. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services.

The following is a 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 by your employer.



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- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- 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 except where medically necessary or indicated.
- 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 therapy.
- Non-medically 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 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.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at 1-888-98-AETNA (1-888-982-3862).

Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al 1-888-98-AETNA (1-888-982-3862).

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to www.aetna.com.

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