

PLAN DESIGN AND BENEFITS - MD PPO HSA COMPATIBLE PLAN 1.5

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible - Medical and Prescription Drugs (per plan year)		\$1,500 Individual \$3,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. All covered medical and prescription drugs, including self-injectables, accumulate toward both 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 (Applies to all expenses unless otherwise stated)	0%	30%
Out-of-Pocket Maximum - Medical and Prescription Drugs (per plan year, includes Deductible)		\$2,500 Individual \$5,000 Family
All covered medical and prescription drug expenses, except amounts over Recognized Charge and failure to pre-certify penalties, accumulate toward both the Preferred and Non-Preferred Out-of-Pocket Maximum. 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 (per member lifetime)	Unlimited	Unlimited
Payment for Non-Preferred Care	Not Applicable	Professional: 105% of Medicare* Facility: Rate approved by the Maryland Health Services Cost Review Commission*
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 (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.)	0% after deductible	30% after deductible
Specialist Office Visits (Includes newborn hearing screening, which is limited to one screening and one confirming screening for newborns. Preferred and Non-Preferred Care combined.)	0% after deductible	30% after deductible
Maternity OB Visits	0% after deductible	30% after deductible
Allergy Testing (given by a physician)	0% after deductible	30% after deductible
Allergy Injections (not given by a physician)	0% after deductible	30% after deductible

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PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE
Routine Adult Physical Exams / Immunizations (Limited to 1 exam every 12 months for members age 14 and older. Preferred and Non-Preferred Care combined.)	\$0 Copay, deductible waived	30%, deductible waived
Well Child Exams / Immunizations (Limited to Children ages 0 - 13. 7 exams in the first 12 months of life; 3 exams in the second 12 months of life; 3 exams in the third 12 months of life; 1 exam per 12 months thereafter. Preferred and Non-Preferred Care combined.)	\$0 Copay, deductible waived	30%, deductible waived
Routine Gynecological Exams (Includes Pap smear and related lab fees. Limited to one routine exam and pap smear per plan year. Preferred and Non-Preferred Care combined.)	\$0 Copay, deductible waived	30%, deductible waived
Routine Mammograms (No age or frequency limits.)	\$0 Copay, deductible waived	30%, deductible waived
Routine Digital Rectal Exams / Prostate Specific Antigen Test (For covered males age 40 and over. Age and frequency schedules may apply.)	\$0 Copay, deductible waived	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. Preferred and Non-Preferred Care combined.)	\$0 Copay, deductible waived	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 Care combined.)	\$0 Copay, deductible waived	30%, deductible waived
Routine Hearing Screening at PCP	Covered as part of a routine physical exam	30%, deductible waived
DIAGNOSTIC PROCEDURES	PREFERRED CARE	NON-PREFERRED CARE
Outpatient Diagnostic Laboratory and X-ray (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	30% after deductible
EMERGENCY MEDICAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Urgent Care Provider	0% after deductible	Paid as Preferred Care.
Emergency Room (Copay waived if admitted.)	0% after deductible	Paid as Preferred Care.
Ambulance	0% after deductible	30% after deductible

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HOSPITAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Coverage (Including maternity & transplants) (If transplant is performed through an Institutes 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.)	0% after deductible	30% after deductible
Outpatient Surgery - Provided in an outpatient hospital department or a freestanding surgical facility.	0% after deductible	30% after deductible
MENTAL HEALTH SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient (Limited to 60 days per member per plan year combined with all other Inpatient Mental Health and Alcohol/Drug Abuse services. Preferred and Non-Preferred Care combined.)	0% after deductible	30% after deductible
Outpatient (Office visits for medication management reimbursed as physical illness.)	0% after deductible	30% after deductible
ALCOHOL / DRUG ABUSE SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Detoxification (Limited to 60 days per member per plan year combined with all other Inpatient Mental Health and Alcohol/Drug Abuse services. Preferred and Non-Preferred Care combined.)	0% after deductible	30% after deductible
Outpatient Detoxification (Office visits for medication management reimbursed as physical illness.)	0% after deductible	30% after deductible
Inpatient Rehabilitation (Limited to 60 days per member per plan year combined with all other Inpatient Mental Health and Alcohol/Drug Abuse services. Preferred and Non-Preferred Care combined.)	0% after deductible	30% after deductible
Outpatient Rehabilitation (Office visits for medication management reimbursed as physical illness.)	0% after deductible	30% after deductible
OTHER SERVICES AND PLAN DETAILS	PREFERRED CARE	NON-PREFERRED CARE
Skilled Nursing Care Facility (Limited to 100 days per member per plan year. Preferred and Non-Preferred Care combined.)	0% after deductible	30% after deductible
Home Health Care	0% after deductible	30% after deductible
Inpatient Hospice Care	0% after deductible	30% after deductible
Outpatient Hospice Care	0% after deductible	30% after deductible

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OTHER SERVICES AND PLAN DETAILS (CONTINUED)	PREFERRED CARE	NON-PREFERRED CARE
Outpatient Rehabilitation Therapy (Includes speech, physical and occupational therapy. Limited to 30 visits per therapy per condition per plan year. Preferred and Non-Preferred Care combined.)	0% after deductible	30% after deductible
Chiropractic Care (Subluxation) (Limited to 20 visits per condition per plan year. Preferred and Non-Preferred Care combined.)	0% after deductible	30% after deductible
Durable Medical Equipment	0% after deductible	30% after deductible
Hearing Aids (Limited to Children ages 0 to 18. \$1,400 benefit maximum per hearing aid per hearing-impaired ear every 36 months. Preferred and Non-Preferred Care combined.)	0% after deductible	30% after deductible
FAMILY PLANNING	PREFERRED CARE	NON-PREFERRED CARE
Infertility Treatment (Limited to diagnosis and treatment for certain covered infertility services, excluding ovum transplants, IVF, GIFT, ZIFT, cryogenic or other preservation techniques or other similar procedures.)	0% after deductible	30% after deductible
Voluntary Sterilization (Including tubal ligation and vasectomy.)	0% after deductible	30% after deductible
PHARMACY - PRESCRIPTION DRUG BENEFITS	PARTICIPATING PHARMACIES	NON-PARTICIPATING PHARMACIES
Plan Year Deductible - Prescription Drug (Must be satisfied before any prescription drug benefits are paid. Deductible applies to all prescription drugs, including self-injectables.)	Pharmacy Deductible Integrated with Medical Deductible	
Plan Year Out-of-Pocket Maximum - Prescription Drug	Pharmacy Out-of-Pocket Maximum Integrated with Medical Out-of-Pocket Maximum	
Prescription Drugs - 30-day supply	\$15 Copay after deductible for generic drugs, \$35 Copay after deductible for preferred brand-name drugs, and \$60 Copay after deductible for non-preferred brand-name drugs	
Maintenance Prescription Drugs - 90-day supply	\$30 Copay after deductible for generic drugs, \$70 Copay after deductible for preferred brand-name drugs, and \$120 Copay after deductible for non-preferred brand-name drugs	
Specialty Care Drugs (Excluding Insulin): 30-day supply	\$200 Copay after deductible	Not Covered
Specialty Care Drugs (Excluding Insulin): 90-day supply	\$400 Copay after deductible	Not Covered
Specialty CareRx - First Prescription for a specialty drug must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy®. Subsequent fills must be through Aetna Specialty Pharmacy®.		
No Mandatory Generic (No MG) - Member is responsible to pay the applicable copay.		
Plan includes: Diabetic supplies, contraceptive drugs and devices obtainable from a pharmacy.		
Pre-certification included.		

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* We cover the cost of care differently based on whether health care providers, such as doctors and hospitals, are "in network" or "out of network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

As an example, you may choose a doctor in our network. You may choose to visit an out-of-network doctor. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount.

- For out-of-network doctors and other professionals, the amount is based on what Medicare pays for these services. The government sets the Medicare rate.
- For Maryland out-of-network hospitals, the amount is based on the rate approved by the Maryland Health Services Cost Review Commission.

Your out-of-network doctor or hospital sets the rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna plan "recognizes." Your doctor may bill you for the dollar amount that Aetna doesn't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit Aetna.com. Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site.

This way of paying out-of-network health care providers applies when you *choose* to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

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. Some benefits listed as excluded may be available on an optional basis to the contract-holder and may be covered when purchased in addition to the medical plan by the contract-holder. Check with your employer for information on additional coverages.

Services and supplies that are generally not covered include, but are not limited to:

- (1) Surgery or related services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies;
- (2) Private duty nursing, unless authorized by the plan;
- (3) Personal Care services and Domiciliary Care services not stated herein;
- (4) Non-replacement fees for blood and blood products;

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- (5) Unless otherwise specified in covered services, dental work or treatment which includes Hospital or professional care in connection with:
- The operation or treatment for the fitting or wearing of dentures,
 - Orthodontic care or malocclusion,
 - Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the treatment is received within 6 months of the accident,
 - Dental implants;
- (6) Experimental services;
- (7) Immunizations related to foreign travel;
- (8) Insulin pumps;
- (9) The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, unless included as a covered benefit;
- (10) Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports, or exams for their prescription or fitting, unless these services are determined to be Medically Necessary;
- (11) Inpatient admissions primarily for physical therapy, unless authorized by the plan;
- (12) Treatment of sexual dysfunction not related to organic disease;
- (13) Services to reverse a voluntary sterilization procedure;
- (14) In vitro fertilization, ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures;
- (15) Practitioner, Hospital, or clinical services related to radial keratotomy, myopic keratomileusis, and surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error;
- (16) Treatment for mental health or substance abuse not authorized by the plan through its managed care system, or a mental health or substance abuse condition determined by the plan through its managed care system to be untreatable;
- (17) Medical or surgical treatment or regimen for reducing or controlling weight;
- (18) Nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy;
- (19) Services that are not Medically Necessary.

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 6 months 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 6 month period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 12 months (18 months for late enrollees) 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 creditable coverage within 63 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 63 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 63 day gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion.

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.

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The pre-existing condition exclusion does not apply to pregnancy nor to a child under the age of 19. 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 not an offer or invitation to contract. An application must be completed to obtain coverage. Plan features and availability may vary by location and group size. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. With the exception of Aetna Rx Home Delivery, 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.

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. 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. 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.

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

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