PLAN DESIGN AND BENEFITS - VA HEALTH NETWORK ONLY CD 1.5 (2000 DED)

PLAN FEATURES	PARTICIPATING PROVIDERS
Deductible (per plan year)	$2,000 Individual $4,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the plan year. No one family member may contribute more than the Individual Deductible amount to the Family Deductible. Deductible credit and deductible carryover do not apply.	
Member Coinsurance	Not Applicable
Out-of-Pocket Maximum (per plan year, includes deductible)	$4,000 Individual $8,000 Family
All covered expenses, except prescription drug benefits, apply toward the Out-of-Pocket Maximum. 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. No one family member may contribute more than the Individual Out-of-Pocket Maximum amount to the Family Out-of-Pocket Maximum.	
Lifetime Maximum	Unlimited
Primary Care Physician Selection	Recommended *
Referral Requirement	Not Applicable *
PHYSICIAN SERVICES	**PARTICIPATING PROVIDERS**
Primary Care Physician Visits *	Office Hours: $25 Copay, deductible waived After Office Hours/Home: $30 Copay, deductible waived
Specialist Office Visits *	$50 Copay, deductible waived
Pre-Natal Maternity	$0 Copay, deductible waived
Maternity - Delivery and Post-Partum Care	$50 Copay after deductible
Allergy Treatment	Same as applicable participating provider office visit member cost sharing.
Allergy Testing	Same as applicable participating provider office visit member cost sharing.
PREVENTIVE CARE	**PARTICIPATING PROVIDERS**
Routine Adult Physical Exams/ Immunizations (Limited to one exam every 12 months.)	$0 Copay, deductible waived
Well Child Exams/Immunizations (Limited to 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.)	$0 Copay, deductible waived
Routine Gynecological Exams (Limited to a routine exam, pap smear and other appropriate tests using any FDA-approved gynecologic cytology screening technologies, once every 365 days.)	$0 Copay, deductible waived
Routine Mammograms	$0 Copay, deductible waived
Women's Health (Includes: Screening for gestational diabetes; HPV (Human Papillomavirus) DNA testing; counseling for sexually transmitted infections; counseling and screening for human immunodeficiency virus; screening and counseling for interpersonal and domestic violence; breastfeeding support, supplies and counseling; and contraceptive methods and counseling. Limitations may apply.)	$0 Copay, deductible waived

PLAN DESIGN AND BENEFITS - VA HEALTH NETWORK ONLY CD 1.5 (2000 DED)

PREVENTIVE CARE (CONTINUED)	PARTICIPATING PROVIDERS
Routine Digital Rectal Exams/Prostate Specific Antigen Test (Recommended for covered males age 40 and over. Age and frequency schedules may apply.)	$0 Copay, deductible waived
Colorectal Cancer Screening (For all members age 50 and over. Frequency schedule applies.)	$0 Copay, deductible waived
Routine Eye Exams at Specialist (Limited to one routine exam per 24 months.)	$0 Copay, deductible waived
Vision Corrective Lenses/Contact Allowance	Not Covered
Routine Hearing Screening at PCP	Covered as part of a routine physical exam.
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.)	$50 Copay, deductible waived
DIAGNOSTIC PROCEDURES	**PARTICIPATING PROVIDERS**
Diagnostic Laboratory (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.)	$0 Copay after deductible
Diagnostic X-ray (except for Complex Imaging Services) - Outpatient Hospital or Other Outpatient Facility	$50 Copay after deductible
Diagnostic X-ray for Complex Imaging Services (Includes MRA/MRS, MRI, PET and CAT Scans)	$200 Copay after deductible
EMERGENCY/URGENT MEDICAL CARE	**PARTICIPATING PROVIDERS**
Urgent Care Provider	$75 Copay after deductible
Non-Urgent use of Urgent Care Provider	Not Covered
Emergency Room (Copay waived if admitted.)	$200 Copay after deductible
Non-Emergency care in an Emergency Room	Not Covered
Emergency Ambulance	$0 Copay after deductible
Non-Emergency Ambulance	Not Covered
HOSPITAL CARE	**PARTICIPATING PROVIDERS**
Inpatient Coverage (Including maternity and transplants. Transplant coverage provided at an IOE contracted facility only.)	30% after deductible
Outpatient Surgery (Provided in an outpatient hospital department or a freestanding surgical facility.)	30% after deductible
MENTAL HEALTH SERVICES	**PARTICIPATING PROVIDERS**
Inpatient	30% after deductible
Outpatient	$50 Copay, deductible waived
ALCOHOL/DRUG ABUSE SERVICES	**PARTICIPATING PROVIDERS**
Inpatient Detoxification	30% after deductible
Outpatient Detoxification	$50 Copay, deductible waived
Inpatient Rehabilitation	30% after deductible
Outpatient Rehabilitation	$50 Copay, deductible waived
Residential Treatment Facility	30% after deductible

PLAN DESIGN AND BENEFITS - VA HEALTH NETWORK ONLY CD 1.5 (2000 DED)

OTHER SERVICES	PARTICIPATING PROVIDERS
Skilled Nursing Facility (Limited to 60 days per plan year)	30% after deductible
Home Health Care (Limited to 60 visits per plan year, no more than 3 intermittent visits per day by a Home Health Care agency, 1 visit equals a period of 4 hours or less.)	$0 Copay after deductible
Hospice Care – Inpatient	30% after deductible
Hospice Care - Outpatient	$0 Copay after deductible
Outpatient Speech Therapy (Limited to 30 visits per member per plan year.)	$50 Copay after deductible
Outpatient Physical and Occupational Therapy (Physical and Occupational Therapy limited to 30 visits [combined] per member per plan year.)	$50 Copay after deductible
Subluxation (Chiropractic) (Limited to 20 visits per member per plan year.)	$10 Copay after deductible
Durable Medical Equipment (Maximum benefit of $5,000 per member per plan year.)	50% after deductible
Early Intervention Services (Birth to Age 3) (Includes speech, language, occupational, physical therapies and assistive technology services and devices for dependents certified as eligible, up to $5,000 per plan year, which cannot be applied to any lifetime maximums under the plan.)	Member cost sharing is based on the type of service performed and the place rendered.
Autism (Covered the same as any other expense. Limited to $35,000 per plan year for eligible individuals under 7 years of age. Includes coverage for Applied Behavioral Analysis. Once the limit has been met, Applied Behavioral Analysis will be covered under Mental Health services.)	Member cost sharing is based on the type of service performed and the place rendered.
FAMILY PLANNING	**PARTICIPATING PROVIDERS**
Infertility Treatment (Coverage for only the diagnosis and surgical treatment of the underlying medical cause.)	Member cost sharing is based on the type of service performed and the place rendered.
Comprehensive Infertility Services	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
Vasectomy	Member cost sharing is based on the type of service performed and the place rendered
Tubal Ligation	$0 Copay, deductible waived
PHARMACY-PRESCRIPTION DRUG BENEFITS	**PARTICIPATING PHARMACIES**
Prescription Drug Deductible	Not Applicable
Prescription Drugs Up to a 30-day supply	$10 Copay for formulary generic drugs, $35 Copay for formulary brand-name drugs, and $60 Copay for non-formulary generic and brand-name drugs

PLAN DESIGN AND BENEFITS - VA HEALTH NETWORK ONLY CD 1.5 (2000 DED)

PHARMACY-PRESCRIPTION DRUG BENEFITS (CONTINUED)	PARTICIPATING PHARMACIES
Prescription Drugs **(Retail or Mail Order)** 31-90 day supply	$20 Copay for formulary generic drugs, $70 Copay for formulary brand-name drugs, and $120 Copay for non-formulary generic and brand-name drugs
Specialty Care Drugs (Self-injectable, infused and oral specialty drugs)	$200 Copay
Aetna 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.	
Formulary generic FDA-approved Women's Contraceptives, certain brand formulary contraceptives when approved, female condoms, spermicides, sponges and emergency contraception covered 100% in network.	
Precertification 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.

* A member may at anytime seek health care from Participating Providers without first contacting his or her Primary Care Physician. When a member chooses not to use his or her Primary Care Physician, the member is entitled to receive benefits for covered services and supplies. A member will be subject to the Primary Care Physician (PCP) cost-share when a member obtains covered benefits from any participating Primary Care Physician. A member will be subject to the Specialist cost-share when a member obtains covered benefits from any participating Specialist.

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 by your plan documents, including costs of services before coverage begins and after coverage terminates.
(2) Cosmetic surgery, including breast reduction.
(3) Custodial care.
(4) Dental care and x-rays.
(5) Donor egg retrieval.
(6) Experimental and investigational procedures (except for coverage for medically necessary routine patient care costs for Members participating in a cancer clinical trial).
(7) Hearing aids.
(8) Immunizations for travel or work.
(9) Implantable drugs and certain injectable drugs including injectable infertility drugs.
(10) 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.

PLAN DESIGN AND BENEFITS - VA HEALTH NETWORK ONLY CD 1.5 (2000 DED)

(11) Nonmedically necessary services or supplies.
(12) Orthotics, except diabetic orthotics.
(13) Over-the-counter medications (except as provided in a hospital) and supplies.
(14) Radial keratotomy or related procedures.
(15) Reversal of sterilization.
(16) Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs.
(17) Special duty nursing.
(18) Therapy or rehabilitation other than those listed as covered in the plan documents.

This material is for informational purposes only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits may vary by location. Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered. 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. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and group size. Plan features are subject to change.

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. If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group. In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

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, pre-certification, 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

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. Aetna Specialty Pharmacy refers to Aetna Specialty Pharmacy, LLC. Both are subsidiaries of Aetna Inc. and are licensed pharmacies that operate through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery and Aetna Specialty Pharmacy may be higher than the cost those pharmacies pay for the drugs and the costs of their specialty pharmacy services. For these purposes, Aetna Specialty Pharmacy's and Aetna Rx Home Delivery's cost of purchasing drugs takes into account discounts, credits and other amounts that those pharmacies may receive from wholesalers, manufacturers, suppliers and distributors.

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group subsidiary companies. For more information about Aetna plans, refer to www.aetna.com. While this material is believed to be accurate as of the print date, it is subject to change.