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Q.

PLAN FEATURES

member's selected PCP.

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PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

IN-NETWORK

Q. FLANTLATURES	IN-INL I WORK
Deductible	None Individual
(per calendar year)	None Family
Member Coinsurance	0%
Applies to all expenses unless otherwis	e stated.
Payment Limit	\$3,500 Individual
(per calendar year)	\$8,750 Family
Certain member cost sharing elements	may not apply toward the Payment Limit.
Pharmacy expenses apply towards the	
	ulting from the application of coinsurance percentage, copays, and deductibles
(except any penalty amounts) may be u	
	e Payment Limit for all family members. The family Payment Limit can be me
	owever no single individual within the family will be subject to more than the
individual Payment Limit amount.	
Lifetime Maximum	
Unlimited except where otherwise indicate	
Primary Care Physician Selection	Optional
Referral Requirement	None
PREVENTIVE CARE	IN-NETWORK
Routine Adult Physical Exams/	Covered 100%
Immunizations	
	1 exam per calendar year age 65 and older
Routine Well Child	Covered 100%
Exams/Immunizations	
	exams in the second 12 months of life, 3 exams in the third 12 months of life,
exam per calendar year thereafter to ag	
Routine Gynecological Care	Covered 100%
Exams	
2 exams per calendar year. Includes ro	
Routine Mammograms	Covered 100%
Women's Health	Covered 100%
	etes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually
	screening for human immunodeficiency virus, screening and counseling for
	eastfeeding support, supplies and counseling.
	ocedures, patient education and counseling. Limitations may apply.
Routine Digital Rectal Exam	Covered 100%
Prostate-specific Antigen Test	Covered 100%
Colorectal Cancer Screening	Member cost sharing is based on the type of service performed and the place
	of service where it is rendered
Recommended: For all members age 5	
Routine Eye Exams	Covered 100%
1 routine exam per 12 months.	
Routine Hearing Screening	Not Covered
PHYSICIAN SERVICES	IN-NETWORK
Office Visits to Non-Specialist	\$30 office visit copay
	al physician, family practitioner or pediatrician.
Specialist Office Visits	\$50 copay
	al physician, family practitioner or pediatrician if the physician is not the
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Audiomotric Hoaring Evam	Not Covered
Audiometric Hearing Exam Pre-Natal Maternity	Covered 100%
Walk-in Clinics	
	\$30 office visit copay
	ing health care facilities. They are an alternative to a physician's office visit for
	ncy illnesses and injuries and the administration of certain immunizations. It is
	services or the ongoing care provided by a physician. Neither an emergency
	a hospital, shall be considered a Walk-in Clinic.
Allergy Testing	Member cost sharing is based on the type of service performed and the place
	of service where it is rendered
Allergy Injections	Member cost sharing is based on the type of service performed and the place
	of service where it is rendered
DIAGNOSTIC PROCEDURES	IN-NETWORK
Diagnostic X-ray	Covered 100%
(other than Complex Imaging Services)	
If performed as a part of a physician of	fice visit and billed by the physician, expenses are covered subject to the
applicable physician's office visit memb	per cost sharing.
Diagnostic Laboratory	Covered 100%
If performed as a part of a physician of	fice visit and billed by the physician, expenses are covered subject to the
applicable physician's office visit memb	
Diagnostic Outpatient Complex	Covered 100%
Imaging	
EMERGENCY MEDICAL CARE	IN-NETWORK
Urgent Care Provider	\$75 copay
Non-Urgent Use of Urgent Care	Not Covered
Provider	
Emergency Room	\$200 copay
Copay waived if admitted	4-00 00pm
Non-Emergency Care in an	Not Covered
Emergency Room	
Emergency Use of Ambulance	Covered 100%
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	IN-NETWORK
Inpatient Coverage	\$750 copay
	covered benefits incurred during a member's inpatient stay.
Inpatient Maternity Coverage	\$750 copay
(includes delivery and postpartum	Ψ. σο σορα,
care)	
,	covered benefits incurred during a member's inpatient stay.
Outpatient Hospital Expenses	Covered 100%
	covered benefits incurred during a member's outpatient visit.
Outpatient Surgery	Covered 100%
	covered benefits incurred during a member's outpatient visit.
Outpatient Surgery - Freestanding	Covered 100%
	COVETEU 10070
Facility The member cost sharing applies to all	covered benefits incurred during a member's cutrations visit
9 11	covered benefits incurred during a member's outpatient visit.
MENTAL HEALTH SERVICES	IN-NETWORK
Inpatient	\$750 copay
	covered benefits incurred during a member's inpatient stay.
Outpatient	\$50 copay
The member cost sharing applies to all	covered benefits incurred during a member's outpatient visit.



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Crisis Intervention Services	\$50 copay
ALCOHOL/DRUG ABUSE	IN-NETWORK
SERVICES	
Inpatient	\$750 copay
The member cost sharing applies to all	covered benefits incurred during a member's inpatient stay.
Residential Treatment Facility	\$750 copay
Outpatient	\$50 copay
The member cost sharing applies to all	covered benefits incurred during a member's outpatient visit.
OTHER SERVICES	IN-NETWORK
Convalescent Facility	Covered 100%
Limited to 60 days per calendar year.	
	covered benefits incurred during a member's inpatient stay.
Home Health Care	Covered 100%
Limited to 120 visits per calendar year.	
	visit. Each visit up to 4 hours by a home health care aide is one visit.
Hospice Care - Inpatient	Covered 100%
	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 - Outpatient	Covered 100%
Limited to 70 eight hour shifts per calen	
Each period of private duty nursing of u	p to 8 hours will be deemed to be one private duty nursing shift.
Outpatient Short-Term	\$50 copay
Rehabilitation	
Includes Speech, Physical, and Occupa	itional Therapy, limited to 60 visits per calendar year, unlimited for early
intervention services from birth to age 3	•
Spinal Manipulation Therapy	\$50 copay
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health
Covered same as any other Outpatient	
	Refer to MBH Outpatient Mental Health
	Mental Health benefit with no visit limits or age restrictions up to 680 hours per a
calendar year.	
Autism Physical Therapy	\$50 copay
Autism Occupational Therapy	\$50 copay
Autism Speech Therapy	\$50 copay
Durable Medical Equipment	50%
Diabetic Supplies	Covered same as PCP office visit cost sharing
Generic FDA-approved Women's	Covered 100%
Contraceptives	
Contraceptive drugs and devices	Covered 100%
not obtainable at a pharmacy	
Hearing Aids	Not Covered
Fertility Drugs (oral and injectable)	Covered 100%
	jectable fertility drugs obtained at a pharmacy are covered under the Rx plan).
Vision Eyewear	Not Covered
Transplants	\$750 copay
	Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery	\$750 copay
	covered benefits incurred during a member's inpatient stay.
Out of Area Dependents	No coverage for non-emergency care received outside the service area.



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FAMILY PLANNING	IN-NETWORK	
Infertility Treatment	Member cost sharing is based on the type of service performed and the place	
	of service where it is rendered	
Diagnosis and treatment of the underlying medical condition.		
Comprehensive Infertility Services	Applicable cost sharing based on the type of service performed and place of	
	service where rendered	
Coverage includes Artificial Insemination and Ovulation Induction.		
Advanced Reproductive	Not Covered	
Technology (ART)		
Vasectomy	Member cost sharing is based on the type of service performed and the place	
	of service where it is rendered	
Tubal Ligation	Covered 100%	
PHARMACY	IN-NETWORK	
Pharmacy Plan Type	Aetna Value Open Formulary	
Retail	\$10 copay for formulary generic drugs, \$30 copay for formulary brand-name	
	drugs, and \$50 copay for non-formulary brand-name and generic drugs up to a	
	30 day supply at participating pharmacies.	
Mail Order	\$20 copay for formulary generic drugs, \$60 copay for formulary brand-name	
	drugs, and \$100 copay for non-formulary brand-name and generic drugs.	
	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Aetna Value Specialty Drugs	\$10 copay for formulary generic drugs, \$30 copay for formulary brand-name	
	drugs, and \$50 copay for non-formulary brand-name and generic drugs up to a	
	30 day supply at participating pharmacies.	
First prescription fill at any retail drug fanetwork.	acility. Subsequent fills must be through our preferred Aetna Specialty Pharmacy	

Value Specialty Drug List

Plan Includes: Diabetic supplies and medication covered at PCP cost sharing and Contraceptive drugs and devices obtainable from a pharmacy.

Performance Enhancing Drugs limited to 4 tablets per month.

Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).

Value Pre-certification included

Value Step Therapy included

One transition fill allowed within 90 days of member's effective date

Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.

Prescription Drug Calendar Year Deductible(must be satisfied before \$100 Individual

any drug benefits are paid)

\$300 Family

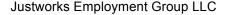
All covered pharmacy expenses accumulate toward both the preferred and non-preferred pharmacy deductible. Unless otherwise indicated, the pharmacy deductible must be met prior to pharmacy benefits being payable. Once family pharmacy deductible is met, all family members will be considered as having met their pharmacy deductible for the remainder of the calendar year

GENERAL PROVISIONS

Dependents Eligibility Spouse, children from birth to age 26 regardless of student status.

Plans are provided by: Aetna Health 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.





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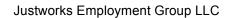
See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances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

- •All medical or 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 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 behavorial disorders;
- Weight control services including surgical procedure, 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 **1-888-982-3862**. Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862**.





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Plan features and availability may vary by location and group size. For more information about Aetna plans, refer to **www.aetna.com**. © 2014 Aetna Inc.