

# HSA COMPATIBLE PLANS

Plan Options	MD Open Access POS HSA Compatible Plan 1.3 <sup>+</sup>		MD Open Access POS HSA Compatible Plan 2.3 <sup>+</sup>	
<b>Member Benefits</b>	In-Network No Referral Needed	Out-of-Network No Referral Needed	In-Network No Referral Needed	Out-of-Network No Referral Needed
<b>Member Coinsurance</b>	N/A	30% after deductible	N/A	30% after deductible
<b>Plan Year Deductible<sup>1</sup></b>	\$1,200 Individual \$2,400 Family In-Network and Out-of-Network Combined		\$1,500 Individual \$3,000 Family In-Network and Out-of-Network Combined	
<b>Plan Year Out-of-Pocket Maximum<sup>2</sup> – Medical and Prescription Drugs</b> (All amounts paid as deductible, coinsurance and copayment for covered services and supplies apply toward the Out-of-Pocket Maximum)	\$2,400 Individual \$4,800 Family In-Network and Out-of-Network Combined		\$2,500 Individual \$5,000 Family In-Network and Out-of-Network Combined	
<b>Lifetime Maximum Benefit</b>	Unlimited	\$2,000,000	Unlimited	\$2,000,000
<b>Wellness On Us<sup>SM</sup></b>				
<b>Well-Baby/Child and Adult Physical Exams</b> (Age and frequency schedules apply. In-network and out-of-network combined)	\$0 copay, deductible waived	30%, deductible waived	\$0 copay, deductible waived	30%, deductible waived
<b>Routine GYN Exams</b> (Limited to one exam and pap smear every 365 days. In-network and out-of-network combined)	\$0 copay, deductible waived	30%, deductible waived	\$0 copay, deductible waived	30%, deductible waived
<b>Routine Mammograms</b>	\$0 copay, deductible waived	30%, deductible waived	\$0 copay, deductible waived	30%, deductible waived
<b>Routine Eye Exam</b> (One exam per 24 months. In-network and out-of-network combined)	\$0 copay, deductible waived	30%, deductible waived	\$0 copay, deductible waived	30%, deductible waived
<b>Aetna Vision<sup>SM</sup> Discount Program</b>	Included	Not Covered	Included	Not Covered
<b>Primary Physician Office Visit<sup>3</sup></b>	\$0 copay after deductible	30% after deductible	\$0 copay after deductible	30% after deductible
<b>Specialist Office Visit<sup>3</sup></b>	\$0 copay after deductible	30% after deductible	\$0 copay after deductible	30% after deductible
<b>Outpatient Services – Lab</b>	\$0 copay after deductible	30% after deductible	\$0 copay after deductible	30% after deductible
<b>Outpatient Services – X-ray</b> (Includes Outpatient Complex Imaging)	\$0 copay after deductible	30% after deductible	\$0 copay after deductible	30% after deductible
<b>Chiropractic Services</b> (20 visits per condition per plan year. In-network and out-of-network combined)	\$0 copay after deductible	30% after deductible	\$0 copay after deductible	30% after deductible
<b>Outpatient Physical, Occupational, Speech Therapy</b> (30 visits per therapy per condition per plan year. In-network and out-of-network combined)	\$0 copay after deductible	30% after deductible	\$0 copay after deductible	30% after deductible
<b>Durable Medical Equipment</b>	\$0 copay after deductible	30% after deductible	\$0 copay after deductible	30% after deductible
<b>Inpatient Hospital</b>	\$0 copay per admission after deductible	30% after deductible	\$0 copay per admission after deductible	30% after deductible
<b>Outpatient Surgery</b>	\$0 copay after deductible	30% after deductible	\$0 copay after deductible	30% after deductible
<b>Emergency Room</b>	\$0 copay after deductible	\$0 copay after deductible	\$0 copay after deductible	\$0 copay after deductible
<b>Urgent Care</b>	\$0 copay after deductible	\$0 copay after deductible	\$0 copay after deductible	\$0 copay after deductible
<b>Mental Health – Inpatient</b> (Maximum of 60 days per plan year. Combined maximum with Inpatient Substance Abuse Rehabilitation. In-network and out-of-network combined)	\$0 copay per admission after deductible	30% after deductible	\$0 copay per admission after deductible	30% after deductible
<b>Substance Abuse – Inpatient</b> (Detox: Unlimited days. Rehab: Maximum of 60 days per plan year. Combined maximum with Inpatient Mental Health. In-network and out-of-network combined)	\$0 copay per admission after deductible	30% after deductible	\$0 copay per admission after deductible	30% after deductible
<b>Prescription Drugs</b>				
<b>Prescription Drug Deductible</b>	Integrated medical/pharmacy deductible			
<b>Plan Year Out-of-Pocket Maximum - Prescription Drugs</b>	Integrated medical/pharmacy out-of-pocket maximum			
<b>Prescription Drugs: 30-day supply</b>	\$10/\$25/\$50 after deductible	Not Covered	\$10/\$25/\$50 after deductible	Not Covered
<b>Maintenance Drugs: 90-day supply</b>	\$20/\$50/\$100 after deductible		\$20/\$50/\$100 after deductible	
<b>Contraceptives and Diabetic Supplies</b>	Included		Included	
<b>Self-Injectables: 30-day supply</b>	\$200 copay after deductible		\$200 copay after deductible	
<b>Self-Injectables: 90-day supply</b>	\$400 copay after deductible		\$400 copay after deductible	

<sup>4</sup>This is a partial description of benefits available; for more information, refer to the specific plan design summary.

<sup>1</sup>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.

<sup>2</sup>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.

<sup>3</sup>"Open Access" Provision: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefits from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to pre-certify or obtain prior approval for certain services.

Note: Please refer to Aetna's Producer World web site at [www.aetna.com](http://www.aetna.com) for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

Health benefits and health insurance plans are offered/underwritten by Aetna Health Insurance Company (Aetna).

Health benefits and health insurance plans contain exclusions and limitations. This material is for information only and is not an offer or invitation to contract. An application must be completed in order to obtain coverage. Rates and benefits vary by location. Investment services are independently offered through HealthEquity, Inc. 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. Information is believed to be accurate as of the production date; however, it is subject to change. For more information on Aetna plans, refer to [www.aetna.com](http://www.aetna.com).