

QPOS PLAN 2



MOORE COLLEGE OF ART & DESIGN
 Proposed effective date: 06-01-2009
 QPOS® - Pennsylvania

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA HEALTH INC. AND AETNA HEALTH INSURANCE COMPANY - FULL RISK

PLAN FEATURES	PARTICIPATING PROVIDERS / REFERRED	NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED
Deductible (per calendar year)	None Individual None Family	\$500 Individual \$1,500 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 calendar year.</p>		
Out-of-Pocket Maximum (per calendar year)	\$1,500 Individual \$3,000 Family	\$3,000 Individual \$9,000 Family
<p>Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. Only those participating providers/referred and non-participating providers/participating providers self referred 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 calendar year.</p>		
Lifetime Maximum	Unlimited unless otherwise indicated.	\$1,000,000
<p>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.</p>		
Primary Care Physician Selection	Required	Not Applicable
<p>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.</p>		
Referral Requirements	Required for all non-emergency, non-urgent and non-Primary Care Physician services, except direct access services	None
PREVENTIVE CARE	PARTICIPATING PROVIDERS / REFERRED	NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED
Routine Adult Physical Exams / Immunizations (Age and frequency schedules apply)	\$15 copay	Not Covered
Well Child Exams / Immunizations (Age and frequency schedules apply)	\$15 copay; deductible waived	Exams not covered; 30% deductible waived for immunizations.
Routine Gynecological Care Exams Includes Pap smear and related lab fees. One exam per calendar year.	\$30 copay; deductible waived	30%; deductible waived
Routine Mammograms One annual mammogram for covered females age 40 and over.	\$30 copay; deductible waived	30%; deductible waived
Routine Digital Rectal Exams / Prostate Specific Antigen Test For males age 40 and over	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.



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Colorectal Cancer Screening For all members 50 and over. Frequency schedule applies	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.
Routine Eye Exam Age/Frequency Schedule may apply. Direct access to participating providers without a referral.	\$30 copay	Not Covered
Routine Hearing Screening	Subject to Routine Physical Exam cost sharing	Subject to Routine Physical Exam benefit.
PHYSICIAN SERVICES	PARTICIPATING PROVIDERS / REFERRED	NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED
Primary Care Physician Visits	Office Hours: \$15 copay After Office Hours/Home: \$20 copay	30%
Specialist Office Visits	\$30 copay	30%
Maternity OB Visits	\$30 copay for initial visit only, thereafter covered 100%	30%
Allergy Treatment	Same as applicable participating provider office visit member cost sharing	30%
Allergy Testing	Same as applicable participating provider office visit member cost sharing	30%
DIAGNOSTIC PROCEDURES	PARTICIPATING PROVIDERS / REFERRED	NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED
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.	Covered 100%	30%
Diagnostic X-ray Outpatient hospital or other Outpatient facility (except for Complex Imaging Services)	\$30 copay	30%
Diagnostic X-ray for Complex Imaging Services	\$30 copay	30%
EMERGENCY MEDICAL CARE	PARTICIPATING PROVIDERS / REFERRED	NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED
Emergency Room	\$100 copay	Refer to participating provider benefit.
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%	Refer to participating provider benefit.
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	PARTICIPATING PROVIDERS / REFERRED	NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED
Inpatient Coverage	\$250 per day for the first 5 days per admission, thereafter Covered 100%	30% per admission

The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.



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Inpatient Maternity Coverage	\$250 per day for the first 5 days per admission, thereafter Covered 100%	30% per admission
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Surgery	\$125 copay per visit	30% per visit
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
MENTAL HEALTH SERVICES	PARTICIPATING PROVIDERS / REFERRED	NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED
Inpatient Serious Mental Illness	\$250 per day for the first 5 days per admission, thereafter Covered 100% Limited to 30 days per calendar year	30% per admission Limited to 30 days per calendar year
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Non-Serious Mental Illness	\$250 per day for the first 5 days per admission, thereafter Covered 100% Limited to 30 days per calendar year	30% per admission Limited to 30 days per calendar year
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Serious Mental Illness	\$30 copay per visit Limited to 60 visits per calendar year	50% per visit Limited to 60 visits per calendar year
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Non-Serious Mental Illness	\$30 copay per visit Limited to 20 visits per calendar year	50% per visit Limited to 20 visits per calendar year
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
ALCOHOL/DRUG ABUSE SERVICES	PARTICIPATING PROVIDERS / REFERRED	NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED
Inpatient Detoxification	\$250 per day for the first 5 days per admission, thereafter Covered 100%	30% per admission 7 days per admission, 4 admissions per lifetime
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Detoxification	\$30 copay	30% per visit
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Inpatient Rehabilitation	\$250 per day for the first 5 days per admission, thereafter Covered 100% Limited to 30 days per calendar year and 90 days per lifetime	30% per admission Limited to 30 days per calendar year and 90 days per lifetime
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Rehabilitation	\$30 copay	30% per visit
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		



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OTHER SERVICES	PARTICIPATING PROVIDERS / REFERRED	NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED
Skilled Nursing Facility	\$250 per day for the first 5 days per admission, thereafter Covered 100% Limited to 120 days per calendar year	30% per admission Limited to 120 days per calendar year
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Home Health Care	\$30 copay Limited to 60 visits per calendar year	30% per visit Limited to 60 visits per calendar year
Limited to 3 intermittent visit per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.		
Hospice Care - Inpatient	\$250 per day for the first 5 days per admission, thereafter Covered 100%	30% per admission \$10,000 lifetime maximum combined for inpatient and outpatient care.
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	Covered 100%	30% per visit \$10,000 lifetime maximum combined for inpatient and outpatient care.
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)	\$30 copay Treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment.	30% Treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment.
Subluxation	\$30 copay Limited to 20 visits per calendar year	30% per visit
Durable Medical Equipment	50% Limited to \$2,500 per calendar year	\$1,000 calendar year maximum. 50% (must precertify if over \$1,500) Limited to \$2,500 per calendar year
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.	30%
Dental	Not Covered	Not Covered
Vision Eyewear	\$100 once per 24 month period	Covered same as participating provider benefit
Transplants	\$250 per day for the first 5 days per admission, thereafter Covered 100% Coverage is provided at an IOE contracted facility only	30% per admission Coverage is provided at an Non-IOE contracted facility only



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Bariatric Surgery The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Not Covered	Not Covered
FAMILY PLANNING	PARTICIPATING PROVIDERS / REFERRED	NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED
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.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
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.	Subject to applicable service type member cost sharing	Subject to applicable service type member cost sharing
PHARMACY - PRESCRIPTION DRUG BENEFITS	PARTICIPATING PROVIDERS / REFERRED	NON-PARTICIPATING PROVIDERS / PARTICIPATING PROVIDERS SELF REFERRED
Retail	\$10 copay for formulary generic drugs, \$20 copay for formulary brand-name drugs, and \$35 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.	Not Covered
Mail Order	\$20 copay for formulary generic drugs, \$40 copay for formulary brand-name drugs, and \$70 copay for non-formulary brand-name and generic drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not Covered
Pharmacy Managed Self Injectables (PMSI) First prescription fill at any retail or mail order 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. Precert included		

Exclusions and Limitations

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

This managed care plan may not cover all of your health care expenses. Read your contract carefully to determine which health care services are covered. To contact the plan if you are a member, call the number on your ID card; all others, call 1-888-98-AETNA (1-888-982-3862).

Health benefits 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. 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.

- 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)**.



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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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