



PLAN DESIGN AND BENEFITS  
PROVIDED BY AETNA LIFE INSURANCE COMPANY - INSURED

PLAN FEATURES	In Network		Out of Network	
<b>Deductible</b> (per calendar year)	\$100	Individual	\$500	Individual
	\$200	Family	\$1,000	Family

The In Network and Out of Network Deductibles are independent of one another. All covered expenses accumulate separately toward each deductible.

Unless otherwise indicated, the Deductible must be met prior to benefits being payable.

Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.

<b>Member Coinsurance</b>	Covered 100%	20%
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Applies to all expenses unless otherwise stated.

<b>Payment Limit</b> (per calendar year)	None	Individual	\$1,500	Individual
	None	Family	\$3,000	Family

All covered expenses accumulate separately toward the in network or out of network payment limit.

Certain member cost sharing elements may not apply toward the Payment Limit.

Only those out of network expenses resulting from the application of coinsurance percentage (except any deductibles, copays, and penalty amounts) may be used to satisfy the Payment Limit.

Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year.

<b>Lifetime Maximum</b>	Unlimited except where otherwise indicated.		
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<b>Payment for Out of Network*</b>	Not Applicable	<b>Professional:</b> 300% of Medicare <b>Facility:</b> 300% of Medicare
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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 or hospital.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount. This amount is based on "reasonable" or "prevailing" charges. We get this data from an external database. Exactly how much Aetna "recognizes" depends on the plan you or your employer picks.

Your out-of-network doctor sets the rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna plan "recognizes" or "allows." 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 maximum out-of-pocket. 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](http://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 doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance 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 copayments, coinsurance and deductibles.

<b>Primary Care Physician Selection</b>	Optional	Not applicable
<b>Certification Requirements -</b>		



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Certification for certain types of out of network 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, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is \$400 per occurrence. It is the members responsibility to complete the pre-certification process.

<b>Referral Requirement</b>	None	None
<b>PREVENTIVE CARE</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Routine Adult Physical Exams/ Immunizations</b> 1 exam every 12 months age 19 and over.	Covered 100%; deductible waived	20% after deductible
<b>Routine Well Child Exams/Immunizations</b> 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 year thereafter to age 19. Includes coverage for blood lead level screenings.	Covered 100%; deductible waived	Covered 100%; deductible waived
<b>Routine Gynecological Care Exams</b> Includes routine tests and related lab fees.	Covered 100%; deductible waived	20% after deductible
<b>Routine Mammograms</b>	Covered 100%; deductible waived	20% after deductible
<b>Routine Digital Rectal Exam / Prostate-specific Antigen Test</b>	Covered 100%; deductible waived	20% after deductible
<b>Colorectal Cancer Screening</b> For all members age 50 and over.	Covered 100%; deductible waived	20% after deductible
<b>Routine Eye Exams</b> 1 routine exam per 24 months	Covered 100%; deductible waived	20% after deductible
<b>Routine Hearing Screening</b>	Covered 100%; deductible waived	20% after deductible
<b>PHYSICIAN SERVICES</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Office Visits to PCP</b> Includes services of an internist, general physician, family practitioner or pediatrician.	\$25 office visit copay; deductible waived	20% after deductible
<b>Specialist Office Visits</b>	\$25 office visit copay; deductible waived	20% after deductible
Allergy Testing (Copay waived when an office visit charge is not made)	\$25 office visit copay; deductible waived	20% after deductible
<b>Allergy Injections</b> (Copay waived when an office visit charge is not made)	\$25 office visit copay; deductible waived	20% after deductible
<b>DIAGNOSTIC PROCEDURES</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Diagnostic Laboratory and X-ray</b> If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing	Covered 100%; deductible waived	20% after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Urgent Care Provider</b> (benefit availability may vary by location)	\$25 copay; deductible waived	20% after deductible
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered	Not Covered
<b>Emergency Room</b>	\$75 copay; deductible waived	\$75 copay; deductible waived
<b>Non-Emergency care in an Emergency Room</b>	Not Covered	Not Covered
<b>Ambulance</b>	Covered 100% after deductible	20% after deductible
<b>HOSPITAL CARE</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Inpatient Coverage</b> The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered 100% after deductible	20% after deductible
<b>Inpatient Maternity Coverage</b> The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered 100% after deductible	20% after deductible



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<b>Outpatient Hospital Expenses</b> (including surgery)	Covered 100% after deductible	20% after deductible
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
<b>MENTAL HEALTH SERVICES</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Inpatient Non-Biologically Based</b>	Covered 100% after deductible	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
<b>Outpatient Non-Biologically Based</b>	\$25 office visit copay; deductible waived	20% after deductible
<b>Inpatient Biologically Based</b>	Covered 100% after deductible	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
<b>Outpatient Biologically Based</b>	\$25 office visit copay; deductible waived	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
<b>Crisis Intervention Services</b>	\$25 office visit copay; deductible waived	20% after deductible
Maximums are combined limit for in network and out of network services.		
<b>ALCOHOL/DRUG ABUSE SERVICES</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Inpatient</b>	Covered 100% after deductible	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
<b>Outpatient</b>	\$25 office visit copay; deductible waived	20% after deductible
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
<b>OTHER SERVICES</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Convalescent Facility</b>	Covered 100% after deductible	20% after deductible
Limited to 120 days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay		
<b>Home Health Care</b>	Covered 100% after deductible	20% after deductible
Limited to 120 visits per calendar year. For the first 40 visits, each 4 hours of home health aide services equals one visit; after the first 40 visits, each visit of up to 4 hours is equal to one visit. Each visit by a nurse or therapist is one visit. In the event of early discharge for maternity confinement, i.e. prior to 48 hours for normal delivery, 96 hours for cesarean section, one Home Health Care visit will be covered. This visit is not subject to copays, deductibles, or coinsurance and does not reduce the Home Health Care maximum.		
<b>Hospice Care - Inpatient</b>	Covered 100% after deductible	Covered 100% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
<b>Hospice Care - Outpatient</b>	Covered 100% after deductible	Covered 100% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
<b>Private Duty Nursing - Outpatient</b> (Limited to 70 eight hour shifts per calendar year)	Covered 100% after deductible	20% after deductible
Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.		
<b>Outpatient Short-Term Rehabilitation</b>	Covered 100% after deductible	20% after deductible
Include Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year.		
<b>Spinal Manipulation Therapy</b>	\$25 office visit copay; deductible waived	20% after deductible
<b>Acupuncture Therapy</b>	Covered 100%; deductible waived	20% after deductible
<b>Durable Medical Equipment</b>	50% after deductible	50% after deductible
<b>Diabetic Supplies</b> -- (if not covered under Pharmacy benefit)	Covered same as PCP office visit cost sharing; after deductible	20% after deductible



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<b>Contraceptive drugs and devices not obtainable at a pharmacy</b> (includes coverage for contraceptive visits)	Covered 100% (payable as any other covered expense) after deductible	20% (payable as any other covered expense) after deductible
<b>Transplants</b>	Covered 100% in network coverage is provided at an IOE contracted facility only; after deductible	20% out of network coverage is provided at a Non-IOE facility; after deductible
<b>Bariatric</b> The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered 100% after deductible	20% after deductible
<b>FAMILY PLANNING</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Infertility Treatment</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Diagnosis and treatment of the underlying medical condition.		
<b>Comprehensive Infertility Services</b>	Covered 100% after deductible	20% after deductible
<b>Voluntary Sterilization</b> Including tubal ligation and vasectomy.	Member cost sharing is based on the type of service performed and the	Member cost sharing is based on the type of service performed and the
<b>PHARMACY</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Retail</b>	\$10 copay for generic drugs, \$20 copay for formulary brand-name drugs, and \$35 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	20% of submitted cost after \$10 copay for generic drugs, \$20 copay for formulary brand-name drugs, and \$35 copay for non-formulary brand-name drugs up to a 30 day supply.
<b>Mail Order</b>	\$20 copay for generic drugs, \$40 copay for formulary brand-name drugs, and \$70 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx	Not applicable

**No Mandatory Generic (NO MG)** - Member is responsible to pay the applicable copay only.

**Plan Includes:** Contraceptive drugs and devices obtainable from a pharmacy, Oral and Injectable fertility drugs (injectable, physician charges for injections are not covered under RX, medical coverage may be limited), Diabetic supplies and medication covered at PCP cost sharing.

Precert for growth hormones included

**GENERAL PROVISIONS**

<b>Dependents Eligibility</b>	Spouse, children from birth to age 26
<b>Pre-existing Conditions Exclusion</b>	Does not apply

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production

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 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

- 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.

If you require language assistance from an Aetna representative, please call Member Services' multilingual hotline at **1-888-982-3862** (140 languages are available. You must ask for an interpreter). **TDD 1-800-628-3323** (hearing impaired only).



Sarah Lawrence College

Proposed Effective Date: 01-01-2012

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Si necesita asistencia lingüística de un representante de Aetna, contamos con una línea directa de Servicios a Miembros disponible en varios idiomas. Comuníquese al **1-888-982-3862** (140 idiomas disponibles. Debe solicitar un intérprete). **TDD 1-800-628-3323** (para personas con problemas de audición únicamente).

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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