

**MARYLAND AETNA SMALL GROUP MEDICAL PLANS**

**Consumer-Directed — HMO HSA-Compatible and Small Group Mandated Plan Options**

PLAN OPTIONS	MD HMO No-Referral HSA-Compatible 1.2**	MD HMO No-Referral HSA-Compatible 2.1**
<b>MEMBER BENEFITS</b>	In-Network No Referral Needed	In-Network No Referral Needed
<b>Member Coinsurance</b>	N/A	N/A
<b>Calendar Year Deductible**</b>	\$1,200 employee \$2,400 family	\$2,000 employee \$4,000 family
<b>Calendar Year Out-of-Pocket Maximum – Medical and Prescription Drugs***</b> (Deductible, covered medical services and supplies and prescription drugs, including self-injectables, apply toward the Out-of-Pocket Maximum.)	\$2,400 employee \$4,800 family	\$2,000 employee \$4,000 family
<b>Lifetime Maximum Benefit</b>	Unlimited	Unlimited
<b>Routine Physical Exams</b> (Includes Children 14-18 years)	\$0 copay (deductible waived)	\$0 copay (deductible waived)
<b>Well-Baby/Child Exams/Immunizations</b> (0-13 years)	\$0 copay (deductible waived)	\$0 copay (deductible waived)
<b>Routine GYN Exams</b> (Limited to one exam and Pap smear every 365 days.)	\$0 copay (deductible waived)	\$0 copay (deductible waived)
<b>Routine Mammograms</b> (Age and frequency schedules apply)	\$0 copay (deductible waived)	\$0 copay (deductible waived)
<b>Primary Physician Office Visit</b>	\$20 copay after deductible	\$0 copay after deductible
<b>Specialist Office Visit</b>	\$30 copay after deductible	\$0 copay after deductible
<b>Outpatient Services – Lab</b>	\$30 copay after deductible	\$0 copay after deductible
<b>Outpatient Services – X-ray</b> (Including Outpatient Complex Imaging)	\$30 copay after deductible	\$0 copay after deductible
<b>Chiropractic Services</b> (20 visits per condition per calendar year)	\$30 copay after deductible	\$0 copay after deductible
<b>Outpatient Physical, Occupational, Speech Therapy</b> (30 visits per therapy per condition per calendar year)	\$30 copay after deductible	\$0 copay after deductible
<b>Durable Medical Equipment</b>	\$0 copay after deductible	\$0 copay after deductible
<b>Inpatient Hospital</b>	\$250 copay per admission after deductible	\$0 copay after deductible
<b>Outpatient Surgery</b>	\$30 copay after deductible	\$0 copay after deductible
<b>Emergency Room</b> (Copay waived if admitted)	\$100 copay after deductible	\$0 copay after deductible
<b>Urgent Care</b>	\$30 copay after deductible	\$0 copay after deductible
<b>Mental Health – Inpatient</b> (Maximum of 60 days per calendar year. Combined maximum with inpatient Substance Abuse Rehabilitation.)	\$250 copay per admission after deductible	\$0 copay after deductible
<b>Substance Abuse – Inpatient</b> (Detox: Unlimited days. Rehab: Maximum of 60 days per calendar year. Combined maximum with inpatient Mental Health.)	\$250 copay per admission after deductible	\$0 copay after deductible
<b>PRESCRIPTION DRUGS</b>		
<b>Prescription Drug Deductible</b>	Integrated medical/pharmacy deductible	Integrated medical/pharmacy deductible
<b>Calendar Year Out-of-Pocket Maximum – Prescription Drugs***</b>	Integrated medical/pharmacy out-of-pocket maximum	Integrated medical/pharmacy out-of-pocket maximum
<b>Prescription Drugs: 30-day supply</b>	\$15/\$25/\$40 after deductible	\$0 after deductible
<b>Maintenance Drugs: 90-day supply</b>	\$30/\$50/\$80 after deductible	\$0 after deductible
<b>Contraceptives and Diabetic Supplies</b>	Included	Included
<b>Self-Injectables</b> (Excluding Insulin) Up to 90-day supply	20% after deductible	\$0 after deductible

\*This is a partial description of benefits available; for more information, refer to the specific plan design summary.

\*\*“No Referral” Provision: A member will pay the Primary Physician Office Visit copay when the member obtains covered benefits from any participating primary care physician. Members will pay the Specialist Office Visit copay when the member obtains covered benefits from any participating specialist.

\*\*\*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 calendar year.

\*\*\*\*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 calendar year.

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

Note: For a summary list of Limitations and Exclusions, refer to pages 12–13. Please refer to Aetna’s Producer World® website 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.