

# Consumer Directed - Health Network Only HSA-compatible Plan Options

Plan Options	MD Health Network Only HSA Comp 2.6 (1500 Ded)*	MD Health Network Only HSA Comp 3.6 (2000 Ded)*	MD Health Network Only HSA Comp 4.6 (2500 Ded)*
<b>Member Benefits</b>	In-Network No Referral Needed	In-Network No Referral Needed	In-Network No Referral Needed
<b>Member Coinsurance</b>	N/A	N/A	N/A
<b>Plan Year Deductible<sup>2</sup></b>	\$1,500 individual \$3,000 family	\$2,000 individual \$4,000 family	\$2,500 individual \$5,000 family
<b>Plan Year Out-of-Pocket Maximum<sup>3</sup></b>	\$2,500 individual \$5,000 family	\$3,000 individual \$6,000 family	\$4,000 individual \$8,000 family
<b>Lifetime Maximum Benefit</b>	Unlimited	Unlimited	Unlimited
<b>Preventive Care</b>			
<b>Well-Baby/Child and Adult Physical Exams</b> (Age and frequency schedules apply)	\$0 copay, ded waived	\$0 copay, ded waived	\$0 copay, ded waived
<b>Routine Gyn Exams</b> (One exam and pap smear every 365 days)	\$0 copay, ded waived	\$0 copay, ded waived	\$0 copay, ded waived
<b>Routine Mammograms</b>	\$0 copay, ded waived	\$0 copay, ded waived	\$0 copay, ded waived
<b>Routine Eye Exam</b> (One exam per 24 months)	\$0 copay, ded waived	\$0 copay, ded waived	\$0 copay, ded waived
<b>Aetna Vision<sup>SM</sup> Discount Program</b>	Included	Included	Included
<b>Primary Physician Office Visit<sup>4</sup></b>	\$25 copay after ded	\$25 copay after ded	\$25 copay after ded
<b>Specialist Office Visit<sup>4</sup></b>	\$40 copay after ded	\$40 copay after ded	\$40 copay after ded
<b>Outpatient Services - Lab/X-ray</b> (Includes Outpatient Complex Imaging)	\$40 copay or 50% of the cost of the service, whichever is less, after ded	\$40 copay or 50% of the cost of the service, whichever is less, after ded	\$40 copay or 50% of the cost of the service, whichever is less, after ded
<b>Chiropractic Services</b> (20 visits per condition per plan year)	\$10 copay after ded	\$10 copay after ded	\$10 copay after ded
<b>Outpatient Physical, Occupational, Speech Therapy</b> (30 visits per therapy per condition per plan year)	\$40 copay after ded	\$40 copay after ded	\$40 copay after ded
<b>Durable Medical Equipment</b>	\$0 copay after ded	\$0 copay after ded	\$0 copay after ded
<b>Inpatient Hospital</b>	\$250 copay per adm after ded	\$250 copay per adm after ded	\$250 copay per adm after ded
<b>Outpatient Surgery</b>	\$40 copay after ded	\$40 copay after ded	\$40 copay after ded
<b>Emergency Room</b> (Copay waived if admitted)	\$100 copay after ded	\$100 copay after ded	\$100 copay after ded
<b>Urgent Care</b>	\$40 copay after ded	\$40 copay after ded	\$40 copay after ded
<b>Prescription Drugs</b>			
<b>Prescription Drugs: 30-day supply<sup>5</sup></b>	\$15/\$35/\$60 after ded	\$15/\$35/\$60 after ded	\$15/\$35/\$60 after ded
<b>Maintenance Drugs: 90-day supply<sup>5</sup></b>	\$30/\$70/\$120 after ded	\$30/\$70/\$120 after ded	\$30/\$70/\$120 after ded
<b>Specialty Care Drugs: 30-day supply</b>	\$200 copay after ded	\$200 copay after ded	\$200 copay after ded
<b>Specialty Care Drugs: 90-day supply</b>	\$400 copay after ded	\$400 copay after ded	\$400 copay after ded

Refer to back for footnotes.

14.36.906.1-MD C (4/12)

\*This is a partial description of benefits available; for more information, refer to the specific plan design summary. 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: For a summary list of Limitations and Exclusions, refer to the Maryland 2-50 Plan Guide. Please refer to Aetna's Producer World® website at [www.aetna.com](http://www.aetna.com) for more detailed benefit descriptions. Or for more information, please contact your licensed agent or Aetna sales representative.

<sup>2</sup>All covered prescription drug and medical expenses, except preventive care services, apply to the deductible. 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>3</sup>All amounts paid as deductibles, copayments, or coinsurance for covered services and supplies apply toward the out-of-pocket maximum. 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>4</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.

<sup>5</sup>Contraceptives and diabetic supplies included. Certain in-network contraceptive drugs are covered 100%, deductible waived, as required by federal health care reform legislation effective August 1, 2012.

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