Quality health plans & benefits
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Aetna Savings Plus
Plan guide

New health plans designed with Pennsylvania businesses in mind

For businesses with 1 – 50 employees
Plans effective January 1, 2015

www.aetna.com

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The health of business, well planned

Same quality local care at a lower cost

The Aetna Savings Plus health benefits plans provide members with the same type of coverage as other Aetna medical plans, but at a lower premium cost. Savings are generated through the use of the Savings Plus network, a quality network of local health care providers.

How do the Savings Plus plans work?

The Aetna Savings Plus plans in Pennsylvania give small businesses the flexibility and choice to best meet their needs. These plans use the Aetna Pennsylvania Savings Plus network.

Each Savings Plus plan has two levels of network benefits:

- Level 1: When members use the Savings Plus network, they realize maximum savings.
- Level 2: When members use non-designated network providers, they will see standard savings and higher member costs.

The Savings Plus plans do not provide benefits for non-network providers.

Members select a primary care physician (PCP) from the network of designated network providers to coordinate care for covered services.

All Savings Plus plans include coverage for doctors' visits, hospital stays, preventive care and more. Refer to pages 4 – 6 for more details.

Health benefits plans are offered and/or underwritten by Aetna Health, Inc. (Aetna).

Savings Plus of Pennsylvania - Hospitals

Below is a list of the Savings Plus HMO network hospitals by level and county. Choose designated hospitals (level 1) for maximum savings.

Level 1 – Maximum savings

Bucks County

Doylestown Hospital
Grand View Hospital
Lower Bucks Hospital

Chester County

Brandywine Hospital
Chester County Hospital
Coatesville Veteran Affairs Medical Center
Jennersville Regional Hospital
Phoenixville Hospital

Delaware County

Crozer-Chester – Community Hospital
Crozer-Chester Medical Center
Delaware County Memorial Hospital
Mercy Catholic Medical Center
Springfield Hospital
Taylor Hospital

Montgomery County

Albert Einstein Medical Center – Montgomery Campus
Holy Redeemer Health System
Pottstown Memorial Medical Center

Philadelphia County

Albert Einstein Medical Center
Albert Einstein Medical Center – Germantown Campus
Chestnut Hill Hospital
Children's Hospital of Philadelphia
Jeanes Hospital
Mercy Philadelphia Hospital
Mercy Suburban Hospital
North Philadelphia Health System
Philadelphia Veteran Affairs Medical Center
Shriner's Hospital for Children
St. Christopher's Hospital for Children
Wills Eye Hospital

Level 2 – Standard savings

Bucks County

Aria Health – Bucks County Campus
St. Luke's Hospital – Quakertown
St. Mary Medical Hospital – Langhorne

Chester County

Paoli Memorial Hospital

Delaware County

Riddle Memorial Hospital

Montgomery County

Abington Memorial Hospital
Bryn Mawr Hospital
Lankenau Hospital
Lansdale Hospital

Philadelphia County

Aria Health – Frankford Campus
Aria Health – Torresdale Campus
Fox Chase Cancer Center
Hahnemann University Hospital
Hospital of the University of Pennsylvania
Methodist Hospital
Nazareth Hospital
Penn Presbyterian Medical Center
Pennsylvania Hospital
Temple University Hospital
Thomas Jefferson University Hospital

For more information contact your independent broker Total Benefit Solutions Inc (215)355-2121 http://www.totalbenefits.net

Saving Plus HMO plans

Plan name	PA Gold Savings Plus HMO 500D/1000D		PA Silver Savings Plus HMO 2500/4500	
Member benefits	**Level 1** Network care designated provider maximum savings	**Level 2** Network care non-designated providers standard savings	**Level 1** Network care designated provider maximum savings	**Level 2** Network care non-designated providers standard savings
Plan year deductible	$0/$0	$0/$0	$2,500/$5,000	$4,500/$9,000
Plan out-of-pocket limit	$6,500/$13,000		$6,500/$13,000	
Deductible & out-of-pocket limit accumulation[1]	Embedded		Embedded	
Primary care physician office visit	$20 copay	$45 copay	$30 copay, deductible waived	$50 copay, deductible waived
Specialist office visit	$50 copay	$75 copay	$60 copay, deductible waived	$100 copay, deductible waived
Walk-in clinics	$20 copay	$20 copay	$30 copay, deductible waived	$30 copay, deductible waived
Diagnostic testing: Lab	$20 copay	$20 copay	$30 copay, deductible waived	$30 copay, deductible waived
Diagnostic testing: X-ray	$50 copay	$75 copay	$60 copay, deductible waived	$100 copay, deductible waived
Imaging (MRA/MRS, MRI, PET and CAT scans)	$300 copay	$500 copay	$350 copay, deductible waived	$500 copay, deductible waived
Inpatient hospital	$500 copayment per day, 5 day copay max per admission	$1,000 copayment per day, 5 day copay max per admission	Covered in full after deductible	Covered in full after deductible
Outpatient surgery	$500 copay	$750 copay	Covered in full after deductible	Covered in full after deductible
Emergency room[2]	$400 copay		$500 copay, deductible waived	
Urgent care	$50 copay	$75 copay	$60 copay, deductible waived	$100 copay, deductible waived
Rehabilitation services (PT/OT/ST) (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST. Levels 1 and 2 combined.)	$50 copay	$50 copay	$60 copay, deductible waived	$60 copay, deductible waived
Chiropractic services (20 visits per plan year. Levels 1 and 2 combined.)	25%	25%	25%, deductible waived	25%, deductible waived
Prescription drugs[3] (up to 30-day supply)				
Prescription drug deductible	Not applicable		Not applicable	
Preferred generic drugs	T1A: $3 copay/T1: $10 copay		T1A: $3 copay/T1: $10 copay	
Preferred brand drugs	$50 copay		$50 copay	
Nonpreferred generic and brand drugs	$125 copay		$125 copay	
Specialty drugs (self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to $500; Nonpreferred: 50% up to $1,000		Preferred: 50% up to $500; Nonpreferred: 50% up to $1,000	

Refer to page 8 for important plan provisions.

For more information contact your independent broker Total Benefit Solutions Inc (215)355-2121 http://www.totalbenefits.net

Saving Plus HMO plans

Plan name	PA Silver Savings Plus HMO 1500 70/50		PA Silver Savings Plus HMO 1650 70/50 HSA	
Member benefits	**Level 1** Network care designated provider maximum savings	**Level 2** Network care non-designated providers standard savings	**Level 1** Network care designated provider maximum savings	**Level 2** Network care non-designated providers standard savings
Plan year deductible	$1,500/$3,000		$1,650/$3,300	
Plan out-of-pocket limit	$6,000/$12,000		$6,000/$12,000	
Deductible & out-of-pocket limit accumulation[1]	Embedded		Non-embedded	
Primary care physician office visit	$35 copay, deductible waived	50% after deductible	$30 copay after deductible	50% after deductible
Specialist office visit	$50 copay, deductible waived	50% after deductible	30% after deductible	50% after deductible
Walk-in clinics	$35 copay, deductible waived	$35 copay, deductible waived	$30 copay after deductible	$30 copay after deductible
Diagnostic testing: Lab	$0 copay, deductible waived	$0 copay, deductible waived	Covered in full after deductible	Covered in full after deductible
Diagnostic testing: X-ray	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Imaging (MRA/MRS, MRI, PET and CAT scans)	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Inpatient hospital	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Outpatient surgery	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Emergency room[2]	30% after deductible		30% after deductible	
Urgent care	$75 copay, deductible waived	50% after deductible	30% after deductible	50% after deductible
Rehabilitation services (PT/OT/ST) (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST. Levels 1 and 2 combined.)	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Chiropractic services (20 visits per plan year. Levels 1 and 2 combined.)	25% after deductible	25% after deductible	25% after deductible	25% after deductible
Prescription drugs[3] (up to 30-day supply)				
Prescription drug deductible	Not applicable		Integrated with medical deductible	
Preferred generic drugs	T1A: $3 copay/T1: $20 copay		T1A: $3 copay after deductible/ T1: $10 copay after deductible	
Preferred brand drugs	50% up to $75		$40 copay after deductible	
Nonpreferred generic and brand drugs	50% up to $125		50% up to $125 after deductible	
Specialty drugs (self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to $500; Nonpreferred: 50% up to $1,000		Preferred: 50% up to $500 after deductible; Nonpreferred: 50% up to $1,000 after deductible	

Refer to page 8 for important plan provisions.

Saving Plus HMO plans

Plan name	PA Bronze Savings Plus HMO 5000/6250	
Member benefits	**Level 1** Network care designated provider maximum savings	**Level 2** Network care non-designated providers standard savings
Plan year deductible	$5,000/$10,000	$6,250/$12,500
Plan out-of-pocket limit	$6,600/$13,200	
Deductible & out-of-pocket limit accumulation[1]	Embedded	
Primary care physician office visit	$15 copay; deductible waived	$50 copay after deductible
Specialist office visit	$50 copay after deductible	$100 copay after deductible
Walk-in clinics	$15 copay, deductible waived	$15 copay, deductible waived
Diagnostic testing: Lab	Covered in full after deductible	Covered in full after deductible
Diagnostic testing: X-ray	$100 copay after deductible	$200 copay after deductible
Imaging (MRA/MRS, MRI, PET and CAT scans)	$250 copay after deductible	$500 copay after deductible
Inpatient hospital	$250 copay per admission after deductible	$500 copay per admission after deductible
Outpatient surgery	$250 copay after deductible	$500 copay after deductible
Emergency room[2]	$250 copay after deductible	
Urgent care	$50 copay after deductible	$150 copay after deductible
Rehabilitation services (PT/OT/ST) (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST. Levels 1 and 2 combined.)	$50 copay after deductible	$50 copay after deductible
Chiropractic services (20 visits per plan year. Levels 1 and 2 combined.)	25% after deductible	25% after deductible
Prescription drugs[3] (up to 30-day supply)		
Prescription drug deductible	Integrated with medical deductible	
Preferred generic drugs	T1A: $3 copay, deductible waived/ T1: $10 copay, deductible waived	
Preferred brand drugs	$50 copay after deductible	
Nonpreferred generic and brand drugs	$75 copay after deductible	
Specialty drugs (self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to $500 after deductible; Nonpreferred: 50% up to $1,000 after deductible	

Refer to page 8 for important plan provisions.

For more information contact your independent broker Total Benefit Solutions Inc (215)355-2121 http://www.totalbenefits.net

Pediatric dental/vision

Pediatric dental and vision mandates are a separate essential health benefit category and are included with your medical benefits. We will cover those services in 2015 according to the benchmark plan coverage.

Pediatric

Plan name	PA Gold Savings Plus HMO 500D/1000D	PA Silver Savings Plus HMO 2500/4500 PA Silver Savings Plus HMO 1500 70/50 PA Bronze Savings Plus HMO 5000/6250	PA Silver Savings Plus HMO 1650 70/50 HSA
	In network	In network	In network
Pediatric dental			
Dental checkup (aka preventive/ diagnostic)	0%	0%, deductible waived	0% after deductible
Dental basic	30%	30% after deductible	30% after deductible
Dental major	50%	50% after deductible	50% after deductible
Dental ortho	50%	50% after deductible	50% after deductible
Pediatric vision			
Vision exam (one exam per 12 months)	0%, deductible waived	0%, deductible waived	0%, deductible waived
Eyeglass frames, prescription lenses or prescription contact lenses*	0%	0% deductible waived	0% after deductible

* The pediatric vision plan will cover the following:

- One set of eyeglass frames per 12 months.
- One pair of prescription lenses per 12 months
- Prescription contact lenses maximum per 12 months: daily disposables (up to 3 month supply), extended wear disposable (up to 6 month supply) and non-disposable lenses (one set).
- Important Notes: This plan will cover either one pair of prescription lenses for eyeglass frames or prescription contact lenses, but not both, per 12 months. Coverage does not include the office visit for the fitting of prescription contact lenses.

Important plan provisions

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.

For a summary list of limitations and exclusions, refer to page 8. Please refer to **www.aetna.com** for specific Summary of Benefits and Coverage documents. Or for more information, please contact your licensed agent or Aetna sales representative.

[1]Embedded – No one family member may contribute more than the individual deductible/out-of-pocket limit amount to the family deductible/out-of-pocket limit. Once the family deductible/out-of-pocket limit is met, all family members will be considered as having met their deductible/out-of-pocket limit for the remainder of the plan year.

Non-Embedded – The individual deductible/out-of-pocket limit can only be met when a member is enrolled for self only coverage with no dependent coverage. The family deductible/out-of-pocket limit can be met by a combination of family members or by any single individual within the family. Once the family deductible/out-of-pocket limit is met, all family members will be considered as having met their deductible/out-of-pocket limit for the remainder of the plan year.

Deductible credit and deductible carryover do not apply.

[2]Emergency Room: Copay is waived if admitted. Coinsurance is not waived if admitted.

[3]Rx Plan Provisions:

- T1A = Value drugs. T1 = Preferred generic drugs.
- Contraceptives and diabetic supplies included.
- If the physician prescribes or the member requests a covered brand name prescription drug when a generic prescription drug equivalent is available, the member will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent plus the applicable cost-sharing. The cost difference between the generic and brand does not count toward the out-of-pocket limit.
- Precertification and step therapy applies.
- Not all drugs are covered. It is important to look at the Drug List (Aetna Value Plus Formulary) to understand which drugs are covered.

Limitations and exclusions

These plans do not cover all health care expenses and include exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, the plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased.

- All medical and hospital services not specifically covered in, or that are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates
- Cosmetic surgery
- Custodial care
- Dental care and dental X-rays
- Donor egg retrieval
- 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
- 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
- Nonmedically necessary services or supplies
- Orthotics
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs
- Special duty nursing
- Therapy or rehabilitation other than those listed as covered in the plan documents
- 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

Contact us

For more information regarding the Aetna Savings Plus plans for Pennsylvania, please contact your Aetna representative.

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).

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits may vary by location. Health benefits plans contain exclusions and limitations. If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Plan features and availability may vary by location and group size. Providers are independent contractors and not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Investment services are independently offered through HealthEquity, Inc. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. 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 about Aetna plans, refer to **www.aetna.com**.

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