PLAN DESIGN

Customer Name: Michael Page International Inc

Proposed Effective Date: 01-01-2015

Policy Period: 12

Data Source ID: Q3148813 - 5 - All Employees/357NYAHMC#2182

Option: MCOA HRA plan alt

Plan: Open POS Plus Plan

Location(s): New York

Specialty Networks Included: None Quoted

Organization Name: Aetna

Prepared: 11/19/2014 01:56 PM

Michael Page International Inc
Proposed Effective Date: 01-01-2015
Open Access® Managed Choice® POS - New York

PLAN DESIGN & BENEFITS
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FUND FEATURES	
HealthFund Amount	$500 Employee $1,000 Family
Amount contributed to the Fund by the employer Fund amount reflected is on a per calendar year basis. The fund received may be prorated based on your effective date of coverage.	
Fund Coinsurance	100%
Percentage at which the Fund will reimburse	
Fund Administration	The Fund will be used to pay for your member responsibility, including your deductible and coinsurance. Once the deductible is met, the underlying medical plan provides coverage and if a Fund balance still exists, the Fund will pay your member responsibility (i.e. your share of coinsurance) until the Out of Pocket Maximum has been reached or the Fund has been exhausted, whichever comes first. Services covered at 100% with no deductible will be paid by the plan and not by the Fund.
Employee Termination from Your HealthFund	Any remaining HealthFund benefit amount is forfeited (or terminated) when the employee's healthFund coverage terminates.
Fund Rollover	N/A
Eligible Fund Expenses	Fund covers same expenses as the medical plan. Expenses above the Reasonable & Customary limit, any plan limits, and any non covered expenses are not eligible for reimbursement under the Fund.
Fund Payment/Assignment	Network Providers: Automatic Assignment to provider. Non-Network Providers: Member may assign payment to provider.
Pro-ration for New Employees	Monthly
Pro-ration for Family Status Change	No pro-ration. Change to new tier based on new employee status.
Prescription Drug Plan	Prescription Drug expenses are integrated with the medical plan (i.e., subject to medical Deductible and applied towards medical Out-of-Pocket Limit) and with the Fund (i.e., eligible for reimbursement from the Fund).

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$1,250 Individual $2,500 Family	$2,500 Individual $5,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Deductible amount.		
Member Coinsurance	10%	30%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit.		

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Certain member cost sharing elements may not apply toward the Payment Limit.
Pharmacy expenses apply towards the Payment Limit.
Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit.
The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Payment Limit amount.

Lifetime Maximum		
Unlimited except where otherwise indicated.		
Payment for Non-Preferred	Not Applicable	Professional: 225% of Medicare Facility: 225% of Medicare

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 we will pay 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 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, we will limit the amount it will pay. This limit is called the "recognized" or "allowed" amount. When you choose out-of-network care, we "recognize" an amount based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" 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 plan "recognizes" or "allows." Your doctor may bill you for the dollar amount that we don'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 our website. You can avoid these extra costs by getting your care from our broad network of health care providers. 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 us 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.

Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -		
Certification for certain types of Non-Preferred 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.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	30%; after deductible
1 exam per calendar year up to age 65, 1 exam per calendar year age 65 and older		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	Covered 100%
7 exams in the first 12 months of life, 3 exams in the 13th-24th months of life, 3 exams 25-36 months, 1 exam per calendar year thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	30%; after deductible
2 exams per calendar year. Includes routine tests and related lab fees.		
Routine Mammograms	Covered 100%; deductible waived	30%; after deductible
Women's Health	Covered 100%; deductible waived	30%; after deductible

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Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		
Routine Digital Rectal Exam	Covered 100%; deductible waived	30%; after deductible
Prostate-specific Antigen Test	Covered 100%; deductible waived	30%; after deductible
Colorectal Cancer Screening For all members age 50 and over.	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Covered under Routine Adult Exams
Routine Eye Exams 1 routine exam per 12 months.	Covered 100%; deductible waived	30%; after deductible
Routine Hearing Exams 1 routine exam per 24 months.	Covered 100%; deductible waived	30%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	10%; after deductible	30%; after deductible
Specialist Office Visits	10%; after deductible	30%; after deductible
Pre-Natal Maternity	Covered 100%; deductible waived	30%; after deductible
E-visit to PCP An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through our authorized internet E-visit service vendor.	10%; after deductible	30%; after deductible
E-visit to Specialist An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through our authorized internet E-visit service vendor.	10%; after deductible	30%; after deductible
Walk-in Clinics Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.	10%; after deductible	30%; after deductible
Allergy Testing	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
Allergy Injections	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
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray All covered expenses, accumulate separately toward the preferred or non-preferred Deductible. 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.	10%; after deductible	30%; after deductible
Diagnostic Laboratory 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.	10%; after deductible	30%; after deductible

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Diagnostic Outpatient Complex Imaging	10%; after deductible	30%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	10%; after deductible	30%; after deductible
Emergency Room	10%; after deductible	Same as preferred care.
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%; after deductible	Same as preferred care.
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	10% for Physician Maternity Services; after deductible; 10% per admission for Facility Services; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Hospital Expenses	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Surgery	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	10% per admission; after deductible	30% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Non-Biologically Based	10% per admission; after deductible	30% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Biologically Based	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Non-Biologically Based	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Crisis Intervention Services	10%; after deductible	30%; after deductible
ALCOHOL/DRUG ABUSE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	10% per admission; after deductible	30% per admission; after deductible
Member cost sharing is based on the type of service performed and the place of service where it is rendered		
Residential Treatment Facility	10%; after deductible	30%; after deductible
Outpatient	10% per visit; after deductible	30% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Convalescent Facility	10%; after deductible	30%; after deductible
Limited to 100 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Home Health Care	10%; deductible waived	25%; deductible waived
Limited to 120 visits per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.		
Hospice Care - Inpatient	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		

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Private Duty Nursing - Outpatient	Not Covered	Not Covered
Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.		
Outpatient Short-Term Rehabilitation	10%; after deductible	30%; after deductible
Includes Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year, unlimited for early intervention services from birth to age 3.		
Autism Behavioral Therapy	10%; after deductible	30%; after deductible
Covered same as any other Outpatient Mental Health benefit		
Autism Applied Behavior Analysis	10%; after deductible	30%; after deductible
Covered same as any other Outpatient Mental Health benefit with no visit limits or age restrictions up to 680 hours per a calendar year.		
Autism Physical, Occupational and Speech Therapy	10%; after deductible	30%; after deductible
Covered same as any other Short Term Rehabilitation expense. No age or visit limit restrictions.		
Spinal Manipulation Therapy	10%; after deductible	30%; after deductible
Durable Medical Equipment	10%; after deductible	30%; after deductible
Diabetic Supplies	Covered same as PCP office visit cost sharing	Covered same as any other medical expense.
Fertility Drugs (oral and injectable)	10%; after deductible	30%; after deductible
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Generic FDA-approved Women's Contraceptives	Covered 100%; deductible waived	Not Covered
Transplants	10%; after deductible Preferred coverage is provided at an IOE contracted facility only.	30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan.	
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	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; after deductible
Diagnosis and treatment of the underlying medical condition.		
Comprehensive Infertility Services	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
Coverage includes Artificial Insemination and Ovulation Induction.		
Advanced Reproductive Technology (ART)	10%; after deductible	30%; after deductible

ART coverage includes: In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery.
Limited to 3 courses of treatment per member's lifetime. Maximum applies to all procedures covered by any of our plans except where prohibited by law.

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Vasectomy	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.
Tubal Ligation	Covered 100%; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible.
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Retail	$5 copay for generic drugs, $20 copay for formulary brand-name drugs, and $40 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	20% of submitted cost after the applicable preferred copay
Mail Order	$10 copay for generic drugs, $40 copay for formulary brand-name drugs, and $80 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not Applicable

First prescription fill at any retail drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®.

Plan Includes: Diabetic supplies and medication covered at PCP cost sharing, Contraceptive drugs and devices obtainable from a pharmacy and Performance Enhancing Medication.
Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).
Precert for growth hormones included. Expanded Precert included with 90 day Transition of Care.
Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Waived

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

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

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 our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

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.
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.

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• 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 **1-888-982-3862.**

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **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.**