ATTACHMENT B
RFA #04-14

DRAFT POTENTIAL CY2015 CAPITATION RATES

This appendix provides initial drafts of potential rates for calendar year 2015 program months.

The "average" PMPM amounts included on the last row of each chart are informational only and were calculated using a projected case mix. The actual case mix will vary from the projections and from one PCO to another.

The Department proposes to pay distinct rates to PCOs who are subject to the ACA Health Insurance Providers Fee.

CMS has not approved HPA capitation rates. The Department will provide a final schedule of proposed CY2015 capitation rates prior to negotiation.

Draft Proposed Region 1 CY 2015 Monthly Capitation Rates		
Rating Group	Without HIPF	With HIPF
Women Ages 21 to 34	$403.41	$417.96
Women Ages 35 to 44	$448.72	$464.91
Women Ages 45 to 54	$552.62	$572.55
Women Ages 55 to 64	$638.27	$661.29
Men Ages 21 to 34	$245.56	$254.41
Men Ages 35 to 44	$341.05	$353.35
Men Ages 45 to 54	$497.08	$515.01
Men Ages 55 to 64	$526.11	$545.08
Average - Informational Only	$420.68	$435.85

Draft Proposed Region 2 CY 2015 Monthly Capitation Rates		
Rating Group	Without HIPF	With HIPF
Women Ages 21 to 34	$403.41	$417.96
Women Ages 35 to 44	$448.72	$464.91
Women Ages 45 to 54	$552.62	$572.55
Women Ages 55 to 64	$638.27	$661.29
Men Ages 21 to 34	$245.56	$254.41
Men Ages 35 to 44	$341.05	$353.35
Men Ages 45 to 54	$497.08	$515.01
Men Ages 55 to 64	$526.11	$545.08

Average - Informational Only	$420.68	$435.85

Draft Proposed Region 3 CY 2015 Monthly Capitation Rates		
Rating Group	Without HIPF	With HIPF
Women Ages 21 to 34	$401.37	$415.85
Women Ages 35 to 44	$448.43	$464.60
Women Ages 45 to 54	$555.73	$575.77
Women Ages 55 to 64	$641.03	$664.15
Men Ages 21 to 34	$246.03	$254.90
Men Ages 35 to 44	$341.79	$354.12
Men Ages 45 to 54	$500.76	$518.82
Men Ages 55 to 64	$529.97	$549.08
Average - Informational Only	$421.66	$436.87

Draft Proposed Region 4 CY 2015 Monthly Capitation Rates		
Rating Group	Without HIPF	With HIPF
Women Ages 21 to 34	$449.36	$465.56
Women Ages 35 to 44	$499.74	$517.76
Women Ages 45 to 54	$622.94	$645.41
Women Ages 55 to 64	$717.69	$743.57
Men Ages 21 to 34	$273.77	$283.65
Men Ages 35 to 44	$380.67	$394.40
Men Ages 45 to 54	$562.70	$583.00
Men Ages 55 to 64	$595.60	$617.09
Average - Informational Only	$471.71	$488.72

Draft Proposed Region 5 CY 2015 Monthly Capitation Rates		
Rating Group	Without HIPF	With HIPF
Women Ages 21 to 34	$449.36	$465.56
Women Ages 35 to 44	$499.74	$517.76
Women Ages 45 to 54	$622.94	$645.41
Women Ages 55 to 64	$717.69	$743.57
Men Ages 21 to 34	$273.77	$283.65
Men Ages 35 to 44	$380.67	$394.40
Men Ages 45 to 54	$562.70	$583.00
Men Ages 55 to 64	$595.60	$617.09
Average - Informational Only	$471.71	$488.72

Draft Proposed Region 6 CY 2015 Monthly Capitation Rates		
Rating Group	Without HIPF	With HIPF
Women Ages 21 to 34	$401.37	$415.85
Women Ages 35 to 44	$448.43	$464.60
Women Ages 45 to 54	$555.73	$575.77
Women Ages 55 to 64	$641.03	$664.15
Men Ages 21 to 34	$246.03	$254.90
Men Ages 35 to 44	$341.79	$354.12
Men Ages 45 to 54	$500.76	$518.82
Men Ages 55 to 64	$529.97	$549.08
Average - Informational Only	$421.66	$436.87

Draft Proposed Region 7 CY 2015 Monthly Capitation Rates		
Rating Group	Without HIPF	With HIPF
Women Ages 21 to 34	$461.57	$478.22
Women Ages 35 to 44	$512.82	$531.32
Women Ages 45 to 54	$633.65	$656.51
Women Ages 55 to 64	$731.40	$757.78
Men Ages 21 to 34	$280.20	$290.31
Men Ages 35 to 44	$389.54	$403.59
Men Ages 45 to 54	$570.48	$591.06
Men Ages 55 to 64	$603.83	$625.61
Average - Informational Only	$481.58	$498.95

Draft Proposed Region 8 CY 2015 Monthly Capitation Rates		
Rating Group	Without HIPF	With HIPF
Women Ages 21 to 34	$551.66	$571.56
Women Ages 35 to 44	$608.76	$630.72
Women Ages 45 to 54	$761.20	$788.65
Women Ages 55 to 64	$875.77	$907.36
Men Ages 21 to 34	$331.85	$343.81
Men Ages 35 to 44	$462.42	$479.10
Men Ages 45 to 54	$688.69	$713.53
Men Ages 55 to 64	$728.92	$755.21
Average - Informational Only	$575.91	$596.68

Draft Proposed Region 9 CY 2015 Monthly Capitation Rates		
Rating Group	Without HIPF	With HIPF
Women Ages 21 to 34	$461.57	$478.22
Women Ages 35 to 44	$512.82	$531.32
Women Ages 45 to 54	$633.65	$656.51
Women Ages 55 to 64	$731.40	$757.78
Men Ages 21 to 34	$280.20	$290.31
Men Ages 35 to 44	$389.54	$403.59
Men Ages 45 to 54	$570.48	$591.06
Men Ages 55 to 64	$603.83	$625.61
Average - Informational Only	$481.58	$498.95

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HEALTHY PENNSYLVANIA RATE METHODOLOGY NARRATIVE

April 25, 2014

Introduction

The purpose of this narrative is to provide an overview of the rate-setting methodology that Mercer Government Human Services Consulting (Mercer), a part of Mercer Health & Benefits LLC, used in developing the Healthy Pennsylvania (Healthy PA) managed care capitation rates for the Commonwealth of Pennsylvania (Commonwealth), for the period of January 1, 2015 to December 31, 2015 (CY 2015). Mercer produced this narrative with input from the Commonwealth of Pennsylvania's Department of Public Welfare (Department). Mercer understands that the final Healthy PA program design and capitation rates may be contingent upon CMS review and approval and could result in changes to this methodology.

The Healthy PA program rating regions are composed of nine Federally-Facilitated Marketplace (FFM) zones, displayed and defined in the following table. Appendix A includes a county map showing the Commonwealth's FFM zones.

RATING REGIONS/COUNTIES CHART

PA-Specific FFM Zones	Counties Included
Zone 1	Clarion, Crawford, Erie, Forest, McKean, Mercer, Venango, and Warren
Zone 2	Cameron, Elk, and Potter
Zone 3	Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne, and Wyoming
Zone 4	Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Lawrence, Washington, and Westmoreland
Zone 5	Bedford, Blair, Cambria, Clearfield, Huntingdon, Jefferson, and Somerset
Zone 6	Centre, Columbia, Lehigh, Mifflin, Montour, Northampton, Northumberland, Schuylkill, Snyder, and Union
Zone 7	Adams, Berks, Lancaster, and York
Zone 8	Bucks, Chester, Delaware, Montgomery, and Philadelphia
Zone 9	Cumberland, Dauphin, Franklin, Fulton, Juniata, Lebanon, and Perry

In addition to separate rating regions, the Healthy PA program considers the different risk characteristics of the enrolled population by establishing eight rating groups. The following table illustrates the eight rating groups:

RATING GROUPS CHART

Rating Group	Rate Cells
1	Women Ages 21 to 34
2	Women Ages 35 to 44
3	Women Ages 45 to 54
4	Women Ages 55 to 64
5	Men Ages 21 to 34
6	Men Ages 35 to 44
7	Men Ages 45 to 54
8	Men Ages 55 to 64

The population eligible for the Healthy PA program will consist of “newly eligible” individuals, ages 21 through 64, with incomes up to 133% of the Federal Poverty Level who do not qualify as medically frail according to criteria established by the Department at the time of Healthy PA enrollment. If an individual meets the criteria for medically frail after enrollment into the Healthy PA program, the member will continue to be enrolled in the Healthy PA program until the next annual eligibility redetermination is completed. Appendix B contains the criteria from the February 2014 Healthy Pennsylvania 1115 Demonstration application that qualify an individual to be deemed medically frail.

The Department has determined that for each calendar year the Healthy PA benefit package will include coverage of Essential Health Benefits and will benchmark to a Marketplace Silver Benefit Package. For CY 2015, this benchmark is the Aetna PA POS CS 3.7 CY (1500 Ded, 10/25/50 RX) 51+ Plan Effective 8/12 V2 benefit package (Aetna Silver Package). A benefits summary for the Aetna Silver Package is provided in Appendix C.

Rate Methodology

Base Data

Since no historical experience exists for the new population eligible for the Healthy PA program, an alternative rate base was established. The starting base Mercer utilized in developing the Healthy PA capitation rates consisted of the certified HealthChoices (HC) Physical Health heritage and expansion Medicaid managed care capitation rate ranges effective July 1, 2014 to December 31, 2014 (2H 2014). The categories of aid (COA) used included the TANF-HB-MAGI 19+, SSI-HH-Other Disabled HC rates and Maternity. Mercer removed ACA 1202 PCP add-on and administration/profit/risk/contingency loads from the capitated rates to get to the projected total medical claims for the 2H 2014 period.

Newly-eligible individuals who will enroll in the Healthy PA program are assumed to be less healthy and, therefore, more expensive than the TANF-HB-MAGI 19+ population. Also, additional costs must be considered for those who qualify as medically frail after initial enrollment into the Healthy PA program and remain enrolled until the next annual eligibility redetermination is

completed. Mercer utilized a blend of the TANF-HB-MAGI 19+ and the SSI-HH-Other Disabled HC to account for the differences in expected claims costs between the Healthy PA program and the TANF-HB-MAGI 19+ population.

Geographic and Demographic Adjustments

Due to the differences in geographic and demographic makeup between the Healthy PA and HC programs, adjustments to the base HC rates were required. Utilizing Pennsylvania-specific data, geographic relativities were developed and applied to the HC rates that were developed for the five HC zones to align counties into respective FFM zones. Additionally, since only individuals ages 21 through 64 are eligible to enroll in the Healthy PA program, age relativities were developed to remove the cost associated with individuals that fall outside of the eligible age range.

Benefit Adjustments

Since the benefits and coverage limits do not line up exactly between the Healthy PA program and the HC program, additional benefit and coverage limit adjustments were required. Several adjustments were made to the HC program rates to align benefits and coverage limits with those in the Aetna Silver Package (e.g., removal of dental benefits and addition of behavioral health benefits).

Maternity and Well-Baby Costs

The Healthy PA program will not have a separate maternity payment in CY 2015. Pregnant women may choose to stay in the Healthy PA program or move to HC and an adjustment was made to the base HC rates to account for maternity costs for the Women 21–34 and Women 35–44 rating groups by zone. In addition to maternity costs, well-baby costs during the maternity inpatient stay were included in the adjustment made for maternity costs. The well-baby cost adjustment was made as part of the Department's purchasing strategy to align with commercial provider pricing structures. The Private Coverage Organizations (PCOs) will not be responsible for newborn costs other than the well-baby costs. To develop this adjustment, historical HC maternity and newborn costs were analyzed by rate cell and FFM zone.

Pent-Up Demand

Individuals eligible for the Healthy PA program presumably have little or no recent access to health care and it is assumed that demand for health care has been suppressed. It is expected that in the initial time following the enrollment of Healthy PA members, services will be used at a higher rate than in the eventual steady-state, otherwise known as pent-up demand. A utilization adjustment has been applied to claims costs to account for this pent-up demand for CY 2015. The pent-up demand factor will ultimately be reduced to zero as the Healthy PA program matures.

Managed Care Adjustments

The base HC rates of the Healthy PA program are based on TANF-HB-MAGI 19+ and the SSI-HH-Other Disabled HC rates. The HC rates are based on experience that reflects a mature and efficient managed care environment. Mercer understands that it takes some time to integrate and

achieve an efficient and effective delivery of services. Adjustments were made to reflect the likely reduced managed care effectiveness of the PCOs during the first year of the Healthy PA program.

Provider Pricing

A key consideration for the Healthy PA program is to ensure that members will have access to quality health care, through both expanded provider networks and increased capacity within current provider networks. The goal of the Department's purchasing strategy is to ensure that PCO provider networks are sufficiently robust to serve the additional Healthy PA membership. In order to both expand provider networks and also increase capacity within the current provider networks, the Department's purchasing strategy is to have PCOs reimburse providers at levels between Medicaid and commercial provider reimbursement levels. Adjustments, by category of service, were applied to the adjusted base HC rates to reflect this change in provider reimbursement levels.

Trend

Trend is an estimate of the change in the overall cost of medical services over a finite period of time. A trend factor is necessary to estimate the expenses of providing health care services in a future period. Being the original base data reflected July to December 2014 HC experience, only nine additional months of trend were required to project the adjusted base experience to the midpoint of the rating period. As part of the CY 2015 rate development for the Healthy PA program, Mercer utilized HC trend rates, along with consideration of other data sources, as needed, to ensure a comprehensive review and development of reasonable trends for CY 2015. These sources included:

- Bureau of Labor Statistics (CPI and PPI).
- Mercer's Survey of Health Care Trends.
- Data from other state Medicaid agencies.
- Medicare trends (applicable to the All SSI & HH rating group).

Administration/Profit/Risk/Contingency Load

In addition to claims costs, non-medical expenses were included in the Healthy PA rates. The non-medical expense costs include, but are not limited to, fixed and variable administrative expenses, and underwriting gain, risk, and contingency. Mercer developed an administration/profit/risk/contingency load for the Healthy PA program based on HC administration/profit/risk/contingency levels, review of published reports containing commercial administration levels, and information from other states.

Health Insurance Provider Fee (HIPF)

For those PCOs with a liability for payment associated with the ACA Section 9010 HIPF, Mercer has recognized the costs associated with this fee as "reasonable, appropriate and attainable costs" to be considered in actuarially sound payments to the plans. The Department seeks to make payments to each PCO that are appropriate for the specific level of this tax expense. To accommodate both situations (PCOs responsible for the tax or PCOs exempt from the tax), two

sets of capitation rates were developed: one set applicable to PCOs not subject to the HIPF and one set applicable to PCOs that are subject to the HIPF. The only difference between the two sets of capitation rates will be an allowance for the HIPF, which will be withheld by the Department until payment is due by the PCOs, when applicable.

Summary

The rate-setting methodology described above results in capitation rates for each of the rating groups within each of the nine FFM zones. The Commonwealth recommends that each PCO independently analyze its own projected medical and administrative expenses, and other premium needs, for comparison to the Commonwealth's rate offers in the aggregate.

In preparing the CY 2015 Healthy PA rates discussed above, Mercer has used and relied upon enrollment, claim, reimbursement level, benefit design, and financial data and information supplied by the Department, its consultants, and its vendors. The Department, its consultants, and its vendors are responsible for the validity and completeness of this supplied data and information. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it. In our opinion, it is appropriate for the intended purposes.

The CY 2015 Healthy PA rates were developed in accordance with generally accepted actuarial practices and principles. These have been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board. Use of the rates for any purpose beyond that stated may not be appropriate.

Healthy Pennsylvania Program
January 2015 - December 2015 Rate Summary

CY 2015 Capitation Rates without HIPF

Rate Cells	FFM Zone 1	FFM Zone 2	FFM Zone 3	FFM Zone 4	FFM Zone 5	FFM Zone 6	FFM Zone 7	FFM Zone 8	FFM Zone 9
Women Ages 21 to 34	$ 403.41	$ 403.41	$ 401.37	$ 449.36	$ 449.36	$ 401.37	$ 461.57	$ 551.66	$ 461.57
Women Ages 35 to 44	$ 448.72	$ 448.72	$ 448.43	$ 499.74	$ 499.74	$ 448.43	$ 512.82	$ 608.76	$ 512.82
Women Ages 45 to 54	$ 552.62	$ 552.62	$ 555.73	$ 622.94	$ 622.94	$ 555.73	$ 633.65	$ 761.20	$ 633.65
Women Ages 55 to 64	$ 638.27	$ 638.27	$ 641.03	$ 717.69	$ 717.69	$ 641.03	$ 731.40	$ 875.77	$ 731.40
Men Ages 21 to 34	$ 245.56	$ 245.56	$ 246.03	$ 273.77	$ 273.77	$ 246.03	$ 280.20	$ 331.85	$ 280.20
Men Ages 35 to 44	$ 341.05	$ 341.05	$ 341.79	$ 380.67	$ 380.67	$ 341.79	$ 389.54	$ 462.42	$ 389.54
Men Ages 45 to 54	$ 497.08	$ 497.08	$ 500.76	$ 562.70	$ 562.70	$ 500.76	$ 570.48	$ 688.69	$ 570.48
Men Ages 55 to 64	$ 526.11	$ 526.11	$ 529.97	$ 595.60	$ 595.60	$ 529.97	$ 603.83	$ 728.92	$ 603.83
FFM Zone Total	$ 420.68	$ 420.68	$ 421.66	$ 471.71	$ 471.71	$ 421.66	$ 481.58	$ 575.91	$ 481.58

Healthy Pennsylvania Program
January 2015 - December 2015 Rate Summary

CY 2015 Capitation Rates with HIPF

Rate Cells	FFM Zone 1	FFM Zone 2	FFM Zone 3	FFM Zone 4	FFM Zone 5	FFM Zone 6	FFM Zone 7	FFM Zone 8	FFM Zone 9
Women Ages 21 to 34	$ 417.96	$ 417.96	$ 415.85	$ 465.56	$ 465.56	$ 415.85	$ 478.22	$ 571.56	$ 478.22
Women Ages 35 to 44	$ 464.91	$ 464.91	$ 464.60	$ 517.76	$ 517.76	$ 464.60	$ 531.32	$ 630.72	$ 531.32
Women Ages 45 to 54	$ 572.55	$ 572.55	$ 575.77	$ 645.41	$ 645.41	$ 575.77	$ 656.51	$ 788.65	$ 656.51
Women Ages 55 to 64	$ 661.29	$ 661.29	$ 664.15	$ 743.57	$ 743.57	$ 664.15	$ 757.78	$ 907.36	$ 757.78
Men Ages 21 to 34	$ 254.41	$ 254.41	$ 254.90	$ 283.65	$ 283.65	$ 254.90	$ 290.31	$ 343.81	$ 290.31
Men Ages 35 to 44	$ 353.35	$ 353.35	$ 354.12	$ 394.40	$ 394.40	$ 354.12	$ 403.59	$ 479.10	$ 403.59
Men Ages 45 to 54	$ 515.01	$ 515.01	$ 518.82	$ 583.00	$ 583.00	$ 518.82	$ 591.06	$ 713.53	$ 591.06
Men Ages 55 to 64	$ 545.08	$ 545.08	$ 549.08	$ 617.09	$ 617.09	$ 549.08	$ 625.61	$ 755.21	$ 625.61
FFM Zone Total	$ 435.85	$ 435.85	$ 436.87	$ 488.72	$ 488.72	$ 436.87	$ 498.95	$ 596.68	$ 498.95

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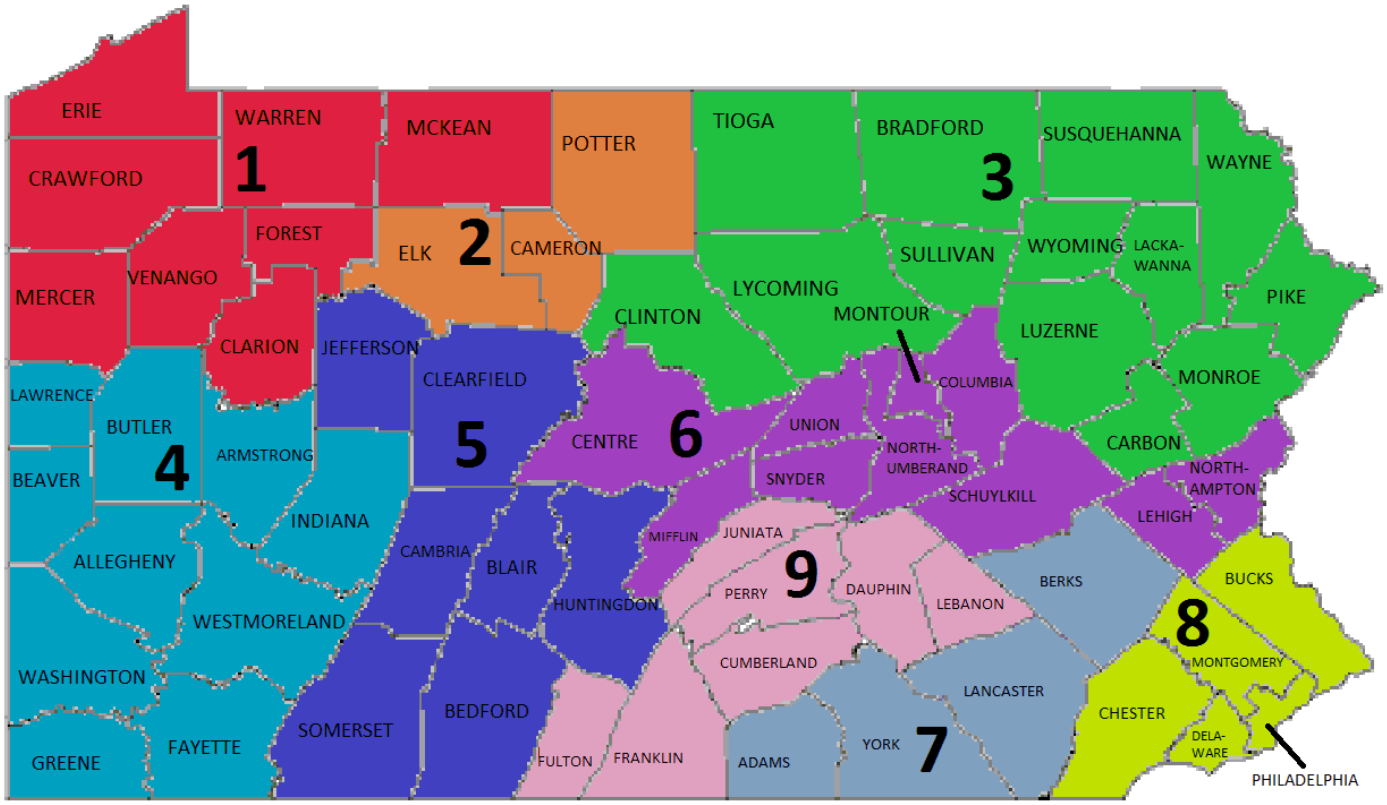
APPENDIX A



ERIE, CRAWFORD, MERCER, VENANGO, WARREN, FOREST, CLARION, MCKEAN

JEFFERSON, CLEARFIELD, CAMBRIA, SOMERSET, BEDFORD, BLAIR, HUNTINGDON

POTTER, CAMERON, ELK

CENTRE, MIFFLIN, UNION, SNYDER, MONTOUR, NORTHUMBERLAND, COLUMBIA, SCHUYLKILL, LEHIGH, NORTHAMPTON

TIOGA, CLINTON, LYCOMING, SULLIVAN, BRADFORD, SUSQUEHANNA, WYOMING, LACKAWANNA, WAYNE, PIKE, MONROE, CARBON, LUZERNE

ADAMS, YORK, LANCASTER, BERKS

CHESTER, DELAWARE, MONTOGOMERY, BUCKS, PHILADELPHIA

LAWRENCE, BEAVER, WASHINGTON, GREENE, BUTLER, ALLEGHENY, WESTMORELAND, ARMSTRONG, INDIANA, FAYETTE

FULTON, FRANKLIN, CUMBERLAND, PERRY, JUNIATA, DAUPHIN, LEBANON

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APPENDIX B

APPENDIX 3: CRITERIA FOR MEDICALLY FRAIL

DEFINITION of Medically Frail: includes individuals with disabling mental disorders (including adults with serious mental illness), individuals with chronic substance use disorders, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their functioning, or individuals with a disability determination based on Social Security criteria.

Pennsylvania has outlined the criteria for who is medically frail or otherwise has special medical needs, as set forth below:

Category	Definition
Individuals with a Disabling Mental Disorder	The individual has a diagnosis of at least one of the following: • psychotic disorder; • schizophrenia; • schizoaffective disorder; • major depression; • bipolar disorder; • delusional disorder • anxiety disorder (obsessive compulsive disorder, post-traumatic stress disorder, or severe panic disorder)
Individuals with chronic substance use disorder	The individual has a chronic substance use disorder: • The individual has a diagnosis of substance use disorder.

Category	Definition
Individuals with serious and complex medical conditions	The individual meets one of the following conditions: • Receiving chemotherapy or radiation therapy for cancer OR • Enrolled in hospice OR • A resident of LTC facility or public/private ICF OR • Has any of the following medical conditions- hemophilia, Gaucher's disease, immune deficiency, HIV/AIDS, sickle cell, cystic fibrosis or post-transplant of lung, heart, liver, pancreas, or small bowel OR • Is ventilator dependent OR • Receives Dialysis treatments OR • Has 2 or more inpatient admissions within 12 months AND o has 3 or more ER visits in 6 months AND o has 4 or more prescription medications per month.
Individuals with a physical disability	The individual has a permanent physical disability that significantly impairs his/her functioning.
Individuals with an intellectual or developmental disability	The individual has an intellectual or developmental disability and therefore exhibits: Intellectual Disability: • Significantly subnormal general intellectual functioning based on standardized testing (IQ). • Significantly subnormal adaptive functioning based on standardized testing. • Occurred in the developmental period before the 22nd birthday. Developmental Disability: • Autism spectrum disorder: The individual is diagnosed with autism and meets the ICF/ORC level of care which is an institutional level of care. The ICF level of care requires functional deficits in addition to the diagnosis.
Individuals with a disability determination	Any individual with a current disability designation by the Social Security Administration

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APPENDIX C

aetna℠

PA 2-100 QPOS
FOR EMPLOYER GROUPS SUBJECT TO FEDERAL MENTAL HEALTH PARITY

PLAN DESIGN AND BENEFITS - PA POS CS 3.7 CY (1500 Ded, 10/25/50 RX) 51+

PLAN FEATURES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Deductible (per calendar year)	$1,500 Individual $3,000 Family	$5,000 Individual $10,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. All covered expenses accumulate separately toward the participating and non-participating Deductible. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. No one family member may contribute more than the Individual Deductible amount to the Family Deductible. Deductible credit applies. Deductible carryover does not apply.		
Member Coinsurance	Not Applicable	50%
Out-of-Pocket Maximum (per calendar year, includes deductible)	$3,000 Individual $6,000 Family	$10,000 Individual $20,000 Family
Amounts over the Recognized Charge, failure to pre-certification penalties and member cost-sharing for prescription drug benefits do not apply toward the Out-of-Pocket Maximum. All covered expenses accumulate separately toward the participating and non-participating Out-of-Pocket Maximum. 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. No one family member may contribute more than the Individual Out-of-Pocket Maximum amount to the Family Out-of-Pocket Maximum.		
Lifetime Maximum	Unlimited	Unlimited
Payment for services from a Non-Participating Provider	Not Applicable	Professional: 105% of Medicare* Facility: 140% of Medicare*
Primary Care Physician Selection	Required	Not Applicable
Precertification Requirement - Certain non-participating provider services require precertification or benefits will be reduced. Refer to your plan documents for a complete list of services that require precertification.		
Referral Requirement	Required for all non-emergency, non-urgent and non-Primary Care Physician services, except direct access services.	Not Applicable
PHYSICIAN SERVICES	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Primary Care Physician Visits	Office Hours: $30 Copay, deductible waived After Office Hours/Home: $35 Copay, deductible waived	50% after deductible
Specialist Office Visits	$50 Copay, deductible waived	50% after deductible
Pre-Natal Maternity	$0 Copay, deductible waived	50% after deductible
Maternity - Delivery and Post-Partum Care	$50 Copay, deductible waived	50% after deductible
Allergy Treatment	Same as applicable participating provider office visit member cost sharing.	50% after deductible
Allergy Testing	$50 Copay, deductible waived	50% after deductible
PREVENTIVE CARE	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Routine Adult Physical Exams/ Immunizations (Limited to one exam every 12 months. Participating and Non-Participating combined.)	$0 Copay, deductible waived	50%, deductible waived

PLAN DESIGN AND BENEFITS - PA POS CS 3.7 CY (1500 Ded, 10/25/50 RX) 51+

PREVENTIVE CARE (CONTINUED)	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Well Child Exams/Immunizations (Limited to 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 12 months thereafter. Participating and Non-Participating combined.)	$0 Copay, deductible waived	50%, deductible waived
Routine Gynecological Exams (Limited to one routine exam and pap smear per 365 days. Participating and Non-Participating combined.)	$0 Copay, deductible waived	50%, deductible waived
Routine Mammograms (Recommended: One annual mammogram for covered females age 40 and over. Participating and Non-Participating combined.)	$0 Copay, deductible waived	50% after deductible
Women's Health (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; and contraceptive methods and counseling. Limitations may apply.)	$0 Copay, deductible waived	Member cost sharing is based on the type of service performed and the place rendered.
Routine Digital Rectal Exams/Prostate Specific Antigen Test (Recommended for covered males age 40 and over. Age and frequency schedules may apply. Participating and Non-Participating combined.)	$0 Copay, deductible waived	Member cost sharing is based on the type of service performed and the place rendered.
Colorectal Cancer Screening (For all members age 50 and over. Frequency schedule applies. Participating and Non-Participating combined.)	$0 Copay, deductible waived	Member cost sharing is based on the type of service performed and the place rendered.
Routine Eye Exams at Specialist (Limited to one routine exam per 24 months. Participating and Non-Participating combined.)	$0 Copay, deductible waived	50% after deductible
Routine Hearing Screening at PCP Covered only as part of a physical exam.	Subject to Routine Physical Exam cost sharing.	Subject to Routine Physical Exam cost sharing.

PLAN DESIGN AND BENEFITS - PA POS CS 3.7 CY (1500 Ded, 10/25/50 RX) 51+

DIAGNOSTIC PROCEDURES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Diagnostic Laboratory (If performed as a part of a physician's office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit cost sharing.)	$0 Copay, deductible waived	50% after deductible
Diagnostic X-ray (except for Complex Imaging Services) - Outpatient Hospital or Other Outpatient Facility	$50 Copay, deductible waived	50% after deductible
Diagnostic X-ray for Complex Imaging Services (Includes MRA/MRS, MRI, PET and CAT Scans)	$200 Copay, deductible waived	50% after deductible
EMERGENCY MEDICAL CARE	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Urgent Care Provider	$50 Copay, deductible waived	50% after deductible
Non-Urgent use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room (Copay waived if admitted.)	$200 Copay, deductible waived	Refer to participating provider benefit.
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Emergency Ambulance	$0 Copay, deductible waived	Refer to participating provider benefit.
Non-Emergency Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Inpatient Coverage (Including maternity and transplants) (Transplants: Coverage, provided at an IOE contracted facility, is subject to Participating cost-sharing. Coverage provided at a non-IOE contracted facility, is subject to Non-Participating cost-sharing.)	$0 Copay per admission after deductible	50% after deductible
Outpatient Surgery (Provided in an outpatient hospital department or a freestanding surgical facility.)	$0 Copay after deductible	50% after deductible
MENTAL HEALTH SERVICES	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Inpatient Serious Mental Illness	$0 Copay per admission after deductible	50% after deductible
Outpatient Serious Mental Illness	$50 Copay, deductible waived	50% after deductible
Inpatient Non-Serious Mental Illness	$0 Copay per admission after deductible	50% after deductible
Outpatient Non-Serious Mental Illness	$50 Copay, deductible waived	50% after deductible
ALCOHOL/DRUG ABUSE SERVICES	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Inpatient Detoxification	$0 Copay per admission after deductible	50% after deductible
Outpatient Detoxification	$50 Copay, deductible waived	50% after deductible
Inpatient Rehabilitation	$0 Copay per admission after deductible	50% after deductible
Outpatient Rehabilitation	$50 Copay, deductible waived	50% after deductible
Residential Treatment Facility	$0 Copay per admission after deductible	50% after deductible

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OTHER SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Skilled Nursing Facility (Limited to 120 days per member per calendar year. Participating and Non-Participating combined.)	$0 Copay per admission after deductible	50% after deductible
Home Health Care (Limited to 60 visits per member per calendar year, no more than 3 intermittent visits per day by a Home Health Care agency, 1 visit equals a period of 4 hours or less. Participating and Non-Participating combined.)	$50 Copay, deductible waived	50% after deductible
Infusion Therapy (Provided in the home or physician's office)	$50 Copay, deductible waived	50% after deductible
Infusion Therapy (Provided in an outpatient hospital department or freestanding facility.)	$0 Copay after deductible	50% after deductible
Hospice Care - Inpatient	$0 Copay per admission after deductible	50% after deductible
Hospice Care - Outpatient	$0 Copay, deductible waived	50% after deductible
Outpatient Physical and Occupational Therapy (Physical and Occupational Therapy limited to 30 visits [combined] per member per calendar year. Participating and Non-Participating combined.)	$50 Copay, deductible waived	50% after deductible
Outpatient Speech Therapy (Limited to 30 visits per member per calendar year. Participating and Non-Participating combined.)	$50 Copay, deductible waived	50% after deductible
Subluxation (Chiropractic) (Limited to 20 visits per member per calendar year. Participating and Non-Participating combined.)	$10 Copay, deductible waived	25% after deductible

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OTHER SERVICES (CONTINUED)	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Treatment of Autism (**Plans issued or renewed prior to 1/1/13:** Covered the same as any other expense. Limited to $36,000 annually for eligible individuals under 21 years of age. Includes coverage for habilitative care and Applied Behavioral Analysis. Once the limit has been met, Applied Behavioral Analysis will be covered under Mental Health services. **Plans issued or renewed on and after 1/1/13:** Covered the same as any other expense. Limited to $37,080 annually for eligible individuals under 21 years of age. Includes coverage for habilitative care and Applied Behavioral Analysis. Once the limit has been met, Applied Behavioral Analysis will be covered under Mental Health services.)	Member cost sharing is based on the type of service performed and the place rendered.	Member cost sharing is based on the type of service performed and the place rendered.
Vision Corrective Lenses/ Contact Lenses Allowance	$100 reimbursement payable once for 24-month period	Refer to participating provider benefit.
Durable Medical Equipment (Maximum benefit of $2,500 per member per calendar year. Participating and Non-Participating combined.)	50%, deductible waived	50% after deductible (Must pre-certify if over $1,500.)
FAMILY PLANNING	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Infertility Treatment (Coverage for only the diagnosis and surgical treatment of the underlying medical cause.)	Member cost sharing is based on the type of service performed and the place rendered.	50% after deductible
Comprehensive Infertility Services	Not Covered	Not Covered
Advanced Reproductive Technology (ART) (Includes In-Vitro Fertilization (IVF), Zygote Intra-Fallopian Transfer (ZIFT), Gamete Intra-Fallopian Transfer (GIFT), cryopreserved embryo transfers, Intra-Cytoplasmic Sperm Injection (ICSI) or ovum microsurgery.)	Not Covered	Not Covered
Vasectomy	Member cost sharing is based on the type of service performed and the place rendered.	Member cost sharing is based on the type of service performed and the place rendered.
Tubal Ligation	$0 Copay, deductible waived	50% after deductible

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PHARMACY- PRESCRIPTION DRUG BENEFITS	PARTICIPATING PHARMACIES	NON-PARTICIPATING PHARMACIES
Prescription Drug Deductible	Not Applicable	Not Applicable
Prescription Drugs Up to a 30-day supply	$10 Copay for generic formulary drugs, $25 Copay for brand-name formulary drugs, and $50 Copay for generic and brand-name non-formulary drugs	Not Covered
Prescription Drugs (Retail or Mail Order) 31-90 day supply	$20 Copay for generic formulary drugs, $50 Copay for brand-name formulary drugs, and $100 Copay for generic and brand-name non-formulary drugs	Not Covered
Specialty Care Drugs (Self-injectable, infused and oral specialty drugs)	$250 copay for formulary and non-formulary drugs	Not Covered
Aetna Specialty CareRx℠ - First Prescription for a specialty drug must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy®. Subsequent fills must be through Aetna Specialty Pharmacy®.		
No Mandatory Generic (No MG) - Member is responsible to pay the applicable copay or coinsurance.		
Plan includes diabetic supplies, oral fertility drugs, contraceptive drugs and devices obtainable from a pharmacy.		
Formulary generic FDA-approved Women's Contraceptives covered 100% in network.		
Precertification and step-therapy included. **90 day Transition of Care (TOC) for Precertification and Step Therapy included.**		

* We cover the cost of services based on whether doctors 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.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. 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. When you choose out-of-network care, Aetna "recognizes" an amount based on what Medicare pays for these services. The government sets the Medicare rate.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna plan "recognizes." 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 out-of-pocket maximums. 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 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.

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This applies when you *choose* to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing 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 cost sharing and deductibles.

What's Not Covered

This plan does not cover all health care expenses and includes exclusions and limitations. Refer to your 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, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased.

(1) All medical or hospital services not specifically covered in, or which are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates.
(2) Cosmetic surgery, including breast reduction.
(3) Custodial care.
(4) Dental care and x-rays.
(5) Donor egg retrieval.
(6) Experimental and investigational procedures (except for coverage for medically necessary routine patient care costs for Members participating in a cancer clinical trial).
(7) Hearing aids.
(8) Home births.
(9) Immunizations for travel or work.
(10) Implantable drugs and certain injectable drugs, including injectable infertility drugs.
(11) 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.
(12) Non-medically necessary services or supplies.
(13) Orthotics, except diabetic orthotics.
(14) Over-the-counter medications (except as provided in a hospital) and supplies.
(15) Radial keratotomy or related procedures.
(16) Reversal of sterilization.
(17) Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs.
(18) Special duty nursing.
(19) Therapy or rehabilitation other than those listed as covered in the plan documents.
(20) 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.

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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.

Groups of 2 - 50 Eligible Employees: All others, for HMO and QPOS products call: 1-888-70-AETNA (1-888-702-3862). For Health Network Option products call: 1-866-529-2517. For Traditional/PPO products call: 1-888-80-AETNA (1-888-802-3862).

Groups of 51 - 100 Eligible Employees: All others, for HMO and QPOS products call: 1-877-402-8742. For Health Network Option products call: 1-877-350-2217. For Traditional/PPO products call: 1-800-535-0880.

This material is for informational purposes 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 and health insurance plans contain exclusions and limitations. Not all health services are covered. 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. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and group size. Plan features are subject to change.

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. 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. In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

If your plan covers outpatient prescription drugs, your plan may include a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally not limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs, such as, pre-certification and step-therapy, please refer to Aetna's website at Aetna.com, or the Aetna Medication Formulary Guide. 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. In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member.
Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage.

Aetna Rx Home Delivery® refers to Aetna Rx Home Delivery, LLC. Aetna Specialty Pharmacy refers to Aetna Specialty Pharmacy, LLC. Both are subsidiaries of Aetna Inc. and are licensed pharmacies that operate through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery and Aetna Specialty Pharmacy may be higher than the cost those pharmacies pay for the drugs and the costs of their specialty pharmacy services. For these purposes, Aetna Specialty Pharmacy's and Aetna Rx Home Delivery's cost of purchasing drugs takes into account discounts, credits and other amounts that those pharmacies may receive from wholesalers, manufacturers, suppliers and distributors.

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group subsidiary companies. For more information about Aetna plans, refer to www.aetna.com. While this material is believed to be accurate as of the print date, it is subject to change.