

ME Individual Portfolio | Summary of Benefits

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Aetna Health Inc.
73250
HIOS Plan ID : 73250ME0040001-00
Section D

Maine

Aetna Whole Health Gold \$5 Copay PD
 Gold

Summary of Features	In Network	Non-Designated
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Deductible		
Individual	\$1,500	\$3,750
Family	\$3,000	\$7,500
Coinsurance <i>(Member Responsibility)</i>	20%	40%
	<i>\$0 once out-of-pocket max. is satisfied</i>	
Out-of-Pocket Maximum		
Individual	\$4,500	\$6,000
Family	\$9,000	\$12,000
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>	
Primary Care Visit to Treat an Injury or Illness <i>(excludes Preventative and X-rays)</i>	\$5 per visit	\$30 per visit
Specialist Visit	\$40 per visit	\$75 per visit after deductible
All Inpatient Hospital Services <i>(includes Mental/Behavioral Health and Substance Abuse)</i>	20% after deductible	40% after deductible
Emergency Room Services	\$250 per visit after deductible	Paid as designated
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	\$40 per visit	\$75 per visit after deductible
Imaging (CT/PET Scans, MRIs)	20% after deductible	\$100+40% after deductible
Rehabilitative Speech Therapy	20% after deductible	Paid as designated
Rehabilitative Occupational and Rehabilitative Physical Therapy	20% after deductible	Paid as designated
Preventive Care/Screening/Immunization	0%	0%
Laboratory Outpatient and Professional Services	20% after deductible	Paid as designated
X-rays and Diagnostic Imaging	20% after deductible	40% after deductible
Skilled Nursing Facility	20% after deductible	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	20% after deductible	40% after deductible
Outpatient Surgery Physician/Surgical Services	20% after deductible	40% after deductible

Pharmacy	In-Network
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Pharmacy Deductible	
Individual	Integrated with Medical
Generics	\$3 / \$10
Preferred Brand Drugs	\$30
Non-Preferred Brand Drugs	\$50
Specialty Drugs (i.e. high-cost) Preferred/Non-Preferred	40% / 50%

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Aetna Whole Health Silver \$10 Copay PD
 Silver

Summary of Features	In Network	Non-Designated
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Deductible		
Individual	\$4,000	\$5,750
Family	\$8,000	\$11,500
Coinsurance <i>(Member Responsibility)</i>	20%	40%
	<i>\$0 once out-of-pocket max. is satisfied</i>	
Out-of-Pocket Maximum		
Individual	\$6,000	\$6,850
Family	\$12,000	\$13,700
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>	
Primary Care Visit to Treat an Injury or Illness <i>(excludes Preventative and X-rays)</i>	\$10 per visit	\$50 per visit after deductible
Specialist Visit	\$60 per visit	\$75 per visit after deductible
All Inpatient Hospital Services <i>(includes Mental/Behavioral Health and Substance Abuse)</i>	20% after deductible	40% after deductible
Emergency Room Services	\$250 per visit after deductible	Paid as designated
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	\$60 per visit	\$75 per visit after deductible
Imaging (CT/PET Scans, MRIs)	\$100+20% after deductible	\$500+40% after deductible
Rehabilitative Speech Therapy	20% after deductible	Paid as designated
Rehabilitative Occupational and Rehabilitative Physical Therapy	20% after deductible	Paid as designated
Preventive Care/Screening/Immunization	0%	0%
Laboratory Outpatient and Professional Services	20% after deductible	Paid as designated
X-rays and Diagnostic Imaging	20% after deductible	40% after deductible
Skilled Nursing Facility	20% after deductible	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$100+20% after deductible	\$500+40% after deductible
Outpatient Surgery Physician/Surgical Services	20% after deductible	40% after deductible

Pharmacy	In-Network
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Pharmacy Deductible	
Individual	\$500
Generics	\$3 / \$10
Preferred Brand Drugs	\$40 after deductible
Non-Preferred Brand Drugs	\$50 after deductible
Specialty Drugs (i.e. high-cost) Preferred/Non-Preferred	40% after deductible / 50% after deductible

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Maine

Aetna Whole Health Bronze \$40 Copay PD
 Bronze

Summary of Features	In Network	Non-Designated
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Deductible		
Individual	\$6,400	\$7,100
Family	\$12,800	\$14,200
Coinsurance <i>(Member Responsibility)</i>	0%	40%
	<i>\$0 once out-of-pocket max. is satisfied</i>	
Out-of-Pocket Maximum		
Individual	\$7,150	\$7,150
Family	\$14,300	\$14,300
	<i>All cost sharing accumulates to the Out of Pocket Maximum above</i>	
Primary Care Visit to Treat an Injury or Illness <i>(excludes Preventative and X-rays)</i>	\$40 per visit	40% after deductible
Specialist Visit	0% after deductible	40% after deductible
All Inpatient Hospital Services <i>(includes Mental/Behavioral Health and Substance Abuse)</i>	0% after deductible	40% after deductible
Emergency Room Services	0% after deductible	Paid as designated
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	0% after deductible	40% after deductible
Imaging (CT/PET Scans, MRIs)	0% after deductible	40% after deductible
Rehabilitative Speech Therapy	0% after deductible	Paid as designated
Rehabilitative Occupational and Rehabilitative Physical Therapy	0% after deductible	Paid as designated
Preventive Care/Screening/Immunization	0%	0%
Laboratory Outpatient and Professional Services	0% after deductible	Paid as designated
X-rays and Diagnostic Imaging	0% after deductible	40% after deductible
Skilled Nursing Facility	0% after deductible	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	0% after deductible	40% after deductible
Outpatient Surgery Physician/Surgical Services	0% after deductible	40% after deductible

Pharmacy	In-Network
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Pharmacy Deductible	
Individual	Integrated with Medical
Generics	\$20 after deductible
Preferred Brand Drugs	\$75 after deductible
Non-Preferred Brand Drugs	50% after deductible
Specialty Drugs (i.e. high-cost) Preferred/Non-Preferred	50% after deductible / 50% after deductible