

PENNSYLVANIA EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Point of Service
Issuer Name	Aetna Health Inc. (a PA corp.)
Product Name	Aetna Health Maintenance Organization
Plan Name	PA POS Cost Sharing 34 1500 Ded
Supplemented Categories (Supplementary Plan Type)	Pediatric Oral (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	No
Habilitative Services Defined by State (Yes/No)	No

BENEFITS AND LIMITS

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered); Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
1	Primary Care Visit to Treat an Injury or Illness	Covered	Primary Care Visit to Treat an Injury or Illness	No							No
2	Specialist Visit	Covered	Specialist Visit	No							No
3	Other Practitioner Office Visit (Nurse, Physician Assistant)	Covered	Other Practitioner Office Visit (Nurse, Physician Assistant)	No							No
4	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered	Facility Fee	No							No
5	Outpatient Surgery Physician/Surgical Services	Covered	Physician/Surgeon Fees	No							No
6	Hospice Services	Covered	Hospice Services	No					Precertification required for out-of-network care. Benefits will be reduced by 50% per service or supply if precertification is not obtained.		No
7	Non-Emergency Care When Traveling Outside the U.S.	Not Covered									
8	Routine Dental Services (Adult)	Not Covered									
9	Infertility Treatment	Not Covered									
10	Long-Term/Custodial Nursing Home Care	Not Covered									
11	Private-Duty Nursing	Not Covered									
12	Routine Eye Exam (Adult)	Covered	Routine Eye Exam (Adult)	Yes	1	Other	1 exam every 24 months				No
13	Urgent Care Centers or Facilities	Covered	Urgent Care	No					No coverage for non-urgent care.		No
14	Home Health Care Services	Covered	Home Health Care	Yes	60	Visits per year			Precertification required for out-of-network care. Benefits will be reduced by 50% per service or supply if precertification is not obtained.		No
15	Emergency Room Services	Covered	Emergency Room Services	No					No coverage for non-emergency care.		No

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16	Emergency Transportation/Ambulance	Covered	Emergency Medical Transportation	No							No
17	Inpatient Hospital Services (e.g., Hospital Stay)	Covered	Inpatient Hospital Services	No					Precertification required for out-of-network care. Benefits will be reduced by 50% per service or supply if precertification is not obtained.		No
18	Inpatient Physician and Surgical Services	Covered	Inpatient Physician and Surgical Services	No					Precertification required for out-of-network care. Benefits will be reduced by 50% per service or supply if precertification is not obtained.		No
19	Bariatric Surgery	Not Covered									
20	Cosmetic Surgery	Not Covered									
21	Skilled Nursing Facility	Covered	Skilled Nursing Care	Yes	120	Days per year			Precertification required for out-of-network care. Benefits will be reduced by 50% per service or supply if precertification is not obtained.		No
22	Prenatal and Postnatal Care	Covered	Prenatal and Postnatal Care	No							No
23	Delivery and All Inpatient Services for Maternity Care	Covered	Delivery and All Inpatient Services	No					Precertification required for out-of-network care. Benefits will be reduced by 50% per service or supply if precertification is not obtained.		No
24	Mental/Behavioral Health Outpatient Services	Covered	Mental/Behavioral Health Outpatient Services	Yes	20	Visits per year				SMI: 60 visits/year; Non-SMI: 20 visits/year	No
25	Mental/Behavioral Health Inpatient Services	Covered	Mental/Behavioral Health Inpatient Services	Yes	30	Days per year			Precertification required for out-of-network care. Benefits will be reduced by 50% per service or supply if precertification is not obtained.	SMI: 30 days/year; Non-SMI: 30 days/year	No

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26	Substance Abuse Disorder Outpatient Services	Covered	Substance Abuse Disorder Outpatient Services	Yes	60	Visits per year				Detox: No limits. Rehab: 60 visits/year, 120 visits per lifetime	No
27	Substance Abuse Disorder Inpatient Services	Covered	Substance Use Disorder Inpatient Services	Yes	30	Days per year			Precertification required for out-of-network care. Benefits will be reduced by 50% per service or supply if precertification is not obtained.	Detox: Unlimited, in-network and 7 days/admission, 4 admission per lifetime out-of-network; Rehab: 30 days/year, 90 days/lifetime	No
28	Generic Drugs	Covered	Generic Drugs	No					No coverage for out-of-network. Precertification and step therapy required with 90 day Transition of Care.	Includes diabetic supplies, oral fertility drugs and contraceptive drugs and devices obtainable from a pharmacy.	No
29	Preferred Brand Drugs	Covered	Formulary Brand Drugs	No					No coverage for out-of-network. Precertification and step therapy required with 90 day Transition of Care.	Includes diabetic supplies, oral fertility drugs and contraceptive drugs and devices obtainable from a pharmacy.	No
30	Non-Preferred Brand Drugs	Covered	Non-Formulary Brand Drugs	No					No coverage for out-of-network. Precertification and step therapy required with 90 day Transition of Care.	Includes diabetic supplies, oral fertility drugs and contraceptive drugs and devices obtainable from a pharmacy.	No
31	Specialty Drugs	Covered	Specialty Drugs	No							No
32	Outpatient Rehabilitation Services	Covered	Rehabilitation Services	Yes	30	Visits per year			PT/OT: 30 visits/year; ST: 30 visits/year		No
33	Habilitation Services	Not Covered									
34	Chiropractic Care	Covered	Chiropractic Care	Yes	20	Visits per year					No

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35	Durable Medical Equipment	Covered	Durable Medical Equipment	Yes	2500	Other	annual maximum		Precertification required for out-of-network care. Benefits will be reduced by 50% per service or supply if precertification is not obtained.		No
36	Hearing Aids	Not Covered									
37	Diagnostic Test (X-Ray and Lab Work)	Covered	Diagnostic test (X-Ray and Lab Work)	No							No
38	Imaging (CT/PET Scans, MRIs)	Covered	Imaging (CT/PET Scans, MRIs)	No							No
39	Preventive Care/ Screening/Immunization	Covered	Preventive Care/Screening/ immunization	Yes	1	Other	Age and frequency schedules may apply				No
40	Routine Foot Care	Not Covered									
41	Acupuncture	Not Covered									
42	Weight Loss Programs	Not Covered									
43	Routine Eye Exam for Children	Covered	Routine eye exam	Yes	1	Visits per year					No
44	Eye Glasses for Children	Covered	Eyeglasses for adults and children	Yes	1	Other	1 pair of glasses (lenses and frames per year				No
45	Dental Check-Up for Children	Covered	Dental Exams	Yes	1	Other	1 every 6 months			Limitations, including dollar limits, may apply.	No

OTHER BENEFITS

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
1	Other	Covered	Basic Dental Care – Child	No						Limitations, including dollar limits, may apply.	No
2	Other	Covered	Major Dental Care – Child	No						Limitations, including dollar limits, may apply.	No
3	Other	Covered	Orthodontia - Child	No						Limitations, including dollar limits, may apply.	No

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

CATEGORY	CLASS	SUBMISSION COUNT
ANALGESICS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	10
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	10
ANESTHETICS	LOCAL ANESTHETICS	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	0
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICOIDS	1
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANTIBACTERIALS	AMINOGLYCOSIDES	6
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	17
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	17
ANTIBACTERIALS	BETA-LACTAM, OTHER	4
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	7
ANTIBACTERIALS	MACROLIDES	5
ANTIBACTERIALS	QUINOLONES	8
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	2
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	4
ANTICONVULSANTS	GAMMA-AMINOBTYRIC ACID (GABA) AUGMENTING AGENTS	5
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	6
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	1
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	3
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	1
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	8
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	4
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	10
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	7
ANTIFUNGALS	NO USP CLASS	22
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2
ANTIMIGRAINE AGENTS	PROPHYLACTIC	4

CATEGORY	CLASS	SUBMISSION COUNT
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	2
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	6
ANTINEOPLASTICS	ALKYLATING AGENTS	6
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	2
ANTINEOPLASTICS	ANTIMETABOLITES	2
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	3
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	2
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	13
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	2
ANTINEOPLASTICS	RETINOIDS	3
ANTIPARASITICS	ANTHELMINTICS	4
ANTIPARASITICS	ANTIPROTOZOALS	12
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	6
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	3
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	3
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	4
ANTIPARKINSON AGENTS	DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS	2
ANTIPARKINSON AGENTS	MONOAMINE OXIDASE B (MAO-B) INHIBITORS	2
ANTIPSYCHOTICS	1ST GENERATION/TYPICAL	10
ANTIPSYCHOTICS	2ND GENERATION/ATYPICAL	9
ANTIPSYCHOTICS	TREATMENT-RESISTANT	1
ANTISPASTICITY AGENTS	NO USP CLASS	6
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	3
ANTIVIRALS	ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	5
ANTIVIRALS	ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS	11
ANTIVIRALS	ANTI-HIV AGENTS, OTHER	4
ANTIVIRALS	ANTI-HIV AGENTS, PROTEASE INHIBITORS	9
ANTIVIRALS	ANTI-INFLUENZA AGENTS	4
ANTIVIRALS	ANTIHEPATITIS AGENTS	12
ANTIVIRALS	ANTIHERPETIC AGENTS	5
ANXIOLYTICS	ANXIOLYTICS, OTHER	4
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	5

CATEGORY	CLASS	SUBMISSION COUNT
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	6
BIPOLAR AGENTS	MOOD STABILIZERS	5
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	21
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD GLUCOSE REGULATORS	INSULINS	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	7
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	0
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	7
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	4
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	4
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	8
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	10
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	9
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	13
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	9
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	4
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	2
CARDIOVASCULAR AGENTS	DIURETICS, LOOP	4
CARDIOVASCULAR AGENTS	DIURETICS, POTASSIUM-SPARING	4
CARDIOVASCULAR AGENTS	DIURETICS, THIAZIDE	6
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES	2
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS	7
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, OTHER	6
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL	3
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS	3
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	4
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	3
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	6
DENTAL AND ORAL AGENTS	NO USP CLASS	8
DERMATOLOGICAL AGENTS	NO USP CLASS	35
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	13
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	5
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	6
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4

CATEGORY	CLASS	SUBMISSION COUNT
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	2
GASTROINTESTINAL AGENTS	LAXATIVES	4
GASTROINTESTINAL AGENTS	PROTECTANTS	2
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	6
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	7
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	8
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	3
GENITOURINARY AGENTS	PHOSPHATE BINDERS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	23
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	NO USP CLASS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	NO USP CLASS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	2
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	6
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	5
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	NO USP CLASS	3
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	9
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	21
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	3
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	11
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	3
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	5
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	13
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	4

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OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	10
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	11
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	14
OTIC AGENTS	NO USP CLASS	6
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	6
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	11
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	10
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	5
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	5
SKELETAL MUSCLE RELAXANTS	NO USP CLASS	6
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	3
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	5
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	7
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	6