

Lincoln University
Medical, Vision, Pharmacy
Provider Benefit Coverage
Delaware HMO and Open Access



**PLAN DESIGN AND BENEFITS
 PROVIDED BY AETNA HEALTH INC. - FULL RISK**

PLAN FEATURES	PARTICIPATING PROVIDERS / REFERRED
Deductible (per calendar year)	None Individual None Family
Out-of-Pocket Maximum (per calendar year) Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. Only those participating providers/referred out of pocket expenses resulting from the application of coinsurance percentage and copays (except any penalty amounts and pharmacy cost sharing) may be used to satisfy the Out-of-Pocket Maximum. Once 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.	\$1,500 Individual \$3,000 Family
Lifetime Maximum	Unlimited unless otherwise indicated.
Primary Care Physician Selection	Required
Referral Requirements	Required for all non-emergency, non-urgent and non-Primary Care Physician services, except direct access services
PREVENTIVE CARE	PARTICIPATING PROVIDERS / REFERRED
Routine Adult Physical Exams / Immunizations (Age and frequency schedules apply)	Covered 100%
Well Child Exams / Immunizations (Age and frequency schedules apply)	Covered 100%
Routine Gynecological Care Exams Includes Pap smear and related lab fees for covered females age 18 and older. One exam per calendar year.	Covered 100%
Routine Mammograms One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over	Covered 100%
Routine Digital Rectal Exams / Prostate Specific Antigen Test For males age 40 and over	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Colorectal Cancer Screening For all members 50 and over. Frequency schedule applies	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Routine Eye Exam Age/Frequency Schedule may apply. Direct access to participating providers without a referral.	Covered 100%
Routine Hearing Screening	Subject to Routine Physical Exam cost sharing
PHYSICIAN SERVICES	PARTICIPATING PROVIDERS / REFERRED
Primary Care Physician Visits	Office Hours: \$20 copay After Office Hours/Home: \$25 copay
Specialist Office Visits	\$40 copay
Maternity OB Visits	Covered 100%
Allergy Treatment	Same as applicable participating provider office visit member cost sharing
Allergy Testing	Same as applicable participating provider office visit member cost sharing
DIAGNOSTIC PROCEDURES	PARTICIPATING PROVIDERS / REFERRED
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.	Covered 100%



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Diagnostic X-ray Outpatient hospital or other Outpatient facility (except for Complex Imaging Services)	\$40 copay
Diagnostic X-ray for Complex Imaging Services	\$40 copay
EMERGENCY MEDICAL CARE	PARTICIPATING PROVIDERS / REFERRED
Urgent Care	\$100 copay
Non-Urgent use of Urgent Care Provider	Not Covered
Emergency Room	\$100 copay
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	Covered 100%
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	PARTICIPATING PROVIDERS / REFERRED
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	\$250 per admission
Inpatient Maternity Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	\$250 per admission
Outpatient Surgery The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered 100% per visit
MENTAL HEALTH SERVICES	PARTICIPATING PROVIDERS / REFERRED
Inpatient Serious Mental Illness The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	\$250 per admission
Inpatient Non-Serious Mental Illness The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	\$250 per admission
Outpatient Serious Mental Illness The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	\$20 copay
Outpatient Non-Serious Mental Illness The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	\$20 copay
ALCOHOL/DRUG ABUSE SERVICES	PARTICIPATING PROVIDERS / REFERRED
Inpatient Detoxification The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	\$250 per admission
Outpatient Detoxification The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	\$20 copay
Inpatient Rehabilitation The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	\$250 per admission
Residential Treatment Facility	\$250 per admission
Outpatient Rehabilitation The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	\$20 copay
OTHER SERVICES	PARTICIPATING PROVIDERS / REFERRED
Skilled Nursing Facility The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	\$250 per admission
Home Health Care	Covered 100%
Hospice Care - Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	\$250 per admission
Hospice Care - Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered 100%
Private Duty Nursing	Not Covered
Outpatient Rehabilitation Therapy (Includes speech, physical and occupational therapy) Treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment.	\$20 copay
Subluxation Limited to 20 visits per calendar year	\$40 copay



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Durable Medical Equipment	Covered 100%
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.
Dental	Not Covered
Vision Eyewear	\$100 once per 24 month period
Transplants	\$250 per admission
Coverage is provided at an IOE contracted facility only	
Bariatric Surgery	Not Covered
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
FAMILY PLANNING	
PARTICIPATING PROVIDERS / REFERRED	
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Diagnosis and treatment of the underlying medical condition.	
Comprehensive Infertility Services	Not Covered
Advanced Reproductive Technology (ART)	Not Covered
ART coverage 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.	
Voluntary Sterilization	Subject to applicable service type member cost sharing
Including tubal ligation and vasectomy.	
PHARMACY - PRESCRIPTION DRUG BENEFITS	
PARTICIPATING PROVIDERS / REFERRED	
Retail	\$5 copay for formulary generic drugs, \$30 copay for formulary brand-name drugs, and \$50 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.
(2 times retail copay for 31-90 day supply at participating pharmacies. Percentage copays will not be doubled)	
Mail Order	\$10 copay for formulary generic drugs, \$60 copay for formulary brand-name drugs, and \$100 copay for non-formulary brand-name and generic drugs up to a 31-90 day supply from Aetna Rx Home Delivery®
Aetna Specialty CareRx	
First prescription fill at any retail drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®	
Mandatory Generic with DAW override (MG W/DAW Override) - the member pays the applicable copay only. If the physician requires brand. If the member requests brand-name when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.	
Plan Includes : Contraceptive drugs and devices obtainable from a pharmacy.	
Oral fertility drugs included.	

Exclusions and Limitations

Plans are provided by: Aetna Health Inc., 151 Farmington Avenue, Hartford, CT 06156. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits 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 agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services.

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.



**PLAN DESIGN AND BENEFITS
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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 1-888-98-AETNA (1-888-982-3862).

Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al 1-888-98-AETNA (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.



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 PROVIDED BY AETNA HEALTH INC. - FULL RISK**

PLAN FEATURES	PARTICIPATING PROVIDERS
Deductible (per calendar year)	None Individual None Family
Out-of-Pocket Maximum (per calendar year) Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. Only those participating providers out of pocket expenses resulting from the application of coinsurance percentage and copays (except any penalty amounts and pharmacy cost sharing) may be used to satisfy the Out-of-Pocket Maximum. Once 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.	\$1,500 Individual \$3,000 Family
Lifetime Maximum	Unlimited unless otherwise indicated.
Primary Care Physician Selection	Not Required
Referral Requirements	None
PREVENTIVE CARE	PARTICIPATING PROVIDERS
Routine Adult Physical Exams / Immunizations (Age and frequency schedules apply)	Covered 100%
Well Child Exams / Immunizations (Age and frequency schedules apply)	Covered 100%
Routine Gynecological Care Exams Includes Pap smear and related lab fees for covered females age 18 and older. One exam per calendar year.	Covered 100%
Routine Mammograms One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over	Covered 100%
Routine Digital Rectal Exams / Prostate Specific Antigen Test For males age 40 and over	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Colorectal Cancer Screening For all members 50 and over. Frequency schedule applies	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Routine Eye Exam Age/Frequency Schedule may apply.	Covered 100%
Routine Hearing Screening	Subject to Routine Physical Exam cost sharing
PHYSICIAN SERVICES	PARTICIPATING PROVIDERS
Office Visits to member's selected Primary Care Physician	Office Hours: \$15 copay After Office Hours/Home: \$20 copay
Specialist Office Visits Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.	\$30 copay
Maternity OB Visits	Covered 100%
Allergy Treatment	Same as applicable participating provider office visit member cost sharing
Allergy Testing	Same as applicable participating provider office visit member cost sharing
DIAGNOSTIC PROCEDURES	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.	Covered 100%
Diagnostic X-ray Outpatient hospital or other Outpatient facility (except for Complex Imaging Services)	\$30 copay
Diagnostic X-ray for Complex Imaging Services	\$30 copay



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EMERGENCY MEDICAL CARE	PARTICIPATING PROVIDERS
Urgent Care	\$100 copay
Non-Urgent use of Urgent Care Provider	Not Covered
Emergency Room	\$100 copay
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	Covered 100%
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	PARTICIPATING PROVIDERS
Inpatient Coverage	\$200 per admission
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Inpatient Maternity Coverage	\$200 per admission
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Outpatient Surgery	Covered 100% per visit
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
MENTAL HEALTH SERVICES	PARTICIPATING PROVIDERS
Inpatient Serious Mental Illness	\$200 per admission
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Inpatient Non-Serious Mental Illness	\$200 per admission
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Outpatient Serious Mental Illness	\$15 copay per visit
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
Outpatient Non-Serious Mental Illness	\$15 copay per visit
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
ALCOHOL/DRUG ABUSE SERVICES	PARTICIPATING PROVIDERS
Inpatient Detoxification	\$200 per admission
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Outpatient Detoxification	\$15 copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
Inpatient Rehabilitation	\$200 per admission
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Residential Treatment Facility	\$200 copay per admission
Outpatient Rehabilitation	\$15 copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
OTHER SERVICES	PARTICIPATING PROVIDERS
Skilled Nursing Facility	\$200 per admission
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Home Health Care	Covered 100%
Hospice Care - Inpatient	\$200 per admission
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Hospice Care - Outpatient	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
Private Duty Nursing	Not Covered
Outpatient Rehabilitation Therapy (Includes speech, physical and occupational therapy)	\$15 copay
Treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment.	
Subluxation	\$30 copay
Limited to 20 visits per calendar year	
Durable Medical Equipment	Covered 100%
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.



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Dental	Not Covered
Vision Eyewear	\$100 once per 24 month period
Transplants	\$200 per admission
Coverage is provided at an IOE contracted facility only	
Bariatric Surgery	Not Covered
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
FAMILY PLANNING	PARTICIPATING PROVIDERS
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Diagnosis and treatment of the underlying medical condition.	
Comprehensive Infertility Services	Not Covered
Advanced Reproductive Technology (ART)	Not Covered
ART coverage 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.	
Voluntary Sterilization	Subject to applicable service type member cost sharing
Including tubal ligation and vasectomy.	
PHARMACY - PRESCRIPTION DRUG BENEFITS	PARTICIPATING PROVIDERS
Retail	\$5 copay for formulary generic drugs, \$30 copay for formulary brand-name drugs, and \$50 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.
(2 times retail copay for 31-90 day supply at participating pharmacies. Percentage copays will not be doubled)	
Mail Order	\$10 copay for formulary generic drugs, \$60 copay for formulary brand-name drugs, and \$100 copay for non-formulary brand-name and generic drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.
Aetna Specialty CareRx	
First prescription fill at any retail drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®	
Mandatory Generic with DAW override (MG W/DAW Override) - the member pays the applicable copay only. If the physician requires brand. If the member requests brand-name when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.	
Plan Includes : Contraceptive drugs and devices obtainable from a pharmacy.	
Oral fertility drugs included.	

Exclusions and Limitations

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

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- All medical and 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.
- Cosmetic surgery.
- 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
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents.
- Nonmedically necessary services or supplies.
- 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.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered in the plan documents.

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