

PLAN DESIGN AND BENEFITS – CA
Aetna EPO

| PLAN FEATURES | PREFERRED CARE | NON-PREFERRED CARE |
|--|--|--------------------|
| Deductible | None | Not Applicable |
| Member Coinsurance | 10% | Not Applicable |
| Coinsurance Maximum (per calendar year, excludes deductible) | \$2,500 per member (2 member maximum) | Not Applicable |
| <p>Certain member cost sharing elements may not apply toward the coinsurance Maximum. Amounts over allowable, copays, failure to pre-certify penalty, payments for Non-SMI/SED mental disorders, substance abuse, Rx, chiropractic, infertility and DME do not apply towards Coinsurance Maximum and continue to be payable after Coinsurance Maximum is reached. Once 2 individual members of a family each satisfy their Coinsurance Maximum separately, all family members will be considered as having met the Coinsurance Maximum for the remainder of the calendar year.</p> | | |
| Lifetime Maximum | \$5,000,000 | Not Applicable |
| Primary Care Physician Selection | Required | Not Applicable |
| Referral Requirement | Required | Not Applicable |
| PREVENTIVE CARE | PREFERRED CARE | NON-PREFERRED CARE |
| Routine Adult Physical Exams / Immunizations Age and Frequency schedules apply. \$300 maximum benefit every 24 months. | \$15 copay | Not Covered |
| Well Child Exams / Immunizations Age and Frequency schedules apply. | \$15 copay | Not Covered |
| Routine Gynecological Care Exams Includes Pap smear and related lab fees. One Routines exam(s) per 365 days | \$30 copay | Not Covered |
| Routine Mammograms One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over. | \$30 copay | Not Covered |
| Routine Digital Rectal Exam / Prostate Specific Antigen Test For covered 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. | Not Covered |
| Colorectal Cancer Screening For all members age 50 and over. | Member cost sharing is based on the type of service performed and the place where it is rendered. | Not Covered |
| Routine Eye Exams | Not Covered (except as part of physical) | Not Covered |
| Routine Hearing Exams | Not Covered (except as part of physical) | Not Covered |
| PHYSICIAN SERVICES | PREFERRED CARE | NON-PREFERRED CARE |
| Office Visits (office hours) Includes services of an internist, general physician, family practitioner or pediatrician for routine care as well as diagnosis and treatment of an illness or injury. | \$15 copay | Not Covered |
| Specialist Office Visits | \$30 copay | Not Covered |
| Maternity OB Visits | 10% | Not Covered |
| Allergy Testing (given by a physician) | \$30 copay | Not Covered |
| Allergy Injections | \$15/\$30 copay; Copay waived when office visit charge is not made. | Not Covered |
| DIAGNOSTIC PROCEDURES | PREFERRED CARE | NON-PREFERRED CARE |
| Outpatient Diagnostic Laboratory and X-ray - (If performed as a part of a physician's office visit and billed by the physician, expenses are covered subject to the member office visit copay) | 10% | Not Covered |
| Outpatient Diagnostic X-ray for Complex Imaging Services (including, but not limited to, MRI, MRA, PET and CAT Scans) | 20% | Not Covered |



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| EMERGENCY MEDICAL CARE | PREFERRED CARE | NON-PREFERRED CARE |
|---|---------------------------------------|---------------------------|
| Urgent Care Provider Benefit Availability may vary by location | \$50 copay | Same as Preferred Care |
| Non-Urgent Use of Urgent Care Provider | Not Covered | Not Covered |
| Emergency Room Copay waived if admitted. | \$100 copay plus 10% | Same as Preferred Care |
| Non-Emergency Care in an Emergency Room | Not Covered | Not Covered |
| Ambulance | 10% | Same as Preferred Care |
| HOSPITAL CARE | PREFERRED CARE | NON-PREFERRED CARE |
| Inpatient Coverage | 10% | Not Covered |
| Inpatient Maternity Coverage | 10% | Not Covered |
| Outpatient Surgery | 10% | Not Covered |
| Outpatient Procedures Other Than Surgery | 10% | Not Covered |
| MENTAL HEALTH SERVICES | PREFERRED CARE | NON-PREFERRED CARE |
| Inpatient Mental Disorders – (Serious Mental Illness & Serious Emotional Disturbances of a Child) | 10% | Not Covered |
| Outpatient Mental Disorders – (Serious Mental Illness & Serious Emotional Disturbances of a Child) | \$30 copay | Not Covered |
| Inpatient Mental Disorders Other than Serious Mental Illness | Not Covered | Not Covered |
| Outpatient Mental Disorders Other than Serious Mental Illness & Serious Emotional Disturbance of a Child Limited to 20 visits per member per calendar year. | \$30 copay | Not Covered |
| ALCOHOL/DRUG ABUSE SERVICES | PREFERRED CARE | NON-PREFERRED CARE |
| Inpatient Detoxification Limited to 3 days per admission; 2 admissions per lifetime. | 10% | Not Covered |
| Outpatient Detoxification | Not Covered | Not Covered |
| Inpatient Rehabilitation | Not Covered | Not Covered |
| Outpatient Rehabilitation | Not Covered | Not Covered |
| OTHER SERVICES AND PLAN DETAILS | PREFERRED CARE | NON-PREFERRED CARE |
| Skilled Nursing Facility (in lieu of hospital) Limited to 60-days per calendar year | 10% | Not Covered |
| Home Health Care Limited to 90 visits per member per calendar year, preferred and non-preferred combined; 1 visit equals a period of 4 hours or less. | \$30 copay | Not Covered |
| Hospice Care – Inpatient Limited to 30 days per member per calendar year. | 10% | Not Covered |
| Hospice Care – Outpatient Maximum benefit of \$5,000 per member per lifetime; preferred and non-preferred combined. | \$30 copay | Not Covered |
| Private Duty Nursing – Outpatient | Not Covered | Not Covered |
| Outpatient Speech Therapy Limited to 20 visits per member per calendar year. | \$30 copay | Not Covered |
| Outpatient Physical and Occupational Therapy Limited to 12 visits per member per calendar year PT & OT combined. | \$30 copay | Not Covered |
| Chiropractic Services Limited to 12 visits per member per calendar year. | \$30 copay | Not Covered |
| Durable Medical Equipment Maximum benefit of \$2,000 per member per calendar year. | 50% | Not Covered |
| OTHER SERVICES AND PLAN DETAILS | PREFERRED CARE | NON-PREFERRED CARE |
| Diabetic Supplies not obtainable at a pharmacy | Payable as any other covered expense. | Not Covered |
| Contraceptive drugs and devices not obtainable at a pharmacy | Payable as any other covered expense | Not Covered |

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| Transplants Preferred coverage is provided at an IOE contracted facility only | 10% | Not Covered |
| FAMILY PLANNING | | |
| Infertility Treatment Coverage only for the diagnosis and treatment of the underlying medical condition. | Member cost sharing is based on the type of service performed and the place where it is rendered. | Not Covered |
| Voluntary Sterilization Including tubal ligation and vasectomy and voluntary abortion | 10% | Not Covered |
| PHARMACY – PRESCRIPTION DRUG BENEFITS | | |
| Retail Up to a 30 day supply Mandatory generics with dispense as written over-ride | \$15 copay for generic formulary and non-formulary drugs, \$35 copay for formulary brand drugs, and \$50 copay for non-formulary brand drugs | NON-PARTICIPATING PHARMACY Not Covered |
| Mail Order Delivery (MOD) 31 - 90 day supply Mandatory generics with dispense as written over-ride | \$30 copay for generic formulary and non-formulary drugs, \$70 copay for brand formulary drugs, and \$100 copay for brand non-formulary drugs | Not Covered |
| Plan includes: Lifestyle/performance prescription drugs (limited to 4 pills per month), contraceptive drugs and devices obtainable from a pharmacy, diabetic supplies. | | |
| Prescription drug calendar year deductible - Must be satisfied before any prescription drug benefits are paid. Applies to brand formulary and brand non-formulary drugs only. | None | Not Applicable |

SPECIAL PROGRAMS/SERVICES

Certain Special programs and Services may be included in your plan: Aetna Navigator™, Fitness, Healthy Outlook, Moms-to-Babies Maternity Management™, National Advantage, National Medical Excellence, Natural Alternatives, Natural Products, Vision One®, and Vitamin Advantage™.

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their 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.

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; Custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; 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; Treatment of those for or related to treatment of obesity or for diet or weight control; Nonmedically necessary services or supplies; Orthotics except as specified in the plan; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and Special duty nursing.

This plan imposes a pre-existing conditions exclusion, which may be waived in some circumstances (that is, creditable coverage) and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis or treatment was recommended or received or for which the individual took prescribed drugs within six months.

Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six month period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to six months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period.

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If you had less than six months of group or three months of individual (including Medicare, Medicaid and Medi-Cal) of creditable coverage immediately before the date you enrolled, your plan's pre-existing conditions exclusion period will be reduced by the amount (that is, number of days) of that prior coverage.

If you had no prior creditable coverage within the six months for group or three months for individual prior to your enrollment date (either because you had no prior coverage or because there was more than a six months of group or three months of individual gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion.

In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any Certificates of Creditable you have. Please contact your Aetna Member Services representative at 1-888-802-3862 for PPO and 1-888-702-3862 for HMO if you need assistance in obtaining a Certificate of Creditable Coverage from your prior carrier or if you have any questions on the information noted above.

The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment; the pre-existing exclusion will be applied from the individual's effective date of coverage.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee any results or outcomes. Consult the plan documents (i.e. Booklet, Booklet-Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. The availability of a plan or program may vary by geographic service area. With the exception of Aetna Rx Home Delivery, LLC, participating providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a nonpreferred provider, Member must obtain the precertification. Precertification requirements may vary.

Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available at the highest copay under plans with an open formulary, or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary. They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after enrollment) are not covered, and medical exceptions are not available for them. Aetna Rx Home Delivery, LLC, is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated reimbursement rates with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services. In prescription plans with copayment or coinsurance tiers, use of formulary drugs generally will result in lower costs to members. However, where the prescription plan utilizes copayments or coinsurance calculated on a percentage basis, there could be some circumstances in which a formulary drug would cost the member more than a non-formulary drug because (i) the negotiated pharmacy payment rate for the formulary drug may be more than the negotiated pharmacy payment rate for the non-formulary drug, and (ii) rebates received by Aetna from drug manufacturers are not reflected in the cost of a prescription drug obtained by a member.

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