



PLAN FEATURES		PARTICIPATING PROVIDERS (REFERRED)	
Maximum Out-of-Pocket Limit		\$2,000 per Member per calendar year \$4,000 per Family per calendar year	
All member copays accumulate toward the Out-of-Pocket Limit, excluding member cost sharing for Prescription Drugs. No individual can contribute more than the individual Out-of-Pocket Limit toward satisfaction of the Family Out-of-Pocket Limit. Once the Family Out-of-Pocket Limit is met all family members will be considered as having met their Out-of-Pocket Limit for the remainder of the calendar year.			
Lifetime Maximum		Unlimited	
Primary Care Physician Selection		Required	
Referral Requirement		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		\$20 per visit	
Well Child Care and Immunizations Age and Frequency Schedules Apply		\$20 per visit	
Routine Gynecological Exam(s)** 1 visit per 365-day period		\$40 per visit	
Mammography One baseline for females age 35-39. One annual mammogram for females age 40 and over.		\$40 per visit	
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 where it is rendered.	
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.	
PHYSICIAN SERVICES		PARTICIPATING PROVIDERS (REFERRED)	
Primary Care Physician Office Visit During Office Hours Non-Office Hours and Home Visits		\$20 per visit \$25 per visit	
Specialist Physician Office Visit		\$40 per visit	
Maternity OB Visit		Same as Specialist Office Visit for initial visit only; thereafter covered at 100%.	
DIAGNOSTIC PROCEDURES		PARTICIPATING PROVIDERS (REFERRED)	
Diagnostic Laboratory and X-Ray		\$40 per service	
Complex Imaging Services		\$40 per service	
EMERGENCY MEDICAL CARE			
Outpatient Emergency Services Hospital Emergency Room or Outpatient Department		\$100 per visit	
Urgent Care Facility (benefit availability may vary by location)		\$50 per visit	
Ambulance		\$100 per trip	
HOSPITAL CARE		PARTICIPATING PROVIDERS (REFERRED)	
Inpatient Hospital Coverage		\$300 per day for up to 5-days per admission; thereafter covered at 100%.	
Inpatient Maternity Coverage		\$300 per day for up to 5-days per admission; thereafter covered at 100%.	
Outpatient Surgery		\$250 per visit	



MENTAL HEALTH SERVICES		PARTICIPATING PROVIDERS (REFERRED)	
Inpatient Serious Mental Illness – (Serious Mental Illness & Serious Emotional Disturbances of a Child) Is covered subject to the same terms as any other illness		\$300 per day for up to 5-days per admission: thereafter covered at 100%.	
Inpatient Mental Health (Non-Serious Mental Illness)		Not Covered	
Outpatient - (Serious Mental Illness & Serious Emotional Disturbances of a Child) Is covered subject to the same terms and conditions as any other illness.		\$40 per visit	
Outpatient Mental Health Visits (Non-Serious Mental Illness) 20 visits per calendar year		\$40 per visit	
ALCOHOL/DRUG ABUSE SERVICES		PARTICIPATING PROVIDERS (REFERRED)	
Inpatient Substance Abuse (Detoxification) No day limit		\$300 per day for up to 5-days per admission: thereafter covered at 100%.	
Outpatient Substance Abuse Visits (Detoxification) No visit limit		\$40 per visit	
OTHER SERVICES		PARTICIPATING PROVIDERS (REFERRED)	
Skilled Nursing Facility Maximum of 60-days per calendar year		\$300 per day for up to 5-days per admission: thereafter covered at 100%. (waived if a Member is transferred from a Hospital to a Skilled Nursing Facility)	
Outpatient Home Health Visits 100 visits per calendar year		\$0 per visit	
Hospice No limit		\$300 per day for up to 5-days per admission: thereafter covered at 100%. (waived if a Member is transferred from a Hospital to a Hospice Care Facility)	
Outpatient Hospice Visits No visit limit		\$0 per visit	
OTHER SERVICES		PARTICIPATING PROVIDERS (REFERRED)	
Outpatient Rehabilitation Benefits - Speech Therapy 20 visits per period of incident of illness or injury beginning with the first day of Treatment per calendar year		\$40 per visit	
Outpatient Rehabilitation – Physical & Occupational Therapy 20 combined Physical and Occupational Therapy visits per incident of illness or injury beginning with the first day of Treatment per calendar year.		\$40 per visit	
Subluxation Benefits (Chiropractic)		Not Covered	
Durable Medical Equipment Benefits Copayment Maximum Annual Benefit (Annual Out-of-Pocket Maximum Does not count toward Maximum Out-of-Pocket Limit)		50% per item \$2,000 per Member, per calendar year	
Infertility Services Coverage for only the diagnosis and treatment of the underlying medical cause.		Member cost sharing is based on the type of service performed and the place where it is rendered.	



PHARMACY – PRESCRIPTION DRUG BENEFIT	PARTICIPATING PHARMACY
Retail – Up to a 30-day supply Mandatory generics with dispense as written over-ride	\$15 copay generic formulary; \$35 copay brand formulary; \$50 copay generic and brand non-formulary
Mail Order Delivery (MOD) – 31 to 90 day supply Mandatory generics with dispense as written over-ride	\$30 copay generic formulary; \$70 copay brand formulary; \$100 copay generic and brand non-formulary.

HMO, or its contracted organization, may use prior authorizations and ongoing reviews to limit the number of outpatient Mental Health or Substance Abuse visits to the maximum it deems to be Covered benefits that are Medically Necessary independent of the maximum number of visits shown in this Schedule of Benefits. This means the Member may not receive the maximum number of outpatient visits shown in this Schedule of Benefits or the number of outpatient visits the Member and the treating Provider believe to be appropriate for a single course of treatment or episode.

****The Member must direct access a gynecologist or obstetrician in her Primary Care Physician’s Professional Medical Group (PMG) or Independent Physicians Association (IPA).**

What’s Not Covered:

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 or the plan design or rider(s) purchased.**

- 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.
- Experimental and investigational procedures, (except for coverage for medically necessary routine patient care costs for Members participating in a cancer clinical trial or as approved through the independent medical review process).
- Hearing aids.
- Immunizations for travel or work.
- 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.
- Nonmedically necessary services or supplies.
- Orthotics, except as specified in the plan
- Over-the-counter medications 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.
- Treatment of behavioral disorders, except Serious Emotional Disturbances of a Child.

Disclaimers

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. Schedule of Benefits, Certificate/Evidence of Coverage, and/or Group Agreement 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. Notice of the change shall be provided in accordance with applicable state law. Certain primary care providers are affiliated with integrated delivery systems or other provider groups (such as independent practice associations and physician-hospital organizations), and members who select these providers will generally be



referred to specialists and hospitals within those systems or groups. However, if a system or group does not include a provider qualified to meet member's medical needs, member may request to have services provided by non-system or non-group providers. Member's request will be reviewed and will require prior authorization from the system or group and/or Aetna to be a covered benefit.

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. Members or Providers may be required to precertify for certain services such as non-emergency inpatient hospital care.

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 Health of California Inc. While this material is believed to be accurate as of the print date, it is subject to change.