Aetna

Aetna Life Insurance Company

Plan Effective Date: 01/01/2005

PLAN DESIGN AND BENEFITS – CA MC $250 80/60

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	$250 per member (2 member maximum)	$500 per member (2 member maximum)
Deductibles accumulate separately between preferred and non-preferred. Once 2 individual members of a family each satisfy their Deductible separately, all family members will be considered as having met their Deductible for the remainder of the calendar year.		
Member Coinsurance	20%; after deductible	40%; after deductible
Coinsurance Maximum (per calendar year, deductible excluded)	$3,000 per member (2 member maximum)	$5,000 per member (2 member maximum)
Amounts accumulate separately toward the preferred and non-preferred Coinsurance Maximum. Certain member cost sharing elements may not apply toward the Coinsurance Maximum. Amounts over allowable, copays, failure to pre-certify penalty, payments for chiropractic, non-SMI/SED mental disorders, Rx, infertility, substance abuse and DME do not apply to Coinsurance maximum and continue to be payable after the maximum Coinsurance is reached. Once 2 individual members of a family each satisfy their Coinsurance Maximum separately, all family members will be considered as having met their Coinsurance Maximum for the remainder of the calendar year.		
Lifetime Maximum - Preferred and Non-Preferred Combined	$5,000,000	
Payment for Non-Preferred Care	Not Applicable	Usual & Customary*
Primary Care Physician Selection	Not Required	Not Applicable
Referral Requirement	None	None
Precertification Requirements – Precertification for certain types of non-preferred care must be obtained to avoid a reduction in benefits paid for that care. Precertification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care and Hospice Care is required. Benefits will be reduced by $400 per occurrence if Precertification is not obtained.		

PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE
Routine Adult Physical Exams / Immunizations Age and Frequency schedules apply. $300 maximum benefit every 24 months, preferred and non-preferred combined.	$20 copay; no deductible	40%; after deductible
Well Child Exams / Immunizations Age and Frequency schedules apply.	$20 copay; no deductible	40%; after deductible
Routine Gynecological Care Exams Includes Pap smear and related lab fees. One Routines exam(s) per 365 days	$20 copay; no deductible	40%; after deductible
Routine Mammograms One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over.	$20 copay; no deductible	40%; after deductible
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.	40%; after deductible
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.	40%; after deductible
Routine Eye Exams	Not Covered (except as part of physical)	Not Covered (except as part of physical)
Routine Hearing Exams	Not Covered (except as part of physical)	Not Covered (except as part of physical)

PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Office Visits (office hours)	$20 copay; no deductible	40%; after deductible
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.		
Specialist Office Visits	$20 copay; no deductible	40%; after deductible
Maternity OB Visits	20%; after deductible	40%; after deductible

PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE

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Allergy Testing (given by a physician)	$20 copay; no deductible	40%; after deductible
Allergy Injections	$20 copay; no deductible; copay waived when office visit charge is not made.	40%; after deductible
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)	20%; after deductible	40%; after deductible
Outpatient Diagnostic X-ray for Complex Imaging Services (including, but not limited to, MRI, MRA, PET and CAT Scans)	30%; after deductible	50%; after deductible
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 20%; after deductible	Same as Preferred Care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Ambulance	20%; after deductible	Same as Preferred Care
HOSPITAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Coverage	20%; after deductible	$250 per admission plus 40%; after deductible
Inpatient Maternity Coverage	20%; after deductible	$250 per admission plus 40%; after deductible
Outpatient Surgery	20%; after deductible	$100 copay plus 40%; after deductible
Outpatient Procedure Other Than Surgery	20%; after deductible	40%; after deductible
MENTAL HEALTH SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Mental Disorders – (Serious Mental Illness & Serious Emotional Disturbances of a Child)	20%; after deductible	$250 per admission plus 40%; after deductible
Outpatient Mental Disorders – (Serious Mental Illness & Serious Emotional Disturbances of a Child)	$20 copay; no deductible	40%; after deductible
Inpatient Mental Disorders Other than Serious Mental Illness	Not Covered	Not Covered
Outpatient Mental Disorders Other than Serious Mental Illness & Serious Emotional Disturbances of a Child Limited to 20 visits per member per calendar year, preferred and non-preferred combined.	$20 copay; no deductible	40%; after deductible. Aetna pays up to $25 per visit.
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Detoxification Limited to 3 days per admission; 2 admissions per lifetime, preferred and non-preferred combined.	20%; after deductible	$250 per admission plus 40%; after deductible
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, preferred and non-preferred combined.	20%; after deductible	$250 per admission plus 40%; after deductible
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.	20%; after deductible	40%; after deductible
Hospice Care – Inpatient Limited to 30 days per member per calendar year; preferred and non-preferred combined.	20%; after deductible	$250 per admission plus 40%; after deductible
OTHER SERVICES AND PLAN DETAILS	**PREFERRED CARE**	**NON-PREFERRED CARE**

Hospice Care – Outpatient Maximum benefit of $5,000 per member per lifetime; preferred and non-preferred combined.	20%; after deductible	40%; after deductible
Private Duty Nursing – Outpatient	Not Covered	Not Covered
Outpatient Speech Therapy Limited to 20 visits per member per calendar year, preferred and non-preferred combined.	20%; after deductible	40%; after deductible
Outpatient Physical and Occupational Therapy Limited to 12 visits per member per calendar year PT & OT combined, preferred and non-preferred combined.	20%; after deductible	40%; after deductible
Chiropractic Services Limited to 12 visits per member per calendar year	20%; after deductible	Not Covered
Durable Medical Equipment Maximum benefit of $2,000 per member per calendar year, preferred and non-preferred combined.	50%; after deductible	50%; after deductible
Diabetic Supplies not obtainable at a pharmacy	Payable as any other covered expense.	Payable as any other covered expense.
Contraceptive drugs and devices not obtainable at a pharmacy	Payable as any other covered expense	Payable as any other covered expense
Transplants Preferred coverage is provided at an IOE contracted facility only	20%; after deductible	40%; after deductible

FAMILY PLANNING	PREFERRED CARE	NON-PREFERRED CARE
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.	Member cost sharing is based on the type of service performed and the place where it is rendered.
Voluntary Sterilization Including tubal ligation, vasectomy and voluntary abortion	Member cost sharing is based on the type of service performed and the place where it is rendered.	Member cost sharing is based on the type of service performed and the place where it is rendered.

PHARMACY – PRESCRIPTION DRUG BENEFITS	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
Retail Up to a 30 day supply Mandatory generics with dispense as written over-ride	$15 copay for generic formulary and non-formulary drugs, $25 copay for formulary drugs, and $40 copay for non-formulary brand named drugs	Not Covered
Mail Order Delivery (MOD) 31 to 90 day supply Mandatory generics with dispense as written over-ride	$30 copay for generic formulary and non-formulary drugs, $50 copay for brand formulary drugs, and $80 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™.

*Payments for out-of-network care is determined based upon the lowest of: the provider's usual charge for furnishing it; or the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in

which charges for the service or supply are made. These charges are referred to in your plan documents as “reasonable” or “recognized” charges.

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; Medical expenses for a pre-existing condition are not covered (full postponement rule) for the first 180 days after the insured’s enrollment date. Look back period for determining a pre-existing condition (conditions for which diagnosis, care or treatment was recommended or received) is 180 days prior to the enrollment date. The pre-existing condition limitation period will be reduced by the number of days of prior creditable coverage the member has as of the enrollment date; 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 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.