Vitalidad Mexico con Aetna℠ HMO $5

Services Apply to SIMNSA Network only (except urgent or emergency care)*

PLAN FEATURES	PARTICIPATING PROVIDERS
Deductible (per calendar year)	None
Member Coinsurance	Not applicable
Copay Maximum **(per calendar year)**	$1,500 per Individual $3,000 per Family
All member copays accumulate toward the Copay Maximum, excluding member cost share for Prescription Drugs. No individual can contribute more than the Individual Copay Maximum toward satisfaction of the Family Copay Maximum. Once the Family Copay Maximum is met, all family members will be considered as having met their Copay Maximum for the remainder of the calendar year.	
Lifetime Maximum	Unlimited except where otherwise indicated.
Primary Care Physician Selection	SIMNSA Providers Only
Referral Requirement	Required for all non-emergency, non-urgent and non-Primary Care Physician services, except direct access services.
PHYSICIAN SERVICES	**PARTICIPATING PROVIDERS**
Primary Care Physician Visits	$5 copay
Specialist Office Visits	$5 copay
Maternity/OB Visits	$5 copay
Allergy Testing	No charge
Allergy Treatment	$5 copay
PREVENTIVE CARE	**PARTICIPATING PROVIDERS**
Routine Adult Physical Exams / Immunizations Limited to 1 exam every 12 months for members age 18 and older.	No charge
Well Child Exams / Immunizations Provides coverage for 9 exams from birth up to age 3; 1 exam per 12 months from age 3 through age 17.	No charge
Routine Gynecological Exams** Includes pap smear, HPV screening and related lab fees. Limited to one visit per 365-day period, unless otherwise recommended by a physician.	No charge
Routine Mammograms One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over.	No charge
Routine Digital Rectal Exams/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 rendered.
Colorectal Cancer Screening For all members age 50 and over. Frequency schedule applies.	Member cost sharing is based on the type of service performed and the place rendered.
Colonoscopy	See Outpatient Surgery Benefit
Routine Eye and Hearing Exams	$5 copay

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DIAGNOSTIC PROCEDURES	PARTICIPATING PROVIDERS
Diagnostic Laboratory and X-ray (except for Complex Imaging Services) - (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.)	No charge
Diagnostic X-ray for Complex Imaging Services (MRI, MRA, PET and CT Scans)	No charge
EMERGENCY/URGENT MEDICAL CARE	**PARTICIPATING PROVIDERS**
Urgent Care Provider (In SIMNSA Network)	$10 copay
Urgent Care Provider (Out of SIMNSA Network)	$35 copay
Non-Urgent use of Urgent Care Provider	Not Covered
Emergency Room (In SIMNSA Network)	$10 copay
Emergency Room (Out of SIMNSA Network)	$100 copay
Non-Emergency care in an Emergency Room	Not Covered
Ambulance (In SIMNSA Network)	No charge
Ambulance (Out of SIMNSA Network)	$50 copay
HOSPITAL CARE	**PARTICIPATING PROVIDERS**
Inpatient Coverage (including maternity & transplants)	No charge
Outpatient Surgery	No charge
MENTAL HEALTH SERVICES	**PARTICIPATING PROVIDERS**
Inpatient Serious Mental Illness & Serious Emotional Disturbances of a Child	No charge
Outpatient Serious Mental Illness & Serious Emotional Disturbances of a Child	$5 copay
Inpatient Other than Serious Mental Illness & Serious Emotional Disturbances of a Child Limited to 20 days per member per calendar year	No charge
Outpatient Other than Serious Mental Illness & Serious Emotional Disturbances of a Child Limited to 20 visits per member per calendar year	$5 copay
ALCOHOL/DRUG ABUSE SERVICES	**PARTICIPATING PROVIDERS**
Inpatient Detoxification	No charge
Outpatient Detoxification	$5 copay
Inpatient Rehabilitation Limited to 30 days per member per calendar year	No charge
Outpatient Rehabilitation Limited to 20 visits per member per calendar year	$5 copay
OTHER SERVICES	**PARTICIPATING PROVIDERS**
Skilled Nursing Facility Limited to 100 days per member per calendar year	No charge
Home Health Care	$5 copay

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Infusion Therapy	$5 copay
Hospice Care - Inpatient	No charge
Hospice Care - Outpatient (Home-based only)	$5 copay
Outpatient Rehabilitation Therapy Includes physical, occupational and speech therapy.	$5 copay
Chiropractic	Not covered
Durable Medical Equipment	No charge
FAMILY PLANNING	**PARTICIPATING PROVIDERS**
Infertility Treatment Coverage for the diagnosis and surgical treatment of the underlying medical cause.	Member cost sharing is based on the type of service performed and the place rendered.
Voluntary Termination of Pregnancy Coverage is prohibited by law in Mexico except in cases to preserve the life of the mother.	Not covered
Voluntary Sterilization Including tubal ligation and vasectomy.	$50 copay
PRESCRIPTION DRUG BENEFITS	**PARTICIPATING PHARMACIES**
Prescription Drugs (In SIMNSA Network)	$5 Generic and Brand
Prescription Drugs (Out of SIMNSA Network / Closed Formulary) Closed formulary is based on medications related to an Emergency Room or Urgent Care visit.	$5 Generic / $15 Brand
Mail Order Prescription Drugs	Not Covered

*For this plan, "Participating Providers" refers to the SIMNSA Network participating providers. For any questions or concerns about accessing and obtaining services from the SIMNSA network please call Member Services at 1-888-98-AETNA (1-888-982-3862)

**Members may directly access participating providers for certain services as outlined in the plan documents.

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 or 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 x-rays.
Donor egg retrieval.
Elective Abortions.
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.

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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.

Non-medically necessary services or supplies.

Orthotics, except as specified in the plan.

Over-the-counter medications and supplies other than for certain covered diabetic drugs and supplies and/or certain contraceptives.

Radial Keratotomy or related procedures.

Reversal of sterilization.

Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs.

Special duty nursing.

Therapy or rehabilitation other than those listed as covered in the plan documents.

Weight reduction programs, or dietary supplements, except as pre-authorized by HMO for the Medically Necessary treatment of morbid obesity.

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 results or outcomes. Consult the plan documents (i.e. Schedule of Benefits, Evidence of Coverage, Group Agreement and Disclosure Brochure) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. The availability of a plan or program may vary by geographic service area. Some benefits are subject to limitations or visit maximums. Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. 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.

If your plan covers outpatient prescription drugs, your plan may include a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally not limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step-therapy, please refer to Aetna's website at Aetna.com, or the Aetna Medication Formulary Guide. Many drugs, including many of those listed on the formulary, are subject to rebate arrangements between Aetna and the manufacturer of the drugs.

Rebates received by Aetna from drug manufacturers are not reflected in the cost paid by a member for a prescription drug. In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage.

Plans are offered by: Aetna Health of California Inc.

While this information is believed to be accurate as of the print date, it is subject to change.