Aetna

Aetna Life Insurance Company

California Small Group MC
Plan Effective Date: 04/01/2009

PLAN DESIGN AND BENEFITS - CA MC $10,000 100/50

PLAN FEATURES	NETWORK CARE	OUT-OF-NETWORK CARE
Deductible (per calendar year)	$10,000 Individual $10,000 Family	
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. All covered expenses accumulate toward both the preferred and non-preferred Deductible. Member cost sharing for certain services including member cost sharing for prescription drugs, as indicated in the plan, are excluded from charges to meet the Deductible. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. No one family member may contribute more than the Individual Deductible amount to the Family Deductible.		
Member Coinsurance (applies to all expenses unless otherwise stated)	0%	50%
Coinsurance maximum (per calendar year, excludes deductible)	$0 Individual $0 Family	Unlimited Individual Unlimited Family
All covered expenses 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, DME, failure to pre-certify penalty, infertility, non-SMI-SED mental disorders, Rx (including self-injectables) and substance abuse do not apply toward the Coinsurance Maximum and continue to be payable after the maximum is reached. Once the Family Maximum Out-of-Pocket Limit is met, all family members will be considered as having met their Maximum Out-of-Pocket Limit for the remainder of the calendar year. No one family member may contribute more than the Individual Maximum Out-of-Pocket Limit amount to the Family Out-of-Pocket Limit.		
Lifetime Maximum	$5,000,000 per member's lifetime. (Network and out-of-Network care combined)	
Payment for Non-Preferred Care	Not Applicable	Recognized Amount*
Primary Care Physician Selection	Not Applicable	Not Applicable
Certification Requirements Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification 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 Certification is not obtained.		
Referral Requirement	None	None
PHYSICIAN SERVICES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Office Visits to Non-Specialist	$15 copay; deductible waived	50% 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 and in-office surgery.		
Specialist Office Visits	0% after deductible	50% after deductible
Primary Care & Specialist Physician E-Visits	$15 copay; deductible waived	Not Covered
An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor. Register at www.relayhealth.com.		
Walk-in Clinics	$15 copay; deductible waived	Not Covered
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor an outpatient department of a hospital, shall be considered a Walk-in Clinic.		

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Maternity OB Visits	0% after deductible	50% after deductible
Surgery (in office)	Applicable Office Visit Copay	50% after deductible
Allergy Testing (given by a physician)	0% after deductible	50% after deductible
Allergy Injections (not given by a physician)	0% after deductible	50% after deductible
PREVENTIVE CARE	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Routine Adult Physical Exams and Immunizations Limited to 1 exam every 12 months for members age 18 and older.	$15 copay; deductible waived	50% after deductible
Well Child Exams and Immunizations Provides coverage for 9 exams from birth up to age 3; 1 exam per 12 months from age 3 through age 17.	$15 copay; deductible waived	50% after deductible
Routine Gynecological Exams Includes Pap smear, HPV screening and related lab fees. Frequency schedule applies.	$15 copay; deductible waived	50% after deductible
Routine Mammograms For covered females age 40 and over. Frequency schedule applies.	$15 copay; deductible waived	50% after deductible
Routine Digital Rectal Exam / Prostate-Specific Antigen Test For covered males age 40 and over. Frequency schedule applies.	Member cost sharing is based on the type of service performed and the place rendered	Member cost sharing is based on the type of service performed and the place rendered
Colorectal Cancer Screening *Sigmoidoscopy and Double Contrast Barium Enema* - 1 every 5 years for all members age 50 and over. *Colonoscopy* - 1 every 10 years for all members age 50 and over. *Fecal Occult Blood Testing* - 1 every year for all members age 50 and over.	Member cost sharing is based on the type of service performed and the place rendered	Member cost sharing is based on the type of service performed and the place rendered
Routine Eye and Hearing Exams Covered only as part of a routine physical exam.	Paid as part of routine physical exam.	Paid as part of routine physical exam.
DIAGNOSTIC PROCEDURES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Outpatient 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 member cost sharing.	$15 copay; deductible waived	50% after deductible
Outpatient Diagnostic X-ray for Complex Imaging Services Including, but not limited to, MRI, MRA, PET and CT Scans. Precertification required.	0% after deductible	50% after deductible. Maximum payment of $800 per service.

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EMERGENCY MEDICAL CARE	NETWORK CARE	OUT-OF-NETWORK CARE
Urgent Care Provider (Benefit Availability may vary by location.)	0% after deductible	0% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted. Copay applies to facility charges only.	0% after deductible	Paid as Network Care
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Emergency Ambulance	0% after deductible	Paid as Network Care
HOSPITAL CARE	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Inpatient Coverage Including maternity (prenatal, delivery and postpartum) & transplants	0% after deductible	50% after deductible. Maximum payment of $750 per day.
Outpatient Surgery Provided in an outpatient hospital department	0% after deductible	50% after deductible. Maximum payment of $400 per surgery.
Outpatient Surgery Provided in a freestanding surgical facility	0% after deductible	50% after deductible. Maximum payment of $400 per surgery.
Outpatient Hospital Services other than Surgery Including, but not limited to, physical therapy, speech therapy, occupational therapy, spinal manipulation, dialysis, radiation therapy.	0% after deductible	50% after deductible. Maximum payment of $300 per visit.
MENTAL HEALTH SERVICES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Inpatient Serious Mental Illness or Serious Emotional Disturbances of a Child	0% after deductible	50% after deductible. Maximum payment of $750 per day.
Outpatient Serious Mental Illness or Serious Emotional Disturbances of a Child	0% after deductible	50% after deductible
Inpatient Other than Serious Mental Illness or Serious Emotional Disturbances of a Child	Not Covered	Not Covered
Outpatient Other than Serious Mental Illness or Serious Emotional Disturbances of a Child Limited to 20 visits per member per calendar year. Network and Out-of-Network combined.	0% after deductible	50% after deductible. Maximum benefit of $25 per visit.
ALCOHOL / DRUG ABUSE SERVICES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Inpatient Detoxification Limited to 3 days per admission, 2 admissions per lifetime. Network and Out-of-Network combined.	0% after deductible	50% after deductible. Maximum payment of $175 per day.
Outpatient Detoxification	Not Covered	Not Covered
Inpatient and Outpatient Rehabilitation	Not Covered	Not Covered

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OTHER SERVICES AND PLAN DETAILS	NETWORK CARE	OUT-OF-NETWORK CARE
Skilled Nursing Facility Limited to 60 days per member per calendar year. Network and Out-of-Network combined.	0% after deductible	50% after deductible. Maximum benefit of $200 per day.
Home Health Care Limited to 90 visits per member per calendar year. Network and Out-of-Network combined; 1 visit equals a period of 4 hours or less.	0% after deductible	50% after deductible. Maximum benefit of $100 per visit.
Infusion Therapy Provided in the home or physician's office	0% after deductible	50% after deductible. Maximum benefit of $50 per visit.
Infusion Therapy Provided in an outpatient hospital department or freestanding facility	0% after deductible	50% after deductible. Maximum benefit of $50 per visit.
Inpatient Hospice Care	0% after deductible	50% after deductible. Maximum benefit of $200 per day.
Outpatient Hospice Care	0% after deductible	50% after deductible
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Outpatient Short-Term Rehabilitation Includes physical, occupational and chiropractic therapy (if provided in the outpatient hospital department, paid under outpatient hospital benefit). Limited to 24 visits per member per calendar year. Network and Out-of-Network combined.	0% after deductible	50% after deductible. Maximum benefit of $25 per visit.
Outpatient Speech Therapy (if provided in the outpatient hospital department, paid under outpatient hospital benefit) Limited to 20 visits per member per calendar year. Network and Out-of-Network combined.	0% after deductible	50% after deductible.
Durable Medical Equipment Maximum benefit of $2,000 per member per calendar year. Limit does not apply to prosthetics or orthotics. Network and Out-of-Network combined.	0% after deductible	50% after deductible.
Diabetic Supplies not obtainable at a pharmacy	Covered same as any other medical expense	Covered same as any other medical expense
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	Applicable Office Visit Copay	50% after deductible
FAMILY PLANNING	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Infertility Treatment Covered 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 rendered	Member cost sharing is based on the type of service performed and the place rendered
Voluntary Sterilization Including tubal ligation and vasectomy	Member cost sharing is based on the type of service performed and the place rendered	Member cost sharing is based on the type of service performed and the place rendered

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PHARMACY - PRESCRIPTION DRUG BENEFITS	PARTICIPATING PHARMACIES	NON-PARTICIPATING PHARMACIES
Retail Up to a 30-day supply	$20 copay for generic drugs, $40 copay for brand name formulary drugs, and $70 copay for brand name non-formulary drugs	Not Covered
Mail Order Delivery 31-90 day supply	$40 copay for generic drugs, $80 copay for brand name formulary drugs, and $140 copay for brand name non-formulary drugs	Not Covered
Self-Injectables (Excluding insulin) Does not accumulate toward Coinsurance maximum.	30% for formulary and non-formulary drugs	Not Covered
Specialty CareRx - First Prescription for a self-injectable drug must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy®. 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 when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan includes: Contraceptive drugs and devices obtainable from a pharmacy and diabetic supplies obtainable from a pharmacy. Lifestyle/performance drugs limited to 4 pills per month. Precerticifation included and 90-day Transition of Care (TOC) for Precertification included.		

*Payment for Out-of-Network facility care is determined based upon Aetna's Allowable Fee Schedule, which is subject to change. Payment for other Out-of-Network care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Network Provider. These charges are referred to in your plan documents as "recognized" charges.

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 purchased.

- 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;
- Non-medically 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, counseling and prescription
- Special duty nursing; and
- Treatment of those services for or related to treatment of obesity or for diet or weight control.

Pre-existing Conditions Exclusion Provision

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 conditions 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 6 months.

Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6 month period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 6 months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period.

If you had less than 6 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 6 months for group or 3 months for individual prior to your enrollment date (either because you had no prior coverage or because there was more than a 6 months of group or 3 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 Coverage you have. Please contact your Aetna Member Services representative at 1-888-802-3862 for MC plans 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 results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred 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.

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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. Precertification requirements may vary.

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. 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. 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.

Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna, Inc., that is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated charge with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services.

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

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Plans are provided by Aetna Life Insurance Company.

For more information about Aetna plans, refer to www.aetna.com.