Aetna

Effective date: 04/01/08

PROVIDED BY AETNA HEALTH OF CALIFORNIA INC. Aetna HMO Deductible Plan - California

CA HMO Deductible $1,000

Your HMO Plan	
Primary Care Physician - You choose a Primary Care Physician. The Aetna HMO Deductible provider network gives you access to a wide selection of Primary Care Physicians (PCP's) and Specialists in the state. Your PCP will coordinate your care and provide referrals to other participating health care professionals.	
Prescription Drugs	**Covered at a copay, no deductible**
Preventive Care	**Covered at the PCP copay, no deductible**
Physician Office Visit PCP	**Covered at the PCP copay, no deductible**
Physician Office Visit Specialist	**Covered at the Specialist copay, no deductible**
Urgent Care Centers	**Covered at a copay, no deductible**
X-Ray and Diagnostic Labs	**Covered at a copay, no deductible**

Services Covered by a Copay

Multiple copays will be applied when multiple services are rendered. The member will be responsible for one copay for each clinical service provided.

Deductible

A deductible is a set amount of expenses you pay each year before your plan begins to pay toward covered services. You will need to meet a deductible for:

Emergency Care
Hospital Care
Outpatient Surgery
Home Health Care
Durable Medical Equipment

Out of Pocket Maximum

The out-of-pocket maximum is a limit on the amount you pay out of your pocket in a given plan year. This feature protects you from financial exposure due to catastrophic health events. When your eligible out-of-pocket expenses reach the maximum limit, your remaining eligible expenses are covered by the HMO plan at 100% for the remainder of the plan year.

PLAN FEATURES	**PARTICIPATING PROVIDERS / REFERRED**
Deductible (per calendar year)	**$1,000 Individual** **$2,000 Family**

Unless otherwise indicated, the Deductible must be met prior to benefits being payable.

Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.

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.

Member Coinsurance	**30%**
Out-of-Pocket Maximum (per calendar year)	**$3,500 Individual** **$7,000 per Family**

Only those participating providers/referred out of pocket expenses resulting from the application of coinsurance percentage, deductible, and copays may be used to satisfy the Out-of Pocket Maximum.

Once Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.

Lifetime Maximum	Unlimited except where otherwise indicated.
Primary Care Physician Selection	Required
Referral Requirements	Required for all non-emergency, non-urgent and non-Primary Care Physicians services, except direct access services.

PREVENTIVE CARE	**PARTICIPATING PROVIDERS / REFERRED**
Routine Adult Physical Exams/ Immunizations Limited to 1 exam every 12 months for members age 18 and older.	$40 copay, deductible waived

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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.	$40 copay, deductible waived
Routine Gynecological Care Exams* Includes Pap smear, HPV screening and related lab fees. Direct access to participating providers. One routine exam per 365 days, unless otherwise recommended by a physician.	$30 copay, deductible waived
Routine Mammograms One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	$40 copay, deductible waived
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 of service where it is rendered.
Colorectal Cancer Screening For all members 50 and over. Frequency schedule applies.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Colonoscopy	See Outpatient Surgery Benefit
Routine Eye & Hearing Exams	Paid as part of a routine physical exam.
PHYSICIAN SERVICES	**PARTICIPATING PROVIDERS / REFERRED**
Primary Care Physician Visits	$40 copay, deductible waived
Specialist Office Visits	$40 copay, deductible waived
First Prenatal Visit	$30 Copay for 1st visit; then covered at 100%, deductible waived. Refer to Inpatient Maternity for delivery charges.
Allergy Testing & Treatment	$40 copay, deductible waived (copay waived when office visit charge is not made)
DIAGNOSTIC PROCEDURES	**PARTICIPATING PROVIDERS / REFERRED**
Diagnostic Laboratory	$40 copay, deductible waived
Diagnostic X-ray	$40 copay, deductible waived
Complex Imaging	$100 copay, deductible waived
URGENT MEDICAL CARE	**PARTICIPATING PROVIDERS / REFERRED**
Urgent Care (benefit availability may vary by location)	$50 copay, deductible waived
MENTAL HEALTH SERVICES	**PARTICIPATING PROVIDERS / REFERRED**
Outpatient Serious Mental Illness or Biologically based Mental illness	$40 copay per visit, deductible waived
Outpatient Other than Serious mental Illness or Biologically Based Mental Illness Limited to 20 visits per calendar year	$40 copay per visit, deductible waived
ALCOHOL/DRUG ABUSE SERVICES	**PARTICIPATING PROVIDERS / REFERRED**
Outpatient Detoxification	$40 copay per visit, deductible waived
Outpatient Rehabilitation	Not Covered
OTHER SERVICES	**PARTICIPATING PROVIDERS / REFERRED**
Outpatient Speech Therapy Limited to 20 visits per calendar year	$40 per visit copay, deductible waived
Outpatient Physical and Occupational Therapy Limited to 20 visits per calendar year combined	$40 per visit copay, deductible waived
Subluxation (Chiropractic)* Limited to 20 visits per calendar year	$15 per visit copay, deductible waived
Infusion Therapy - Home or Physician's Office	$40 per visit copay, deductible waived
Infusion Therapy - OP Facility	$40 per visit copay, deductible waived

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Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies
Family Planning	
Infertility Treatment Diagnosis and treatment of the underlying medical condition	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Voluntary Sterilization Including tubal ligation and vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
EMERGENCY MEDICAL CARE	**PARTICIPATING PROVIDERS / REFERRED**
Emergency Room	$100 copay after deductible
Ambulance	$100 copay after deductible
HOSPITAL CARE	**PARTICIPATING PROVIDERS / REFERRED**
Inpatient Coverage	30% after deductible
Inpatient Maternity Coverage	30% after deductible
Outpatient Surgery in Hospital	30% after deductible
Outpatient Surgery in Free-Standing Surgery Center	30% after deductible
MENTAL HEALTH SERVICES	**PARTICIPATING PROVIDERS / REFERRED**
Inpatient Severe Mental Illness or Biologically Based Mental Illness	30% after deductible
Inpatient Other than Severe Mental Illness or Biologically Based Mental Illness	Not Covered
ALCOHOL/DRUG ABUSE SERVICES	**PARTICIPATING PROVIDERS / REFERRED**
Inpatient Detoxification	30% after deductible
Inpatient Rehabilitation	Not Covered
OTHER SERVICES	**PARTICIPATING PROVIDERS / REFERRED**
Skilled Nursing Facility Limited to 100 days per calendar year	30% after deductible
Home Health Care Limited to 100 visits per calendar year	$40 copay after deductible
Hospice Care - Inpatient	30% after deductible
Hospice Care - Outpatient	$40 copay per visit after deductible
Durable Medical Equipment Maximum benefit of $2,000 per member per calendar year. Limit does not apply to prosthetics or orthotics.	50% of the cost of the item (of calendared rate), after deductible
Bariatric Surgery	30% after deductible
Transplants	30% after deductible
PHARMACY - PRESCRIPTION DRUG BENEFITS	**PARTICIPATING PROVIDERS / REFERRED**
Retail	$20 copay for generic drugs, $40 copay for formulary brand-name drugs, and $60 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies
Mail order	2 x retail

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 and the brand price.

Plan includes lifestyle/performance drugs (limited to 4 pills per month), contraceptive drugs, devices obtainable from a pharmacy and diabetic supplies. Precertification and step-therapy included.

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

What's Not Covered

”Aetna” is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The Aetna companies that offer, underwrite or administer benefits include Aetna Health Inc.. While this material is believed to be accurate as of the print date, it is subject to change.

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).
• Hearing aids.
• Home births
• Immunizations for travel or work
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• 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.
• Nonmedically necessary services or supplies.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) 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.

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 document (i.e. Schedule of Benefits, Certificate of Coverage, Evidence of Coverage, Group Agreement, Group Insurance 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. Some benefits are subject to limitations or visit maximums. With the exception of Aetna Rx Home Delivery, all 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.

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Aetna Pharmacy Management refers to an internal business unit of Aetna Health Management, LLC. 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 www.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. 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.

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 a 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.

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 obtains covered services from participating providers, the provider will obtain precertification. If the Member obtains covered services from a nonparticipating provider, the Member must obtain the precertification. Precertification requirements may vary. Members may refer to their plan documents for a complete list of medical services that require precertification. Certain benefits like comprehensive infertility and advanced reproductive technology (ART) services, if covered under your plan, are subject to a select network of participating providers, from which you will be required to seek care to receive covered benefits.

Members or providers may be required to precertify, or obtain prior approval of coverage for certain services such as non-emergency inpatient hospital care. Certain benefits like comprehensive infertility and advanced reproduction technology (ART) services, if covered under your plan, are subject to a select network of participating providers, from which you will be required to seek care to receive covered benefits.

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