

**PLAN DESIGN AND BENEFITS- CA HMO \$10/\$30**

<b>PLAN FEATURES</b>	<b>PARTICIPATING PROVIDERS</b>
<b>Deductible</b> (per calendar year)	None
<b>Member Coinsurance</b>	Not applicable
<b>Out-of-Pocket Maximum</b> (per calendar year)	\$2,000 per Individual \$4,000 per Family
All member copays accumulate toward the Out-of-Pocket Maximum, excluding member cost share for Prescription Drugs. No individual can contribute more than the Individual Out-of-Pocket Maximum toward satisfaction of the Family Out-of-Pocket Maximum. Once the 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.	
<b>Lifetime Maximum</b>	Unlimited except where otherwise indicated.
<b>Primary Care Physician Selection</b>	Required
<b>Referral Requirement</b>	Required for all non-emergency, non-urgent and non-Primary Care Physician services, except direct access services.
<b>PHYSICIAN SERVICES</b>	<b>PARTICIPATING PROVIDERS</b>
<b>Primary Care Physician Visits</b>	Office Hours: \$10 copay After Office Hours/Home: \$15 copay
<b>Specialist Office Visits</b>	\$30 copay
<b>Maternity/OB Visits</b>	Same as Specialist Office Visit for initial visit only; thereafter covered at 100%.
<b>Allergy Testing &amp; Treatment</b>	\$30 copay (copay waived when office visit charge is not made)
<b>PREVENTIVE CARE</b>	<b>PARTICIPATING PROVIDERS</b>
<b>Routine Adult Physical Exams/ Immunizations</b> Limited to 1 exam every 12 months for members age 18 and older.	\$10 copay
<b>Well Child Exams/Immunizations</b> Provides coverage for 9 exams from birth up to age 3; 1 exam per 12 months thereafter up to age 18.	\$10 copay
<b>Routine Gynecological Exams*</b> Includes pap smear and related lab fees. Limited to one visit per 365 -day period.	\$30 copay
<b>Routine Mammograms</b> One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over.	\$30 copay
<b>Routine Digital Rectal Exams/Prostate Specific Antigen Test</b> For covered males age 40 and over	Member cost sharing is based on the type of service performed and the place rendered.
<b>Colorectal Cancer Screening</b> 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.
<b>Colonoscopy</b>	See Outpatient Surgery Benefit
<b>Routine Eye and Hearing Exams</b>	Paid as part of a routine physical exam.

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<b>DIAGNOSTIC PROCEDURES</b>	<b>PARTICIPATING PROVIDERS</b>
<b>Diagnostic Laboratory and X-ray (except for Complex Imaging Services)</b> - (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.)	\$30 copay
<b>Diagnostic X-ray for Complex Imaging Services</b> (MRI, MRA, PET and CT Scans)	\$30 copay
<b>EMERGENCY/URGENT MEDICAL CARE</b>	<b>PARTICIPATING PROVIDERS</b>
<b>Urgent Care Provider</b> (benefit availability may vary by location)	\$50 copay
<b>Non-Urgent use of Urgent Care Provider</b>	Not Covered
<b>Emergency Room</b>	\$100 copay
<b>Non-Emergency care in an Emergency Room</b>	Not Covered
<b>Ambulance</b>	\$100 copay
<b>HOSPITAL CARE</b>	<b>PARTICIPATING PROVIDERS</b>
<b>Inpatient Coverage</b> (including maternity & transplants)	\$300 copay
<b>Outpatient Surgery</b> Performed in a Hospital Outpatient Facility	\$250 copay
<b>Outpatient Surgery</b> Performed in a Facility Other than a Hospital Outpatient Facility	\$50 copay
<b>MENTAL HEALTH SERVICES</b>	<b>PARTICIPATING PROVIDERS</b>
<b>Inpatient Serious Mental Illness or Biologically Based Mental Illness</b>	\$300 copay
<b>Outpatient Serious Mental Illness or Biologically Based Mental Illness</b>	\$30 copay
<b>Inpatient Other than Serious Mental Illness or Biologically Based Mental Illness</b>	Not Covered
<b>Outpatient Other than Serious Mental Illness or Biologically Based Mental Illness</b> Limited to 20 visits per member per calendar year	\$30 copay
<b>ALCOHOL/DRUG ABUSE SERVICES</b>	<b>PARTICIPATING PROVIDERS</b>
<b>Inpatient Detoxification</b>	\$300 copay
<b>Outpatient Detoxification</b>	\$30 copay
<b>Inpatient Rehabilitation</b>	Not Covered
<b>Outpatient Rehabilitation</b>	Not Covered
<b>OTHER SERVICES</b>	<b>PARTICIPATING PROVIDERS</b>
<b>Transplant - Facility Expense Services</b> Coverage provided for transplants that are not experimental and non-investigational at approved facilities – generally Institutes of Excellence contracted facilities only. Precertification required.	\$300 copay

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<b>Skilled Nursing Facility</b> Limited to 100 days per member per calendar year	\$300 copay
<b>Home Health Care</b> Limited to 100 visits per member per calendar year; 1 visit equals a period of 4 hours or less.	\$0 copay
<b>Infusion Therapy</b> Provided at Home or in the Physician's Office	\$10 copay
<b>Infusion Therapy</b> Provided in OP Hospital or Facility	\$30 copay
<b>Hospice Care - Inpatient</b>	\$300 copay
<b>Hospice Care - Outpatient</b>	\$0 copay
<b>Outpatient Rehabilitation Therapy</b> Includes physical and occupational therapy. Limited to 20 visits per member per calendar year.	\$30 copay
<b>Outpatient Speech Therapy</b> Limited to 20 visits per member per calendar year	\$30 copay
<b>Subluxation (Chiropractic)</b> Limited to 20 visits per member per calendar year	\$15 copay
<b>Durable Medical Equipment</b> Maximum benefit of \$2,000 per member per calendar year	50% per item
<b>FAMILY PLANNING</b>	<b>PARTICIPATING PROVIDERS</b>
<b>Infertility Treatment</b> Coverage for only 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.
<b>Voluntary Sterilization</b> Including tubal ligation and vasectomy.	Member cost sharing is based on the type of service performed and the place rendered.
<b>PHARMACY-PRESCRIPTION DRUG BENEFITS</b>	<b>PARTICIPATING PHARMACIES</b>
<b>Retail</b> Up to a 30-day supply Mandatory generics with dispense as written over-ride	\$15 copay for generic formulary drugs, \$35 copay for brand name formulary drugs, and \$50 copay for brand name and generic non-formulary drugs
<b>Mail Order</b> 31- 90 day supply at participating pharmacies. Mandatory generics with dispense as written over-ride	2 x retail
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.	
<b>SPECIAL PROGRAMS</b>	
Certain Special programs 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™	

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

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#### 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.

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 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. NOTE: Some states require coverage for diabetes related care and/or congenital defects.

Over-the-counter medications and supplies. NOTE: Some states require coverage for certain covered diabetic drugs and supplies and/or certain contraceptives.

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.

Treatment of behavioral disorders.

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, Certificate of Coverage, Evidence of Coverage, Group Agreement, Group Insurance Certificate and/or Group Policy) 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.

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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](http://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.

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.