

**PLAN DESIGN AND BENEFITS - CA EPO Limited (Open Access)**

<b>PLAN FEATURES</b>	<b>PREFERRED CARE</b>
<b>Deductible</b> (per calendar year)	\$1,000 per member
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. 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.	
<b>Member Coinsurance</b> (applies to all expenses unless otherwise stated)	50%
<b>Coinsurance Maximum</b> (per calendar year, excludes deductible)	\$4,500 per member
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 (including self-injectables), substance abuse and DME do not apply to Coinsurance Maximum and continue to be payable after the maximum is reached.	
<b>Annual Maximum</b>	\$30,000 per member per calendar year
<b>Primary Care Physician Selection</b>	Not Applicable
<b>Referral Requirement</b>	None
<b>PHYSICIAN SERVICES</b>	<b>PREFERRED CARE</b>
<b>Office Visits to Non-Specialist</b> 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. <i>(covered providers may vary by state)</i>	50% after deductible
<b>Specialist Office Visits</b>	50% after deductible
<b>E-Visit (register at <a href="http://www.relayhealth.com">www.relayhealth.com</a>)</b>	50% after deductible
<b>Walk-In-Clinics</b>	50% after deductible
<b>Maternity OB Visits</b>	50% after deductible
<b>Surgery (in office)</b>	50% after deductible
<b>Allergy Testing</b> (given by a physician)	50% after deductible
<b>Allergy Injections</b> (not given by a physician)	50% after deductible
<b>PREVENTIVE CARE</b>	<b>PREFERRED CARE</b>
<b>Routine Adult Physical Exams / Immunizations</b> Limited to 1 exam every 12 months for members age 18 and older. \$300 maximum benefit every 12 months.	\$15 copay; deductible waived
<b>Well Child Exams / Immunizations</b> 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
<b>Routine Gynecological Exams</b> Includes Pap smear, HPV screening and related lab fees Frequency schedule applies.	\$15 copay; deductible waived
<b>Routine Mammograms</b> For covered females age 40 and over Frequency schedule applies	\$15 copay; deductible waived

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<b>Routine Digital Rectal Exam / Prostate-Specific Antigen Test</b> 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
<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 &amp; Hearing Exams</b> Covered only as part of a routine physical exam	Paid as part of a routine physical exam
<b>DIAGNOSTIC PROCEDURES</b>	<b>PREFERRED CARE</b>
<b>Outpatient 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 member cost sharing. If performed in the outpatient hospital department, payable under outpatient hospital plan provisions.	50% after deductible
<b>Outpatient Diagnostic X-ray for Complex Imaging Services</b> Including, but not limited to, MRI, MRA, PET and CT Scans	50% after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>PREFERRED CARE</b>
<b>Urgent Care Provider</b> Benefit Availability may vary by location	50% after deductible
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered
<b>Emergency Room</b> Copoly waived if admitted	50% after \$100 copay after deductible
<b>Non-Emergency care in an Emergency Room</b>	Not Covered
<b>Emergency Ambulance</b>	50% after deductible
<b>HOSPITAL CARE</b>	<b>PREFERRED CARE</b>
<b>Inpatient Coverage</b> Including maternity [prenatal, delivery and postpartum] & transplants	50% after deductible
<b>Outpatient Surgery</b> Provided in an outpatient hospital department	50% after deductible
<b>Outpatient Surgery</b> Provided in a freestanding surgical facility	50% after deductible
<b>MENTAL HEALTH SERVICES</b>	<b>PREFERRED CARE</b>
<b>Inpatient Serious Mental Illness &amp; Serious Emotional Disturbances of a Child</b>	50% after deductible
<b>Outpatient Serious Mental Illness &amp; Serious Emotional Disturbances of a Child</b>	50% after deductible

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<b>Inpatient Other than Serious Mental Illness &amp; Serious Emotional Disturbances of a Child</b>	Not covered
<b>Outpatient Other than Serious Mental Illness &amp; Serious Emotional Disturbances of a Child</b> Limited to 20 visits per member per calendar year	50% after deductible
<b>ALCOHOL / DRUG ABUSE SERVICES</b>	<b>PREFERRED CARE</b>
<b>Inpatient Detoxification</b> Limited to 3 days per admission, 2 admissions per lifetime	50% after deductible
<b>Outpatient Detoxification</b>	Not covered
<b>Inpatient Rehabilitation</b>	Not covered
<b>Outpatient Rehabilitation</b>	Not covered
<b>OTHER SERVICES AND PLAN DETAILS</b>	<b>PREFERRED CARE</b>
<b>Skilled Nursing Family</b> Limited to 60 days per member per calendar year	50% after deductible
<b>Home Health Care</b> Limited to 90 visits per member per calendar year; 1 visit equals a period of 4 hours or less	50% after deductible
<b>Infusion Therapy</b> Provided in the home or physician's office	50% after deductible
<b>Infusion Therapy</b> Provided in an outpatient hospital department or freestanding facility	50% after deductible
<b>Inpatient Hospice Care</b> Limited to 30 days per member per calendar year	50% after deductible
<b>Outpatient Hospice Care</b> Up to a maximum benefit of \$5,000 per member per lifetime	50% after deductible
<b>Private Duty Nursing - Outpatient</b>	Not covered
<b>Outpatient Speech Therapy</b> Limited to 20 visits per member per calendar year	50% after deductible
<b>Outpatient Physical, Occupational Therapy and Chiropractic Therapy</b> Limited to 24 visits per member per calendar year	50% after deductible
<b>Durable Medical Equipment</b> Maximum benefit of \$2,000 per member per calendar year. Limit does not apply to prosthetics or orthotics.	50% after deductible
<b>Diabetic Supplies not obtainable at a pharmacy</b>	Covered same as any other medical expense
<b>Contraceptive drugs and devices not obtainable at a pharmacy</b> Includes coverage for contraceptive visits	Covered same as any other medical expense

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<b>FAMILY PLANNING</b>	<b>PREFERRED CARE</b>
<b>Infertility Treatment</b> 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
<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>Prescription drug calendar year deductible</b> (must be satisfied before any prescription drug benefits are paid)	Integrated with Medical Deductible
<b>Retail</b> Up to a 30-day supply	\$20 copay for generic drugs \$40 copay for brand name formulary drugs \$70 copay for brand name non-formulary drugs
<b>Mail Order Delivery</b> 31-90 day supply	2 x Retail
<b>Self-Injectables (not including insulin)</b> Does not accumulate toward the Coinsurance Maximum.	50% for formulary and non-formulary drugs
<b>Mandatory Generic with DAW override (MG w/DAW Override)</b> - 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.	
<b>Plan includes:</b> Contraceptive drugs and devices obtainable from a pharmacy and diabetic supplies obtainable from a pharmacy. Lifestyle/performance drugs (limited to 4 pills per month).	

**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 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
- Nonmedically necessary services or supplies
- Orthotics, except as specified in the plan documents
- Over-the-counter medications and supplies

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- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs
- 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 six 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 3 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 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 limitations 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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Some benefits are subject to limitation 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). Precertifications 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](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.

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

Plans are provided by Aetna Life Insurance Company.