





Effective date: 10/01/2010

PROVIDED BY AETNA HEALTH OF CALIFORNIA INC.

Aetna HMO Deductible Plan - California

**CA HMO Deductible \$1,000**

<b>PREVENTIVE CARE</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>
<b>Routine Adult Physical Exams/ Immunizations</b> Limited to 1 exam every 12 months for members age 18 and older.	No Charge
<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.	No Charge
<b>Routine Gynecological Care Exams*</b> 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.	No Charge
<b>Routine Mammograms</b> One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	No Charge
<b>Routine Digital Rectal Exams / Prostate Specific Antigen Test</b> For males age 40 and over	No Charge
<b>Colorectal Cancer Screening (includes routine sigmoidoscopy and preventive colonoscopy)</b> For all members 50 and over. Frequency schedule applies.	No Charge
<b>Colonoscopy</b> (non-preventive)	See Outpatient Surgery Benefit
<b>Routine Eye &amp; Hearing Exams</b>	Paid as part of a routine physical exam.
<b>PHYSICIAN SERVICES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>
<b>Primary Care Physician Visits</b>	\$40 copay, deductible waived
<b>Specialist Office Visits</b>	\$40 copay, deductible waived
<b>Primary Care &amp; Specialist Physician E-Visit</b>	Not Covered
<b>Walk-In Clinics</b>	Not Covered
<b>First Prenatal Visit</b>	\$30 Copay for 1st visit; then covered at 100%, deductible waived. Refer to Inpatient Maternity for delivery charges.
<b>Allergy Testing &amp; Treatment</b>	\$40 copay, deductible waived
<b>DIAGNOSTIC PROCEDURES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>
<b>Diagnostic Laboratory</b>	\$40 copay, deductible waived
<b>Diagnostic X-ray</b>	\$40 copay, deductible waived
<b>Complex Imaging</b>	\$100 copay, deductible waived
<b>URGENT MEDICAL CARE</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>
<b>Urgent Care</b> (benefit availability may vary by location)	\$50 copay, deductible waived
<b>MENTAL HEALTH SERVICES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>
<b>Outpatient Serious Mental Illness or Biologically based Mental illness</b>	\$40 copay per visit, deductible waived
<b>Outpatient Other than Serious mental Illness or Biologically Based Mental Illness</b> Limited to 20 visits per calendar year	\$40 copay per visit, deductible waived
<b>ALCOHOL/DRUG ABUSE SERVICES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>
<b>Outpatient Detoxification</b>	\$40 copay per visit, deductible waived
<b>Outpatient Rehabilitation</b>	Not Covered



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<b>OTHER SERVICES</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>
<b>Outpatient Speech Therapy</b> Limited to 20 visits per calendar year	\$40 per visit copay, deductible waived
<b>Outpatient Physical and Occupational Therapy</b> Limited to 20 visits per calendar year combined	\$40 per visit copay, deductible waived
<b>Subluxation (Chiropractic)*</b> Limited to 20 visits per calendar year	\$15 per visit copay, deductible waived
<b>Infusion Therapy - Home or Physician's Office</b>	\$40 per visit copay, deductible waived
<b>Infusion Therapy - OP Facility</b>	\$40 per visit copay, deductible waived
<b>Diabetic Supplies</b>	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies
<b>Family Planning</b>	
<b>Infertility Treatment</b> 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.
<b>Voluntary Sterilization</b> 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.
<b>EMERGENCY MEDICAL CARE</b>	
<b>Emergency Room</b>	\$100 copay after deductible
<b>Ambulance</b>	\$100 copay after deductible
<b>HOSPITAL CARE</b>	
<b>Inpatient Coverage</b>	30% after deductible
<b>Inpatient Maternity Coverage</b>	30% after deductible
<b>Outpatient Surgery in Hospital</b>	30% after deductible
<b>Outpatient Surgery in Free-Standing Surgery Center</b>	30% after deductible
<b>MENTAL HEALTH SERVICES</b>	
<b>Inpatient Severe Mental Illness or Biologically Based Mental Illness</b>	30% after deductible
<b>Inpatient Other than Severe Mental Illness or Biologically Based Mental Illness</b>	Not Covered
<b>ALCOHOL/DRUG ABUSE SERVICES</b>	
<b>Inpatient Detoxification</b>	30% after deductible
<b>Inpatient Rehabilitation</b>	Not Covered
<b>OTHER SERVICES</b>	
<b>Skilled Nursing Facility</b> Limited to 100 days per calendar year	30% after deductible
<b>Home Health Care</b> Limited to 100 visits per calendar year	\$40 copay after deductible
<b>Hospice Care - Inpatient</b>	30% after deductible
<b>Hospice Care - Outpatient</b>	\$40 copay per visit 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% of the cost of the item (of contracted rate), after deductible
<b>Bariatric Surgery</b>	30% after deductible
<b>Transplants</b>	30% after deductible



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<b>PHARMACY - PRESCRIPTION DRUG BENEFITS</b>	<b>PARTICIPATING PROVIDERS / REFERRED</b>
<b>Retail</b> Up to a 30-day supply	\$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
<b>Mail Order</b> Up to a 90-day supply	2x 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.

**\*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.



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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.

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](http://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.



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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 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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