

**PLAN DESIGN AND BENEFITS - CA MC Basic**

<b>PLAN FEATURES</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Deductible</b> (per calendar year)	\$2,000 per member (2-member maximum)	\$2,000 per member (2-member maximum)
<p>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 2 individual members of a family each satisfy their Deductible amount separately, all family members will be considered as having met their Deductible for the remainder of the calendar year.</p>		
<b>Member Coinsurance</b> (applies to all expenses unless otherwise stated)	20%	50%
<b>Coinsurance maximum</b> (per calendar year, excludes deductible)	\$3,000 Individual (2-member maximum)	\$5,000 Individual (2-member maximum)
<p>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 2 individual members of a family each satisfy their Coinsurance maximum separately, all family members will be considered as having met their Coinsurance Maximum for the remainder of the calendar year.</p>		
<b>Lifetime Maximum</b>	\$5,000,000 per member's lifetime. (Network and out-of-Network care combined)	
<b>Payment for Non-Preferred Care</b>	Not Applicable	Recognized Amount*
<b>Primary Care Physician Selection</b>	Not Applicable	Not Applicable
<b>Certification Requirements</b>		
<p>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.</p>		
<b>Referral Requirement</b>	None	None
<b>PHYSICIAN SERVICES</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Office Visits to Non-Specialist</b>	\$20 copay; deductible waived**	Not Covered
<p>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.</p>		
<b>Specialist Office Visits</b>	\$20 copay; deductible waived**	Not Covered
<b>Primary Care &amp; Specialist Physician E-Visits</b>	Not Covered	Not Covered
<b>Walk-in Clinics</b>	Not Covered	Not Covered
<b>Maternity OB Visits</b>	20% after deductible	50% after deductible
<b>Surgery (in office)</b>	\$20 copay; deductible waived**	Not Covered

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<b>Allergy Testing</b> (given by a physician)	Not Covered	Not Covered
<b>Allergy Injections</b> (not given by a physician)	Not Covered	Not Covered
<b>PREVENTIVE CARE</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Routine Adult Physical Exams and Immunizations</b> Limited to 1 exam every 12 months for members age 18 and older.	\$20 copay; deductible waived**	Not Covered
<b>Well Child Exams and Immunizations</b> Provides coverage for 9 exams from birth up to age 3; 1 exam per 12 months from age 3 through age 17.	\$20 copay; deductible waived**	Not Covered
<b>Routine Gynecological Exams</b> Includes Pap smear, HPV screening and related lab fees. Frequency schedule applies.	\$20 copay; deductible waived**	Not Covered
<b>Routine Mammograms</b> For covered females age 40 and over. Frequency schedule applies.	\$20 copay; deductible waived	Not Covered
<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**	Not Covered
<b>Colorectal Cancer Screening</b> <i>Sigmoidoscopy and Double Contrast Barium Enema</i> - 1 every 5 years for all members age 50 and over. <i>Colonoscopy</i> - 1 every 10 years for all members age 50 and over. <i>Fecal Occult Blood Testing</i> - 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**	Not Covered
<b>Routine Eye and Hearing Exams</b> Covered only as part of a routine physical exam.	Paid as part of routine physical exam.	Not Covered
<b>DIAGNOSTIC PROCEDURES</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK 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.	\$20 copay; deductible waived. Limited to \$300 per member per calendar year.	Not Covered
<b>Outpatient Diagnostic X-ray for Complex Imaging Services</b> Including, but not limited to, MRI, MRA, PET and CT Scans. Precertification required.	Not Covered	Not Covered

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<b>EMERGENCY MEDICAL CARE</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Urgent Care Provider</b>	Not Covered	Not Covered
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered	Not Covered
<b>Emergency Room</b> Copay waived if admitted. Copay applies to facility charges only.	\$100 copay plus 20% after deductible	Paid as Network Care
<b>Non-Emergency care in an Emergency Room</b>	Not Covered	Not Covered
<b>Emergency Ambulance</b>	20% after deductible	Paid as Network Care
<b>HOSPITAL CARE</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Inpatient Coverage</b> Including maternity (prenatal, delivery and postpartum) & transplants	20% after deductible	50% after deductible. Maximum payment of \$750 per day.
<b>Outpatient Surgery</b> Provided in an outpatient hospital department	\$150 copay plus 30% after deductible	50% after deductible. Maximum payment of \$400 per surgery.
<b>Outpatient Surgery</b> Provided in a freestanding surgical facility	20% after deductible	50% after deductible. Maximum payment of \$400 per surgery.
<b>Outpatient Hospital Services other than Surgery</b> Including, but not limited to, physical therapy, speech therapy, occupational therapy, spinal manipulation, dialysis, radiation therapy.	Not Covered	Not Covered
<b>MENTAL HEALTH SERVICES</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Inpatient Serious Mental Illness or Serious Emotional Disturbances of a Child</b>	20% after deductible	50% after deductible. Maximum payment of \$750 per day.
<b>Outpatient Serious Mental Illness or Serious Emotional Disturbances of a Child</b>	\$20 copay; deductible waived**	Not Covered
<b>Inpatient Other than Serious Mental Illness or Serious Emotional Disturbances of a Child</b>	Not Covered	Not Covered
<b>Outpatient Other than Serious Mental Illness or Serious Emotional Disturbances of a Child</b>	Not Covered	Not Covered
<b>ALCOHOL / DRUG ABUSE SERVICES</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Inpatient Detoxification</b>	Not Covered	Not Covered
<b>Outpatient Detoxification</b>	Not Covered	Not Covered
<b>Inpatient and Outpatient Rehabilitation</b>	Not Covered	Not Covered
<b>OTHER SERVICES AND PLAN DETAILS</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK CARE</b>
<b>Skilled Nursing Facility</b> Limited to 60 days per member per calendar year. Network and Out-of-Network combined.	20% after deductible	50% after deductible. Maximum benefit of \$200 per day.

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<b>Home Health Care</b> 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.	20% after deductible	50% after deductible. Maximum benefit of \$100 per visit.
<b>Infusion Therapy</b> Provided in the home or physician's office	20% after deductible	50% after deductible. Maximum benefit of \$50 per visit.
<b>Infusion Therapy</b> Provided in an outpatient hospital department or freestanding facility	30% after deductible	50% after deductible. Maximum benefit of \$50 per visit.
<b>Inpatient Hospice Care</b>	20% after deductible	50% after deductible. Maximum benefit of \$200 per day.
<b>Outpatient Hospice Care</b>	20% after deductible	50% after deductible
<b>Private Duty Nursing - Outpatient</b>	Not Covered	Not Covered
<b>Outpatient Short-Term Rehabilitation</b> Includes physical and occupational therapy	\$20 copay; deductible waived**	Not Covered
<b>Outpatient Speech Therapy</b>	\$20 copay; deductible waived**	Not Covered
<b>Chiropractic</b>	\$20 copay; deductible waived**	Not Covered
<b>Durable Medical Equipment</b>	Not Covered	Not Covered
<b>Diabetic Supplies not obtainable at a pharmacy</b>	Covered same as any other medical expense	Covered same as any other medical expense
<b>Contraceptive drugs and devices not obtainable at a pharmacy</b> (includes coverage for contraceptive visits)	\$20 copay; deductible waived**	Not Covered
<b>FAMILY PLANNING</b>	<b>NETWORK CARE</b>	<b>OUT-OF-NETWORK 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	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	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>NON-PARTICIPATING PHARMACIES</b>
<b>Retail</b> Up to a 30-day supply	\$15 copay for generic drugs, 50% copay for brand name formulary drugs, and 50% copay for brand name non-formulary drugs	Not Covered
<b>Mail Order Delivery</b> 31-90 day supply	\$30 copay for generic drugs, 50% copay for brand name formulary drugs, and 50% copay for brand name non-formulary drugs	Not Covered
<b>Self-Injectables (Excluding insulin)</b>	Not Covered	Not Covered
<b>Prescription Drug Calendar Year Maximum</b>	\$1,000 per member per calendar year	Not Covered

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**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. Precertification 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.

\*\*This plan provides limited benefits only and does not constitute a comprehensive insurance plan. As such, it may not cover all of the expenses associated with your health care needs. Office visits are limited to three per member per calendar year for all types of office visits combined (primary care physician, specialist physician, preventive care, chiropractic, PT/OT/ST, mental health). Routine lab and x-rays provided by the provider during a covered office visit and billed with the office visit is included in the office visit copay. Preventive care (routine physicals, well child exams and routine GYN) are included in the three office visit benefit. If the member chooses not to use any/all of his or her three office visits for preventive care, preventive care is still covered at the plan coinsurance after the deductible.

**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.

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**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.

If you had no prior creditable coverage within the 6 months prior to your enrollment date (either because you had no prior coverage or because there was more than a [enter break in coverage period] 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.

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.

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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. 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](http://www.aetna.com).

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