

HMO \$15

PLAN FEATURES	PARTICIPATING PROVIDERS
Deductible (per calendar year)	None
Member Coinsurance	Not applicable
Copay Maximum (per calendar year)	\$2,000 per Individual \$4,000 per Family
All member copays accumulate toward the Copay Maximum, excluding member cost share for Prescription Drugs. No individual can contribute more than the Individual Copay Maximum toward satisfaction of the Family Copay Maximum. Once the Family Copay Maximum is met, all family members will be considered as having met their Copay Maximum for the remainder of the calendar year.	
Lifetime Maximum	Unlimited except where otherwise indicated.
Primary Care Physician Selection	Required
Referral Requirement	Required for all non-emergency, non-urgent and non-Primary Care Physician services, except direct access services.
PHYSICIAN SERVICES	PARTICIPATING PROVIDERS
Primary Care Physician Visits	Office Hours: \$15 copay
Specialist Office Visits	\$15 copay
Primary Care and Specialist Physician E-Visits	Not Covered
Walk-In-Clinics	Not Covered
Maternity/OB Visits	Same as Specialist Office Visit for initial visit only; thereafter covered at 100%.
Allergy Testing & Treatment	\$15 copay
PREVENTIVE CARE	PARTICIPATING PROVIDERS
Routine Adult Physical Exams / Immunizations Limited to 1 exam every 12 months for members age 18 and older.	\$15 copay
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.	\$15 copay
Routine Gynecological Exams* Includes pap smear, HPV screening and related lab fees. Limited to one visit per 365-day period, unless otherwise recommended by a physician.	\$15 copay
Routine Mammograms One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over.	\$15 copay
Routine Digital Rectal Exams/Prostate Specific Antigen Test For covered males age 40 and over	Member cost sharing is based on the type of service performed and the place rendered.
Colorectal Cancer Screening 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.
Colonoscopy	See Outpatient Surgery Benefit
Routine Eye and Hearing Exams	Paid as part of a routine physical exam.



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DIAGNOSTIC PROCEDURES	PARTICIPATING PROVIDERS
Diagnostic Laboratory and X-ray (except for Complex Imaging Services) - (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.)	\$15 copay
Diagnostic X-ray for Complex Imaging Services (MRI, MRA, PET and CT Scans)	\$15 copay
EMERGENCY/URGENT MEDICAL CARE	PARTICIPATING PROVIDERS
Urgent Care Provider (benefit availability may vary by location)	\$50 copay
Non-Urgent use of Urgent Care Provider	Not Covered
Emergency Room	\$100 copay
Non-Emergency care in an Emergency Room	Not Covered
Ambulance	\$100 copay
HOSPITAL CARE	PARTICIPATING PROVIDERS
Inpatient Coverage (including maternity & transplants)	\$150 copay per day up to 3-days per admit
Outpatient Surgery Performed in a Hospital Outpatient Facility	\$250 copay
Outpatient Surgery Performed in a Facility Other than a Hospital Outpatient Facility	\$100 copay
MENTAL HEALTH SERVICES	PARTICIPATING PROVIDERS
Inpatient Serious Mental Illness & Serious Emotional Disturbances of a Child	\$150 copay per day up to 3-days per admit
Outpatient Serious Mental Illness & Serious Emotional Disturbances of a Child	\$15 copay
Inpatient Other than Serious Mental Illness & Serious Emotional Disturbances of a Child	Not Covered
Outpatient Other than Serious Mental Illness & Serious Emotional Disturbances of a Child Limited to 20 visits per member per calendar year	\$15 copay
ALCOHOL/DRUG ABUSE SERVICES	PARTICIPATING PROVIDERS
Inpatient Detoxification	\$150 copay per day up to 3-days per admit
Outpatient Detoxification	\$15 copay
Inpatient Rehabilitation	Not Covered
Outpatient Rehabilitation	Not Covered
OTHER SERVICES	PARTICIPATING PROVIDERS
Transplant - Facility Expense Services Coverage provided for transplants that are not experimental and non-investigational at approved facilities – generally Institutes of Excellence contracted facilities only. Precertification required.	\$150 copay per day up to 3-days per admit
Skilled Nursing Facility Limited to 100 days per member per calendar year	\$150 copay per day up to 3-days per admit



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Home Health Care Limited to 100 visits per member per calendar year; 1 visit equals a period of 4 hours or less.	\$0 copay
Infusion Therapy Provided at Home or in the Physician's Office	\$15 copay
Infusion Therapy Provided in OP Hospital or Facility	\$15 copay
Hospice Care - Inpatient	\$150 copay per day up to 3-days per admit
Hospice Care - Outpatient	\$0 copay
Outpatient Rehabilitation Therapy Includes physical and occupational therapy. Limited to 20 visits per member per calendar year.	\$15 copay
Outpatient Speech Therapy Limited to 20 visits per member per calendar year	\$15 copay
Subluxation (Chiropractic)* Limited to 20 visits per member per calendar year	\$15 copay
Durable Medical Equipment Maximum benefit of \$2,000 per member per calendar year. Limit does not apply to prosthetics or orthotics.	50% per item
FAMILY PLANNING	PARTICIPATING PROVIDERS
Infertility Treatment 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.
Voluntary Sterilization Including tubal ligation and vasectomy.	Member cost sharing is based on the type of service performed and the place rendered.
PHARMACY-PRESCRIPTION DRUG BENEFITS	PARTICIPATING PHARMACIES
Retail Up to a 30-day supply	\$15 copay for generic formulary drugs, \$35 copay for brand name formulary drugs, and \$50 copay for brand name and generic non-formulary drugs
Mail Order 31- 90 day supply at participating pharmacies.	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 included.	

HMO, or its contracted organization, may use prior authorizations and ongoing reviews to limit the number of outpatient Mental or Substance Abuse visits to the maximum it deems to be Covered that are Medically Necessary independent of the maximum number of visits shown in this Schedule of Benefits. This means the Member may not receive the maximum number of outpatient visits shown in this Schedule of Benefits or the number of outpatient visits the Member and the treating Provider believe to be appropriate for a single course of treatment or episode.

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

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.

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, 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.



Aetna Health of California, Inc.

**CALIFORNIA Small Group HMO
Plan Effective Date: 04/01/2009**

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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.