

# Colorado Health Benefit Plan Description Form

## Aetna Life Insurance Company

Name of Carrier

## MC \$3,500 (EMB) 80/50 (HSA-Compatible) (12/09)

Name of Plan

### PART A: TYPE OF COVERAGE

<b>1. TYPE OF PLAN</b>	<b>Open Access Managed Choice Point of Service Plan</b> (Network plan with in and out-of-network benefits)
<b>2. OUT-OF-NETWORK CARE COVERED?<sup>1</sup></b>	<b>Yes, but patient pays more for out-of-network care</b>
<b>3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE</b>	Plan is available in the following areas: Adams, Alamosa, Arapahoe, Archuleta, Baca, Bent, Boulder, Broomfield, Chaffee, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Delta, Denver, Dolores, Douglas, Eagle, El Paso, Elbert, Fremont, Garfield, Gilpin, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Jefferson, Kiowa, Kit Carson, La Plata, Lake, Larimer, Las Animas, Lincoln, Logan, Mesa, Mineral, Moffat, Montezuma, Montrose, Morgan, Otero, Ouray, Park, Phillips, Pitkin, Prowers, Pueblo, Rio Blanco, Rio Grande, Routt, Saguache, San Juan, San Miguel, Sedgwick, Summit, Teller, Washington, Weld and Yuma.

### PART B: SUMMARY OF BENEFITS

**Important Note:** This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnosis, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact term and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	IN-NETWORK	OUT-OF-NETWORK
<b>4. DEDUCTIBLE TYPE<sup>2</sup></b>	Calendar Year. In-Network and Out-of-Network accumulate separately.	Calendar Year. In-Network and Out-of-Network accumulate separately.
<b>4. ANNUAL DEDUCTIBLE<sup>2a</sup></b> a) Individual <sup>2b</sup> (embedded) b) Family <sup>2c</sup>	a) Individual - \$3,500 b) Family - \$7,000	a) Individual - \$7,000 b) Family - \$14,000
<b>5. OUT-OF-POCKET ANNUAL MAXIMUM<sup>3</sup></b> a) Individual  b) Family	a) Individual - \$5,800 Includes copays and deductible  b) Family - \$11,600 Includes copays and deductible	a) Individual - \$15,000 Includes copays and deductible  b) Family - \$30,000 Includes copays and deductible.

	IN-NETWORK	OUT-OF-NETWORK
<b>6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE</b>	\$5,000,000	
<b>7A. COVERED PROVIDERS</b>	See provider directory for complete list.	All providers licensed or certified to provide covered benefits.
<b>7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?</b>	Not applicable. Primary Care Physicians not required.	Not applicable
<b>8. MEDICAL OFFICE VISITS<sup>4</sup></b> a) Primary Care Providers  b) Specialist	a) 20% after deductible if visit made to Internist, General Physician, Family Practitioner or Pediatrician.  b) 20% after deductible for specialist visit.	50% after deductible
<b>9. PREVENTIVE CARE<sup>5</sup></b> a) Children's services - 7 exams in the first 12 months of life, 2 exams in the 13th - 24th months of life, 1 exam per 12 months up to age 18. Includes coverage for immunizations.  b) Adult services - 1 exam every 12 - months for adults under age 65 and every 12-months for adults age 65 and older. Includes coverage for immunizations.	a) Covered at 100%. Not subject to deductible.	a) 50%. Not subject to deductible.
	b) Covered at 100%. Not subject to deductible.	b) 50% after deductible.
Maximums are combined for both in-network and out-of-network services.		
<b>10. MATERNITY</b> a) Prenatal care  b) Delivery & inpatient well baby care	a) 20% after deductible  b) 20% after deductible	a) 50% after deductible  b) 50% after deductible

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>11. PRESCRIPTION DRUGS<sup>6</sup></b>  No Mandatory Generics        Includes coverage for contraceptive drugs and devices obtainable from a pharmacy.	Retail: \$20 copay for generic drugs; \$40 copay for formulary brand drugs and \$70 copay for non-formulary brand drugs after Integrated Medical/Rx Deductible up to a 30-day supply.  Mail Order: Two-times the retail copay after Integrated Medical/Rx Deductible for a 31 to 90 day supply.  30% member cost share for self-injectables, limited to a \$250 copay for a 30-day supply after Integrated Medical/Rx Deductible for self-injectables. The initial prescription must be filled at a Participating Retail Pharmacy, Participating Mail Order Pharmacy or Network Specialty Pharmacy. All refills must be filled by a Network Specialty Pharmacy.	Not covered
<b>12. INPATIENT HOSPITAL</b>	20% after deductible	50% after deductible
<b>13. OUTPATIENT / AMBULATORY SURGERY</b>	20% after deductible	50% after deductible
<b>14. DIAGNOSTICS</b>		
a.1) Laboratory	a.1) 20% after deductible	a.1) 50% after deductible
a.2) X-Ray	a.2) 20% after deductible	a.2) 50% after deductible
b) MRI, nuclear medicine and other high-tech services; precertification required.	b) 20% after deductible	b) 50% after deductible
c) Mammography - Limited to one baseline for females ages 35-40 and one each year for females age 40 and older	c) Covered at 100%. Not subject to deductible.	c) Covered at 100%. Not subject to deductible.
<b>15. EMERGENCY CARE<sup>7,8</sup></b>	20% after deductible	20% after deductible
	No coverage for Non-emergency use of Emergency Room.	

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>16. AMBULANCE (Ground and Air)</b>	20% after deductible	20% after deductible
<b>17. URGENT, NON-ROUTINE, AFTER HOURS CARE</b>	20% after deductible	20% after deductible
	No coverage for Non-Urgent Use of an Urgent Care Provider.	
<b>18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE<sup>9</sup></b>	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
<b>19. OTHER MENTAL HEALTH CARE</b>  a) Inpatient care - Limited to 45-full days or 90-partial days per calendar year.  b) Outpatient care - Limited to 20 visits per calendar year.	a) 20% after deductible.	a) 50% after deductible.
	b) 20% after deductible	b) 50% after deductible
	Maximums are combined for both in-network and out-of-network services.	
<b>20. ALCOHOL &amp; SUBSTANCE ABUSE CARE</b>  a) Detox - Inpatient - Alcoholism limited to 45 full or 90 partial days per calendar year; combined with Inpatient Rehabilitation. Drug limited to 30 full or 60 partial days per calendar year; combined with Inpatient Rehabilitation.  b) Detox - Outpatient - Alcoholism limited to 15 visits per calendar year (no less than \$500); combined with Outpatient Rehabilitation. Drug limited to limited to 15 visits per calendar year; combined with Outpatient Rehabilitation.  c) Rehabilitation - Inpatient - Alcoholism limited to 45 full or 90 partial days per calendar year; combined with Inpatient Detox. Drug limited to 30 full or 60 partial days per calendar year; combined with Inpatient Detox.  d) Rehabilitation - Outpatient - Alcoholism limited to 15 visits per calendar year (no less than \$500); combined with Outpatient Detox. Drug limited to limited to 15 visits per calendar year; combined with Outpatient Detox.	a) 20% after deductible	a) 50% after deductible
	b) 20% after deductible	b) 50% after deductible
	c) 20% after deductible	c) 50% after deductible
	d) 20% after deductible	d) 50% after deductible
	Maximums are combined for both in-network and out-of-network services.	

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>21A. PHYSICAL, OCCUPATIONAL, CHIROPRACTIC THERAPY-</b> Limited to 24 visits per calendar year.	20% after deductible	50% after deductible
	Maximums are combined for both in-network and out-of-network services.	
<b>21B. SPEECH THERAPY</b> - Limited to 20 visits per calendar year.	20% after deductible	50% after deductible
	Maximums are combined for both in-network and out-of-network services.	
<b>22. DURABLE MEDICAL EQUIPMENT</b> - Limited to \$3,000 per calendar year. Limit does not apply to prosthetic arms or legs.	20% after deductible	Not covered
<b>23. OXYGEN</b>	Combined with Durable Medical Equipment. See line 22.	Combined with Durable Medical Equipment. See line 22.
<b>24. ORGAN TRANSPLANTS</b>	20% after deductible	Not covered
<b>25. HOME HEALTH CARE</b> - Limited to 60 visits per calendar year.	20% after deductible	50% after deductible
	Maximums are combined for both in-network and out-of-network services.	
<b>26. HOSPICE CARE</b> Bereavement counseling following the death of a family member. Limited to a separate \$1,150 maximum.	20% after deductible 20% after deductible up to 12 months following death.	50% after deductible 50% after deductible up to 12 months following death.
	Maximums are combined for both in-network and out-of-network services.	
<b>27. SKILLED NURSING FACILITY CARE</b> Limited to 60-days per calendar year.	20% after deductible	50% after deductible
	Maximums are combined for both in-network and out-of-network services.	
<b>28. DENTAL CARE</b>	Available as a separate dental care plan.	Available as a separate dental care plan.
<b>29. VISION CARE</b>	Available as a separate vision care plan.	Available as a separate vision care plan.
<b>30. CHIROPRACTIC CARE</b>	Refer to Physical, Occupational and Chiropractic Therapy Benefit. Refer to line 21A.	Refer to Physical, Occupational and Chiropractic Therapy Benefit. Refer to line 21A.

	IN-NETWORK	OUT-OF-NETWORK
<b>31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)</b>		
<b>ROUTINE GYN EXAM and PAP SMEAR</b> Limited to one exam per calendar year.	Covered at 100%. Not subject to deductible	50% after deductible
<b>ROUTINE CANCER SCREENING COVERAGE</b>		
a) Breast Cancer Screening	a) Covered at 100%. Not subject to deductible.	a) Covered at 100%. Not subject to deductible.
b) Cervical Cancer Screening	b) Covered at 100%. Not subject to deductible.	b) 50% after deductible
c) Colorectal Cancer Screening - Includes digital rectal exam and fecal occult blood test. One screening annually for any man age 40 and over.	c) Covered at 100%. Not subject to deductible.	c) 50%. Not subject to deductible.
d) Prostate Cancer Screening - Includes prostate-specific antigen (PSA) blood test. One screening annually for any man age 40 and over.	d) Covered at 100%. Not subject to deductible.	d) 50%. Not subject to deductible.

**PART C: LIMITATIONS AND EXCLUSIONS**

<b>32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.<sup>10</sup></b>	Business Groups of One: 12 months for all pre-existing conditions. Business Groups of 2 to 50: 6 months for all pre-existing conditions.
<b>33. EXCLUSIONARY RIDERS.</b> Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
<b>34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?</b>	A pre-existing condition is a condition for which medical advice, diagnosis, care, treatment was recommended or received within the last six-months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, or other special enrollees, or for pregnancy.
<b>35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?</b>	Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier, agent or plan sponsor (e.g., employer). Review them to see if a service or treatment you may need is excluded from the policy.

## PART D: USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	No
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes	Yes
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes
39. What is the main customer service number?	1-888-802-3862	1-888-802-3862
40. Whom do I/call if I have a complaint or want to file a grievance? <sup>11</sup>	1-888-802-3862	1-888-802-3862
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, CO 80202	
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group or large group; and if it is a short-term policy.	Policy Form #GR-29N. All size groups.	
43. Does the plan have a binding arbitration clause?	No	No

### ENDNOTES:

<sup>1</sup>"Network" refers to a specified group of physicians, hospitals, medial clinics and other health care providers that your plan may require you to use in order to get any coverage at all under the plan, or that the plan may encourage you to use because it pays more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

<sup>2</sup>"Deductible Type" indicates whether the deductible period is "Calendar Year" (January 1 through December 31) or "Benefit Year" (i.e., based on a benefit year beginning on the policy's anniversary date) or if the deductible is based on other requirements such as "Per Accident or Injury" or "Per Confinement".

<sup>2a</sup>"Deductible" means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible should be noted in boxes 8 through 31.

<sup>2b</sup>"Individual" means the deductible amount you and each individual covered by a non-HSA qualified policy will have to pay for allowable covered expenses before the carrier will cover those expenses. "Single" means the deductible amount you will have to pay for allowable covered expenses under an HSA-qualified plan when you are the only individual covered by the plan.

<sup>2c</sup>"Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., "\$3,000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family"). "Non-Single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.

<sup>3</sup>"Out-of-pocket maximum" means the deductible amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum should be noted in boxes 8 through 31.

<sup>4</sup> Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness.

<sup>5</sup> Well-baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; they are not separate copayments.

<sup>6</sup> Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name or non-preferred.

<sup>7</sup>"Emergency care" means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent layperson having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.

<sup>8</sup> Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, than urgent care copayments apply.

<sup>9</sup>"Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder and panic disorder.

<sup>10</sup> Waiver of pre-existing conditions exclusions. State law requires carriers to waive some or all of the pre-existing conditions exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

<sup>11</sup> Grievances. Colorado law requires all plans to use grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

This is to provide notice as required under recent federal law (the Women's Health and Cancer Rights Act, effective October 21, 1998).

Under this health plan, coverage will be provided to a member who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy for:

- 1) reconstruction of the breast on which a mastectomy has been performed;
- 2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
- 3) prostheses; and
- 4) treatment of physical complications of all stages of mastectomy, including lymph-edemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductible and coinsurance provisions that apply for the mastectomy.

## EXCLUSIONS

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 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 by your employer.

All medical or hospital services not specifically covered in, or which are limited or excluded on the plan documents, including costs of services before coverage begins and after coverage terminates; 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; Home births;

Immunization 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; Non-medically necessary services or supplies; Orthotics, unless specified in the plan; Over-the-counter medications 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; and Treatment of those services for or related to treatments of obesity or for diet or weight control.

## DISCLAIMERS

The 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.

Some benefits are subject to limitations or 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, and outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will contain the precertification. When the Member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary.

Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary. They may also be subject to precertification or step-therapy. non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after enrollment) are not covered, and medical exceptions are not available for them.

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