Colorado Health Benefit Plan Description Form

Aetna Life Insurance Company

Managed Choice OA 7500 with Unlimited Primary Care Visits plus Dental

Part A: TYPE OF COVERAGE

1. TYPE OF PLAN	**Managed Choice Open Access Plan** (Network plan with in and out-of-network benefits)
2. OUT-OF-NETWORK CARE COVERED?[1]	**Yes; patient pays more for such out-of-network care**
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	**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, Otter, 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, diagnoses, 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 terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	IN-NETWORK	**OUT-OF-NETWORK**
4. DEDUCTIBLE TYPE[2] **ANNUAL DEDUCTIBLE**[2A] **a) Individual** [2B] **b) Family** [2c]	a) Individual - $7,500 b) Family – $15,000	a) Individual – $10,000 b) Family – $20,000
4 A. INPATIENT HOSPITAL DEDUCTIBLE a) Individual b) Family	None per confinement	None per confinement
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] **a) Individual b) Family c) Is deductible included in the**	a) Individual - $10,000. Excludes copay b) Family – $20,000. Excludes copay.	a) Individual - $12,500. Excludes copay b) Family – $25,000. Excludes copay.

out-of-pocket maximum?	c) Yes – deductible is included in the out-of-pocket maximum	c) Yes – deductible is include in the out-of-pocket maximum.
6. LIFETIME OR BENEFIT MAXI-MUM PAID BY THE PLAN FOR ALL CARE	$5,000,000	$5,000,000
7A. COVERED PROVIDERS	See provider directory for complete list.	All providers licensed or certified to provide covered benefits.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Not applicable. Primary Care Physicians not required.	Not applicable
8. MEDICAL OFFICE VISITS[4] **a) Primary Care Providers** **b) Specialists**	a) $30 copay; deductible waived b) 20% after deductible	a) 50% after deductible b) 50% after deductible
9. PREVENTIVE CARE **a) Children's services [5]** **b) Adults' services**	a) $30 office visit copay. Not subject to deductible. 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) $30 office visit copay. Not subject to deductible. 1 Exam every 365 days. $200 Annual Maximum Maximums are combined for both in-network and out-of-network services.	a) 50% after deductible b) 50% after deductible. $200 Annual Maximum Maximums are combined for both in-network and out-of-network services.
10. MATERNITY **a) Prenatal care** **b) Delivery & inpatient well baby care[5]**	a) No coverage except for Complications of Pregnancy or Complications of childbirth. b) No coverage except for Complications of Pregnancy or Complications of childbirth. Coverage same as any other similar sickness or disease – 20% after deductible.	a) No coverage except for Complications of Pregnancy or Complications of childbirth. b) No coverage except for Complications of Pregnancy or Complications of childbirth. Coverage same as any other similar sickness or disease – 50% after deductible.
11. PRESCRIPTION DRUGS[6] **Level of coverage and restrictions on prescriptions**	Retail: 0% after $15 copay for generic drugs not subject to pharmacy deductible; Formulary	Retail: $15 copay plus 50% coinsurance for generic drugs not subject to pharmacy

Mandatory Generic with 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.) *Contraceptive drugs and devices* *Fertility drugs (oral and injectable) included* Diabetic supplies included Performance Enhancement Drugs Prescription Drug Individual Calendar Year Deductible (must be satisfied before any prescription drug benefits are paid) Prescription Drug Family Calendar Year Deductible Limit Prescription Drug Calendar Year Maximum (combined maximum for drugs received in or out of network)	and Non-Formulary not covered. 30 day supply. Mail Order: 0% after two times retail copay for a 31- 60 day supply Included Excluded Diabetic supplies included Not covered None No family deductible Unlimited	deductible; Formulary and Non-Formulary not covered. 30 day supply. Mail Order: 50% after two times retail copay for a 31- 60 day supply Included Excluded Diabetic supplies included Not covered None No family deductible Unlimited
12. INPATIENT HOSPITAL	20% after deductible	50% after deductible
13. OUTPATIENT/AMBULATORY SURGERY	20% after deductible	50% after deductible
14. DIAGNOSTICS **a) Laboratory & x-ray** **b) MRI, nuclear medicine, and other high-tech services**	b) 20% after deductible b) 20% after deductible	b) 50% after deductible b) 50% after deductible
15. EMERGENCY CARE [7,8]	20% after $150 emergency room copay, subject to deductible. (waived if confined) Non-Emergency Care in Emergency Room: 50% after deductible	20% after $150 emergency room copay, subject to deductible. (waived if confined) Non-Emergency Care in Emergency Room: 50% after

		deductible
16. AMBULANCE	20% after deductible; Maximum benefit $5,000 per trip	20% after deductible; Maximum benefit $5,000 per trip
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	$50 copay; deductible waived	50% after deductible
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	20% after deductible	50% after deductible
19. OTHER MENTAL HEALTH CARE **a) Inpatient care** **b) Outpatient care**	a) Not covered b) Not covered	a) Not covered b) Not covered
20. ALCOHOL & SUBSTANCE ABUSE	Not covered except as treatment of drug and alcohol dependencies associated with severe, biologically based mental or nervous disorders. 20% after deductible	Not covered except as treatment of drug and alcohol dependencies associated with severe, biologically based mental or nervous disorders. 50% after deductible
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	Physical/Occupational Therapy: 20% after deductible; Limited to 24 visits per calendar year. $25 Maximum benefit per visit. Maximums are combined for both in-network and out-of-network services. Speech Therapy: Limited to services supplied by Home Health Care agency or a Skilled Nursing Facility. Maximums are combined for in-network and out-of-network services. Refer to lines 25 and 27.	Physical/Occupational Therapy: 50% after deductible; Limited to 24 visits per calendar year. $25 Maximum benefit per visit. Maximums are combined for both in-network and out-of-network services. Speech Therapy: Limited to services supplied by Home Health Care agency or a Skilled Nursing Facility. Maximums are combined for in-network and out-of-network services. Refer to lines 25 and 27.
22. DURABLE MEDICAL EQUIPMENT	20% after deductible; Limited to $2,000 per calendar year. Limit does not apply to prosthetic devices. Maximums are combined for both in-network and out-of-network services.	50% after deductible; Limited to $2,000 per calendar year. Limit does not apply to prosthetic devices. Maximums are combined for both in-network and out-of-network services.
23. OXYGEN	Combined with Durable Medical Equipment. See line 22.	Combined with Durable Medical Equipment. See line 22.

24. ORGAN TRANSPLANTS	20% after deductible	50% after deductible
25. HOME HEALTH CARE	20% after deductible. Limited to 60 visits per calendar year. Maximums are combined for both in-network and out-of-network services.	50% after deductible. Limited to 60 visits per calendar year. Maximums are combined for both in-network and out-of-network services.
26. HOSPICE CARE	20% after deductible	50% after deductible
27. SKILLED NURSING FACILITY CARE	20% after deductible; Limited to 30 days per calendar year. Maximums are combined for both in-network and out-of-network services.	50% after deductible; Limited to 30 days per calendar year. Maximums are combined for both in-network and out-of-network services.
28. DENTAL CARE	Available as a separate dental care plan.	Available as a separate dental care plan.
29. VISION CARE	Not covered	Not covered
30. CHIROPRACTIC CARE	Combined benefit with Physical / Occupational Therapy, Refer to line 21.	Combined benefit with Physical / Occupational Therapy. Refer to line 21.
31. SIGNIFICANT ADDITIONAL COVERED SERVICES		
ROUTINE MAMMOGRAPHY a) WOMEN AGE 35 - 39 b) WOMEN AGE 40 AND OLDER	a) $0 copay. Not subject to deductible for 1 baseline mammogram b) $0 copay. Not subject to deductible for 1 annual mammogram	a) 50% for 1 baseline mammogram. Not subject to deductible b) 50% for 1 annual mammogram. Not subject to deductible
DIGITAL RECTAL EXAM AND ROUTINE PROSTATE CANCER SCREENING FOR MEN AGE 40 OR OLDER	$0 copay. Not subject to deductible	50% after deductible
SPECIALIST OFFICE VISITS	20% after deductible	50% after deductible

CONGENITAL DEFECTS (Coverage for a dependent child under the age of 5 for physical, occupational and speech therapy to treat a congenital defect or birth abnormality other than a cleft lip or a cleft palate.)	20% after deductible up to 20 visits per calendar year Maximums are a combined limit for in-network and out-of-network services for Speech, Occupational and Physical Therapy.	50% after deductible up to 20 visits per calendar year Maximums are a combined limit for in-network and out-of-network services for Speech, Occupational and Physical Therapy.

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.[10]	Twelve-months for all pre-existing conditions
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	A pre-existing condition is an illness, injury, disease or physical condition for which medical advice, diagnosis, care or treatment, including the use of prescription drugs was recommended or received from a physician during the twelve (12) months immediately preceding the Member's effective date of coverage.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	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?	866-565-1236	
40. Whom do I write/call if I have a complaint or want to file a grievance?[11]	Members can call the customer service number listed in line 39 for complaints/grievance	
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.	INDIVIDUAL MEDICAL GR 11741 INDIVIDUAL DENTAL GR 11826 INDIVIDUAL PREVENTATIVE AND HOSPITAL GR 11741-LME	
43. Does the plan have a binding arbitration clause?	No	

Endnotes

[1] "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay 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).

[2] "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 a "Per Accident or Injury" or "Per Confinement".

[2a] "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.

[2b] "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 health plan when you are the only individual covered by the plan.

[2c] “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 member”) 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.

[3] "Out-of-pocket maximum" means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductibles 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.

[4] Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness.

[5] Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments.

[6] Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

[7] “Emergency care” means all services delivered in an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person 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.

[8] 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, then urgent care copayments apply.

[9] “Biologically based mental illnesses” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

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

[11] Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

This is to provide notice as required under the 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 lymphedemas.

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

Exclusions & Limitations

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 the 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 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;
- Over-the-counter medications and supplies;
- Reversal of sterilization;
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling;
- Special duty nursing.

Disclaimers

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.

Some benefits are subject to limitations 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). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a nonpreferred 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.