



Arizona, California, Connecticut, Colorado, Delaware, District of Columbia, Florida, Georgia, Illinois, Maryland, Maine, New Jersey, Nevada, New York, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas, Virginia

**PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA HEALTH INC**

PLAN FEATURES	PARTICIPATING PROVIDERS / REFERRED
Out-of-pocket Maximum Only those out of pocket expenses resulting from the application of coinsurance percentage and copays on the following benefits may be used to satisfy the Out-of-Pocket Maximum: inpatient hospital, skilled nursing facility, inpatient mental health, inpatient substance abuse, outpatient surgery, outpatient mental health, outpatient substance abuse and DME.	Unlimited
Lifetime Maximum	Unlimited except for where otherwise indicated
Primary Care Physician Selection	Required
Referral Requirements	Required for all non-emergency, non-urgent and non-Primary Care physicians services, except direct access services.
PREVENTIVE CARE	PARTICIPATING PROVIDERS / REFERRED
Routine Physical Exams/Immunizations (One annual exam/Pneumonia, Flu, Hepatitis B)	Covered 100%
Routine Gynecological Care Exams Includes related lab fees for covered females age 18 and older. Direct Access to participating providers One routine GYN visit and pap smear every 365 days	Covered 100%
Routine Mammograms One baseline mammogram for members 35-39; and one annual mammogram for members age 40 and over	Covered 100%
Routine Digital Rectal Exams / Prostate Specific Antigen Test For males age 40 and over.	Covered 100%
Colorectal Cancer Screening For all members 50 and over.	Covered 100%
Bone Density Testing	Covered 100%
Routine Eye Exam Direct access to participating providers. One annual exam.	Covered 100%
Routine Hearing Screening One (1) annual exam	Covered 100%
Hearing Aid Reimbursement	\$500 once every 36 months
PHYSICIAN SERVICES	PARTICIPATING PROVIDERS / REFERRED
Primary Care Physician Visits (Office hours)	\$15 copay
(After Office Hours)	\$20 copay (does not apply to CA)
Specialist Office Visits	\$15 copay
Podiatry Limited to Medicare covered benefits only	\$15 copay
Allergy Testing/Treatment For initial testing by a specialist; PCP copay for routine injections at PCP office with or without physician encounter	\$15 copay
DIAGNOSTIC PROCEDURES	PARTICIPATING PROVIDERS / REFERRED
Diagnostic Laboratory and X-Ray	\$15 copay

EMERGENCY MEDICAL CARE	PARTICIPATING PROVIDERS / REFERRED
Urgent Care Provider	\$35 copay
Emergency Room; Worldwide (waived if admitted)	\$35 copay
Ambulance	\$15 copay per trip
HOSPITAL CARE	PARTICIPATING PROVIDERS / REFERRED
Inpatient Coverage	Covered 100%
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Surgery	Covered 100%
The member cost sharing applies to covered benefits incurred during a member's outpatient visit.	
MENTAL HEALTH SERVICES	PARTICIPATING PROVIDERS / REFERRED
Inpatient Mental Illness	Covered 100%
(Combined with Inpatient Substance Abuse)	190 Lifetime days
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Mental Illness	\$15 copay
The member cost sharing applies to covered benefits incurred during a member's outpatient visit.	
ALCOHOL/DRUG ABUSE SERVICES	PARTICIPATING PROVIDERS / REFERRED
Inpatient Substance Abuse (Detox and Rehab)	Covered 100%
(Combined with Inpatient Mental Health)	190 Lifetime days
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Outpatient Substance Abuse (Detox and Rehab)	\$15 copay
The member cost sharing applies to covered benefits incurred during a member's outpatient visit.	
OTHER SERVICES	PARTICIPATING PROVIDERS / REFERRED
Skilled Nursing Facility	\$0 copay Days 1-10 \$25 copay Days 11-20 \$50 copay Days 21-100
(100 days per Medicare benefit period; prior authorization from HMO required)	
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Home Health Care	Covered 100%
Hospice Care	Covered by Medicare at Medicare certified Hospice
Outpatient Short-Term Therapy (speech, physical, cardiac and occupational)	\$15 copay
Chiropractic Care	\$15 copay
For manual manipulation of the spine to the extent covered by Medicare	
Durable Medical Equipment/Prosthetic Devices	Covered 100%
Diabetic Supplies	No copay for strips, lancets and glucometer
Outpatient Complex Radiology	\$15 copay
Outpatient Dialysis	\$15 copay
Dental *	Discounts where available
Vision Eyewear Allowance	Lens Discounts
Coaching	Included
One phone call per week	

PHARMACY - PRESCRIPTION DRUG BENEFITS	Cost Share
Prescription drug calendar year deductible	None

Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible.

Retail - Cost-Sharing up to Catastrophic Coverage	\$10 Copay for Generic
	\$25 Copay for Preferred Brand
	\$30 Copay for Non-Preferred Brand

Up to one month (31 day) supply at indicated copay or coinsurance
(Three month (90 day) supply available at retail. Dollar copayments or applicable coinsurance will apply for each month supply.)

Mail Order through Aetna Rx Home Delivery - Cost-Sharing up to Catastrophic Coverage	\$20 Copay for Generic
	\$50 Copay for Preferred Brand
	\$60 Copay for Non-Preferred Brand

Up to a three month (90 day) supply available via our preferred vendor, Aetna Rx Home Delivery.

Catastrophic Coverage	Greater of \$2.40 or 5% for covered generic (including brand drugs treated as generic) drugs. Greater of \$6.00 or 5% for all other covered drugs.
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Catastrophic Coverage benefits start once \$4,350 in true out-of-pocket costs is incurred.

Requirements:	
Precertification	Yes
Step-Therapy	Yes
Formulary	Open
Mandatory Generic (MG)	No
Non-Part D Rider	Covered

- Agents when used for weight loss
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Barbiturates
- Benzodiazepines
- Drugs when used for the treatment of sexual or erectile dysfunction

* Dental Riders are not available in the following service areas : DE01, ME01, NY03, VA01, and TX05

Please refer to the plan documents (Evidence of Coverage) for a complete listing of benefits, exclusions and limitations. The following is a partial listing of exclusions and limitations under the Aetna Golden Medicare Plan:

- All applicable services not referred by your network primary care doctor, except for services received as a result of an emergency or urgent situation;
- Services that are not medically necessary or covered under the Original Medicare Program
- Plastic or cosmetic surgery unless medically necessary
- Custodial care
- Experimental procedures or treatments beyond Original Medicare limits
- Routine foot care that is not medically necessary
- Drugs used for weight loss, weight gain or anorexia
- Drugs used for cosmetic purposes or to promote hair growth
- Outpatient drugs that the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs used to promote fertility
- Drugs used for symptomatic relief of cough and colds
- Non-prescription drugs (OTC)

This material is for informational purposes only. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Aetna does not provide care or guarantee access to health services. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Discount Programs provide access to discounted prices and are not insured benefits. While this material is believed to be accurate as of the print date, it is subject to change.

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.

You must use network pharmacies to receive plan benefits except in limited, non-routine circumstances when a network pharmacy is not available, including illness while traveling within the United States but outside of the plan's service area where there is no network pharmacy. An additional cost may be incurred for drugs received at an out-of-network pharmacy.

If you qualify for extra help with the Medicare prescription drug plan, premium and costs at the pharmacy may be lower. Upon enrollment in the Aetna Medicare plan, Medicare will tell us how much extra help an individual is getting. An individual can obtain information on whether they qualify by calling 1-800-Medicare (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

Benefits coverage is provided by Aetna Health Inc., Aetna Health of California Inc. and/or Aetna Health of Illinois Inc., which are Medicare Advantage organizations with a Medicare contract and benefits, limitations, service areas and premiums subject to change on January 1 of each year

You must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable. You must use network providers except for emergent care or out-of-area urgent care/renal dialysis. If your primary physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.