



Arizona, District of Columbia, Florida, Georgia, Illinois, Maryland, New Jersey, New York, Ohio, Pennsylvania, Texas, Virginia

2007 Small Group 5.2  
Aetna Golden Choice™ Plan - PPO

PLAN DESIGN AND BENEFITS  
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	Preferred Providers	Non-Preferred Providers
<b>Deductible</b> (per calendar year)	None Employee	\$250 Employee

Unless otherwise indicated, the Deductible must be met prior to benefits being payable.

<b>Member Coinsurance</b>	None	20%
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Applies to all expenses unless otherwise stated.

<b>Payment Limit</b> (per calendar year)	None Employee	\$2,500 Employee
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Certain member cost sharing elements may not apply toward the Payment Limit.

<b>Lifetime Maximum</b>	Unlimited except for where otherwise indicated	Unlimited except for where otherwise indicated
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Unlimited except where otherwise indicated.

<b>Primary Care Physician Selection</b>	Optional	Not Applicable
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#### Certification Requirements

There is not a requirement for member pre-certification. If a member fails to obtain precertification they will not be denied services or will any penalty amount be applied. However, precertification is requested on certain services including inpatient hospital, inpatient mental health, skilled nursing and home health care

<b>Referral Requirement</b>	None	None
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PREVENTIVE CARE	Preferred Providers	Non-Preferred Providers
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<b>Routine Physicals/ Immunizations</b>	Covered 100%	20% after deductible
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One annual exam/pneumococcal, Flu, Hepatitis B

<b>Routine Gynecological Care Exams</b>	Covered 100%	20% after deductible
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Included Pap smear and related lab

<b>Routine Mammograms</b>	Covered 100%	20% after deductible
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One baseline mammogram for members 35-39; and one annual mammogram for members age 40 and over

<b>Routine Digital Rectal Exam / Prostate-specific Antigen Test</b>	Covered 100%	20% after deductible
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For covered males age 40 and over

<b>Colorectal Cancer Screening</b>	Covered 100%	20% after deductible
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For all members age 50 and over.

<b>Bone Density</b>	Covered 100%	20% after deductible
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<b>Routine Eye Exams</b>	Covered 100%	20% after deductible
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<b>Routine Hearing Exams</b>	Covered 100%	20% after deductible
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One(1) annual exam

<b>Hearing Aid Reimbursement</b>	Up to \$800 every 36 months	
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<b>PHYSICIAN SERVICES</b>	<b>Preferred Providers</b>	<b>Non-Preferred Providers</b>
<b>Primary Care Physician Visits</b>	\$5 copay	20% after deductible
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. Lower cost sharing will be apply to services when provided by selected PCP. Specialist cost sharing will apply when no PCP selection is made.		
<b>Specialist Office Visits (non-surgical)</b>	\$15 copay	20% after deductible
<b>Office Visits for Surgery</b>	\$15 copay	20% after deductible
<b>Allergy Testing</b>	\$15 copay	20% after deductible
<b>Allergy Injections</b>	\$15 copay	20% after deductible
For initial testing by a specialist; PCP copay for routine injections at PCP office with or without physician encounter		
<b>DIAGNOSTIC PROCEDURES</b>	<b>Preferred Providers</b>	<b>Non-Preferred Providers</b>
<b>Complex Radiology</b>	\$100 copay	20% after deductible
<b>Diagnostic Laboratory and X-ray</b>	\$15 copay	20% after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>Preferred Providers</b>	<b>Non-Preferred Providers</b>
<b>Urgent Care Provider</b>	\$40 copay	100% after \$50 copay
<b>Emergency Room; Worldwide (waived if admitted)</b>	\$50 copay	100% after \$50 copay
<b>Ambulance</b>	\$125 copay per trip	20% after deductible
<b>HOSPITAL CARE</b>	<b>Preferred Providers</b>	<b>Non-Preferred Providers</b>
<b>Inpatient Coverage</b>	Covered 100%	20% after deductible
The member cost sharing applies to covered benefits incurred during a member's inpatient stay		
<b>Outpatient Hospital Expenses (including surgery)</b>	\$125 copay	20% after deductible
The member cost sharing applies to covered benefits incurred during a member's outpatient visit		
<b>MENTAL HEALTH SERVICES</b>		
<b>Inpatient (Combined with Inpatient Substance Abuse)</b>	Covered 100%	20% after deductible
Limited to 190 days per lifetime in a psychiatric facility		
The member cost sharing applies to covered benefits incurred during a member's inpatient stay		
Maximum are a combined limit for preferred and non-preferred services.		
<b>Outpatient</b>	\$15 copay	20% after deductible
The member cost sharing applies to covered benefits incurred during a member's outpatient visit		



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**ALCOHOL/DRUG ABUSE SERVICES**

<b>Inpatient</b>	Covered 100%	20% after deductible
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(Combined with Inpatient Mental Health)

Limited to 190 days per lifetime in a psychiatric facility

The member cost sharing applies to covered benefits incurred during a member's inpatient stay

Maximums are a combined limit for preferred and non-preferred services.

<b>Outpatient</b>	\$15 copay	20% after deductible
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The member cost sharing applies to covered benefits incurred during a member's outpatient visit

<b>OTHER SERVICES</b>	<b>Preferred Providers</b>	<b>Non-Preferred Providers</b>
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<b>Skilled Nursing Facility</b>	\$0 days 1-10 \$100 days 11-100	20% after deductible
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Limited to 100 days per Medicare benefit period.

The member cost sharing applies to covered benefits incurred during a member's inpatient stay

<b>Home Health Care</b>	\$15 copay	20% after deductible
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Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one v

<b>Hospice Care</b>	Covered by Medicare at a Medicare certified hospice	Covered by Medicare at a Medicare certified hospice
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<b>Outpatient Rehabilitation</b>	\$15 copay	20% after deductible
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Includes speech, physical, and occupational therapy.

<b>Chiropractic Care</b>	\$15 copay	20% after deductible
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For manipulation of the spine to the extent covered by Medicare

<b>Durable Medical Equipment</b>	25%	30% after deductible, subject to pre-certification
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<b>Podiatry</b>	\$15 copay, limited to Medicare covered benefits only	20% after deductible
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<b>Diabetic Supplies</b>	Covered 100% for strips, lancets, and glucometer.	20% after deductible for strips, lancets, and glucometer.
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<b>Outpatient</b>	\$15 copay	20% after deductible
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**Dialysis/Chemotherapy/Radiation**

<b>Dental</b>	Dental Discount	Not covered
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<b>Vision Eyewear Allowance</b>	\$100 reimbursement every 24 months	Same as preferred care.
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**PHARMACY - PRESCRIPTION DRUG PARTICIPATING PROVIDERS / REFERRED BENEFITS**

**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.

**Initial Coverage Limit (ICL)** \$2,400 Covered Medicare Prescription Drug Expenditure  
The Initial Coverage Limit includes the applicable plan deductible. Until covered Medicare Prescription Drug expenses reach the Initial Coverage Limit (and after the deductible is satisfied), cost-sharing is as follows:

**Retail - Cost-Sharing up to the Initial Coverage Limit** \$10 Copay for Preferred Generic

\$20 Copay for Preferred Brand

\$35 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 Initial Coverage Limit** \$20 Copay for Preferred Generic

\$40 Copay for Preferred Brand

\$70 Copay for Non-Preferred Brand

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

**Coverage Gap** Coverage Gap Eliminated: Cost sharing above continues up to \$3,850 in true out-of-pocket expenses

Once covered Medicare Prescription Drug expenses have reached the Initial Coverage Limit, the Coverage Gap begins. It ends when \$3,850 in true out-of-pocket costs for Covered Part D drugs is incurred.

**Catastrophic Coverage** Greater of \$2.15 or 5% for covered generic (including brand drugs treated as generic) drugs. Greater of \$5.35 or 5% for all other covered drugs.

The Catastrophic Coverage benefits start once you have incurred \$3,850 in true out-of-pocket costs.

**Requirements:**

**Precertification** Yes

**Step-Therapy** Yes

**Formulary** Open

**Mandatory Generic (MG)** Yes



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**Glossary:**

**Deductible** – The first phase of coverage under a Medicare Prescription Drug plan. The deductible is the amount of money that a member pays for covered services, including prescription drugs, before the health plan provides coverage for a service or prescription.

**Initial Coverage Limit (ICL)** - The point at which the second phase of coverage under a Medicare Prescription Drug plan ends. This occurs when covered Medicare Prescription Drug expenses reach the defined amount, of \$2,400 unless otherwise specified. Prior to the initial coverage limit, the plan's cost-sharing provisions will apply after any applicable deductible is met.

**Coverage Gap** - The third phase of coverage in a Medicare Prescription Drug plan. Once covered Medicare Prescription Drug expenses have reached the initial coverage limit, the coverage gap begins and it ends when the member has incurred \$3,850 in true out-of-pocket costs. During the gap, a member will generally be responsible for 100% of prescription drug costs, unless the plan has provided separate cost-sharing provisions for the gap.

**Catastrophic Coverage** - The fourth phase of coverage in a Medicare Prescription Drug plan. Provides a safety net for members who incur high levels of covered drug spending. If true out-of-pocket expenditures reach \$3,850, then cost-sharing will fall to modest amounts for any further covered prescriptions. The cost-sharing provisions of the catastrophic coverage will never be greater than the larger of 5% or \$2.15 for covered generic (including brand drugs treated as generic), and \$5.35 for any other covered drugs.

**Precertification** - Process under which certain drugs require prior authorization (prior approval) before members can obtain them as a covered benefit. The precertification program is based upon current medical findings, manufacturer labeling information and Food and Drug Administration guidelines. The precertification requirement applies to medications that are more likely than others to be taken incorrectly, used inappropriately or in amounts that exceed recommendations for dosage or length of treatment. Physicians must call the Pharmacy Management Precertification Unit and request coverage for medications on the Precertification List.

**Step Therapy** - A type of precertification under which certain medications will be excluded from coverage unless members try one or more “prerequisite” drug(s) first, or unless a medical exception is obtained.

**Closed Formulary** - Prescription Drug coverage is limited only to Medicare Part D medications designated as covered on the Aetna Medicare Preferred Drug List.

**Open Formulary** - All Medicare Part D medications may be eligible for coverage. Non-preferred levels of copay may apply to some medications on the Aetna Medicare Preferred Drug List.

**Mandatory Generics** - The member pays the generic copayment plus the difference in cost between the brand and generic drug if a generic drug is available and a brand-name drug is dispensed.

**Specialty Medications** - Part D medications that include very high cost and unique items, for example genomic and biotech products, that are excluded from tiering exception requests.



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**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 Choice Plan:**

- 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, gain or anorexia
- Cosmetic drugs
- Prescription vitamins and minerals, except prenatal vitamins and fluoride
- Barbiturates
- Outpatients drugs that the manufacturer requires testing/monitoring for, and limits that testing or obtaining the drug to itself or a designee
- Drugs used to promote fertility
- Drugs used for symptomatic relief of cough and colds
- Non-prescription drugs (OTC)
- Benzodiazepines

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 arranges for the provision of healthcare/dental services. However, Aetna itself is not a provider of healthcare/dental services and therefore, cannot guarantee any results or outcomes. Consult the plan documents (Evidence of Coverage) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. The availability of a plan or program may vary by geographic service area. With the exception of Aetna Rx Home Delivery® service and Aetna Specialty Pharmacy, participating providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. 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 law.

Aetna receives rebates from the manufacturers of many drugs, including many that are on the Preferred Drug List. These rebates do not reduce the amount you pay for an individual prescription drug. However, they help control the overall costs of prescription drug coverage. Your pharmacy benefit provides coverage for many drugs that are not on this list. Also, in some cases, if you need to pay a percentage of the cost of the drug or an amount to meet a deductible, or if your benefit is subject to an annual maximum, your costs may be higher for a preferred drug than they would be for a non-preferred drug. You can find out more about the terms and limitations on your plan by reading your plan documents. You can also contact Member Services. The Preferred Drug List is subject to change.



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Aetna Rx Home Delivery® refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy that operates through mail-order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost it pays for the drugs and the costs of its mail-order pharmacy services. For these purposes, Aetna Rx Home Delivery's cost of purchasing drugs takes into account discounts, credits and other amounts that it may receive from wholesalers, manufacturers, suppliers and distributors.

While this material is believed to be accurate as of the print date, it is subject to change.

Benefits coverage is provided by Aetna Life Insurance Company, a Medicare Advantage organization, with a Medicare contract and benefits, limitations, service areas and premiums are 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. Higher costs apply for out-of-network services. Precertification, or prior approval of coverage, is requested for certain services. Providers must be licensed and eligible to receive payment under the federal Medicare program.**

Enrollees must use network pharmacies to receive plan benefits except under emergency circumstances. Covered Part D drugs are available at out-of-network pharmacies in special circumstances, 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 an individual qualifies for extra help with the Medicare prescription drug plan costs, 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/TTD users should call 1-874-486-2048.