

## Colorado Health Benefit Plan Description Form

**Aetna Life Insurance Company**

Name of Carrier

**Aetna Affordable Health Choices<sup>®</sup> limited benefits insurance plan**

- Net Plus -

Name of Plan

### PART A: TYPE OF COVERAGE

<b>1. TYPE OF PLAN</b>	Preferred Provider Plan
<b>2. OUT-OF-NETWORK CARE COVERED?<sup>1</sup></b>	Yes; patient pays more for such out-of-network care
<b>3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE</b>	Plan is available throughout the state of Colorado.

### 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
<b>4. DEDUCTIBLE TYPE<sup>2</sup></b>	Coverage Year Deductible <sup>2A</sup>	Coverage Year Deductible <sup>2A</sup>
<b>4A. INPATIENT HOSPITAL DEDUCTIBLE</b> a) Individual <sup>2B</sup> b) Family <sup>2C</sup>	a) Individual - \$200 b) Family - \$400 (2 individual deductibles per family)	a) Individual - \$300 b) Family - \$600 (2 individual deductibles per family)
<b>4B. OUTPATIENT DEDUCTIBLE</b> a) Individual <sup>2B</sup> b) Family <sup>2C</sup>	a) Individual - \$100 b) Family - \$200 (2 individual deductibles per family)	a) Individual - \$300 b) Family - \$600 (2 individual deductibles per family)
<b>5. OUT-OF-POCKET ANNUAL MAXIMUM<sup>3</sup></b> a) Individual b) Family c) Is deductible included in the out-of-pocket maximum?	No out-of-pocket maximum.	No out-of-pocket maximum.

<b>6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE</b>	<p>\$1,000 per coverage year outpatient maximum.</p> <p>\$7,500 per coverage year for inpatient charges subject to the following limits:</p> <ul style="list-style-type: none"> <li>- Room and board expenses are limited to \$250 per day.</li> <li>- Surgeons' fees are limited to \$1,500 per coverage year.</li> <li>- Anesthesiologists' fees are limited to \$250 per coverage year.</li> <li>- Other hospital services are limited to \$1,000 per coverage year.</li> </ul> <p><i>Once these limits are reached, these benefits will no longer pay for these charges. The plan will continue to pay for room and board and Inpatient Professional Services until the maximum benefits for those services are reached or until the overall inpatient maximum is reached, whichever comes first.</i></p>	<p>\$1,000 per coverage year outpatient maximum.</p> <p>\$7,500 per coverage year for inpatient charges subject to the following limits:</p> <ul style="list-style-type: none"> <li>- Room and board expenses are limited to \$250 per day.</li> <li>- Surgeons' fees are limited to \$1,500 per coverage year.</li> <li>- Anesthesiologists' fees are limited to \$250 per coverage year.</li> <li>- Other hospital services are limited to \$1,000 per coverage year.</li> </ul> <p><i>Once these limits are reached, these benefits will no longer pay for these charges. The plan will continue to pay for room and board and Inpatient Professional Services until the maximum benefits for those services are reached or until the overall inpatient maximum is reached, whichever comes first.</i></p>
<b>7A. COVERED PROVIDERS</b>	See provider directory for complete list.	See provider directory for complete list.
<b>7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?</b>	Yes.	Not applicable.
<b>8. MEDICAL OFFICE VISITS<sup>4</sup></b> <b>a) Primary Care Providers</b> <b>b) Specialists</b>	a) Covered at 100% after a \$15 per visit copay not subject to a deductible. b) Covered at 100% after a \$15 per visit copay not subject to a deductible.	a) Covered at 50%. b) Covered at 50%.

<b>9. PREVENTIVE CARE</b> <b>a) Children's services</b> <b>b) Adults' services</b>	a) Covered at 100% after a \$15 per visit copay not subject to a deductible; up to \$100 per coverage year. b) Covered at 100% after a \$15 per visit copay not subject to a deductible; up to \$100 per coverage year.	a) Covered at 50%; up to \$100 per coverage year. b) Covered at 50%; up to \$100 per coverage year.
<b>10. MATERNITY</b> <b>a) Prenatal care</b> <b>b) Delivery &amp; inpatient well baby care<sup>5</sup></b>	a) Covered as a Medical Office Visit (for outpatient services) b) Covered as Inpatient Hospital charges at 50%	a) Covered as Medical Office Visits (for outpatient services) b) Covered as Inpatient Hospital charges at 50%
<b>11. PRESCRIPTION DRUGS<sup>6</sup></b> Level of coverage and restrictions on prescriptions	Prescription drugs are covered under the in network provisions of the Outpatient benefit (70%)	Prescription drugs are covered under the in network provisions of the Outpatient benefit (70%)
<b>12. INPATIENT HOSPITAL</b>	Covered at 50% subject to limits listed under #6 above.	Covered at 50% subject to limits listed under #6 above.
<b>13. OUTPATIENT/ AMBULATORY SURGERY</b>	Covered as a Medical Office Visit (for outpatient services)	Covered as a Medical Office Visit (for outpatient services)
<b>14. DIAGNOSTICS</b> <b>a) Laboratory &amp; x-ray</b> <b>b) MRI, nuclear medicine, and other high-tech services</b>	a) Covered as a Medical Office Visit (for outpatient services) b) Covered as a Medical Office Visit (for outpatient services)	a) Covered as a Medical Office Visit (for outpatient services) b) Covered as a Medical Office Visit (for outpatient services)
<b>15. EMERGENCY CARE<sup>7,8</sup></b>	Covered as Outpatient at 70%.	Covered as Outpatient at 50%.
<b>16. AMBULANCE</b>	Covered as Outpatient at 70%.	Covered as Outpatient at 50%.
<b>17. URGENT, NON-ROUTINE, AFTER HOURS CARE</b>	Not covered.	Not covered.
<b>18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE<sup>9</sup></b>	Covered as a Medical Office Visit (for outpatient services)	Covered as a Medical Office Visit (for outpatient services)
<b>19. OTHER MENTAL HEALTH CARE</b> <b>a) Inpatient care</b> <b>b) Outpatient care</b>	a) Covered at 50%. b) Covered as a Medical Office Visit (for outpatient services)	a) Covered at 50%. b) Covered as a Medical Office Visit (for outpatient services)
<b>20. ALCOHOL &amp; SUBSTANCE ABUSE</b>	Covered as a Medical Office Visit (for outpatient services)	Covered as a Medical Office Visit (for outpatient services)
<b>21. PHYSICAL, OCCUPATIONAL, &amp; SPEECH THERAPY</b>	Covered as Outpatient at 70%.	Covered as Outpatient at 50%.
<b>22. DURABLE MEDICAL EQUIPMENT</b>	Covered as Outpatient at 70%.  <i>See policy for types and circumstances of coverage.</i>	Covered as Outpatient at 50%.  <i>See policy for types and circumstances of coverage.</i>
<b>23. OXYGEN</b>	Covered as Outpatient at 70%	Covered as Outpatient at 50%.

<b>24. ORGAN TRANSPLANTS</b>	Covered at 50%.	Covered at 50%.
<b>25. HOME HEALTH CARE</b>	Covered at 70%.	Covered at 50%.
<b>26. HOSPICE CARE</b>	Covered at 70%.	Covered at 50%.
<b>27. SKILLED NURSING FACILITY CARE</b>	Covered at 70%.	Covered at 50%.
<b>28. DENTAL CARE</b>	Covered for dental care and treatment that is required because of an injury and rendered within 6 months of that injury.	Covered for dental care and treatment that is required because of an injury and rendered within 6 months of that injury.
<b>29. VISION CARE</b>	None.	None.
<b>30. CHIROPRACTIC CARE</b>	Chiropractic services are covered the same as medical office visits.	Chiropractic services are covered the same as medical office visits.
<b>31. SIGNIFICANT ADDITIONAL COVERED SERVICES</b>		
ROUTINE MAMMOGRAPHY a) WOMEN AGE 35 - 39 b) WOMEN AGE 40 AND OLDER	a) One baseline mammogram per year. b) One mammogram per year.	a) One baseline mammogram per year. b) One mammogram per year.
DIGITAL RECTAL EXAM AND ROUTINE PROSTATE CANCER SCREENING FOR MEN AGE 40 OR OLDER	One exam and screening per year.	One exam and screening per year.
SUPPLEMENTAL INPATIENT MEDICAL EXPENSES (Maximum inpatient benefit per coverage year must be exhausted first. Other Hospital Services are not covered under this benefit. Room and board charges and Inpatient Professional Services are covered.)	Covered at 80% after inpatient hospital base medical benefit is exhausted, up to a maximum benefit of \$45,000 per coverage year.	Covered at 60% after inpatient hospital base medical benefit is exhausted, up to a maximum benefit of \$45,000 per coverage year.

**PART C: LIMITATIONS AND EXCLUSIONS**

<p><b>32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED <sup>10</sup></b></p>	<p>For the first 365 days after an insured person enrolls, the plan will not pay for medical expenses for pre-existing conditions. The plan will reduce the pre-existing condition period by the number of days of "prior creditable coverage" as of the enrollment date. "Creditable coverage" means prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act of 1996. The pre-existing condition exclusion does not apply to pregnancy or to children under 19 years of age including a newborn child or a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.</p>
<p><b>33. EXCLUSIONARY RIDERS</b> Can an individual's specific, pre-existing condition be entirely excluded from the policy?</p>	<p>No</p>
<p><b>34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?</b></p>	<p>Pre-existing conditions are those conditions for which the insured person received diagnosis, care or treatment within 180 days before that person enrolled in the plan.</p>
<p><b>35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?</b></p>	<p>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.</p>

**PART D: USING THE PLAN**

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?</b>	No	No
<b>37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?</b>	No	No
<b>38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</b>	Yes	Yes
<b>39. What is the main customer service number?</b>	1-888-772-9682	
<b>40. Whom do I write/call if I have a complaint or want to file a grievance?<sup>11</sup></b>	1-888-772-9682	
<b>41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?</b>	1-888-772-9682 to file a complaint, to file an appeal to a denied claim, or to obtain an external review request form.	
<b>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.</b>	AMA110004750, large group	
<b>43. Does the plan have a binding arbitration clause?</b>	No	

## Endnotes

<sup>1</sup> "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). If you live in an area that does not have a preferred health care provider, you will be considered out-of-area and receive benefits for eligible expenses as if you were using a preferred provider. Please note that if you travel to an area that has a preferred health care provider but use a non-preferred health care provider, you will not be eligible for preferred provider benefits. However, if you have a life-threatening medical emergency and use a non-preferred provider, you can call member services within two business days of the medical emergency treatment and your claim for the covered expenses will be treated as if presented by a preferred provider. Call member services Monday through Friday between 8 a.m. and 8 p.m. ET, at **1-888-772-9682**.

<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 a "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 health 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 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.

<sup>3</sup> "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.

<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; there 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 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.

<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, then 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 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.

<sup>11</sup> 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 and 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.

Plans are administered by Strategic Resource Company (SRC), an Aetna Company.

**Attachment  
Cancer Screening Coverage**

**Colorado Health Benefit Plan Description Form Addendum**

**Aetna Life Insurance Company**  
Name of Carrier

**Aetna Affordable Health Choices® limited medical benefits plan**  
Name of Plan

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**Breast Cancer Screening:**

- Age 35 through 39, one baseline mammography
- Age 40 and older, one routine mammogram every year

**Prostate Cancer screening:**

- Age 40 through 49, one screening per year which will include a prostate specific antigen (PSA) blood test and a digital rectal examination; for **Members** who are at an increased risk of developing prostate cancer as determined by **Member's Physician**.
- Age 50 and older, one screening every year which will include a prostate specific antigen (PSA) blood test and a digital rectal examination.

**Cervical Cancer screening:**

- Routine gynecological examinations, including Pap smears, for routine care.

**Colorectal Cancer screening:**

Members aged 50 years and older

- Sigmoidoscopy (considered medically necessary every 5 years for persons at average risk); or
- Double contrast barium enema (DCBE) (considered medically necessary every 5 years for persons at average risk); or
- Colonoscopy (considered medically necessary every 10 years for persons at average risk).
- In addition, Aetna considers screening with annual immunohistochemical or guaiac-based fecal occult blood testing (FOBT), either alone or in conjunction with sigmoidoscopy, medically necessary preventive services for members beginning at age 50 years.

**High-Risk Screening:**

- A first-degree relative (sibling, parent, child) who has had colorectal cancer or an adenomatous polyposis (screening is considered medically necessary beginning at age 40 years);
- Family history of familial adenomatous polyposis (screening is considered medically necessary beginning at puberty);
- Family history of hereditary non-polyposis colorectal cancer (HNPCC) (screening is considered medically necessary beginning at age 20 years).
- Aetna considers annual FOBT, alone or in conjunction with sigmoidoscopy, a medically necessary preventive service for screening of colorectal cancer.