PLAN DESIGN AND BENEFITS
TRADITIONAL CHOICE MEDICARE INTEGRATION PLAN
PROVIDED BY AETNA LIFE INSURANCE COMPANY INC

Please Note:

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

State mandates may apply.

See plan documents for a complete description of benefits, exclusions, limitations, and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services.

PLAN FEATURES	
Deductible (per calendar year)	None
Member Coinsurance Applies to all expenses unless otherwise stated.	0%
Payment Limit (per calendar year)	Not applicable
Lifetime Maximum	Unlimited except where otherwise indicated.
Primary Care Physician Selection	Not applicable
Certification Requirements	Not applicable
Referral Requirement	None
PREVENTIVE CARE	
Annual Wellness Visit (Routine Adult Physical Exam) One routine exam every 12 months	0%,
Immunizations Pneumonia, Flu, Hepatitis B, Zostavax Shingles vaccine	0%
Routine Well Child Exams/ Immunizations[1]	0%
7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam every 12 months thereafter to age 18.	
Routine Gynecological Care Exams	0%
1 routine GYN exam per year including pap smears & related lab fees	
Routine Mammograms No age or frequency limits	0%
Women's Health	0%
Includes: Screening for gestational diabetes, HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for Human Immunodeficiency Virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies, and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	
Routine Digital Rectal Exam (DRE) / Prostate-specific Antigen (PSA) Test	0%
Colorectal Cancer Screening	0%
For all members age 50 and over. Frequency based on the type of service performed.	
Routine Eye Exams One routine eye exam per 12 months	0%
Routine Hearing Exams One routine hearing exam per 12 months.	0% (Evaluation test)

[1] Well Child Visits are available for eligible dependents only. Please refer to Dependent Eligibility under the General Provisions section of this plan summary.

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Hearing Aid Reimbursement One hearing aid every 36 months	
PHYSICIAN SERVICES	
Office Visits to Non-Specialist Includes services of an internist, general physician, family practitioner, or pediatrician.	0%
Specialist Office Visits	0%
Office Visits for Surgery	0%
Pre-natal Maternity	0%
Allergy Testing	0%
Allergy Injections	0%
DIAGNOSTIC PROCEDURES	
Diagnostic Laboratory and X-ray	0%
EMERGENCY MEDICAL CARE	
Urgent Care Provider (benefit availability may vary by location)	0%
Non-Urgent Use of Urgent Care Provider	0%
Emergency Room	0%
Non-Emergency care in an Emergency Room	50%
Ambulance	0%
HOSPITAL CARE	
Inpatient Coverage (semi private room)	0%
Inpatient Maternity Coverage	0%
Outpatient Hospital Expenses (including surgery)	0%
MENTAL HEALTH SERVICES	
Inpatient	0%
Outpatient	0%
ALCOHOL/DRUG ABUSE SERVICES	
Inpatient	0%
Outpatient	0%
OTHER SERVICES	
Convalescent Facility Limited to 120 days per calendar year The member cost sharing applies to all covered benefits incurring during a member's inpatient stay	0%
Home Health Care	0%
Hospice Care - Inpatient Applies to all covered benefits incurred during a member's inpatient stay in a Medicare certified facility and covered by Medicare.	0%
Hospice Care - Outpatient Applies to all covered benefits incurred during a Hospice outpatient visit and covered by Medicare.	0%
Private Duty Nursing - Outpatient	Not Covered
Outpatient Short-Term Rehabilitation Unlimited visits. Includes speech, physical, and occupational therapy.	0%
Spinal Manipulation Therapy	0%
Durable Medical Equipment	0%
Diabetic Supplies	0%

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Fertility Drugs (oral and injectible)	Not Covered
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	0% (payable as any other covered expense)
Generic FDA-approved Women's Contraceptives	0%
Vision Eyewear Allowance	Lens Discount
Transplant When Medicare is not primary, requires pre-authorization by National Medical Excellence (NME)/ Institutes of Excellence (IOE) Transplant Program. Covers transplants that are not experimental or investigational.	0%
Bariatric Surgical treatment of morbid obesity.	Not covered
FAMILY PLANNING	
Infertility Treatment Diagnosis and treatment of the underlying medical condition.	0%
Comprehensive Infertility Services and Advanced Reproductive Technology Artificial Insemination and Ovulation Induction and advanced reproductive technology are excluded	Not covered
Tubal ligation	0%
Vasectomy	Not Covered
GENERAL PROVISIONS	
Dependents Eligibility	Covers Medicare primary spouse as well as incapacitated children if Medicare primary.
Pre-existing Conditions Exclusion	Does not apply

The following is a list of 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 and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental X-rays.
• Donor egg retrieval.
• Durable Medical Equipment
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Hearing aids
• Home births
• Immunizations for travel or work except where medically necessary or indicated.
• Implantable drugs and certain injectible drugs including injectible infertility drugs.
• Infertility services, including 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.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Orthotics except diabetic orthotics.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling or prescription

drugs.

• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Treatment of behavioral disorders.
• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of co-morbid conditions.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at xxx-xxx-xxxx
Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al xxx-xxx-xxxx

How Coordination of Benefits Works

This section explains how the benefits under this plan summary coordinate with benefits available under Medicare.

Medicare, as used in this plan summary, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

You are eligible for Medicare if you are:

- Covered under it by reason of age, disability, or
- End Stage Renal Disease; or
- Not covered under it because you:
  1. Refused it;
  2. Dropped it; or
  3. Failed to make a proper request for it.

If you are eligible for Medicare, Medicare is the primary payor and this plan is the secondary payor. This means that the benefits under this plan summary coordinate with the benefits that Medicare pays.

For example, the benefits under this plan summary will be calculated based on what would have been paid on the claim in the absence of other health insurance coverage. This amount will be applied to any allowable expense under the plan that was unpaid by the primary plan (i.e., Medicare). The amount will be reduced so that when combined with the amount paid by the primary plan (i.e. Medicare), the total benefits paid or provided by all plans for the claim do not exceed 100 % of the total allowable expense. In addition, any amounts that would have been credited in the absence of other coverage will be credited to the deductible included under this plan summary.