County of Santa Barbara
Effective Date: 07/01/2008
Low Option HMO
HMO Low Option $20 copay - California

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA HEALTH OF CALIFORNIA INC. - FULL RISK

PLAN FEATURES	PARTICIPATING PROVIDERS / REFERRED
Deductible (per calendar year)	None Individual None Family
Out-of-Pocket Maximum (per calendar year)	$1,500 Individual $3,000 Family
Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. Only those participating providers/referred out of pocket expenses resulting from the application of coinsurance percentage and copays (except any penalty amounts and pharmacy cost sharing) may be used to satisfy the Out-of Pocket Maximum. Once Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.	
Lifetime Maximum	Unlimited
Primary Care Physician Selection	Required
Referral Requirements	Required for all non-emergency, non-urgent and non-Primary Care Physician services, except direct access services
PREVENTIVE CARE	**PARTICIPATING PROVIDERS / REFERRED**
Routine Adult Physical Exams / Immunizations (Age and frequency schedules apply)	$20 copay
Well Child Exams / Immunizations (Age and frequency schedules apply)	$20 copay
Routine Gynecological Care Exams Includes Pap smear, HPV screening, and related lab fees. Direct access to participating providers without a referral. Members may choose ob/gyns as PCPs. One exam per calendar year.	$20 copay
Routine Mammograms One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over	$20 copay
Routine Digital Rectal Exams / Prostate Specific Antigen Test For males age 40 and over	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Colorectal Cancer Screening For all members 50 and over. Frequency schedule applies	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Routine Eye Exam Age/Frequency Schedule may apply. Direct access to participating providers without a referral.	$20 copay

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Routine Hearing Screening	$20 copay
PHYSICIAN SERVICES	**PARTICIPATING PROVIDERS / REFERRED**
Primary Care Physician Visits	Office Hours: $20 copay After Office Hours/Home: $25 copay
Specialist Office Visits	$20 copay
Maternity OB Visits	$20 copay for initial visit only, thereafter covered 100%
Allergy Treatment	$20 copay
Allergy Testing	$20 copay
DIAGNOSTIC PROCEDURES	**PARTICIPATING PROVIDERS / REFERRED**
Diagnostic Laboratory If performed as a part of a physician's office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit cost sharing.	100%
Diagnostic X-ray Outpatient hospital or other Outpatient facility (except for Complex Imaging Services)	100%
Diagnostic X-ray for Complex Imaging Services	100%
EMERGENCY MEDICAL CARE	**PARTICIPATING PROVIDERS / REFERRED**
Urgent Care	$20 copay
Non-Urgent use of Urgent Care Provider	Covered
Emergency Room	$100 copay (waived if admitted)
Non-Emergency Care in an Emergency Room	Not Covered
Ambulance	100%
HOSPITAL CARE	**PARTICIPATING PROVIDERS / REFERRED**
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	$250 per admission copay + 20%
Inpatient Maternity Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	$250 per admission copay + 20%
Outpatient Surgery The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	100%
MENTAL HEALTH SERVICES	**PARTICIPATING PROVIDERS / REFERRED**
Inpatient Serious Mental Illness and Serious Emotional Disturbances of a Child The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	$250 per admission copay + 20%
Inpatient Non-Serious Mental Illness The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	$250 per admission copay + 20%
Outpatient Serious Mental Illness and Serious Emotional Disturbances of a Child The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	$20 copay per visit
Outpatient Non-Serious Mental Illness Unlimited visits per calendar year The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	$25 copay per visit
ALCOHOL/DRUG ABUSE SERVICES	**PARTICIPATING PROVIDERS / REFERRED**
Inpatient Detoxification 30 days per calendar year The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	$250 per admission copay + 20%
Outpatient Rehabilitation 20 visits per calendar year The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	$25 copay

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OTHER SERVICES	PARTICIPATING PROVIDERS / REFERRED
Skilled Nursing Facility	$250 per admission copay
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. Limited to 100 days per year.	
Home Health Care Limited to 100 visits per year.	$20 copay
Hospice Care - Inpatient	$250 per admission copay + 20%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Hospice Care - Outpatient	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	
Private Duty Nursing	100% covered if pre-authorized
Outpatient Rehabilitation Therapy (Includes speech, physical, and occupational therapy)	$20 copay
Chiropractic	$20 copay – up to 30 visits per calendar year
Durable Medical Equipment	100%
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.
Dental	Not Covered
Vision Eyewear	Not Covered
Transplants Coverage is provided at an IOE contracted facility only	$250 per admission copay + 20%
Bariatric Surgery	$250 per admission copay + 20%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
FAMILY PLANNING	**PARTICIPATING PROVIDERS / REFERRED**
Infertility Treatment Diagnosis and treatment of the underlying medical condition.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Comprehensive Infertility Services	Not Covered
Coverage includes Artificial Insemination and Ovulation Induction	
Advanced Reproductive Technology (ART)	Not Covered
ART coverage includes In-Vitro Fertilization (IVF), Zygote Intra-Fallopian Transfer (ZIFT), Gamete Intra-Fallopian Transfer (GIFT), cryopreserved embryo transfers, Intra-Cytoplasmic Sperm Injection (ICSI) or ovum microsurgery.	
Voluntary Sterilization Including tubal ligation and vasectomy.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
PHARMACY - PRESCRIPTION DRUG BENEFITS	**PARTICIPATING PROVIDERS / REFERRED**
Deductible	$25 Annually brand/brand non-formulary
Retail	$10 copay for formulary generic drugs, $35 copay for formulary brand-name drugs, and $50 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.
Mail Order	$20 copay for formulary generic drugs, $70 copay for formulary brand-name drugs, and $100 copay for non-formulary brand-name and generic drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.

Pharmacy Managed Self Injectables (PMSI)
Self Injectables: Covered 4th Tier, 20%, $100 maximum
First prescription fill at any retail or mail order drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®

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Plan Includes : Contraceptive drugs and devices obtainable from a pharmacy and Performance Enhancing Medication.

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 state mandates or the plan design or rider(s) purchased.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates.
- Cosmetic surgery.
- Custodial care.
- Dental care and dental x-rays.
- Donor egg retrieval.
- 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
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- 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.
- 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.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered in the plan documents.

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 any results or outcomes. Consult the plan document (i.e. Schedule of Benefits, Certificate of Coverage, Evidence of Coverage, Group Agreement, Group Insurance Certificate and/or Group Policy) 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. Some benefits are subject to limitations or visit maximums. With the exception of Aetna Rx Home Delivery, all participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. 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 state law.

Certain primary care providers are affiliated with integrated delivery systems or other provider groups (such as independent practice associations and physician-hospital organizations), and members who select these providers will generally be referred to specialists and hospitals within those systems or groups. However, if a system or group does not include a provider qualified to meet member's medical needs, member may request to have services provided by a non-system or non-group providers. Member's request will be reviewed and will require prior authorization from the system or group and/or Aetna to be a covered benefit.

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.

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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 obtains covered services from participating providers, the provider will obtain precertification. If the Member obtains covered services from a nonparticipating provider, the Member must obtain the precertification. Precertification requirements may vary. Members may refer to their plan documents for a complete list of medical services that require precertification. Certain benefits like comprehensive infertility and advanced reproductive technology (ART) services, if covered under your plan, are subject to a select network of participating providers, from which you will be required to seek care to receive covered benefits.
Members or providers may be required to precertify, or obtain prior approval of coverage for certain services such as non-emergency inpatient hospital care. Certain benefits like comprehensive infertility and advanced reproduction technology (ART) services, if covered under your plan, are subject to a select network of participating providers, from which you will be required to seek care to receive covered benefits.

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