

California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Indiana, Massachusetts, Maryland, Maine, Michigan, North Carolina, New Jersey, Nevada, New York, Ohio, Pennsylvania, South Carolina, Texas, Virginia

PLAN DESIGN AND BENEFITS  
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	Preferred Providers	Non-Preferred Providers
<b>Deductible</b> (per calendar year) Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Deductible is NOT applicable to Hearing Aid Reimbursement, Vision Reimbursement, Dental and Medicare prescription drug coverage.	\$0 Deductible	\$0 Deductible
<b>Member Coinsurance</b> Applies to all expenses unless otherwise stated.	N/A	20%
<b>Annual Maximum Out-of-Pocket Limit</b>	\$6,700	N/A
<b>Annual Maximum Out-of-Pocket Catastrophic Limit (Plan Level)</b> Annual Maximum Out-of-pocket Limit applies to all medical expenses EXCEPT Hearing Aid Reimbursement, Vision Reimbursement, Dental and Medicare prescription drug coverage.	N/A	\$10,000
<b>Primary Care Physician Selection</b>	Optional	Not Applicable

**Lower cost sharing will only apply when services are provided by the member's selected PCP.**

**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 care, inpatient mental health and substance abuse, skilled nursing facility, home health care and some durable medical equipment.

Referral Requirement	None	None
PREVENTIVE CARE	Preferred Providers	Non-Preferred Providers
<b>Routine Physicals</b> One annual exam. Pneumococcal, Flu, Hepatitis B covered 100%	Covered 100%	20%
<b>Routine Gynecological Care Exams</b> Included Pap smear and related lab fees	Covered 100%	20%
<b>Routine Mammograms</b> One baseline mammogram for members 35-39; and one annual mammogram for members age 40 and over	Covered 100%	20%

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<b>Routine Digital Rectal Exam / Prostate-specific Antigen Test</b> For covered males age 40 and over	Covered 100%	20%
<b>Colorectal Cancer Screening</b> For all members age 50 and over.	Covered 100%	20%
<b>Bone Density</b>	Covered 100%	20%
<b>Routine Eye Exams</b> One(1) annual exam	Covered 100%	20%
<b>Routine Hearing Exams</b> One(1) annual exam	Covered 100%	20%
<b>Hearing Aid Reimbursement</b>	\$500 once every 36 months	Same as Preferred tier

<b>PHYSICIAN SERVICES</b>	<b>Preferred Providers</b>	<b>Non-Preferred Providers</b>
<b>Primary Care Physician Visits</b>	100% after \$20 copay	20%
<b>Primary Care Physician Visits (after hours)</b>	100% after \$20 copay	20%

Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery. Lower cost sharing will 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>	100% after \$20 copay	20%
<b>Office Visits for Surgery</b>	100% after \$20 copay	20%
<b>Allergy Testing/Treatment</b>	100% after \$20 copay	20%
<b>Allergy Injections</b> For initial testing by a specialist; PCP copay for routine injections at PCP office with or without physician encounter	Covered 100%	20%

<b>DIAGNOSTIC PROCEDURES</b>	<b>Preferred Providers</b>	<b>Non-Preferred Providers</b>
<b>Diagnostic Laboratory and X-ray</b>	100% after \$20 copay	20%

<b>EMERGENCY MEDICAL CARE</b>	<b>Preferred Providers</b>	<b>Non-Preferred Providers</b>
<b>Urgent Care Provider</b>	100% after \$20 copay	100% after \$20 copay
<b>Emergency Room; Worldwide (waived if admitted)</b>	100% after \$50 copay	100% after \$50 copay
<b>Ambulance</b>	100% after \$20 copay	20%

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<b>HOSPITAL CARE</b>		
	<b>Preferred Providers</b>	<b>Non-Preferred Providers</b>
<b>Inpatient Coverage</b>	Covered 100%	20%
The member cost sharing applies to covered benefits incurred during a member's inpatient stay		
<b>Outpatient Hospital Expenses</b> (including surgery)	Covered 100%	20%
The member cost sharing applies to covered benefits incurred during a member's outpatient visit		
<b>MENTAL HEALTH SERVICES</b>		
	<b>Preferred Providers</b>	<b>Non-Preferred Providers</b>
<b>Inpatient</b>	Covered 100%	20%
The member cost sharing applies to covered benefits incurred during a member's inpatient stay		
<b>Outpatient</b>	100% after \$20 copay	20%
The member cost sharing applies to covered benefits incurred during a member's outpatient visit		
<b>ALCOHOL/DRUG ABUSE SERVICES</b>		
	<b>Preferred Providers</b>	<b>Non-Preferred Providers</b>
<b>Inpatient</b>	Covered 100%	20%
The member cost sharing applies to covered benefits incurred during a member's inpatient stay		
<b>Outpatient</b>	100% after \$20 copay	20%
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>
<b>Skilled Nursing Facility</b>	\$0 days 1-10 \$25 days 11-20 \$50 days 21-100	20%
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>	Covered 100%	20%
Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.		
<b>Hospice Care</b>	Covered by Medicare at a Medicare certified hospice	Covered by Medicare at a Medicare certified hospice
<b>Outpatient Short-Term Rehabilitation</b>	100% after \$20 copay	20%
Includes speech, physical, and occupational therapy.		
<b>Chiropractic Care</b>	100% after \$15 copay	20%
For manipulation of the spine to the extent covered by Medicare		

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<b>Durable Medical Equipment</b>	Covered 100%	20%
<b>Podiatry</b> Limited to Medicare covered benefits only	100% after \$20 copay	20%
<b>Diabetic Supplies</b>	Covered 100%	20%
<b>Outpatient Complex Radiology</b>	100% after \$20 copay	20%
<b>Outpatient Dialysis</b>	100% after \$20 copay	Same as in-network
<b>Part B Drugs</b>	Covered 100%	Covered 100%
<b>Dental *</b>	Dental Discounts	Not Applicable
<b>Vision Eyewear Allowance</b>	\$70 reimbursement every 24 months	Same as preferred care.
<b>Coaching</b> One phone call per week	Included	Not covered
<b>PHARMACY - PRESCRIPTION DRUG BENEFITS</b>	<b>Cost Share</b>	
<b>Prescription drug calendar year deductible</b>	None	

Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are

**Initial Coverage Limit (ICL)** \$2,840 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:

<b>Retail - Member Cost-Sharing up to the Initial Coverage Limit</b>	Member pays \$10 Copay for Tier 1 Generic
	Member pays \$20 Copay for Tier 2 Preferred Brand
	Member pays \$40 Copay for Tier 3 Non-Preferred Brand

Up to one month (31 day) supply at indicated copay or coinsurance



Columbia University  
Aetna Medicare<sup>SM</sup> Plan (PPO)  
Custom Medicare 20 PPO Plan  
Rx Group O9 RNL

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Three month (90 day) supply available at retail. Dollar copayments or applicable coinsurance will apply for each month supply.

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**Mail Order through Aetna Rx Home Delivery** Member pays \$20 Copay for Tier 1 Generic

**- Member Cost-Sharing up to Initial**

**Coverage Limit**

Member pays \$40 Copay for Tier 2 Preferred Brand

Member pays \$80 Copay for Tier 3 Non-Preferred Brand

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

**Coverage Gap\***

Once covered Medicare Prescription Drug expenses have reached the Initial Coverage Limit, the Coverage Gap begins. Member cost sharing under the plan between the Initial Coverage Limit and until \$4,550 in true out-of-pocket costs for Covered Part D drugs is incurred is as follows:

**Retail - Member Cost-Sharing during**

**Coverage Gap\***

Member pays \$10 Copay for Tier 1 Generic

Member pays \$40 Copay for Tier 2 Preferred Brand

Member pays \$80 Copay for Tier 3 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** Member pays \$20 Copay for Tier 1 Generic

**- Member Cost Sharing during Coverage**

**Gap\***

Member pays \$80 Copay for Tier 2 Preferred Brand

Member pays \$160 Copay for Tier 3 Non-Preferred Brand

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

**Catastrophic Coverage**

Greater of \$2.50 or 5% for covered generic (including brand drugs treated as generic) drugs. Greater of \$6.30 or 5% for all other covered drugs.

Catastrophic Coverage benefits start once \$4,550 in true out-of-pocket costs is incurred.

**Requirements:**

**Precertification**

Yes

**Step-Therapy**

Yes

**Formulary**

Standard (Three Tier)

\* Dental Benefits are not available in all service areas. Refer to your plan documents for a complete description of the benefits or discounts available.

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**Not all services are covered. 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**

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.

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 Medicare<sup>SM</sup> Plan (PPO) and Aetna Medicare Rx<sup>®</sup> (PDP):

- 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
- Outpatient Prescription Drugs except those covered under Original Medicare Part B;

**\*Beginning in 2011, the Medicare Coverage Gap Discount Program will provide manufacturer discounts on brand name drugs to Part D enrollees who have reached the coverage gap and are not already receiving “Extra Help.” A 50% discount on the negotiated price (excluding the dispensing fee) will be available for those brand name drugs from manufacturers that have agreed to pay the discount.**

**There are three general rules about drugs that Medicare drug plans will not cover under Part D. This plan cannot:**

- cover a drug that would be covered under Medicare Part A or Part B.
- cover a drug purchased outside the United States and its territories.
- generally cover drugs prescribed for “off label” use, unless supported by criteria included in certain reference books (eg, American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI).

Additionally, certain types of drugs or categories of drugs are not normally covered by a Medicare Prescription Drug Plan. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs”. These drugs include:

- Drugs used for the treatment of weight loss, weight gain or anorexia;
- Drugs used for cosmetic purposes or to promote hair growth;
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations;

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- Barbiturates;
  - 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;
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- Drugs used to promote fertility;
  - Drugs used for symptomatic relief of cough and colds;
  - Non-prescription drugs, also called over-the counter (OTC);
  - Benzodiazepines;
  - Drugs when used for the treatment of sexual or erectile dysfunction.

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

Health Benefits and Health Insurance plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna). Coverage is provided through a Medicare Advantage organization or a Medicare prescription drug plan sponsor with a Medicare contract. 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 may 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.

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.

Members 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 an individual qualifies 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 for extra help by calling 1-800-Medicare (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

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Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Information is believed to be accurate as of the production date; however, it is subject to change. In the event of a conflict or inconsistency between this material and plan documents, the terms of the plan document shall govern.

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Discount programs provide access to discounted prices and are not insured benefits. The member is responsible for the full cost of the discounted services. Health benefits and health insurance plans contain exclusions and limitations.

If you require language assistance from an Aetna representative, please call Member Services' multilingual hotline at **1-888-982-3862** (140 languages are available. You must ask for an interpreter). **TDD 1-800-628-3323** (hearing impaired only).

Si necesita asistencia lingüística de un representante de Aetna, contamos con una línea directa de Servicios a Miembros disponible en varios idiomas. Comuníquese al **1-888-982-3862** (140 idiomas disponibles. Debe solicitar un intérprete). **TDD 1-800-628-3323** (para personas con problemas de audición únicamente).

For more information about Aetna plans, refer to [www.aetna.com](http://www.aetna.com).  
2011 Aetna Medicare

**\*\*\*This is the end of this plan benefit summary\*\*\***