

2011-2012 Comparison of Aetna MedicareSM Plans (HMO): Small Group Markets



	2011 Medicare HMO 1.6	2012 Medicare HMO 1.7	2011 Medicare HMO 2.6	2012 Medicare HMO 2.7	2011 Medicare HMO 3.6	2012 Medicare HMO 3.7	2011 Medicare HMO 4.6	2012 Medicare HMO 4.7	2011 Medicare HMO 5.6	2012 Medicare HMO 5.7
Maximum Out-of-Pocket Limit (includes deductible) Cross apply	\$6,700	\$6,700	\$6,700	\$6,700	\$6,700	\$6,700	\$6,700	\$6,700	\$6,700	\$6,700
PCP	\$35	\$35	\$20	\$20	\$20	\$20	\$10	\$10	\$10	\$10
Specialty Care										
Office Visits	\$50	\$50	\$35	\$35	\$35	\$35	\$25	\$25	\$25	\$25
X-rays/Lab Tests (includes CAT)	\$50	\$50	\$35	\$35	\$35	\$35	\$25	\$25	\$25	\$25
Complex Radiology (includes PET/MRI)	\$200	\$200	\$175	\$175	\$175	\$175	\$175	\$175	\$175	\$175
Radiation Therapy	\$50	\$50	\$35	\$35	\$35	\$35	\$25	\$25	\$25	\$25
Outpatient Kidney Dialysis	\$50	\$30	\$35	\$30	\$35	\$30	\$25	\$25	\$25	\$25
Therapy (Physical, Occupational & Speech)	\$50	\$50	\$35	\$35	\$35	\$35	\$25	\$25	\$25	\$25
Home Health Services	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Diabetic Self-Monitoring/ Supplies	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay
DME	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%
Prosthetic Devices	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%
Outpatient Surgery	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$200
Hospital Admission	\$265 day 1-5	\$265 day 1-5	\$300 day 1-3	\$300 day 1-3	\$300 day 1-3	\$300 day 1-3	\$300 per stay	\$300 per stay	\$300 per stay	\$300 per stay
Emergency Room (Copay waived if admitted-worldwide)	\$50 copay	\$65 copay	\$50 copay	\$65 copay	\$50 copay	\$65 copay	\$50 copay	\$65 copay	\$50 copay	\$65 copay
Urgent Care (Rider required)	\$50 copay	\$50 copay	\$40 copay	\$50 copay	\$40 copay	\$50 copay	\$40 copay	\$50 copay	\$40 copay	\$50 copay
Ambulance	\$150 copay	\$150 copay	\$150 copay	\$150 copay	\$150 copay	\$150 copay	\$150 copay	\$150 copay	\$150 copay	\$150 copay
Preventive Care ⁽¹⁾										
Routine Physical	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay
Routine Eye (SOOPT >\$0)	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay
Routine GYN Exam	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay
Routine Mammogram	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay
Bone Mass Measurement	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay
Colorectal Screening Exams	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay
Prostate Cancer Screening Exams	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay
Immunizations (Pneumonia, Flu and Hepatitis B)	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay
Routine Hearing Exam	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay	No copay
Chiropractic Care (Limited to Medicare covered benefits only)	\$15	\$20	\$15	\$20	\$20	\$20	\$15	\$20	\$15	\$20
Routine Podiatry Services	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Non-Routine Podiatry Services (Medicare covered)	\$50	\$50	\$35	\$35	\$35	\$35	\$25	\$25	\$25	\$25
Skilled Nursing Care (100 days per Medicare benefit period; prior hospital stay not required)	\$0 day 1-10 ; \$100 day 11-101	\$0 day 1-10 ; \$100 day 11-100	\$0 day 1-10 ; \$100 day 11-103	\$0 day 1-10 ; \$100 day 11-100	\$0 day 1-10 ; \$100 day 11-105	\$0 day 1-10 ; \$100 day 11-100	\$0 day 1-10 ; \$100 day 11-107	\$0 day 1-10 ; \$100 day 11-100	\$0 day 1-10 ; \$100 day 11-109	\$0 day 1-10 ; \$100 day 11-100
Mental Health - Parity Applies										
Inpatient Mental Health (Unlimited day)	\$265 day 1-5	\$265 day 1-5	\$300 day 1-3	\$300 day 1-3	\$300 day 1-3	\$300 day 1-3	\$300 per stay	\$300 per stay	\$300 per stay	\$300 per stay
OP Mental Health	\$50	\$40	\$35	\$35	\$35	\$35	\$25	\$25	\$25	\$25
Inpatient Substance Abuse (Unlimited day)	\$265 day 1-5	\$265 day 1-5	\$300 day 1-3	\$300 day 1-3	\$300 day 1-3	\$300 day 1-3	\$300 per stay	\$300 per stay	\$300 per stay	\$300 per stay
OP Substance Abuse	\$50	\$40	\$35	\$35	\$35	\$35	\$25	\$25	\$25	\$25
Hearing Aid Reimbursement	Discount Program	Discount Program	Up to \$800/36 months	Up to \$800/36 months	Up to \$800/36 months	Up to \$800/36 months	Up to \$800/36 months	Up to \$800/36 months	Up to \$800/36 months	Up to \$800/36 months
Coaching	Included	Included	Included	Included	Included	Included	Included	Included	Included	Included
Informed Health	Med Mgmt Program	Med Mgmt Program	Med Mgmt Program	Med Mgmt Program	Med Mgmt Program	Med Mgmt Program	Med Mgmt Program	Med Mgmt Program	Med Mgmt Program	Med Mgmt Program
Prescription Lens Reimbursement	Discount Program	Discount Program	\$100/24 months	\$100/24 months	\$100/24 months	\$100/24 months	\$100/24 months	\$100/24 months	\$100/24 months	\$100/24 months
Optional Dental Riders NOT AVAILABLE IN ALL MARKETS	\$5	N/A	\$5	N/A	\$5	N/A	\$5	N/A	\$5	N/A

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Pharmacy Benefit ⁽²⁾										
1 Month (up to 31 day) Supply at In-Network Retail Pharmacy										
Annual Deductible	\$125	\$125	\$125	\$125	\$0	\$0	\$125	\$125	\$0	\$0
In-Network Retail 1 Month - Member Copays/Coinsurance during Initial Coverage Period (ICP) ⁽³⁾										
Tier 1: Preferred Generic	\$5	\$5	\$5	\$5	\$5	\$5	\$5	\$5	\$5	\$5
Tier 2: Non-Preferred Generic	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25
Tier 3: Preferred Brand	\$40	\$40	\$40	\$40	\$40	\$40	\$40	\$40	\$40	\$40
Tier 4: Non-Preferred Brand	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75
Tier 5: Specialty Tier ⁽⁴⁾	30%	30%	30%	30%	33%	33%	30%	30%	33%	33%
Initial Coverage Limit (ICL) ⁽⁵⁾	\$2,840	\$2,930	\$2,840	\$2,930	\$2,840	\$2,930	\$2,840	\$2,930	\$2,840	\$2,930
In-Network Retail 1 Month - Member Copays/Coinsurance between Initial Coverage Limit and TrOOP Threshold (Coverage Gap) ⁽⁶⁾										
Tier 1: Preferred Generic	93%	86%	93%	86%	\$5	\$5	93%	86%	\$5	\$5
Tier 2: Non-Preferred Generic	93%	86%	93%	86%	93%	86%	93%	86%	93%	86%
Tier 3: Preferred Brand	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Tier 4: Non-Preferred Brand	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Tier 5: Specialty Tier ⁽⁴⁾	Generic: 93% Brand: 100%	Generic: 86% Brand: 100%	Generic: 93% Brand: 100%	Generic: 86% Brand: 100%	Generic: 93% Brand: 100%	Generic: 86% Brand: 100%	Generic: 93% Brand: 100%	Generic: 86% Brand: 100%	Generic: 93% Brand: 100%	Generic: 86% Brand: 100%
True Out-of-Pocket (TrOOP) Limit ⁽⁷⁾	\$4,550	\$4,700	\$4,550	\$4,700	\$4,550	\$4,700	\$4,550	\$4,700	\$4,550	\$4,700
Catastrophic Coverage	Greater of 5% OR \$2.50 for generic drugs/drugs treated like generic and \$6.30 for other drugs	Greater of 5% OR \$2.60 for generic drugs/drugs treated like generic and \$6.50 for other drugs	Greater of 5% OR \$2.50 for generic drugs/drugs treated like generic and \$6.30 for other drugs	Greater of 5% OR \$2.60 for generic drugs/drugs treated like generic and \$6.50 for other drugs	Greater of 5% OR \$2.50 for generic drugs/drugs treated like generic and \$6.30 for other drugs	Greater of 5% OR \$2.60 for generic drugs/drugs treated like generic and \$6.50 for other drugs	Greater of 5% OR \$2.50 for generic drugs/drugs treated like generic and \$6.30 for other drugs	Greater of 5% OR \$2.60 for generic drugs/drugs treated like generic and \$6.50 for other drugs	Greater of 5% OR \$2.50 for generic drugs/drugs treated like generic and \$6.30 for other drugs	Greater of 5% OR \$2.60 for generic drugs/drugs treated like generic and \$6.50 for other drugs
Formulary	Base Closed									

¹ Preventive care benefits include: routine physical, routine hearing exam, routine eye exam, routine gynecological exam, routine mammogram, bone mass measurement, colorectal cancer screening, prostate cancer screenings and pneumonia, flu and Hepatitis B immunizations.

² Members must use network pharmacies to receive plan benefits except in limited, non-routine circumstances when a network pharmacy is not available. Coverage is limited to a 10-day supply and additional cost may be incurred for drugs received at an out-of-network pharmacy.

³ Initial Coverage Period cost sharing applies between the plan deductible and the Initial Coverage Limit.

⁴ The specialty tier includes drugs which cost at least \$600 per month and are not eligible for tiering exception requests.

⁵ The Initial Coverage Limit (ICL) is the total amount paid by Aetna AND the member for covered Part D drugs.

⁶ The Medicare Coverage Gap Discount Program will provide manufacturer discounts on brand 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) is available for those brand name drugs from manufacturers that have agreed to pay the discount.

⁷ Once member out-of-pocket costs for covered Part D drugs reaches TrOOP threshold, Catastrophic Coverage applies.

This material is for informational purpose only. See plan documents for a complete description of benefits, exclusions, limitations, and conditions of coverage. The Aetna HMO Medicare Plan is available for groups with retirees in certain counties in AZ, CA, CO, CT, DC, DE, FL, GA, IL, KS, KY, MA, MD, ME, MO, NC, NJ, NV, NY, OH, OK, PA, TN, TX and VA. A Medicare Advantage organization with a Medicare contract. Health insurance plans are offered by Aetna Health Inc., Aetna Health of California Inc. and/or Aetna Life Insurance Company.