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MTN Health Insurance, LLC

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## Colorado Health Plan Description Form

### Aetna Life Insurance Company

### High - Deductible Managed Choice OA 3000

#### PART A: TYPE OF COVERAGE

<b>1. TYPE OF PLAN</b>	<b>Managed Choice Open Access Plan</b> (Network plan with in and out-of-network benefits)
<b>2. OUT-OF-NETWORK CARE COVERED?<sup>1</sup></b>	<b>Yes, but patient pays more for out-of-network care</b>
<b>3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE</b>	Plan is available in the following areas: Adams, Alamosa, Arapahoe, Archuleta, Baca, Bent, Boulder, Broomfield, Chaffee, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Delta, Denver, Dolores, Douglas, Eagle, El Paso, Elbert, Fremont, Garfield, Gilpin, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Jefferson, Kiowa, Kit Carson, La Plata, Lake, Larimer, Las Animas, Lincoln, Logan, Mesa, Mineral, Moffat, Montezuma, Montrose, Morgan, Otter, Ouray, Park, Phillips, Pitkin, Prowers, Pueblo, Rio Blanco, Rio Grande, Routt, Saguache, San Juan, San Miguel, Sedgwick, Summit, Teller, Washington, Weld and Yuma.

#### 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, diagnosis, 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.

	IN-NETWORK	OUT-OF-NETWORK
<b>4. ANNUAL DEDUCTIBLE<sup>2</sup></b> a) Individual b) Family	a) Individual - \$3,000 b) Family - \$6,000	a) Individual - \$ 6,000 b) Family - \$12,000
<b>5. OUT-OF-POCKET ANNUAL MAXIMUM<sup>3</sup></b> a) Individual  b) Family	a) Individual - \$5,000  b) Family - \$10,000	a) Individual - \$10,000  b) Family - \$20,000

	IN-NETWORK	OUT-OF-NETWORK
<b>6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE</b>	\$5,000,000	
<b>7A. COVERED PROVIDERS</b>	See provider directory for complete list.	All providers licensed or certified to provide covered benefits.
<b>7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?</b>	Not applicable. Primary Care Physicians not required.	Not applicable
<b>8. ROUTINE MEDICAL OFFICE VISITS<sup>4</sup></b>  a) Non-Specialist  b) Specialist	a) 90% after deductible non-specialist office visit copay if visit made to Internist, General Physician, Family Practitioner or Pediatrician.  b) 90% after deductible	50% after deductible
<b>9. PREVENTIVE CARE<sup>5</sup></b> a) Children's services - 7 exams in the first 12 months of life, 2 exams in the 13th - 24th months of life, 1 exam per 12 months up to age 18. Includes coverage for immunizations.  b) Adult services - 1 exam every 365 days. \$200 Annual Maximum applies.	a) 100% after \$25 copay, not subject to deductible.  a) 100% after \$25 copay, not subject to deductible.	a) 50%. After deductible.  b) 50% after deductible.
Maximums are combined for both in-network and out-of-network services.		
<b>10. MATERNITY</b> No coverage except for Complications of Pregnancy or Complications of childbirth.	Coverage same as any other similar sickness or disease	Coverage same as any other similar sickness or disease
<b>11. PRESCRIPTION DRUGS<sup>6</sup></b>  Mandatory Generics with DAW Override (The member pays the applicable copay only, if the physician requires brand. If the member requests brand when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.)  Includes coverage for contraceptive drugs and devices obtainable from a pharmacy.	Retail: After Medical Deductible \$15 Copay generic drugs, \$25 Copay formulary brand drugs and \$40 Copay for non-formulary brand drugs, up to a 30-day supply.  Mail Order: 2 times copay for retail pharmacy for a 31-60-day supply.	Retail: After Medical Deductible, 50% plus \$15 Copay generic drugs, 50% plus \$25 Copay formulary brand drugs and 50% plus \$40 Copay for non-formulary brand drugs, up to a 30-day supply.  Mail Order: 2 times copay for retail pharmacy for a 31-60-day supply.

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>12. INPATIENT HOSPITAL</b>	90% after deductible	50% after deductible
<b>13. OUTPATIENT / AMBULATORY SURGERY</b>		
a) Outpatient Hospital	a) 90% after deductible	a) 50% after deductible
b) Freestanding Facility	b) 90% after deductible	b) 50% after deductible
<b>14. DIAGNOSTICS</b>		
a) Laboratory & X-Ray	a) 90% after deductible	a) 50% after deductible
b) MRI, nuclear medicine and other high-tech services	b) 90% after deductible	b) 50% after deductible
c) Mammography - Limited to one baseline for females ages 35-40 and one each year for females age 40 and older	c) 90% after \$0 copay. Not subject to deductible.	c) 50% after deductible.
<b>15. EMERGENCY CARE<sup>7, 8</sup></b>	90% after \$100 Copay, deductible applies (Copay waived if admitted)	90% after \$100 Copay, deductible applies (Copay waived if admitted)
Non-Emergency Care in Emergency Room	50% after deductible	50% after deductible
<b>16. AMBULANCE (Ground and Air)</b>	90% after deductible; Maximum benefit \$1,000 per trip	90% after deductible; Maximum benefit \$1,000 per trip
<b>17. URGENT, NON-ROUTINE, AFTER HOURS CARE</b>	90% after deductible	50% after deductible
	50% after deductible for Non-Urgent Use of an Urgent Care Provider.	
<b>18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE<sup>9</sup></b>	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
<b>19. OTHER MENTAL HEALTH CARE</b>		
a) Inpatient care -	a) Not Covered	b) Not Covered
b) Outpatient care -	a) Not Covered	b) Not Covered
<b>20. ALCOHOL &amp; SUBSTANCE ABUSE CARE-Not covered unless associated with biologically based mental illness care</b>		
a) Detox - Inpatient	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
b) Detox - Outpatient	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
c) Rehabilitation - Inpatient	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
d) Rehabilitation - Outpatient	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>21A. PHYSICAL, OCCUPATIONAL, CHIROPRACTIC THERAPY</b> - Limited to 24 visits per calendar year. \$25 Max. Benefit per visit.	90% after deductible	50% after deductible
	Maximums are combined for both in-network and out-of-network services.	
<b>21B. SPEECH THERAPY</b> - Limited to services supplied by a Home Health agency or at a Skilled Nursing Facility.	Refer to lines 25 and 27	Refer to lines 25 and 27
	Maximums are combined for both in-network and out-of-network services.	
<b>22. DURABLE MEDICAL EQUIPMENT</b> - Limited to \$2,000 per calendar year. Limit does not apply to prosthetic devices.	90% after deductible	50% after deductible
	Maximums are combined for both in-network and out-of-network services.	
<b>23. OXYGEN</b>	Combined with Durable Medical Equipment. See line 22.	Combined with Durable Medical Equipment. See line 22.
<b>24. ORGAN TRANSPLANTS</b>	90% after deductible	50% after deductible
<b>25. HOME HEALTH CARE</b> - Limited to 30 visits per calendar year.	90% after deductible	50% after deductible
	Maximums are combined for both in-network and out-of-network services.	
<b>26. HOSPICE CARE</b> - Limited to \$10,000 lifetime maximum for Inpatient and Outpatient Care.	90% after deductible	50% after deductible
	Maximums are combined for both in-network and out-of-network services.	
<b>27. SKILLED NURSING FACILITY CARE</b> Limited to 30-days per calendar year.	90% after deductible	50% after deductible
	Maximums are combined for both in-network and out-of-network services.	
<b>28. DENTAL CARE</b>	Available as a separate dental care plan.	Available as a separate dental care plan.
<b>29. VISION CARE</b>	Not Covered	Not Covered
<b>30. CHIROPRACTIC CARE</b>	Refer to Physical, Occupational and Chiropractic Therapy Benefit. Refer to line 21A.	Refer to Physical, Occupational and Chiropractic Therapy Benefit. Refer to line 21A.
<b>31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)</b>		
<b>ROUTINE GYN EXAM and PAP SMEAR</b> Limited to one exam per calendar year.	100% after \$0 copay. Not subject to deductible.	50% after deductible
<b>INFUSION THERAPY</b> a) Home or physician's office	90% after deductible	50% after deductible
	b) OP facility	90% after deductible

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>COLONOSCOPY</b>	Same as Outpatient / Ambulatory Surgery. Refer to line 13A and 13B.	Same as Outpatient / Ambulatory Surgery. Refer to line 13A and 13B.
<b>ROUTINE CANCER SCREENING COVERAGE</b>		
a) Routine Mammography Screening-single baseline mammogram for women thirty-five years of age and under forty years of age; not less than once every two calendar years or contract years for women forty years of age and under fifty years of age, but at least once each such calendar year or contract year for a woman with risk factors to breast cancer and annual screening, on a calendar year or contract year basis, for women who are fifty to sixty-five years of age	Refer to line 14 C	Refer to line 14 C
b) Colorectal Cancer Screening - Includes digital rectal exam and fecal occult blood test. One screening annually for any man age 40 and over.	100% after \$0 copay. Not subject to deductible.	50% after deductible
c) Prostate Cancer Screening - Includes prostate-specific antigen (PSA) blood test. One screening annually for any man age 40 and over.	100% after \$0 copay. Not subject to deductible.	50% after deductible

### **PART C: LIMITATIONS AND EXCLUSIONS**

<b>32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.<sup>10</sup></b>	Twelve-months for all pre-existing conditions.
<b>33. EXCLUSIONARY RIDERS.</b> Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
<b>34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?</b>	A pre-existing condition is an illness, injury, disease or physical condition for which medical advice, diagnosis, care or treatment, including the use of prescription drugs was recommended or received from a physician during the twelve (12) months immediately preceding the Member's effective date of coverage
<b>35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?</b>	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.

**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>	Yes	Yes
<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>	No	Yes
<b>39. What is the main customer service number?</b>	866-565-1236	866-565-1236
<b>40. Whom do I/call if I have a complaint or want to file a grievance?<sup>11</sup></b>	Members can call the customer service number listed in line 39 for complaints/grievance	Members can call the customer service number listed in line 39 for complaints/grievance
<b>41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?</b>	Write to: Colorado Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, CO 80202	
<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>	INDIVIDUAL MEDICAL GR 11741, INDIVIDUAL DENTAL GR11826, INDIVIDUAL PREVENTATIVE AND HOSPITAL GR 11741 - LME	
<b>43. Does the plan have a binding arbitration clause?</b>	No	No

**PART E: COST**

<b>44. What is the cost of this plan?</b>	Contact your agent, this insurance company, or your employer, as appropriate, to find out the premium for this plan. In some cases, plan costs are included with this form.
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**PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH EXPENSES, ADMINISTRATION AND PROFIT.**

<p><u>Any person interested in applying for coverage, or who is covered by, or who purchased coverage under this plan may request answers to the questions listed below. The request may be made orally or in writing to the agent marketing the plan or directly to the insurance company and shall be answered within five (5) business days of the receipt of the request.</u></p>	
<p>What are the three most frequently used methods of payment for primary care physicians?</p>	
<p>What are the three most frequently used methods of payment for physician specialists?</p>	
<p>What other financial incentives determine physician payment?</p>	
<p>What percentage of total Colorado premiums are spent on health care expenses as distinct from administration and profit?</p>	

## ENDNOTES:

<sup>1</sup>"Network" refers to a specified group of physicians, hospitals, medial clinics and other health care providers that your plan may require you to use in order to get any coverage at all under the plan, or that the plan may encourage you to use because it pays 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).

<sup>2</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) 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 may be noted in boxes 8 through 31.

<sup>3</sup>"Out-of-pocket maximum". The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments or other costs depending on the contract for that plan.

<sup>4</sup> Routine 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; they 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 services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent layperson 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, than urgent care copayments apply.

<sup>9</sup>"Biological 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 conditions exclusions. State law requires carriers to waive some or all of the pre-existing conditions 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 grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

This is to provide notice as required under recent 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 lymph-edemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductible and coinsurance provisions that apply for the mastectomy.

## EXCLUSIONS

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 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 or hospital services not specifically covered in, or which are limited or excluded on the plan documents, including costs of services before coverage begins and after coverage terminates; 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; Home births; Immunization 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, ICSA and other related services, unless specifically listed as covered in your plan documents; Non-medically necessary services or supplies; Orthotics, unless specified in the plan; Over-the-counter medications 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; and Treatment of those services for or related to treatments of obesity or for diet or weight control.

## DISCLAIMERS

The 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., Comprehensive Medical Expense Policy and/or Summary of Coverage) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. Preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. 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 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, and outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will contain the precertification. When the Member utilizes a non-preferred 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