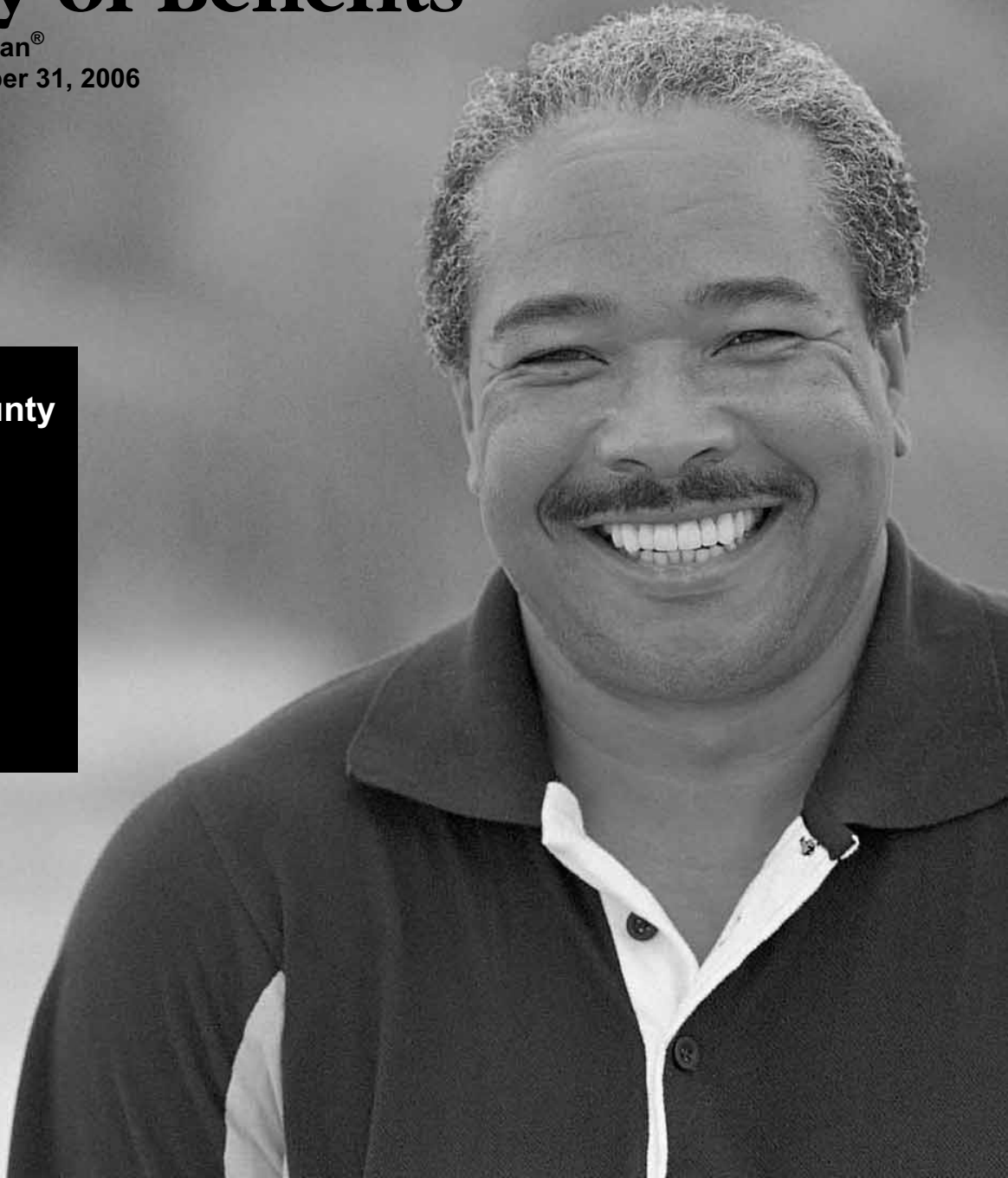


Summary of Benefits

Aetna Golden Medicare Plan®
January 1, 2006 – December 31, 2006

San Bernardino County



We want you to knowSM

 **Aetna® Medicare**

San Bernardino County

Thank you for your interest in Aetna Golden Medicare Premier Plan. Our plan is offered by AETNA HEALTH OF CALIFORNIA, INC., a Medicare Advantage Health Maintenance Organization (HMO). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover, every limitation, or every exclusion. To get a complete list of our benefits, please call Aetna and ask for the "Evidence of Coverage."

You Have Choices in Your Health Care.

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Aetna Golden Medicare Premier Plan. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare program.

You may join or leave a plan only at certain times. Please call Aetna at the telephone listed at the end of this introduction, or 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048.

How Can I Compare My Options?

You can compare Aetna Golden Medicare Plan and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer additional benefits, which may change from year to year.

Where is Aetna Golden Medicare Plan Available?

The service area for this plan includes: San Bernardino* County, CA. You must live in San Bernardino County, CA to join the plan. If you are in prison, you can't join this plan.

Can I Choose My Doctors?

Aetna Golden Medicare Plan has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time. You

can ask for a current Provider Directory for an up-to-date list. Our number is listed at the end of this introduction.

What Happens if I Go to a Doctor Who's Not in Your Network?

If you choose to go to a doctor outside our network, you must pay for these services yourself. Neither Aetna Health Inc. nor the Original Medicare Plan will pay for these services.

Where Can I Get My Prescriptions if I Join This Plan?

Aetna Golden Medicare Plan has formed a network of pharmacies. You can use any pharmacy in our network. The pharmacies in our network can change at any time. You can ask for a current Pharmacy Network List. Our number is listed at the end of this introduction.

What Happens if I Go To a Pharmacy That's Not In Your Network?

If you go to a pharmacy that's not in our network, you might have to pay more for your prescriptions. You also might have to follow special rules before getting your prescription in order for the prescription to be covered under our plan. For more information, call the telephone number at the end of this introduction.

Does My Plan Cover Medicare Part B Or Part D Drugs?

Aetna Golden Medicare Plan does cover both Medicare Part B prescription drugs and Part D prescription drugs.

Does My Plan Have A Prescription Drug Formulary?

Aetna Golden Medicare Premier Plan uses a formulary. A formulary is a preferred list of drugs selected to meet patient needs. The plan may periodically make changes to the formulary. If the formulary changes, affected enrollees will be notified, in writing, before the change is made. Contact Aetna for details.

What Is A Medication Therapy Management (MTM) Program?

A Medication Therapy Management (MTM) Program is a benefit that your plan may offer. You may be identified to participate in a program designed for your specific health and pharmacy needs. It is recommended that you take full advantage of this covered benefit if you are selected. Contact Aetna for more details.

What Types Of Drugs May Be Covered Under Medicare Part B?

The following outpatient prescription drugs may be covered under Medicare Part B. This may include, but is not limited to, the following types of drugs. Contact Aetna for more details.

- Some Antigenes: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin alpha or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.

- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen. Inhalation and infusion drugs provided through DME.

*Partial San Bernardino county includes the following zip codes:

91701 91784 92310 92327 92350 92374 92401 92415
91708 91786 92311 92329 92352 92376 92402 92418
91709 91798 92313 92333 92354 92377 92403 92420
91710 92252 92314 92335 92356 92378 92404 92423
91730 92256 92315 92336 92357 92382 92405 92424
91737 92277 92316 92337 92358 92385 92406 92427
91739 92278 92317 92339 92359 92386 92407 93558
91743 92284 92318 92340 92365 92391 92408 93562
91758 92285 92321 92341 92368 92392 92410 93592
91761 92301 92322 92342 92369 92394 92411
91762 92305 92324 92345 92371 92397 92412
91763 92307 92325 92346 92372 92398 92413
91764 92308 92326 92347 92373 92399 92414

PLEASE CALL AETNA HEALTH, INC. FOR MORE INFORMATION ABOUT THIS PLAN.

Please call Aetna Health of California, Inc. for more information about this plan.

Visit us at www.aetnamedicare.com or, call us:

Customer Service Hours:

Monday, Tuesday, Wednesday, Thursday, Friday, 8:00 a.m. - 5:00 p.m. Pacific

Current members should call (800)-282-5366 for questions related to the Medicare Advantage program. (TDD (800)-628-3323)

Prospective members should call (800)-832-2640 for questions related to the Medicare Advantage program. (TDD (800)-628-3323)

Current members should call (800)-282-5366 for questions related to the Medicare Part D Prescription Drug program. (TDD (800)-628-3323)

Prospective members should call (800)-832-2640 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (800)-628-3323)

For more information about Medicare, call 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Or, visit www.medicare.gov on the web.

If you have special needs, this document may be available in other formats.

Section 2**Summary of Benefits
Aetna Golden Medicare Plan®****January 1, 2006 –
December 31, 2006****San Bernardino County**

If you have any questions about this plan's benefits or costs, please contact Aetna Health of California, Inc.

Benefit Category	Original Medicare	Aetna Golden Medicare Premier Plan
IMPORTANT INFORMATION		
1 - Premium and Other Important Information	You pay the Medicare Part B premium of \$88.50 each month. (This is the 2006 amount and may change January 1, 2007.)	There is no additional premium beyond the Medicare Part B premium of \$88.50 each month for your plan benefits and your Medicare Part D prescription drug benefits. (This is the 2006 amount and may change January 1, 2007.)
2 – Doctor and Hospital Choice (For more information, See Emergency - 15 and Urgently Needed Care - 16.)	You may go to any doctor, specialist or hospital that accepts Medicare.	You must go to network doctors, specialists, and hospitals. You need a referral to go to network hospitals and certain doctors, including specialists for certain services. A separate doctor office visit copayment may apply for certain services. A visitor/travel program is available.
SUMMARY OF BENEFITS		
Inpatient Care		
3 – Inpatient Hospital Care (includes substance abuse and rehabilitation services)	You pay for each benefit period ⁽³⁾ : Days 1-60: an initial deductible of \$952 Days 61-90: \$238 each day Day 91-150: \$476 each lifetime reserve day. ⁽⁴⁾ (These are the 2006 amounts and may change January 1, 2007.) Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. ⁽⁴⁾	You pay: <ul style="list-style-type: none">• \$50 each day for day(s) 1 - 5• \$0 each day for day(s) 6 - 90 for a Medicare-covered stay at a network hospital. There is no copayment for additional days received at a network hospital. You are covered for unlimited days each benefit period.

⁽³⁾ A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

⁽⁴⁾ Lifetime reserve days can only be used once.

Benefit Category	Original Medicare	Aetna Golden Medicare Premier Plan
4 – Inpatient Mental Health Care	You pay the same deductible and copayments as inpatient hospital care (above) except Medicare beneficiaries may only receive 190 days in a psychiatric hospital in a lifetime.	You pay: <ul style="list-style-type: none"> • \$50 each day for day(s) 1 - 5 • \$0 each day for day(s) 6 - 90 for a Medicare-covered stay at a network hospital. Medicare beneficiaries may only receive 190 days in a psychiatric hospital in a lifetime.
5 – Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	You pay for each benefit period ⁽³⁾ , following at least a 3-day covered hospital stay: Days 1-20: \$0 for each day Days 21-100: \$119 for each day (These are the 2006 amounts and may change January 1, 2007.) There is a limit of 100 days for each benefit period. ⁽³⁾	You pay: <ul style="list-style-type: none"> • \$0 each day for day(s) 1 - 20 • \$20 each day for days(s) 21 - 100 for a stay at a Skilled Nursing Facility. No prior hospital stay is required. You are covered for 100 days each benefit period.
6 – Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	There is no copayment for all covered home health visits.	There is no copayment for Medicare-covered home health visits.
7 –Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must receive care from a Medicare-certified hospice.	You must receive care from a Medicare-certified hospice.

⁽³⁾ A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Benefit Category	Original Medicare	Aetna Golden Medicare Premier Plan
Outpatient Care		
8 – Doctor Office Visits	You pay 20% of Medicare-approved amounts. ⁽¹⁾⁽²⁾	You pay \$5 for each primary care doctor office visit for Medicare-covered services. You pay \$10 for each specialist visit for Medicare-covered services. See 32 - Routine Physical Exams for more information.
9 - Chiropractic Services	You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers. You pay 100% for routine care. You pay 20% of Medicare-approved amounts. ⁽¹⁾⁽²⁾	You pay \$10 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).
10 - Podiatry Services	You are covered for medically necessary foot care, including care for medical conditions affecting the lower limbs. You pay 100% for routine care. You pay 20% of Medicare-approved amounts. ⁽¹⁾⁽²⁾	You pay \$10 for each Medicare-covered visit (medically necessary foot care).
11 - Outpatient Mental Health Care	You pay 50% of Medicare-approved amounts with the exception of certain situations and services for which you pay 20% of approved charges. ⁽¹⁾⁽²⁾	For Medicare-covered mental health services, you pay \$25 for each individual/group therapy visit.
12 – Outpatient Substance Abuse Care	You pay 20% of Medicare-approved amounts. ⁽¹⁾⁽²⁾	For Medicare-covered services, you pay \$10 for each individual/group visit.
13 - Outpatient Services/Surgery	You pay 20% of Medicare-approved amounts for the doctor. ⁽¹⁾⁽²⁾ You pay 20% of outpatient facility charges. ⁽¹⁾⁽²⁾	You pay \$100 for each Medicare-covered visit to an ambulatory surgical center. You pay \$100 for each Medicare-covered visit to an outpatient hospital facility.

⁽¹⁾ Each year, you pay a total of one \$124 deductible.

⁽²⁾ If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

Benefit Category	Original Medicare	Aetna Golden Medicare Premier Plan
14 - Ambulance Services (medically necessary ambulance services)	You pay 20% of Medicare-approved amounts or applicable fee schedule charge. ⁽¹⁾⁽²⁾	You pay \$100 for each Medicare-covered ambulance services.
15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	You pay 20% of the facility charge or applicable copayment for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. ⁽¹⁾⁽²⁾ You pay 20% of doctor charges. ⁽¹⁾⁽²⁾ NOT covered outside the U.S. except under limited circumstances.	You pay \$50 for each Medicare-covered emergency room visit; you do not pay this amount if you are immediately admitted to the hospital. Worldwide coverage.
16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	You pay 20% of Medicare-approved amounts or applicable copayment. ⁽¹⁾⁽²⁾ NOT covered outside the U.S. except under limited circumstances.	You pay \$5 to \$25 for each Medicare-covered urgently needed care visit. Worldwide coverage.
17 - Outpatient Rehabilitation Services (occupational therapy, physical therapy, speech and language therapy)	You pay 20% of Medicare-approved amounts. ⁽¹⁾⁽²⁾	You pay \$10 for each Medicare-covered occupational therapy visit. You pay \$10 for each Medicare-covered physical therapy and/or speech/language therapy visit.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	You pay 20% of Medicare-approved amounts. ⁽¹⁾⁽²⁾	You pay 20% of the cost for each Medicare-covered item. Authorization rules may apply for services. Contact plan for details
19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	You pay 20% of Medicare-approved amounts. ⁽¹⁾⁽²⁾	You pay 20% of the cost for each Medicare-covered item.

⁽¹⁾ Each year, you pay a total of one \$124 deductible.

⁽²⁾ If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

Benefit Category	Original Medicare	Aetna Golden Medicare Premier Plan
20 - Diabetes Self-Monitoring Training and Supplies (includes coverage for glucose monitors, test strips, lancets, and self-management training)	You pay 20% of Medicare-approved amounts. ⁽¹⁾⁽²⁾	There is no copayment for diabetes self-monitoring training. There is no copayment for diabetic supplies.
21 - Diagnostic Tests, X-Rays, and Lab Services	You pay 20% of Medicare-approved amounts, except for approved lab services. ⁽¹⁾⁽²⁾ There is no copayment for Medicare-approved lab services.	You pay: <ul style="list-style-type: none"> • \$0 for each Medicare-covered clinical/diagnostic lab service. • \$10 for each Medicare-covered radiation therapy service • \$0 to \$100 for each Medicare-covered x-ray visit.
PREVENTIVE SERVICES		
22 - Bone Mass Measurement (for people with Medicare who are at risk)	You pay 20% of Medicare-approved amounts. ⁽¹⁾⁽²⁾	There is no copayment for each Medicare-covered bone mass measurement.
23 - Colorectal Screening Exams (for people with Medicare age 50 and older)	You pay 20% of Medicare-approved amounts. ⁽¹⁾⁽²⁾	There is no copayment for each Medicare-covered colorectal screening exam.
24 – Immunizations (flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, pneumonia vaccine)	There is no copayment for the pneumonia and flu vaccines. You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine. ⁽¹⁾⁽²⁾ You may only need the pneumonia vaccine once in your lifetime. Please contact your doctor for further details.	There is no copayment for the pneumonia and flu vaccines. No referral necessary for Medicare-covered influenza and pneumonia vaccines. No referral necessary for other immunizations. There is no copayment for the Hepatitis B vaccine.

⁽¹⁾ Each year, you pay a total of one \$124 deductible.

⁽²⁾ If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

Benefit Category	Original Medicare	Aetna Golden Medicare Premier Plan
25 - Mammograms (Annual Screening) (for women with Medicare age 40 and older)	You pay 20% of Medicare approved amounts. ⁽¹⁾⁽²⁾ No referral necessary for Medicare-covered screenings.	There is no copayment for Medicare-covered Screening Mammograms. No referral necessary for Medicare-covered screenings.
26 - Pap Smears and Pelvic Exams (for women with Medicare)	There is no copayment for a pap smear once every 2 years, annually for beneficiaries at high risk. ⁽²⁾ You pay 20% of Medicare-approved amounts for pelvic exams. ⁽²⁾	There is no copayment for: <ul style="list-style-type: none"> • Medicare-covered Pap Smears and Pelvic Exams • additional Pap Smears and Pelvic Exams up to 1 Pap Smear(s) and Pelvic Exam(s) every year
27 - Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	There is no copayment for approved lab services and a copayment of 20% of Medicare-approved amounts for other related services. ⁽¹⁾⁽²⁾	There is no copayment for Medicare-covered prostate cancer screening exams.
28 – Outpatient Prescription Drugs	You pay 100% for most prescription drugs, unless you enroll in the Medicare Part D Prescription Drug program.	This plan uses a formulary. A formulary is a preferred list of drugs selected to meet patient needs at a lower cost. If the formulary changes, you will be notified, in writing, before the change. To view the plan’s formulary, go to www.aetnamedicare.com on the web. People who have low incomes, who live in long term care facilities, or who have access to Indian/Tribal/Urban (Indian Health Service) facilities may have different out-of-pocket drug costs. Contact the plan for details. There is no deductible. Before the total yearly drug costs (paid by both you and your plan) reach \$2,250, you pay the following for prescription drugs: <ul style="list-style-type: none"> • \$2 for a one-month (30 day) supply of Tier One Preferred-Generic drugs you get at an in-network preferred pharmacy. • \$20 for a one-month (30 day) supply of Tier Two – Preferred Brand drugs you get at an in-network preferred pharmacy.

⁽¹⁾ Each year, you pay a total of one \$124 deductible

⁽²⁾ If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

Benefit Category	Original Medicare	Aetna Golden Medicare Premier Plan
28 – Outpatient Prescription Drugs (continued)		<ul style="list-style-type: none"> • \$40 for a one-month (30 day) supply of Tier Three Non-Preferred - Generic and Brand drugs you get at an in-network preferred pharmacy. • \$6 for a three-month (90 day) supply of Tier One Preferred - Generic drugs you get at an in-network preferred pharmacy. • \$60 for a three-month (90 day) supply of Tier Two – Preferred Brand drugs you get at an in-network preferred pharmacy. • \$120 for a three-month (90 day) supply of Tier Three Non-Preferred - Generic and Brand drugs you get at an in-network preferred pharmacy. • \$2 for a 15 day supply of Tier One Preferred - Generic drugs you get at an out-of-network pharmacy. • \$20 for a 15 day supply of Tier Two - Preferred Brand drugs you get at an out-of-network pharmacy. • \$40 for a 15 day supply of Tier Three Non-Preferred-Generic and Brand drugs you get at an out-of-network pharmacy. • \$4 for a three-month (90 day) supply of mail order Tier One Preferred - Generic drugs from our preferred mail order vendor, Aetna Rx Home Delivery. • \$6 for a three-month (90 day) supply of mail order Tier One Preferred - Generic drugs from a non-preferred mail order vendor. • \$40 for a three-month (90 day) supply of mail order Tier Two - Preferred Brand drugs from our preferred mail order vendor, Aetna Rx Home Delivery. • \$60 for a three-month (90 day) supply of mail order Tier Two - Preferred Brand drugs from a non-preferred mail order vendor. • \$80 for a three-month (90 day) supply of mail order Tier Three Non-Preferred – Generic and Brand drugs from our preferred mail order vendor, Aetna Rx Home Delivery. • \$120 for a three-month (90 day) supply of mail order Tier Three Non-Preferred – Generic and Brand drugs from a non-preferred mail order vendor.

Benefit Category	Original Medicare	Aetna Golden Medicare Premier Plan
28 – Outpatient Prescription Drugs (continued)		<p>After the total yearly drug costs (paid by both you and your plan) reach \$2,250, you pay the following for prescription drugs:</p> <ul style="list-style-type: none"> • \$2 for a one-month (30 day) supply of Tier One Preferred - Generic drugs you get at an in-network preferred pharmacy. • \$40 for a one-month (30 day) supply of Tier Three Non-Preferred Generic drugs you get at an in-network preferred pharmacy. • \$6 for a three-month (90 day) supply of Tier One Preferred - Generic drugs you get at an in-network preferred pharmacy. • \$120 for a three-month (90 day) supply of Tier Three Non-Preferred Generic drugs you get at an in-network preferred pharmacy. • \$2 for a 15 day supply of Tier One Preferred-Generic drugs you get at an out-of-network pharmacy. • \$40 for a 15 day supply of Tier Three Non-Preferred- Generic drugs you get at an out-of-network pharmacy. • \$4 for a three-month (90 day) supply of mail order Tier One Preferred-Generic drugs from our preferred mail order vendor, Aetna Rx Home Delivery. • \$6 for a three-month (90 day) supply of mail order Tier One Preferred-Generic drugs from a non-preferred mail order vendor. • \$80 for a three-month (90 day) supply of mail order Tier Three Non-Preferred Generic drugs from our preferred mail order vendor, Aetna Rx Home Delivery. • \$120 for a three month (90 day) supply of mail order Tier Three Non-Preferred- Generic drugs from a non-preferred mail order vendor. • 100% for all Tier Two-Brand drugs you get at an in-network preferred pharmacy, out-of-network pharmacy, or from a mail order vendor. • 100% for all Tier Three-Non-Preferred Brand drugs you get at an in-network preferred pharmacy, out-of-network pharmacy, or from a mail order vendor.

Benefit Category	Original Medicare	Aetna Golden Medicare Premier Plan
<p>28 – Outpatient Prescription Drugs (continued)</p>		<p>After your yearly out-of-pocket drug costs reach \$3,600, you pay the greater of:</p> <ul style="list-style-type: none"> • \$2 for generic or a preferred brand drug and \$5 for all other drugs, or: • 5% coinsurance. <p>Certain prescription drugs will have maximum quantity limits. Contact plan for details.</p> <p>Your provider must get prior authorization from Aetna Golden Medicare Premier Plan for certain prescription drugs. Contact Aetna for details.</p> <p>See page 15 for more information about Outpatient Prescription Drugs.</p>



**ADDITIONAL
BENEFITS**
(What Original Medicare
Does Not Cover)

We want you to knowSM

 **Aetna[®] Medicare**

Benefit Category	Original Medicare	Aetna Golden Medicare Premier Plan
29 – Dental Services	In general, you pay 100% for dental services.	In general, you pay 100% for dental services.
30 - Hearing Services	<p>You pay 100% for routine hearing exams and hearing aids.</p> <p>You pay 20% of Medicare-approved amounts for diagnostic hearing exams.⁽¹⁾⁽²⁾</p>	<p>There is no copayment for hearing aids. You pay:</p> <ul style="list-style-type: none"> • \$10 for each Medicare-covered hearing exam (diagnostic hearing exams). • \$0 for each routine hearing test up to 1 test(s) every year. <p>You are covered up to \$500 for hearing aids every three years.</p>
31 - Vision Services	<p>You are covered for one pair of eyeglasses or contact lenses after each cataract surgery.⁽¹⁾⁽²⁾</p> <p>For people with Medicare who are at risk, you are covered for annual glaucoma screenings.⁽¹⁾⁽²⁾</p> <p>You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye.⁽¹⁾⁽²⁾</p> <p>You pay 100% for routine eye exams and glasses.</p>	<p>There is no copayment for the following items:</p> <ul style="list-style-type: none"> • Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery). <p>You pay:</p> <ul style="list-style-type: none"> • \$10 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye). • \$0 for each routine eye exam, limited to 1 exam(s) every year.
32 - Physical Exams	<p>If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your new Part B coverage.</p> <p>This will not include laboratory tests. Please contact your plan for further details.</p> <p>You pay 20% of the Medicare-approved amount.⁽¹⁾⁽²⁾</p>	<p>If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your new Part B coverage. This will not include laboratory tests. Please contact your plan for further details.</p> <p>There is no copayment for routine physical exams.</p> <p>You are covered up to 1 exam(s) every year.</p>
33 - Health/Wellness Education	You pay 100%.	<p>You are covered for the following:</p> <ul style="list-style-type: none"> • Health Club Membership/ Fitness Classes.

⁽¹⁾ Each year, you pay a total of one \$124 deductible.

⁽²⁾ If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

Benefit Category	Aetna Golden Medicare Premier Plan
OPTIONAL SUPPLEMENTAL PACKAGE #1	
Premium and Other Important Information	Preventive Dental: You pay \$5 each month, in addition to your monthly plan premium of \$0 and the Medicare Part B premium, for these optional benefits: <ul style="list-style-type: none"> • Dental Services
Dental Services	You pay: <ul style="list-style-type: none"> • \$5 for an office visit that includes the following services: <ul style="list-style-type: none"> • Oral exams up to 2 visit(s) every year • Cleanings up to 2 visit(s) every year
OPTIONAL SUPPLEMENTAL PACKAGE #2	
Premium and Other Important Information	Advantage Dental: You pay \$10 each month, in addition to your monthly plan premium of \$0 and the Medicare Part B premium, for these optional benefits: <ul style="list-style-type: none"> • Dental Services
Dental Services	Additional dental benefits are available. See page 19 for additional information about Optional Dental Plans.

San Bernardino County

The Aetna Golden Medicare Plan is an HMO that manages your health benefits coverage within Aetna's large provider network. This allows us to deliver more benefits than Original Medicare, such as:

- A wide choice of network doctors, hospitals and specialists.
- Virtually no paperwork when using network providers.
- Worldwide urgent and emergency care.

Do I Need to Select a Primary Care Doctor?

Yes, you are required to select a primary care doctor with this plan. You can select a primary care doctor from Aetna's large provider network by:

- Using our DocFind® directory of doctors and hospitals on www.aetnamedicare.com.
- Referring to the enclosed Provider Directory.
- Calling the toll-free Member Services number on your member ID card.

What do I Pay for Preventive Care?

You have no copay for the following in-network routine services (limitations may apply):

- Physical, hearing and vision exams.
- Bone mass measurement.
- Colorectal screening.
- Prostate cancer screening.
- Pelvic exam.
- Flu, pneumonia and hepatitis B vaccinations.
- Mammograms and Pap smears.
- Diabetes monitoring.

Do I Get a Fitness Benefit?

Yes. As an Aetna Golden Medicare Plan member, you are automatically enrolled in our Fitness Program administered by American WholeHealth. You'll receive services through a standard membership with a participating facility. There are no copays or time restrictions. Call American WholeHealth toll-free at 1-877-243-3004 for details and a list of participating facilities.

Does My Plan Include the New Medicare Prescription Drug Coverage?

Yes. The Aetna Golden Medicare Plan in your area includes the new Medicare prescription drug coverage available in 2006. This plan is called a **Medicare Advantage-Prescription Drug Plan (MA-PD)**, and includes the Golden Medicare Premier Plan that is available in your area.

Note: If you do not join a plan that includes Medicare prescription drug coverage or a Medicare Prescription Drug plan during the initial enrollment period, federal law may require you to pay a penalty to join at a later date. If you have questions about when you may join a Medicare Prescription Drug Plan, please contact Member Services at 1-800-282-5366 (TDD: 1-800-628-3323), Monday through Friday, 8 a.m. to 5 p.m.

What are My Costs with an Aetna Medicare Advantage-Prescription Drug Plan?

Aetna Golden Medicare Premier Plan*	
Annual Deductible	\$0
<i>Amount you pay, up to \$2,250 in total covered prescription drug expenses (after meeting deductible):</i>	
- 30-day supply of covered prescription drugs at a retail pharmacy	\$2 copay for preferred generic drugs; \$20 copay for preferred brand drugs; \$40 copay for non-preferred drugs.
- 90-day supply of covered prescription drugs through our preferred mail order** vendor, Aetna Rx Home Delivery	\$4 copay for preferred generic drugs; \$40 copay for preferred brand drugs; \$80 copay for non-preferred drugs.
<i>Amount you pay between \$2,250 in total covered prescription drug expenses, and until you reach \$3,600 in out-of-pocket covered prescription drug costs (the “coverage gap”):</i>	
- 30-day supply of covered prescription drugs at a retail pharmacy	\$2 copay for preferred generic drugs; \$40 copay for non-preferred generic; 100% for brand drugs.
- 90-day supply of covered prescription drugs through our preferred mail order** vendor, Aetna Rx Home Delivery	\$4 copay for preferred generic drugs; \$80 copay for non-preferred generic; 100% for brand drugs.
<i>Amount you pay for covered drugs after reaching \$3,600 in out-of-pocket covered prescription drug costs:</i>	
	\$2 for generic or a preferred brand drug that is a multi-source drug and \$5 for all other drugs, or 5% coinsurance.

* Generic substitution applies.

**You may pay a higher copayment if you use a non-preferred contracted mail order pharmacy.

What is a Formulary (Aetna's Preferred Drug List)?

Aetna's Preferred Drug List, also known as a **formulary**, provides you and your doctor with a listing of quality, cost-effective, generic and brand medications approved by the U.S. Food and Drug Administration (FDA). Depending on your plan, when your doctor prescribes drugs on this list, it can help reduce your costs and the overall cost of health care. Our list is approved by the federal government and may change throughout the year. Depending on the type of change, members taking the medication will receive notification. You can find our Preferred Drug List at www.aetnamedicare.com. You can also call Member Services at 1-800-282-5366 (TDD:1-800-628-3323), Monday through Friday, 8 a.m. to 5 p.m.

The Aetna Golden Medicare Premier Plan uses an **open formulary**, which means you have coverage for drugs on the Preferred Drug List, as well as many that are not. You will pay a higher copay for covered drugs that are not on the list. Review Aetna's Preferred Drug List for more information.

Will I be Able to Stay on My Current Medications?

Possibly. To ease your transition to the new prescription drug plan, a number of chronic medications, which are important for members to access during this transition, have been identified and included on a "Transition of Coverage" list. This list can be found by calling Member Services toll-free number at 1-800-282-5366 (TDD: 1-800-628-3323), Monday through Friday, 8 a.m. to 5 p.m. In order to provide a smooth transition, if you fill a prescription for one of these medications during the first 90 days of coverage under your new Aetna plan, the drug will be covered for the entire plan year. If your doctor approves your use of an alternative medication that is on Aetna's Preferred Drug List, we encourage you to consider using this alternative medication. More information on this policy can be obtained by calling Member Services.

How Do I Get My Prescriptions Filled?

In-Network Retail Pharmacies

Except in certain circumstances, you must use Aetna network pharmacies to receive coverage (see below). We have more than 51,000 network pharmacies located in all 50 states, the District of Columbia, Puerto Rico, Guam and the Virgin Islands. Simply show your Aetna member ID card at any network pharmacy to receive your covered prescription drugs. You will receive our negotiated discount price for your drugs even when you are required to pay a copay or deductible.

To find a participating pharmacy:

- Use our DocFind[®] directory at www.aetnamedicare.com.
- Refer to the Provider Directory.
- Check with your current pharmacy to see if they participate in the Aetna Medicare Prescription Drug program.
- Call Member Services toll-free number at 1-800-282-5366 (TDD: 1-800-628-3323), Monday through Friday, 8 a.m. to 5 p.m.

If you do not show your member ID card, you will pay 100 percent of the retail pharmacy cost of a drug at the time of purchase. You will also be required to submit a claim to Aetna for reimbursement, and you may be subject to additional costs based on the actual cost of the drug.

Note: *The cost of your medication is based on Aetna's negotiated charge with network pharmacies and includes rebates that Aetna receives from drug manufacturers.*

Out-of-Network Retail Pharmacies

You may use a non-network pharmacy in certain situations, including the following: 1) the covered drug you need is out of stock at a network pharmacy, 2) you have an emergency, or 3) you are traveling. You will be limited to a 15-day supply (or the smallest package size available to treat your medical condition) and will pay a copay (if applicable). To be reimbursed for the cost of the drug minus your copayment (if applicable), you may need to submit claim forms to Aetna.

Mail-Order Pharmacy

You can obtain covered prescription drugs through mail order, which is especially helpful when you are taking medications on a regular basis. You can save money when you order a 90-day supply of covered drugs from our **preferred** mail-order vendor, Aetna Rx Home Delivery[®]. By using our preferred mail-order vendor, you'll also enjoy:

- **Convenience:** Quick and confidential FREE shipping of your medications to the location of your choice.
- **Ease of Use:** Our mail-order brochure provides all the information you need to get started.
- **Quality Service:** Registered pharmacists check orders for accuracy and are available 24 hours a day, 7 days a week in case of an emergency. Customer Service representatives are available Monday through Friday, 7 a.m.-11 p.m. ET; Saturday, 8 a.m.-9:30 p.m. ET; and Sunday, 8 a.m.-6 p.m. ET. Our toll-free number is 1-866-612-3862 (TTY 1-800-201-9457).

Can I Get Help with Prescription Costs if I Have Limited Income and Resources?

If you have qualified for additional assistance for your Medicare Prescription Drug Plan costs, the amount of your premium and cost at the pharmacy will be less. Once you have joined an Aetna Medicare Prescription Drug Plan, Medicare will tell us how much assistance you are receiving, and we will send you information on the amount you will pay. If you are not receiving this additional assistance, you should contact 1-800 MEDICARE (TTY/TDD users call 1-877-486-2048), your State Medicaid Office, or local Social Security Administration Office to see if you might qualify.

What Else do I Need to Know About Aetna Medicare Advantage-Prescription Drug Plans?

Aetna members are automatically enrolled in our medication therapy management program. This program will help you and your doctor: 1) identify drug safety issues specific to you, 2) help manage your prescription drug costs and 3) identify opportunities to improve your current drug therapy. You and your doctor may receive informational mailings or be contacted by Aetna regarding this program. *If you wish to decline participation at any time, just call Member Services at 1-800-282-5366 (TDD: 1-800-628-3323), Monday through Friday, 8 a.m. to 5 p.m.*

Your drug coverage may also include the following programs:

- 1. Generic Substitution:** The use of generic drugs where appropriate can lower your out-of-pocket prescription drug costs. If a member or doctor requests a brand drug when a generic is available, the member is responsible for the generic copay, plus the difference in cost between the brand and generic drug. Generics are as safe and effective as their brand-name equivalents but cost much less. Please ask your doctor if a generic drug is available and appropriate for you.
- 2. Step Therapy:** Some drugs are covered by your plan only after one or more "alternative" drugs that are clinically appropriate and cost effective, are tried first. If a specific step-therapy drug is medically necessary for you, your doctor can contact us to request coverage without a trial of the alternative drug(s).
- 3. Precertification:** This process helps encourage safe, cost-effective use of prescription drugs by requiring your doctor to obtain prior authorization before certain drugs will be covered. This process applies to drugs that 1) should only be prescribed for certain conditions, 2) are likely to be taken inappropriately for too long, 3) have an equally effective, less-expensive drug alternative or 4) may be covered under the Medicare Part B benefit. Quantity limits are included as part of our precertification program and are designed to help promote appropriate and efficient medication use and enhanced patient safety.

The precertification and step-therapy lists can be found in the Aetna Preferred Drug List online at www.aetnamedicare.com, or by calling Member Services at 1-800-282-5366 (TDD: 1-800-628-3323), Monday through Friday, 8 a.m. to 5 p.m.

***Note:** If you have drug coverage through a current or former employer or union, and this coverage is on average at least as good as the new Medicare prescription drug coverage (called "creditable coverage"), you may want to stay in that employer plan to receive prescription drug benefits. If your current employer plan has creditable coverage, you can avoid higher payments later if you sign up for the Medicare drug benefit at another time. Speak to your employer or benefits administrator to learn more.*

What Prescription Drugs are Not Covered by Aetna Medicare Advantage-Prescription Drug Plans?

Nonprescription drugs and prescription drugs and supplies listed in the limitations and exclusions section of the Evidence of Coverage are not covered. A partial list of these drugs includes:

- Medications used for symptomatic relief of cough and colds.
- Medications to promote fertility.
- Drugs for weight loss, anorexia or weight gain.
- Vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- Medications for cosmetic purposes or hair growth.
- Barbiturates and benzodiazepines.

Note: This plan does not cover any drug that does not, by federal or state law, require a prescription (i.e., an over-the-counter (OTC) drug), even when a prescription is written.

Members have the right to submit a grievance or an appeal concerning coverage decisions by Aetna. However this does not guarantee coverage of a particular prescription drug. If you feel Aetna should cover a drug and we do not, please refer to the Evidence of Coverage for details on the process to file an appeal or grievance.

What is the Evidence of Coverage?

The Evidence of Coverage document gives members a complete list of benefits, including limitations, exclusions, applicable cost sharing, such as copays and coinsurance, and plan rules. This document is provided upon enrollment and once annually thereafter. If you're a current member, your 2006 Evidence of Coverage will be mailed to you at a later date.

Does the Aetna Golden Medicare Plan Include Dental Benefits?

As an Aetna Golden Medicare Plan member, you have the option to buy one of two Aetna dental plans for an additional monthly premium:

You Pay:	Aetna Preventive Dental Plan	Aetna Advantage Dental Plan
Additional plan premium	\$5 per month	\$10 per month
Per-visit copay	\$5 (must use selected primary care dentist)	\$5 (must use selected primary care dentist)
Covered services (partial list)	<ul style="list-style-type: none"> • Oral and emergency exams • Cleanings • Oral hygiene consultations 	<ul style="list-style-type: none"> • Oral and emergency exams • Cleanings • Oral hygiene consultations • X-rays • Restorative care: retention pins, fillings, minor denture adjustments • Periodontic care
Reduced-fee services (partial list; must be provided by an Aetna network dentist)	<ul style="list-style-type: none"> • X-rays • Restorative care: fillings and minor denture adjustments • Oral surgery • Crowns, bridges, dentures 	<ul style="list-style-type: none"> • Crowns, bridges, dentures • Root canals • Oral surgery, including non-surgical extractions and related medications
A complete list of services available under these plans can be found in the Evidence of Coverage. Limitations and exclusions apply.		

Enrolling in an Optional Dental Plan is as Easy as 1-2-3.

Check off the appropriate box for Optional Dental Plans on the Aetna Medicare Advantage Plan Enrollment Form. If you are a current member, contact Member Services at the number on your ID card and request a Plan Change Form.

1. Select your primary care dentist from our network dentists listed in the Aetna Golden Medicare Plan Provider Directory (available at www.aetnamedicare.com).
2. Show your Aetna ID card and pay a \$5 copay for covered services. Your network dentist will submit claims for you.

Are There Any Exclusions or Limitations to the Aetna Golden Medicare Plan?

The following is a partial list of exclusions and limitations of the Aetna Golden Medicare Plan. For a complete list, please refer to your Evidence of Coverage:

- Non-Medicare covered injectables, unless available under your plan. Please see Aetna's Preferred Drug List for details.

- Routine foot care that is not medically necessary.
- Plastic or cosmetic surgery that is not medically necessary.
- Custodial care.
- Experimental procedures or treatments beyond Original Medicare limits.
- All applicable services not referred by your network primary care doctor, except for direct access benefits or care received as a result of an emergency or urgent situation and out-of-area dialysis services; neither Original Medicare nor Aetna will pay for non-referred services.
- Optional dental plans exclude: services and supplies not furnished by a network dentist (except for out-of-area emergency dental care); plastic, reconstructive or cosmetic surgery; experimental services, supplies or procedures; treatment of jaw joint disorders; hospitalization.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The Aetna companies that offer, underwrite or administer benefits coverage are Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Health of Illinois Inc.

Aetna Rx Home Delivery® refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy that operates through mail-order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost it pays for the drugs and the costs of its mail-order pharmacy services. For these purposes, Aetna Rx Home Delivery's cost of purchasing drugs takes into account discounts, credits and other amounts that it may receive from wholesalers, manufacturers, suppliers and distributors.

Aetna receives rebates from the manufacturers of many drugs, including many that are on the Preferred Drug List. These rebates do not reduce the amount you pay for an individual prescription drug. However, they help control the overall costs of prescription drug coverage. Your pharmacy benefit provides coverage for many drugs that are not on this list. Also, in some cases, if you need to pay a percentage of the cost of the drug or an amount to meet a deductible, or if your benefit is subject to an annual maximum, your costs may be higher for a "preferred drug" than they would be for a "non-preferred drug." You can find out more about the terms and limitations on your plan by reading your plan documents. You can also contact Member Services. The preferred drug list is subject to change.

This material is for informational purposes only and contains only a partial, general description of plan benefits or programs and does not constitute a contract. Consult the plan documents (Summary of Benefits, Evidence of Coverage) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. Aetna does not provide health care services and, therefore, cannot guarantee any results or outcomes. The availability of a plan or program may vary by geographic service area. With the exception of Aetna Rx Home Delivery, all participating physicians, hospitals and other health care providers are independent contractors in private practice and are neither employees nor agents 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.

Translation of this material into another language may be available. For assistance, please call Member Services at 1-800-282-5366 (TDD: 1-800-628-3323), Monday through Friday, 8 a.m. to 5 p.m.

Puede estar disponible la traducción de este material en otro idioma. Por favor, para ayuda llame a Servicios al Miembro al 1-800-282-5366/TDD: 1-800-628-3323, de Lunes a Viernes de 8 a.m. a 5 p.m.

You must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable. You must reside in the Aetna MA-PD service area. You must use network providers except for emergent care or out of area urgent care/renal dialysis. Coverage is provided through a Medicare Advantage organization with a Medicare contract and benefits, limitations, service areas and premiums are subject to change on January 1 of each year.

