

**The McClatchy Company  
Aetna Plan Designs  
Effective Jan. 1, 2009**

*This matrix is intended to be used to help you compare coverage benefits and is a summary only. The Summary of Coverage booklet should be consulted for a detailed description of coverage benefits and limitations.*

BENEFIT PROVISIONS	Aetna Choice		Routine Care	
	(PPO)		(High Deductible)	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
<b>MEMBER COST SHARING</b>				
<b>Medical Lifetime Maximum</b>	Unlimited		Unlimited	
<b>Annual Deductible - Individual / Family</b>	\$250 / \$750		\$500 / \$1,500	\$1,000 / \$3,000
<b>Coinsurance Limit - Individual / Family</b>	\$3,000 / \$9,000		\$5,000 / \$10,000	\$10,000 / \$20,000
<b>Plan Coinsurance</b>	80% after deductible	60% after deductible	70% after deductible	30% after deductible
<b>PROFESSIONAL SERVICES</b>				
<b>Physician's Office Visit</b>	80% after deductible	60% after deductible	100% after \$20 copay	30% after deductible
<b>Specialist Office Visit</b>	80% after deductible	60% after deductible	100% after \$35 copay	30% after deductible
<b>Urgent Care Visit</b>	80% after deductible	60% after deductible	100% after \$35 copay	30% after deductible
<b>Inpatient Pre-Certification / Penalty</b> - Applies to all inpatient services including hospitals, skilled nursing facilities, hospice and mental/nervous and chemical dependency stays.	Provider responsible; no penalty	Member responsible; \$250 penalty	Provider responsible; no penalty	Member responsible; \$250 penalty
<b>TYPE OF SERVICE</b>				
<b>Acupuncture</b> - 12 visits per calendar year maximum.	80% after deductible	60% after deductible	100% after office visit or specialist copay	30% after deductible
<b>Allergy Testing</b>	80% after deductible	60% after deductible	100% after office visit or specialist copay	30% after deductible
<b>Allergy Treatment</b>	80% after deductible	60% after deductible	70% after deductible	30% after deductible
<b>Ambulance</b> - Must be medically necessary.	80% after deductible	80% after deductible	70% after deductible	70% after deductible
<b>Diagnostic X-ray and Lab</b> - Physician's office	80% after deductible	60% after deductible	100% after office visit or specialist copay	30% after deductible
<b>Diagnostic X-ray and Lab</b> - Outpatient hospital or facility	80% after deductible	60% after deductible	70% after deductible	30% after deductible
<b>Durable Medical Equipment/ Prosthetics</b> - Rental of wheelchair, walker, cane, insulin pump, apnea monitor, hospital bed, foot orthotics, wigs, etc.; must be medically necessary.	80% after deductible	60% after deductible	70% after deductible	30% after deductible
<b>Calendar year maximum:</b>	\$10,000		\$10,000	
<b>Emergency Room</b> - Includes associated lab, diagnostic x-rays, facility and professional services; copay waived if confined.	\$75 copay, then 80% after deductible		\$75 copay, then 70% after deductible	
<b>Non-emergency use of E.R. Penalty:</b>	No Coverage		No Coverage	

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	(PPO)		(High Deductible)	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
<b>Hearing Aids</b> - Hearing aid coverage once every 36 mos. for adults; 24 mos. for children through age 18	80% after deductible	60% after deductible	70% after deductible	30% after deductible
<b>Per Purchase Maximum (incl. in DME max):</b>	\$1,000		\$1,000	
<b>Home Health Care</b> - Pre-certification required.	80% after deductible	60% after deductible	70% after deductible	30% after deductible
<b>Home Health Care Maximum:</b>	120 visits / individual / year		120 visits / individual / year	
<b>Hospice Care - Inpatient and Outpatient</b> - Pre-certification required.	80% after deductible	60% after deductible	70% after deductible	30% after deductible
<b>Hospital Inpatient</b> - Includes inpatient surgery expenses, room & board, physician expenses, routine nursery care, prescription drugs and all other inpatient care. Pre-certification required.	80% after deductible	60% after deductible	70% after deductible	30% after deductible
<b>Private Room Limit:</b>	Semi-private		Semi-private	
<b>Per Admission Copay:</b> (Does not apply to Hospice, SNF or other facilities.)	\$250	\$500	\$500	\$1,000
<b>Per Admission Copay Limit</b> (all admissions):	3x / individual / year		3x / individual / year	
<b>Hospital Outpatient</b> - Includes surgery centers and ambulatory centers.	80% after deductible	60% after deductible	70% after deductible	30% after deductible
<b>Outpatient Surgery</b> - Includes all services performed with regard to an outpatient surgery performed in a hospital, ambulatory surgical center or a doctor's office, including physician's charges.	80% after deductible	60% after deductible	70% after deductible	30% after deductible
<b>RAPs</b> - Radiologists, Anesthesiologists and Pathologists	80% after deductible	60% after deductible	70% after deductible	30% after deductible
<b>Short Term Rehabilitation</b> - Outpatient physical, speech & occupational therapy; includes neurodevelopment therapy for children under age 6; includes massage/naturopaths if there is a treatment plan. Medical review after 24 visits.	80% after deductible	60% after deductible	100% after \$35 copay	30% after deductible
<b>Short Term Rehab Maximum:</b>	None		None	
<b>Skilled Nursing Facility / Convalescent Facility</b> - Pre-certification required.	80% after deductible	60% after deductible	70% after deductible	30% after deductible
<b>Skilled Nursing Facility Maximum:</b>	100 days / individual / year		100 days / individual / year	
<b>Spinal Disorders / Chiropractic Therapies</b>	80% after deductible	60% after deductible	100% after \$35 copay	30% after deductible
<b>Spinal Manipulation Maximum:</b>	20 visits / individual / year		20 visits / individual / year	

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	(PPO)		(High Deductible)	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
<b>MENTAL / NERVOUS DISORDERS / CHEMICAL DEPENDENCY</b>				
<b>Inpatient Mental / Nervous Disorders and Chemical Dependency - Pre-certification required.</b>	80% after deductible	60% after deductible	70% after deductible	30% after deductible
<b>Per Admission Copay:</b>	\$250	\$500	\$500	\$1,000
<b>Per Admission Copay Limit (all admissions):</b>	3x / individual / year		3x / individual / year	
<b>Inpatient Mental/Nervous and Chemical Dependency Maximum (combined)</b>	45 days / individual / year		45 days / individual / year	
<b>Outpatient Mental / Nervous Disorders and Chemical Dependency</b>	80% after deductible	60% after deductible	100% after office visit or specialist copay	30% after deductible
<b>Outpatient Mental / Nervous &amp; Chemical Dependency Maximum (combined) Visits</b>	40 visits / individual / year (Only 20 of these 40 visits can be used for out-of-network providers.)		40 visits / individual / year (Only 20 of these 40 visits can be used for out-of-network providers.)	
<b>ROUTINE / PREVENTIVE CARE</b>				
<b>Preventive Care - Includes associated laboratory and x-ray expenses; in-network and out-of-network paid at 100% of allowed. Subject to age and frequency limitations as set forth in the U.S. Preventive Services Task Force guidelines.</b>	100% coinsurance of allowed amount, deductible waived for all routine care		100% coinsurance of allowed amount, deductible and copay waived for all routine care	
<b>PRESCRIPTION DRUGS</b>				
<b>RETAIL CARD PROGRAM</b>				
<b>Generic Copay</b>	\$15	No Coverage	\$15	No Coverage
<b>Brand-Formulary Copay</b>	20% with \$25 min / \$75 maximum co-pay	No Coverage	20% with \$25 min / \$75 maximum co-pay	No Coverage
<b>Brand-NonFormulary Copay</b>	40% with \$50 min / \$125 maximum co-pay	No Coverage	40% with \$50 min / \$125 maximum co-pay	No Coverage
<b>Aetna Specialty CareRx Copay</b>	20% with \$25 min / \$75 maximum co-pay	No Coverage	20% with \$25 min / \$75 maximum co-pay	No Coverage
<b>Retail Maximum Supply</b>	30 day supply	No Coverage	30 day supply	No Coverage
<b>MAIL ORDER DRUG (MOD) PROGRAM</b>				
<b>MOD Generic Copay</b>	\$30	No Coverage	\$30	No Coverage
<b>MOD Brand-Formulary Copay</b>	20% with \$50 min / \$150 maximum co-pay	No Coverage	20% with \$50 min / \$150 maximum co-pay	No Coverage
<b>MOD Brand-NonFormulary Copay</b>	40% with \$100 min / \$250 maximum co-pay	No Coverage	40% with \$100 min / \$250 maximum co-pay	No Coverage
<b>MOD Maximum Supply</b>	31-90 day supply	No Coverage	31-90 day supply	No Coverage

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<b>FAMILY PLANNING</b>				
<b>Contraceptive Devices, Implants &amp; Injectables</b>	80% after deductible	60% after deductible	70% after deductible	30% after deductible
<b>Infertility</b> - Covers diagnosis & treatment of underlying cause only.	80% after deductible	60% after deductible	70% after deductible	30% after deductible
<b>Infertility - Treatment other than diagnosis and underlying cause.</b>	No Coverage		No Coverage	
<b>Maternity</b>	80% after deductible	60% after deductible	70% after deductible	30% after deductible