

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

BENEFIT PROVISIONS	Select	Choice		Routine Care	
	(HMO-like) (IN-NETWORK)	(PPO)		(High Deductible)	
MEMBER COST SHARING		IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Medical Lifetime Maximum	Unlimited	Unlimited		Unlimited	
Annual Deductible - Individual / Family	None	\$250 / \$750		\$500 / \$1,500	\$1,000 / \$3,000
Coinsurance Limit - Individual / Family	None	\$3,000 / \$9,000		\$5,000 / \$10,000	\$10,000 / \$20,000
Plan Coinsurance	100% coinsurance	80% after deductible	60% after deductible	70% after deductible	30% after deductible
PROFESSIONAL SERVICES					
Physician's Office Visit	100% after \$20 copay	80% after deductible	60% after deductible	100% after \$20 copay	30% after deductible
Specialist Office Visit	100% after \$35 copay	80% after deductible	60% after deductible	100% after \$35 copay	30% after deductible
Urgent Care Visit	100% after \$35 copay	80% after deductible	60% after deductible	100% after \$35 copay	30% after deductible
Inpatient Pre-Certification / Penalty - Applies to all inpatient services including hospitals, skilled nursing facilities, hospice and mental/nervous and chemical dependency stays.	Provider responsible; no penalty	Provider responsible; no penalty	Member responsible; \$250 penalty	Provider responsible; no penalty	Member responsible; \$250 penalty
TYPE OF SERVICE					
Acupuncture - 12 visits per calendar year maximum.	100% after office visit or specialist copay	80% after deductible	60% after deductible	100% after office visit or specialist copay	30% after deductible
Allergy Testing	100% after office visit or specialist copay	80% after deductible	60% after deductible	100% after office visit or specialist copay	30% after deductible
Allergy Treatment	100% coinsurance	80% after deductible	60% after deductible	70% after deductible	30% after deductible
Ambulance - Must be medically necessary.	100% coinsurance	80% after deductible	80% after deductible	70% after deductible	70% after deductible
Diagnostic X-ray and Lab - Physician's office	100% after office visit or specialist copay	80% after deductible	60% after deductible	100% after office visit or specialist copay	30% after deductible
Diagnostic X-ray and Lab - Outpatient hospital or facility	100% coinsurance	80% after deductible	60% after deductible	70% after deductible	30% after deductible
Durable Medical Equipment/ Prosthetics - Rental of wheelchair, walker, cane, insulin pump, apnea monitor, hospital bed, foot orthotics, wigs, etc.; must be medically necessary.	100% coinsurance	80% after deductible	60% after deductible	70% after deductible	30% after deductible
Calendar year maximum:	\$10,000	\$10,000		\$10,000	

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Emergency Room - Includes associated lab, diagnostic x-rays, facility and professional services; copay waived if confined.	100% after \$100 copay	\$75 copay, then 80% after deductible		\$75 copay, then 70% after deductible	
Non-emergency use of E.R. Penalty:	No Coverage	No Coverage		No Coverage	
Hearing Aids - Hearing aid coverage once every 36 mos. for adults; 24 mos. for children through age 18	100% coinsurance	80% after deductible	60% after deductible	70% after deductible	30% after deductible
Per Purchase Maximum (incl. in DME max):	\$1,000	\$1,000		\$1,000	
Home Health Care - Pre-certification required.	100% coinsurance	80% after deductible	60% after deductible	70% after deductible	30% after deductible
HHC Maximum:	120 visits / individual / year	120 visits / individual / year		120 visits / individual / year	
Hospice Care - Inpatient and Outpatient - Pre-certification required.	100% coinsurance	80% after deductible	60% after deductible	70% after deductible	30% after deductible
Hospital Inpatient - Includes inpatient surgery expenses, room & board, physician expenses, routine nursery care, prescription drugs and all other inpatient care. Pre-certification required.	100% coinsurance	80% after deductible	60% after deductible	70% after deductible	30% after deductible
Private Room Limit:	Semi-private	Semi-private		Semi-private	
Per Admission Copay: (Does not apply to Hospice, SNF or other facilities.)	\$250 / day, max \$1250 / stay	\$250	\$500	\$500	\$1,000
Per Admission Copay Limit (all admissions):	max \$3750/year	3x / individual / year		3x / individual / year	
Hospital Outpatient - Includes surgery centers and ambulatory centers.	100% coinsurance	80% after deductible	60% after deductible	70% after deductible	30% after deductible
Outpatient Surgery - 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.	100% coinsurance	80% after deductible	60% after deductible	70% after deductible	30% after deductible
RAPs - Radiologists, Anesthesiologists and Pathologists	100% coinsurance	80% after deductible	60% after deductible	70% after deductible	30% after deductible

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		IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Short Term Rehabilitation - Outpatient physical, speech & occupational therapy; includes neurodevelopmental therapy for children under age 6; includes massage/naturopaths if there is a treatment plan. Medical review after 24 visits.	100% after \$35 copay	80% after deductible	60% after deductible	100% after \$35 copay	30% after deductible
STR Maximum:	None	None		None	
Skilled Nursing Facility / Convalescent Facility - Pre-certification required.	100% coinsurance	80% after deductible	60% after deductible	70% after deductible	30% after deductible
SNF Maximum:	100 days / individual / year	100 days / individual / year		100 days / individual / year	
Spinal Disorders / Chiropractic Therapies	100% after \$35 copay	80% after deductible	60% after deductible	100% after \$35 copay	30% after deductible
Spinal Manipulation Maximum:	20 visits / individual / year	20 visits / individual / year		20 visits / individual / year	
MENTAL/NERVOUS DISORDERS / CHEMICAL DEPENDENCY					
Inpatient Mental/Nervous Disorders and Chemical Dependency - Pre-certification required.	100% coinsurance	80% after deductible	60% after deductible	70% after deductible	30% after deductible
Per Admission Copay:	\$250 / day, max \$1250 / stay	\$250	\$500	\$500	\$1,000
Per Admission Copay Limit (all admissions):	max \$3750/year	3x / individual / year		3x / individual / year	
Inpatient Mental/Nervous and Chemical Dependency Maximum (combined)	45 days / individual / year	45 days / individual / year		45 days / individual / year	
Outpatient Mental/Nervous Disorders and Chemical Dependency	100% after office visit or specialist copay	80% after deductible	60% after deductible	100% after office visit or specialist copay	30% after deductible
Outpatient Mental/Nervous & Chemical Dependency Maximum (combined) Visits	40 visits / individual / year	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)	
ROUTINE / PREVENTIVE CARE					
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.	100% coinsurance	100% coinsurance; deductible waived	100% coinsurance of allowed amount, deductible waived	100% coinsurance; deductible waived	100% coinsurance of allowed amount, deductible waived

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		IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
PRESCRIPTION DRUGS					
RETAIL CARD PROGRAM					
Generic Copay	\$15	\$15	No Coverage	\$15	No Coverage
Brand-Formulary Copay	20% with \$25 min/\$75 maximum co-pay	20% with \$25 min/\$75 maximum co-pay	No Coverage	20% with \$25 min/\$75 maximum co-pay	No Coverage
Brand-NonFormulary Copay	40% with \$50 min/\$125 maximum co-pay	40% with \$50 min/\$125 maximum co-pay	No Coverage	40% with \$50 min/\$125 maximum co-pay	No Coverage
Aetna Specialty CareRx Copay	20% with \$25 min/\$75 maximum co-pay	20% with \$25 min/\$75 maximum co-pay	No Coverage	20% with \$25 min/\$75 maximum co-pay	No Coverage
Retail Maximum Supply	30 day supply	30 day supply	No Coverage	30 day supply	No Coverage
MAIL ORDER DRUG (MOD) PROGRAM					
MOD Generic Copay	\$30	\$30	No Coverage	\$30	No Coverage
MOD Brand-Formulary Copay	20% with \$50 min/\$150 maximum co-pay	20% with \$50 min/\$150 maximum co-pay	No Coverage	20% with \$50 min/\$150 maximum co-pay	No Coverage
MOD Brand-NonFormulary Copay	40% with \$100 min/\$250 maximum co-pay	40% with \$100 min/\$250 maximum co-pay	No Coverage	40% with \$100 min/\$250 maximum co-pay	No Coverage
MOD Maximum Supply	31-90 day supply	31-90 day supply	No Coverage	31-90 day supply	No Coverage
FAMILY PLANNING					
Contraceptive Devices, Implants & Injectables	100% coinsurance	80% after deductible	60% after deductible	70% after deductible	30% after deductible
Infertility - Covers diagnosis & treatment of underlying cause only.	100% after office visit or specialist copay	80% after deductible	60% after deductible	70% after deductible	30% after deductible
Infertility-Treatment other than diagnosis and underlying cause	No Coverage	No Coverage	No Coverage	No Coverage	No Coverage
Maternity	100% coinsurance after office visit or specialist copay (co-pay applies to the first prenatal visit only)	80% after deductible	60% after deductible	70% after deductible	30% after deductible