Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | **Plan Type:** POS

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.HealthReformPlanSBC.com** or by calling **1-888-802-3862**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: Individual **$5,000** / Family **$10,000**. Out-of-network: Individual **$10,000** / Family **$20,000**. Does not apply to certain office visits and preventive care in-network.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. In-network: Individual **$5,750** / Family **$11,500**. Out-of-network: Individual **$19,000** / Family **$38,000**.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for services, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.aetna.com** or call 1-888-802-3862 for a list of in-network **providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit, deductible waived	30% coinsurance	————————none————————
	Specialist visit	$60 copay/visit	30% coinsurance	————————none————————
	Other practitioner office visit	$60 copay/visit for Chiropractic care	30% coinsurance for Chiropractic care	Coverage is limited to 20 visits for Chiropractic care.
	Preventive care /screening /immunization	No charge	30% coinsurance, except deductible waived for well child, well baby & immunizations	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	Lab: No charge; X-ray: $30 copay/visit	30% coinsurance	————————none————————
	Imaging (CT/PET scans, MRIs)	$250 copay/visit	30% coinsurance	Out-of-network precertification required or a $400 per occurrence penalty applies.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.aetna.com/pharmacy-insurance/individuals-families	Preferred generic drugs	Tier 1A: $3 copay up to a 30 day supply, $7.50 copay up to a 90 day supply; Tier 1: $15 copay up to a 30 day supply, $37.50 copay up to a 90 day supply, deductible waived	Tier 1A: $3 copay up to a 30 day supply; Tier 1: $15 copay up to a 30 day supply, deductible waived	Covers up to 30 day supply (retail prescription), 31-90 day supply (retail & mail order prescription). No coverage for mail order prescriptions out-of-network. Applicable cost share plus difference (brand minus generic cost) applies for brand when generic available. No charge for preferred generic FDA-approved women's contraceptives in-network. Precertification and step therapy required.
	Preferred brand drugs	$45 copay up to a 30 day supply, $112.50 copay up to a 90 day supply	$45 copay up to a 30 day supply	
	Non-preferred generic/brand drugs	$75 copay up to a 30 day supply, $187.50 copay up to a 90 day supply	$75 copay up to a 30 day supply	
	Specialty drugs	Preferred: 30% coinsurance up to a $250 maximum for up to a 30 day supply; Non-preferred: 40% coinsurance up to a $500 maximum for up to a 30 day supply	Preferred: 30% coinsurance up to a $250 maximum for up to a 30 day supply; Non-preferred: 40% coinsurance up to a $500 maximum for up to a 30 day supply	————————none————————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/visit for hospital facility; $150 copay/visit for free standing facility	30% coinsurance	————————none————————
	Physician/surgeon fees	0% coinsurance	30% coinsurance	————————none————————
If you need immediate medical attention	Emergency room services	$500 copay/visit	$500 copay/visit	Copay waived if admitted. Out-of-network emergency room services cost-share same as in-network. No coverage for non-emergency care.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
	Emergency medical transportation	$500 copay/trip	$500 copay/trip	Out-of-network cost-share same as in-network.
	Urgent care	$75 copay/visit	30% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/admission	30% coinsurance	Out-of-network precertification required or a $400 per occurrence penalty applies.
	Physician/surgeon fee	0% coinsurance	30% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$60 copay/visit	30% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	$250 copay/admission	30% coinsurance	Out-of-network precertification required or a $400 per occurrence penalty applies.
	Substance use disorder outpatient services	$60 copay/visit	30% coinsurance	——————none——————
	Substance use disorder inpatient services	$250 copay/admission	30% coinsurance	Out-of-network precertification required or a $400 per occurrence penalty applies.
If you are pregnant	Prenatal and postnatal care	Prenatal: No charge; Postnatal: 0% coinsurance	30% coinsurance	——————none——————
	Delivery and all inpatient services	$250 copay/admission	30% coinsurance	Out-of-network precertification required or a $400 per occurrence penalty applies.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	30% coinsurance	Coverage is limited to 60 visits.
	Rehabilitation services	$60 copay/visit	30% coinsurance	Coverage is limited to 20 visits for Physical Therapy & Occupational Therapy combined and 20 visits for Speech Therapy, rehabilitation & habilitation combined.
	Habilitation services	$60 copay/visit	30% coinsurance	Coverage is limited to 20 visits for Physical Therapy & Occupational Therapy combined and 20 visits for Speech Therapy, rehabilitation & habilitation combined.
	Skilled nursing care	$250 copay/admission	30% coinsurance	Coverage is limited to 50 days. Out-of-network precertification required or a $400 per occurrence penalty applies.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
	Durable medical equipment	0% coinsurance	30% coinsurance	————————none————————
	Hospice service	Inpatient: $250 copay/admission; Outpatient: 0% coinsurance	30% coinsurance	Out-of-network precertification required or a $400 per occurrence penalty applies.
If your child needs dental or eye care	Eye exam	No charge	30% coinsurance	Coverage is limited to 1 exam every 12 months.
	Glasses	No charge	30% coinsurance	Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses every 12 months.
	Dental check-up	No charge	No charge	Coverage is limited to 2 exams per calendar year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture - except as form of anesthesia.
- Bariatric surgery
- Cosmetic surgery - except when medically necessary.
- Dental care (Adult) - except accidental injury.
- Hearing aids
- Infertility treatment - except the diagnosis and surgical treatment of underlying conditions.
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care - Coverage is limited to 20 visits.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-888-802-3862. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact us by calling the toll free number on your Medical ID Card. If your group health plan is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**. You may also contact the Georgia Office of Insurance and Safety Fire Commissioner, Customer Services Division, (800) 656-2298, **http://www.oci.ga.gov/consumerservice/home.aspx**

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 1-888-802-3862.

如果需要中文的帮助，请拨打这个号码 1-888-802-3862.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-802-3862.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-802-3862.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $2,730
- **Patient pays:** $4,810

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$4,600
Copays	$10
Coinsurance	$0
Limits or exclusions	$200
Total	**$4,810**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,920
- **Patient pays:** $2,480

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,300
Copays	$100
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,480**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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PLAN DESIGN AND BENEFITS - GA Silver OAMC 5000 100/70 Choice (2016)

GA Group Business 1-50 Employees

PLAN FEATURES	NETWORK CARE	OUT-OF-NETWORK CARE
Primary Care Physician Selection	Not Required	Not Required
Deductible (per calendar year)	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 Family
Unless otherwise indicated, the deductible must be met before benefits can be paid.		
Claims from in-network and out-of-network providers do not cross-accumulate to satisfy the deductible.		
As indicated in the plan, member cost sharing for certain services are excluded from the charges to meet the deductible.		
No one family member may contribute more than the individual deductible amount to the family deductible.		
Member Coinsurance (applies to all expenses unless otherwise stated)	0%	30%
Out-of-Pocket (OOP) Maximum (per calendar year, includes deductible)	$5,750 Individual $11,500 Family	$19,000 Individual $38,000 Family
Claims from in-network and out-of-network providers do not cross-accumulate to satisfy the out-of-pocket maximums.		
Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and copays may be used to satisfy the out of pocket maximum.		
No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum.		
Payment for Out-of-Network Care*	Not applicable	Professional: 90% of Medicare Facility: 90% of Medicare
Certification Requirements		
Certification for certain types of out-of-network care must be obtained to avoid a reduction in benefits paid for that care. Certification for hospital admissions, treatment facility admissions, skilled nursing facility admissions, home health care, and hospice care is required. If the necessary certification is not received, payment for services will be reduced by $400 per occurrence		
Referral Requirement	Not Required	Not applicable
PHYSICIAN SERVICES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Office Visits to Non-Specialist	$30 copay deductible waived	30% after deductible
Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illness or injury.		
Specialist Office Visits	$60 copayment after deductible	30% after deductible
Walk-in Clinics	$30 copay deductible waived	30% after deductible
Walk-in clinics are network, free-standing health care facilities. They are an alternative to a doctor's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor an outpatient department of a hospital, is considered a walk-in clinic.		
Maternity - Delivery and Post-Partum Care	Covered in full after deductible	30% after deductible
Allergy Testing (given by a physician)	Member cost sharing is based on the type of service performed and the place rendered.	30% after deductible
Allergy Injections (not given by a physician)	Covered in full after deductible	30% after deductible
PREVENTIVE CARE	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Preventive care services are covered in accordance with Health Care Reform.		
Routine Adult Physical Exams and Immunizations Limited to 1 exam every 12 months.	Covered in full	30% after deductible
Well Child Exams and Immunizations Provides coverage for 7 exams in the first year of life; 3 exams in the second year; 3 exams in the third year; and 1 exam per 12 months from age 3 to age 22.	Covered in full	30% deductible waived
Routine Gynecological Exams Includes Pap smear, HPV screening and related lab fees. Limited to 1 exam every 12 months.	Covered in full	30% after deductible
Routine Mammograms For covered females age 40 and over. Frequency schedule applies.	Covered in full	30% after deductible

Women's Health Includes: Screening for gestational diabetes; HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted infections; counseling and screening for human immunodeficiency virus; screening and counseling for interpersonal and domestic violence; breastfeeding support, supplies and counseling; Limitations may apply.	Covered in full	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Prenatal Maternity	Covered in full	30% after deductible
Routine Digital Rectal Exam / Prostate-Specific Antigen Test For covered males age 40 and over. Frequency schedule applies.	Covered in full	30% after deductible
Colorectal Cancer Screening Sigmoidoscopy and Double Contrast Barium Enema - 1 every 5 years for all members age 50 and over. Preventive Colonoscopy - 1 every 10 years for all members age 50 and over. Fecal Occult Blood Testing - 1 every year for all members age 50 and over.	Covered in full	30% after deductible
Routine Eye and Hearing Screenings	Paid as part of routine physical exam.	Paid as part of routine physical exam.
HEARING SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Hearing Exam (by Specialist)	Not covered	Not covered
Hearing Aid	Not covered	Not covered
VISION SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Adult Routine Eye Exams (Refraction)	Not covered	Not covered
Pediatric Routine Eye Exams (Refraction) Coverage is limited to 1 exam every 12 months.	Covered in full	30% after deductible
Adult Vision Hardware	Not covered	Not covered
Pediatric Vision Hardware Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses every 12 months.	Covered in full	30% after deductible
DIAGNOSTIC PROCEDURES	NETWORK CARE	OUT-OF-NETWORK CARE
Outpatient Diagnostic Laboratory	Covered in full	30% after deductible
Outpatient Diagnostic X-ray (except for Complex Imaging Services)	$30 copayment after deductible	30% after deductible
Outpatient Diagnostic X-ray for Complex Imaging Services Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required.	$250 copayment after deductible	30% after deductible
EMERGENCY MEDICAL CARE	NETWORK CARE	OUT-OF-NETWORK CARE
Urgent Care Provider (Benefit Availability may vary by location.)	$75 copayment after deductible	30% after deductible
Non-Urgent Use of Urgent Care Provider	Not covered	Not covered
Emergency Room Copay waived if admitted.	$500 copayment after deductible	Paid as in-network
Non-Emergency care in an Emergency Room	Not covered	Not covered
Emergency Ambulance	$500 copayment after deductible	Paid as in-network
Non-Emergency Ambulance	$500 copayment after deductible	30% after deductible
HOSPITAL CARE	NETWORK CARE	OUT-OF-NETWORK CARE
Inpatient Coverage Including maternity (prenatal, delivery and postpartum) and transplants.	$250 copayment per admission after deductible	30% after deductible

Outpatient Surgery Provided in an outpatient hospital department.	$250 copayment after deductible	30% after deductible
Outpatient Surgery Provided in a freestanding surgical facility.	$150 copayment after deductible	30% after deductible
Colonoscopy (non-preventive)	Member cost sharing is based on the type of service performed and the place rendered.	Member cost sharing is based on the type of service performed and the place rendered.
Transplants Coverage at the in-network cost share is limited to IOE only. Non-IOE par facilities and out-of-network facilities are covered at out-of-network cost sharing.	$250 copayment per admission after deductible	30% after deductible
MENTAL HEALTH and ALCOHOL/DRUG ABUSE SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Inpatient Mental Health	$250 copayment per admission after deductible	30% after deductible
Outpatient Mental Health	$60 copayment after deductible	30% after deductible
Inpatient Detoxification	$250 copayment per admission after deductible	30% after deductible
Outpatient Detoxification	$60 copayment after deductible	30% after deductible
Inpatient Rehabilitation	$250 copayment per admission after deductible	30% after deductible
Outpatient Rehabilitation	$60 copayment after deductible	30% after deductible
OTHER SERVICES AND PLAN DETAILS	NETWORK CARE	OUT-OF-NETWORK CARE
Skilled Nursing Facility Coverage is limited to 50 days per calendar year. Network and Out-of-Network combined.	$250 copayment per admission after deductible	30% after deductible
Home Health Care Coverage is limited to 60 visits per calendar year. Network and Out-of-Network combined; 1 visit equals a period of 4 hours or less.	Covered in full after deductible	30% after deductible
Infusion Therapy Provided in the home or physician's office.	Covered in full after deductible	30% after deductible
Infusion Therapy Provided in the outpatient hospital department of freestanding facility.	Covered in full after deductible	30% after deductible
Inpatient Hospice Care	$250 copayment per admission after deductible	30% after deductible
Outpatient Hospice Care	Covered in full after deductible	30% after deductible
Private Duty Nursing -Outpatient	Not covered	Not covered
Outpatient Short-Term Rehabilitation - Physical Therapy If provided in the outpatient hospital department, paid under outpatient hospital benefit. Coverage is limited to 20 visits per calendar year PT/OT combined, rehabilitation & habilitation combined. Network and Out-of-Network combined.	$60 copayment after deductible	30% after deductible
Outpatient Short-Term Rehabilitation - Occupational Therapy If provided in the outpatient hospital department, paid under outpatient hospital benefit. Coverage is limited to 20 visits per calendar year PT/OT combined, rehabilitation & habilitation combined. Network and Out-of-Network combined.	$60 copayment after deductible	30% after deductible

Outpatient Short-Term Rehabilitation - Speech Therapy If provided in the outpatient hospital department, paid under outpatient hospital benefit. Coverage is limited to 20 visits per calendar year, rehabilitation & habilitation combined. Network and Out-of-Network combined.	$60 copayment after deductible	30% after deductible
Outpatient Chiropractic If provided in the outpatient hospital department, paid under outpatient hospital benefit. Coverage is limited to 20 visits per calendar year.	$60 copayment after deductible	30% after deductible
Acupuncture	Not covered	Not covered
Durable Medical Equipment	Covered in full after deductible	30% after deductible
Diabetic Supplies not obtainable at a pharmacy	Covered same as any other medical expense.	Covered same as any other medical expense.
FAMILY PLANNING	NETWORK CARE	OUT-OF-NETWORK CARE
Infertility Treatment - Diagnostic only Covered only for the diagnosis and treatment of the underlying medical condition.	Member cost sharing is based on the type of service performed and the place rendered.	30% after deductible
Infertility Treatment - Artificial Insemination or Ovulation Induction	Not covered	Not covered
Advanced Reproductive Technology. Including, but not limited to, GIFT, ZIFT, IVF, ICSI, ovum microsurgery and cryopreserved embryo transfers.	Not covered	Not covered
Voluntary Sterilization - Vasectomy	Member cost sharing is based on the type of service performed and the place rendered.	30% after deductible
Voluntary Sterilization - Tubal Ligation	Covered in full	30% after deductible
ADULT DENTAL SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Adult Dental Services (not oral surgery)	Not covered	Not covered
PEDIATRIC DENTAL SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Preventive & Diagnostic (includes exams, cleanings, x-rays, fluoride, sealants)	Covered in full	Covered in full
Basic (includes space maintainers, fillings, anesthesia, denture adjustments)	30% after deductible	30% after deductible
Major (includes crowns, endodontics, periodontics, oral surgery, dentures, bridges)	40% after deductible	40% after deductible
Orthodontia (limited to medically necessary orthodontia) Coverage is limited to age 0-19 after 24 month waiting period.	40% after deductible	40% after deductible
PHARMACY DEDUCTIBLE	NETWORK CARE	OUT-OF-NETWORK CARE
Prescription drug calendar year deductible	Prescription drugs purchased at a network pharmacy are subject to the in-network medical deductible which must be satisfied before any prescription drug benefits are paid.	Prescription drugs purchased at a non-network pharmacy are subject to the non-network medical deductible which must be satisfied before any prescription drug benefits are paid.
PHARMACY - PRESCRIPTION DRUG BENEFITS	NETWORK CARE	OUT-OF-NETWORK CARE
Retail Up to a 30-day supply		
Generic Drugs	Low Cost Generic: $3 copay deductible waived Generic: $15 copay deductible waived	Low Cost Generic: $3 copay deductible waived Generic: $15 copay deductible waived
Preferred Brand Drugs	$45 copayment after deductible	$45 copayment after deductible
Non-Preferred Drugs	Generic & Brand: $75 copayment after deductible	Generic & Brand: $75 copayment after deductible

Specialty Drugs Includes self-injectable, infused and oral specialty drugs (retail and mail order up to a 30-day supply, excludes insulin).	Specialty Preferred: 30% up to $250 after deductible Specialty Nonpreferred: 40% up to $500 after deductible	Specialty Preferred: 30% up to $250 after deductible Specialty Nonpreferred: 40% up to $500 after deductible
Mail Order Delivery	When you fill your prescription by mail order, you may save money Up to 90 days supply. 30 day supply= retail cost share; 31-90 day supply= MOD cost share. when compared to the cost to purchase your prescriptions at your local retail pharmacy.	
Generic Drugs	Low Cost Generic: $7.50 copay deductible waived Generic: $37.50 copay deductible waived	Not covered Not covered
Preferred Brand Drugs	$112.50 copayment after deductible	Not covered
Non-Preferred Drugs	Generic & Brand: $187.50 copayment after deductible	Not covered
Specialty Drugs Includes self-injectable, infused and oral specialty drugs	Not covered Not covered	Not covered Not covered
Specialty CareRx℠ - For more information, please go to **www.aetnaspecialtycarerx.com**		

Choose Generic - Included. See Aetna Formulary for details.
If the physician prescribes or the member requests a covered brand name prescription drug when a generic prescription drug equivalent is available, the member will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent plus the applicable cost-sharing. The cost difference between the generic and brand does not count toward the Out of Pocket Maximum.

Precertification - Included. See Aetna Formulary for details.

Step Therapy - Included. See Aetna Formulary for details.

Pharmacy Plan includes:

Diabetic supplies obtainable from a pharmacy (Including: needles, syringes, test strips, lancets and alcohol swabs - available at retail or mail order).

Coverage is excluded for lifestyle/performance drugs.

Formulary generic FDA-approved Womens Contraceptives covered 100% in network.

In-Network and Out-of-Network Providers

We cover the cost of services based on whether doctors are "in-network" or "out-of-network". We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a provider who is out-of-network, your Aetna health plan may pay some of that provider 's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

Your doctor sets his or her own rate to charge you. It may be higher - sometimes much higher - than what your Aetna plan "recognizes". Your non-network doctor may bill you for the dollar amount that Aetna doesn't "recognize". You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums.

To learn more about how we pay out-of-network benefits visit **www.aetna.com**. Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to **www.aetna.com** and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site.

This applies when you choose to get care out-of-network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in the network. You pay cost sharing and deductibles for your in-network level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

What's Not Covered

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 of 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 purchased.

- All medical or hospital services not specifically covered in or which are limited or excluded in the plan documents
- Charges related to any eye surgery mainly to correct refractive errors
- Cosmetic surgery, including breast reduction
- Custodial care
- Adult dental care and x-rays

- Donor egg retrieval
- Experimental and investigational procedures
- Immunizations for travel or work
- Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents
- Non-medically necessary services or supplies
- Orthotics except as specified in the plan
- Over-the-counter medications and supplies
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs
- Special duty nursing
- Weight reduction programs, or dietary supplements

This 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. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

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, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. Precertification requirements may vary.

If your plan covers outpatient prescription drugs, your plan includes a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step therapy, please refer to our website at **www.aetna.com**, or the Aetna Medication Formulary Guide. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. In addition, in circumstances where your prescription plan uses copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage.

Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna, Inc., that is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated charge with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services.

While this information is believed to be accurate as of the print date, it is subject to change.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Benefits are provided by Aetna Life Insurance Company (ALIC).

For more information about Aetna plans, refer to **www.aetna.com**.