aetna : **GA Silver OAMC 5000 100/70 Choice**

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage at **https://www.aetna.com/sbcsearch/getpolicydocs?u=071800-080020-051607** or by calling **1-866-529-2517**. For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider**, or other underlined terms see the Glossary. You can view the Glossary at **https://www.healthcare.gov/sbc-glossary/** or call 1-866-529-2517 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall **deductible**?	In-network: Employee **$5,000** / Family **$10,000**. Out-of-network: Employee **$10,000** / Family **$20,000**.	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your **deductible**?	Certain office visits and preventive care in-network.	This **plan** covers some items and services even if you haven't yet met the annual **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost sharing** and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other **deductibles** for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the **out-of-pocket limit** for this plan?	In-network: Employee **$5,750** / Family **$11,500**. Out-of-network: Employee **$19,000** / Family **$38,000**.	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
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**.
Will you pay less if you use a **network provider**?	Yes. See **www.aetna.com/docfind** or call 1-866-529-2517 for a list of in-network providers.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays (**balance billing**). Be aware, your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a **referral** to see a **specialist**?	No.	You can see the **specialist** you choose without a **referral**.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit, deductible does not apply	30% coinsurance	None
	Specialist visit	$60 copay/visit	30% coinsurance	None
	Preventive care/screening/ immunization	No charge	30% coinsurance, except deductible does not apply for well child, well baby & immunizations	You may have to pay for services that are not preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
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 $400 penalty applies per occurrence.
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 SG Value Plus Five Tier Open Formulary	Preferred generic drugs	Tier 1A: $3 copay for up to a 30 day supply, $7.50 copay for up to a 90 day supply; Tier 1: $15 copay for up to a 30 day supply, $37.50 copay for up to a 90 day supply, deductible does not apply	Tier 1A: $3 copay for up to a 30 day supply; Tier 1: $15 copay for up to a 30 day supply, deductible does not apply	Covers up to a 30 day supply (retail prescription), 31-90 day supply (retail & mail order prescription). 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. No coverage for mail order prescriptions out-of-network.
	Preferred brand drugs	$45 copay for up to a 30 day supply, $112.50 copay for up to a 90 day supply	$45 copay for up to a 30 day supply	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
	Non-preferred generic/brand drugs	$75 copay for up to a 30 day supply, $187.50 copay for up to a 90 day supply	$75 copay for up to a 30 day supply	
	Preferred specialty drugs, non-preferred 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 care	$500 copay/visit	$500 copay/visit	Copay waived if admitted. Out-of-network emergency room care cost-share same as in-network. No coverage for non-emergency care.
	Emergency medical transportation	0% coinsurance	0% coinsurance	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 $400 penalty applies per occurrence.
	Physician/surgeon fees	0% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$60 copay/visit	30% coinsurance	None
	Inpatient services	$250 copay/admission	30% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	30% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance	30% coinsurance	None
	Childbirth/delivery facility services	$250 copay/admission	30% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	30% coinsurance	Coverage is limited to 120 visits.
	Rehabilitation services	$60 copay/visit	30% coinsurance	Coverage is limited to 40 visits for Physical Therapy & Occupational Therapy combined, 40 visits for Speech Therapy.
	Habilitation services	$60 copay/visit	30% coinsurance	Coverage is limited to 40 visits for Physical Therapy & Occupational Therapy combined and 40 visits for Speech Therapy, rehabilitation & habilitation separate.
	Skilled nursing care	$250 copay/admission	30% coinsurance	Coverage is limited to 60 days. Out-of-network precertification required or $400 penalty applies per occurrence.
	Durable medical equipment	0% coinsurance	30% coinsurance	Excludes vehicle modifications, home modifications & exercise equipment.
	Hospice services	Inpatient: $250 copay/admission; Outpatient: 0% coinsurance	30% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.
If your child needs dental or eye care	Children's eye exam	No charge	30% coinsurance	Coverage is limited to 1 exam every 12 months age 0-19.
	Children's 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 age 0-19.
	Children's dental check-up	No charge	No charge	Coverage is limited to 2 exams per calendar year.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture - except as form of anesthesia.
- Bariatric surgery
- Cosmetic surgery
- 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 - except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - Coverage is limited to 20 visits.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Georgia Office of Insurance and Safety Fire Commissioner, Customer Services Division, (800) 656-2298, **http://www.oci.ga.gov/consumerservice/home.aspx**.

- If your group health coverage 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**.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.
- If your coverage is a church **plan**, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.
- Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance **Marketplace**. For more information about the **Marketplace**, visit **www.HealthCare.gov** or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your **plan** for a denial of a **claim**. This complaint is called a **grievance** or **appeal**. For more information about your rights, look at the explanation of benefits you will receive for that medical **claim**. Your **plan** documents also provide complete information to submit a **claim appeal** or a **grievance** for any reason to your **plan**. For more information about your rights, this notice, or assistance, contact us by calling the toll free number on your Medical ID Card.

- Georgia Office of Insurance and Safety Fire Commissioner, Customer Services Division, (800) 656-2298, **http://www.oci.ga.gov/consumerservice/home.aspx**.
- If your group health coverage 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**.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan Meet Minimum Value Standard? Yes.

If your **plan** doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a **plan** through the **Marketplace.**

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this **plan** might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the **cost sharing** amounts (**deductibles**, **copayments** and **coinsurance**) and **excluded services** under the **plan**. Use this information to compare the portion of costs you might pay under different health **plans**. Please note these coverage examples are based on self-only coverage.

Peg is Having a baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$5,000
Specialist copayment	$60
Hospital (facility) copayment	$250
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$5,000
Copays	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,382**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$5,000
Specialist copayment	$60
Hospital (facility) copayment	$250
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$4,200
Copays	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4,585**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$5,000
Specialist copayment	$60
Hospital (facility) copayment	$250
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,900
Copays	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-529-2517.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

TTY: 711

Language Assistance:

For language assistance in your language call 1-866-529-2517 at no cost.

Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-866-529-2517 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-866-529-2517
Chinese -	欲取得繁體中文語言協助，請撥打 1-866-529-2517，無需付費。
French -	Pour une assistance linguistique en français appeler le 1-866-529-2517 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-866-529-2517 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-866-529-2517 an.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-866-529-2517 પર કૉલ કરો.
Hindi -	हिन्दी में भाषा सहायता के लिए, 1-866-529-2517 पर मुफ्त कॉल करें।
Japanese -	日本語で援助をご希望の方は、1-866-529-2517 まで無料でお電話ください。
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-529-2517번으로 전화해 주십시오.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-866-529-2517 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Portuguese -	Para obter assistência linguística em português ligue para o 1-866-529-2517 gratuitamente.
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-529-2517.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-866-529-2517.
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy goị miễn phí đến số 1-866-529-2517.

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PLAN DESIGN AND BENEFITS - GA Silver OAMC 5000 100/70 Choice (2017)

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 age 0-19.	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 age 0-19.	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	Covered in full after deductible	Paid as in-network
Non-Emergency Ambulance	Covered in full after deductible	Paid as in-network
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 60 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 120 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 Network and Out-of-Network combined.	$250 copayment per admission after deductible	30% after deductible
Outpatient Hospice Care Network and Out-of-Network combined.	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 40 visits per calendar year PT/OT combined, rehabilitation & habilitation separate. 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 40 visits per calendar year PT/OT combined, rehabilitation & habilitation separate. 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 40 visits per calendar year, rehabilitation & habilitation separate. 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
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.	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 31-90 days – excludes specialty drugs 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**.