

**Aetna Customer Service: 1-877-440-4709**

<i>Amounts and Percentages shown below are what the Plan Member pays</i>	Aetna Select		Aetna Choice POS II	
	In-Network Only	In-Network	Out-of-Network*	
<b>Calendar Year Deductible</b> Employee/Family	None	None	\$500/\$1000	
<b>Out-of-Pocket Maximum</b> Employee/Family	None	\$1000/\$2000	\$2500/\$5000	
<b>Lifetime Maximum</b>	Unlimited	Unlimited	Unlimited	
<b>Precertification</b>	Provider Responsibility	Provider Responsibility	Member Responsibility	
<b>Physician Services</b>				
<b>Primary Care Office Visit</b>	\$20 co-pay	\$20 co-pay	30% co-insurance after deductible	
<b>Specialist Office Visit</b> <ul style="list-style-type: none"> <li>Aexcel/Value Network Specialist</li> <li>Non-designated Specialist</li> </ul>	\$20 co-pay \$30 co-pay	\$20 co-pay \$30 co-pay	30% co-insurance after deductible	
<b>Allergy Care</b> <ul style="list-style-type: none"> <li>Office Visit</li> <li>Injection or Serum given not in conjunction with an Office Visit</li> </ul>	\$20 PCP co-pay or \$30 Specialist co-pay  Covered in full	\$20 PCP co-pay or \$30 Specialist co-pay  Covered in full	30% co-insurance after deductible	
<b>Maternity Physician Visit</b>	\$30 co-pay Initial visit only	\$30 co-pay Initial visit only	30% co-insurance after deductible	
<b>Chiropractor Care –</b> <ul style="list-style-type: none"> <li>24 visit maximum per calendar year</li> </ul>	\$30 co-pay	\$30 co-pay	30% co-insurance after deductible	
<b>Preventive Care</b>				
<b>Routine Physical Exam &amp; Immunizations</b>	\$20 PCP co-pay or \$30 Specialist co-pay	\$20 PCP co-pay or \$30 Specialist co-pay	30% co-insurance after deductible	
<b>Routine Gynecology Exam</b>	\$20 co-pay, whether PCP, Specialist, Aexcel/Value or non-designated provider	\$20 co-pay, whether PCP, Specialist, Aexcel/Value or non-designated provider	30% co-insurance after deductible	
<b>Pap Smear</b>	Covered in full	Covered in full	30% co-insurance after deductible	
<b>Routine Annual Mammography</b>	Covered in full	Covered in full	30% co-insurance after deductible	
<b>Routine Eye Exam</b>	\$30	\$30	30% co-insurance after deductible	
<b>Outpatient Services</b>				
<b>Outpatient Surgery</b> <ul style="list-style-type: none"> <li>Facility charges in an outpatient hospital or ambulatory surgery center</li> </ul>	\$100 co-pay	10% co-insurance	30% co-insurance after deductible	
<b>X-Ray &amp; Laboratory</b>	Covered in full	Covered in full as part of office visit, 10% co-insurance if performed in outpatient facility setting	30% co-insurance after deductible	

\*Out-of-network services are subject to an application of reasonable and customary charge limits.

	Aetna Select		Aetna Choice POS II	
Plan Features	In-Network Only		In-Network	Out-of-Network*
<b>Hospital Services</b>				
<b>Inpatient Services</b>	\$100 co-pay per day, for a maximum of three days (\$300) per confinement		10% co-insurance	30% co-insurance after deductible
<b>Emergency Room</b>	\$100 co-pay, waived if admitted		\$100 co-pay, waived if admitted	\$100 co-pay, waived if admitted
<b>Urgent Care</b>	\$50 co-pay		\$50 co-pay	30% co-insurance after deductible
<b>Ambulance</b>	Covered in full		Covered in full	Covered in full
<b>Mental Health/Chemical Dependency</b>				
<b>Inpatient Care</b>	\$100 co-pay per day, for a maximum of three days (\$300) per confinement		10% co-insurance	30% co-insurance after deductible
<ul style="list-style-type: none"> <li>60 day per calendar year limit on Mental Health and Chemical Dependency combined</li> </ul>				
<b>Outpatient Care</b>	\$30 co-pay		\$30 co-pay	30% co-insurance after deductible
<ul style="list-style-type: none"> <li>40 visits per calendar year Mental Health and Chemical Dependency combined</li> </ul>				
<b>Other Services</b>				
<b>Infertility Services</b>				
Combined In- and Out-of-Network limits and maximums apply				
<ul style="list-style-type: none"> <li><b>Office Visit</b> <ul style="list-style-type: none"> <li>Aexcel/Value Network Provider</li> <li>Non-designated Provider</li> </ul> </li> </ul>	\$20 co-pay \$30 co-pay	\$20 co-pay \$30 co-pay	30% co-insurance after deductible	
<ul style="list-style-type: none"> <li><b>Surgery</b></li> </ul>	\$100 co-pay for outpatient hospital or ambulatory surgery center	10% co-insurance	30% co-insurance after deductible	
<ul style="list-style-type: none"> <li><b>Lifetime Maximum</b></li> </ul>	\$25,000	\$25,000 in- and out-of-network expenses combined		
<b>Short Term Rehabilitation</b>	\$30 co-pay		\$30 co-pay	30% co-insurance after deductible
<ul style="list-style-type: none"> <li>Including Physical Therapy (PT), Speech Therapy (ST) and Occupational Therapy (OT)</li> <li>60 visit per calendar year limit for PT, ST and OT combined</li> </ul>				
<b>Durable Medical Equipment</b>	Covered in full		10% co-insurance	30% co-insurance after deductible
<b>Prescription Drugs</b>				
<b>Retail Pharmacy (up to 30-day supply)</b>				
<ul style="list-style-type: none"> <li>Generic</li> </ul>	\$10 co-pay	\$10 co-pay	\$10 co-pay	Not Covered
<ul style="list-style-type: none"> <li>Brand Name Formulary</li> </ul>	\$25 co-pay	\$25 co-pay	\$25 co-pay	Not Covered
<ul style="list-style-type: none"> <li>Brand Name Non-Formulary</li> </ul>	\$45 co-pay	\$45 co-pay	\$45 co-pay	Not Covered
<b>Mail-Order Service (up to 90-day supply)</b>				
<ul style="list-style-type: none"> <li>Generic</li> </ul>	\$20 co-pay	\$20 co-pay	\$20 co-pay	Not Covered
<ul style="list-style-type: none"> <li>Brand Name Formulary</li> </ul>	\$50 co-pay	\$50 co-pay	\$50 co-pay	Not Covered
<ul style="list-style-type: none"> <li>Brand Name Non-Formulary</li> </ul>	\$90 co-pay	\$90 co-pay	\$90 co-pay	Not Covered

\*Out-of-network services are subject to an application of reasonable and customary charge limits.

This benefit summary is intended to be a brief outline of coverage. The entire provisions of benefits, limitations, maximums, and exclusions are contained in the Summary Plan Description. In the event of a conflict between this document and the Summary Plan Description, the terms of the Summary Plan Description will prevail.