

aetna® : Aetna PPO Choice (Aetna Choice® POS II)

 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, visit www.aetna.com/sbcsearch or call 1-888-982-3862. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	Network: \$500 Individual/\$1,000 Family. Out-of-Network: \$2,000 Individual/\$4,000 Family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Preventive care, office visits, telehealth, urgent care, emergency room, and prescription drugs are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. This <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Network: \$4,000 Individual/\$8,000 Family. Out-of-Network: \$8,000 Individual/\$16,000 Family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.aetna.com/docfind or call 1-888-982-3862 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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 Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	<u>Primary care visit to treat an injury or illness</u>	\$25 <u>copayment</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Telehealth visits available at a \$10 <u>copayment</u> .
	<u>Specialist visit</u>	\$50 <u>copayment</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	No <u>referral</u> required.
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive.
If you have a test	<u>Diagnostic test (x-ray, blood work)</u>	10% <u>coinsurance</u> (lab); 20% <u>coinsurance</u> (x-ray)	40% <u>coinsurance</u>	Preauthorization may be required for certain procedures.
	<u>Imaging (CT/PET scans, MRIs)</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Preauthorization may be required.
If you need drugs to treat your illness or condition	<u>Generic drugs</u>	\$10 <u>copayment</u> /prescription; <u>deductible</u> does not apply	Not covered	30-day retail supply. 90-day mail order available at 2.5× the retail <u>copayment</u> .
	<u>Preferred brand drugs</u>	\$35 <u>copayment</u> /prescription; <u>deductible</u> does not apply	Not covered	
	<u>Non-preferred brand drugs</u>	\$60 <u>copayment</u> /prescription; <u>deductible</u> does not apply	Not covered	
	<u>Specialty drugs</u>	\$100 <u>copayment</u> /prescription; <u>deductible</u> does not apply	Not covered	Certain drugs require approval before they will be covered.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Preauthorization may be required.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need immediate medical attention	Emergency room care	\$250 <u>copayment</u> /visit	\$250 <u>copayment</u> /visit	<u>Copayment</u> waived if admitted.
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	Urgent care	\$75 <u>copayment</u> /visit; <u>deductible</u> does not apply	\$75 <u>copayment</u> /visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Preauthorization required.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need mental health or substance abuse services	Outpatient services	\$25 <u>copayment</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Includes psychiatry and therapy at the primary care <u>copayment</u> .
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Preauthorization required.

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.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Weight loss programs
- Routine foot care
- Non-emergency care when traveling outside the U.S.

Other Covered Services (Limitations may apply to these services.)

- Acupuncture (limited)
- Bariatric surgery (with preauthorization)
- Chiropractic care (limited visits)
- Hearing aids (limited)
- Infertility treatment (diagnosis only)
- Private-duty nursing (limited)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. Contact the plan at 1-888-982-3862, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or your state insurance department.