

Small Business Solutions

Medical Plan Options

Florida



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AETNA SMALL GROUP MEDICAL PLANS

Aetna Primary Care Plan HMO Open Access Options+

MEMBER BENEFITS	HMO Open Access 101	HMO Open Access 102	HMO Open Access 103	HMO Open Access 104	HMO Open Access 105
In-Network Coinsurance/ Out-of-Network Coinsurance*	N/A	N/A	80%	70%	70%
Calendar Year Deductible Individual/Family	N/A	N/A	N/A	\$500/\$1,000	\$1,000/\$2,000
Calendar Year Out of Pocket Individual/Family	\$2,500/\$5,000	\$3,000/\$6,000	\$5,000/\$10,000	\$5,000/\$10,000	\$5,000/\$10,000
Hospital Inpatient Copay/ Deductible/Coinsurance per admit*	\$500	\$1,500	80%	70%	70%
Primary Care Physician Office Visit Copay/Coinsurance	\$15	\$15	\$15	\$15	\$15
Specialist Office Visit Copay/ Coinsurance	\$30	\$40	\$50	\$50	\$50
Outpatient Diagnostic/X-ray/Lab*	\$30	\$40	\$50	\$50	\$50
Outpatient Complex Imaging (CAT, MRI, MRA/MRS, and PET Scans)*	\$100	\$150	\$200	\$200	\$300
Outpatient Surgery Copay or Coinsurance*	\$250	\$500	80%	70%	70%
Urgent Care	\$35	\$50	\$75	\$75	\$75
Emergency Room Copay waived if admitted	\$100	\$100	\$150	\$150	\$200
Durable Medical Equipment Copay*	80%	80%	80%	70%	70%
DME Calendar Year Maximum	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000
Mental Health — Inpatient 30 days per calendar year*	\$500	\$1,500	80%	70%	70%
Substance Abuse Rehabilitation*	\$500	\$1,500	80%	70%	70%
Lifetime Maximums	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000
PHARMACY					
Triple Tier Copay	\$10/\$30/\$40	\$10/\$30/\$40	\$10/\$35/\$50	\$10/\$35/\$50	\$10/\$45/\$60
Mail Order Drug Copay (31-60 day supply)	2x retail	2x retail	2x retail	2x retail	2x retail
Contraceptives	Included	Included	Included	Included	Included

+ This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage copayments indicate what Aetna is required to pay.

*Coinsurance applies after the deductible is met where applicable.

AETNA SMALL GROUP MEDICAL PLANS

Aetna Choice Plan POS Options+

MEMBER BENEFITS	POS Open Access 101		POS Open Access 102		POS Open Access 103		POS Open Access 104	
	In-Network	Out-of Network	In-Network	Out-of Network	In-Network	Out-of Network	In-Network	Out-of Network
Coinsurance/Out-of-Network Coinsurance*	N/A	70%	N/A	60%	80%	50%	70%	50%
Calendar Year Deductible Individual/Family	N/A	\$500/ \$1,000	N/A	\$1,000/ \$2,000	N/A	\$1,000/ \$2,000	\$500/ \$1,000	\$1,000/ \$2,000
Calendar Year Out of Pocket Individual/Family	\$2,500/ \$5,000	\$4,000/ \$8,000	\$3,000/ \$6,000	\$6,000/ \$12,000	\$5,000/ \$10,000	\$6,000/ \$12,000	\$5,000/ \$10,000	\$6,000/ \$12,000
Hospital Inpatient Copay/ Deductible/Coinsurance per admit*	\$500	70%	\$1,500	60%	80%	50%	70%	50%
Primary Care Physician Office Visit Copay/Coinsurance*	\$15	70%	\$15	60%	\$15	50%	\$15	50%
Specialist Office Visit Copay/ Coinsurance*	\$30	70%	\$40	60%	\$50	50%	\$50	50%
Outpatient Diagnostic/X-ray/Lab*	\$30	70%	\$40	60%	\$50	50%	\$50	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS, and PET Scans)*	\$100	70%	\$150	60%	\$200	50%	\$200	50%
Outpatient Surgery Copay or Coinsurance*	\$250	70%	\$500	60%	80%	50%	70%	50%
Urgent Care*	\$35	70%	\$50	60%	\$75	50%	\$75	50%
Emergency Room Copay waived if admitted*	\$100	same as in-network	\$100	same as in-network	\$150	same as in-network	\$150	same as in-network
Durable Medical Equipment Copay*	80%	70%	80%	60%	80%	50%	70%	50%
DME Calendar Year Maximum	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000
Mental Health — Inpatient 30 days per calendar year*	\$500	70%	\$1,500	60%	80%	50%	70%	50%
Substance Abuse Rehabilitation*	\$500	70%	\$1,500	60%	80%	50%	70%	50%
Lifetime Maximums	\$5,000,000	\$1,000,000	\$5,000,000	\$1,000,000	\$5,000,000	\$1,000,000	\$5,000,000	\$1,000,000
PHARMACY								
Triple Tier Copay	\$10/\$30/\$40 Not covered		\$10/\$30/\$40 Not covered		\$10/\$35/\$50 Not covered		\$10/\$35/\$50 Not covered	
Mail Order Drug Copay (31-60 day supply)	2x retail	Not covered	2x retail	Not covered	2x retail	Not covered	2x retail	Not covered
Contraceptives	Included	Not covered	Included	Not covered	Included	Not covered	Included	Not covered

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*Coinsurance applies after the deductible is met where applicable.

NOTE: Payment for Out-of-Network facility care is determined based upon Aetna's allowable fee schedule. Payment for other Out-of-Network care is determined based upon the negotiated charge that would apply if such services or supplies were received from an In-Network provider. These charges are referred to in your Plan Document as "recognized" changes.

AETNA SMALL GROUP MEDICAL PLANS

Aetna Choice Plan POS Options+

MEMBER BENEFITS	POS Open Access 105 (HSA Compatible*)		POS Open Access 106 (HSA Compatible*)		POS Open Access 107 (HSA Compatible*)		POS Open Access 108 (HSA Compatible*)	
	In-Network	Out-of Network	In-Network	Out-of Network	In-Network	Out-of Network	In-Network	Out-of Network
In-Network Coinsurance/ Out-of-Network Coinsurance**	100%	80%	80%	60%	80%	60%	100%	80%
Calendar Year Deductible Individual/Family	\$2,200/ \$4,400	\$3,500/ \$7,000	\$2,200/ \$4,400	\$3,500/ \$7,000	\$3,000/ \$6,000	\$5,000/ \$10,000	\$5,000/ \$10,000	\$7,000/ \$14,000
Calendar Year Out of Pocket Individual/Family	\$2,200/ \$4,400	\$5,000/ \$10,000	\$3,000/ \$6,000	\$6,000/ \$12,000	\$4,000/ \$8,000	\$7,500/ \$15,000	\$5,000/ \$10,000	\$8,500/ \$17,000
Hospital Inpatient Copay/ Deductible/Coinsurance per admit**	100%	80%	80%	60%	80%	60%	100%	80%
Primary Care Physician Office Visit Copay/Coinsurance**	100%	80%	80%	60%	80%	60%	100%	80%
Specialist Office Visit Copay/ Coinsurance**	100%	80%	80%	60%	80%	60%	100%	80%
Routine Physical Exams (Adult/Child)**	100% deductible waived	80%	100% deductible waived	60%	100% deductible waived	60%	100% deductible waived	80%
Routine OB/GYN**	100% deductible waived	80%	100% deductible waived	60%	100% deductible waived	60%	100% deductible waived	80%
Outpatient Diagnostic/X-ray/Lab**	100%	80%	80%	60%	80%	60%	100%	80%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS, and PET Scans)**	100%	80%	80%	60%	80%	60%	100%	80%
Outpatient Surgery Copay or Coinsurance**	100%	80%	80%	60%	80%	60%	100%	80%
Urgent Care**	100%	80%	80%	60%	80%	60%	100%	80%
Emergency Room Copay waived if admitted**	100%	same as in-network	80%	same as in-network	80%	same as in-network	100%	same as in-network
Durable Medical Equipment Copay**	100%	80%	80%	60%	80%	60%	100%	80%
DME Calendar Year Maximum	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000
Mental Health — Inpatient 30 days per calendar year**	100%	80%	80%	60%	80%	60%	100%	80%
Substance Abuse Rehabilitation**	100%	80%	80%	60%	80%	60%	100%	80%
Lifetime Maximums	\$5,000,000	\$1,000,000	\$5,000,000	\$1,000,000	\$5,000,000	\$1,000,000	\$5,000,000	\$1,000,000
PHARMACY								
Triple Tier Copay	Discount Card Available		Discount Card Available		Discount Card Available		Discount Card Available	
Mail Order Drug Copay (31-60 day supply)	Not covered		Not covered		Not covered		Not covered	
Contraceptives	Not covered		Not covered		Not covered		Not covered	

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*Based upon Treasury guidance available as of the print date.

**Coinsurance applies after the deductible is met where applicable.

NOTE: Payment for Out-of-Network facility care is determined based upon Aetna's allowable fee schedule. Payment for other Out-of-Network care is determined based upon the negotiated charge that would apply if such services or supplies were received from an In-Network provider. These charges are referred to in your Plan Document as "recognized" changes.

AETNA SMALL GROUP MEDICAL PLANS

Aetna Managed Choice Plan Options+

MEMBER BENEFITS	Managed Choice Open Access 101		Managed Choice Open Access 102		Managed Choice Open Access 103		Managed Choice Open Access 104 First Dollar \$500/\$1,000	
	In-Network	Out-of Network	In-Network	Out-of Network	In-Network	Out-of Network	In-Network	Out-of Network
In-Network Coinsurance/ Out-of-Network Coinsurance*	N/A	70%	90%	70%	80%	60%	80%	60%
Calendar Year Deductible Individual/Family	N/A	\$500/ \$1,000	\$500/ \$1,000	\$1,000/ \$2,000	\$750/ \$1,500	\$1,500/ \$3,000	\$1,500/ \$3,000	\$1,500/ \$3,000
Calendar Year Out of Pocket Individual/Family	\$2,500/ \$5,000	\$4,000/ \$8,000	\$2,000/ \$4,000	\$4,000/ \$8,000	\$4,000/ \$8,000	\$8,000/ \$16,000	\$3,000/ \$6,000	\$3,000/ \$6,000
Hospital Inpatient Copay/ Deductible/Coinsurance per admit*	\$500	70%	90% after \$100 copay	70% after \$100 copay	80% after \$500 copay	60% after \$500 copay	80% after \$150 per day copay- 3 day max	60% after \$150 per 3 day max
Primary Care Physician Office Visit Copay/Coinsurance*	\$15	70%	\$15	70%	\$15	60%	\$25	60%
Specialist Office Visit Copay/ Coinsurance*	\$30	70%	\$30	70%	\$40	60%	\$35	60%
Outpatient Diagnostic/X-ray/ Lab*	\$30	70%	90%	70%	80%	60%	80%	60%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS, and PET Scans)*	\$100	70%	90%	70%	80%	60%	80%	60%
Outpatient Surgery Copay or Coinsurance*	\$250	70%	90% after \$100 copay	70% after \$100 copay	80% after \$150 copay	60% after \$150 copay	80% after \$150 copay	60%
Urgent Care*	\$35	70%	\$35	70%	\$50	60%	\$50	60%
Emergency Room Copay waived if admitted*	\$100	Same as in-network	\$100	Same as in-network	\$200	Same as in-network	80% after \$125 copay	Same as in-network
Durable Medical Equipment Copay*	80%	70%	90%	50%	80%	50%	80%	50%
DME Calendar Year Maximum	\$2,000		\$2,000		\$2,000		\$2,000	
Mental Health — Inpatient 30 days per calendar year*	\$500	70%	90% after \$100 copay	70% after \$100 copay	80% after \$500 copay	60% after \$500 copay	80% after \$150 per day 3-day max	60% after \$150 per day 3-day max
Substance Abuse Rehabilitation*	\$500	70%	90% after \$100 copay	70% after \$100 copay	80% after \$500 copay	60% after \$500 copay	80% after \$150 per day 3-day max	60% after \$150 per day 3-day max
Lifetime Maximums	\$5,000,000		\$5,000,000		\$5,000,000		\$2,000,000	
PHARMACY								
Triple Tier Copay	\$10/\$30/\$40	70% after copay	\$10/\$30/\$40	70% after copay	\$10/\$35/\$50	70% after copay	\$15/\$30/\$45	70% after copay
Mail Order Drug Copay (31-60 day supply)	2x retail	Not covered	2x retail	Not covered	2x retail	Not covered	2x retail	Not covered
Contraceptives	Included	Included	Included	Included	Included	Included	Included	Included

+ This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage copayments indicate what Aetna is required to pay.

*Coinsurance applies after the deductible is met where applicable.

NOTE: Payment for Out-of-Network facility care is determined based upon Aetna's allowable fee schedule. Payment for other Out-of-Network care is determined based upon the negotiated charge that would apply if such services or supplies were received from an In-Network provider. These charges are referred to in your Plan Document as "recognized" changes.

AETNA SMALL GROUP MEDICAL PLANS

Aetna Managed Choice Plan Options+

MEMBER BENEFITS	Managed Choice Open Access 105 (HSA Compatible*)		Managed Choice Open Access 106 (HSA Compatible*)		Managed Choice Open Access 107 (HSA Compatible*)		Managed Choice Open Access 108 (HSA Compatible*)	
	In-Network	Out-of Network	In-Network	Out-of Network	In-Network	Out-of Network	In-Network	Out-of Network
In-Network Coinsurance/ Out-of-Network Coinsurance**	100%	80%	80%	60%	80%	60%	100%	80%
Calendar Year Deductible Individual/Family	\$2,200/ \$4,400	\$3,500/ \$7,000	\$2,200/ \$4,400	\$3,500/ \$7,000	\$3,000/ \$6,000	\$5,000/ \$10,000	\$5,000/ \$10,000	\$7,000/ \$14,000
Calendar Year Out of Pocket Individual/Family	\$2,200/ \$4,400	\$5,000/ \$10,000	\$3,000/ \$6,000	\$6,000/ \$12,000	\$4,000/ \$8,000	\$7,500/ \$15,000	\$5,000/ \$10,000	\$8,500/ \$17,000
Hospital Inpatient Copay/ Deductible/Coinsurance per admit**	100%	80%	80%	60%	80%	60%	100%	80%
Primary Care Physician Office Visit Copay/Coinsurance**	100%	80%	80%	60%	80%	60%	100%	80%
Specialist Office Visit Copay/ Coinsurance**	100%	80%	80%	60%	80%	60%	100%	80%
Routine Physical Exams (Adult/Child)**	100% deductible waived	80%	80% deductible waived	60%	80% deductible waived	60%	100% deductible waived	80%
Routine OB/GYN**	100% deductible waived	80%	80% deductible waived	60%	80% deductible waived	60%	100% deductible waived	80%
Outpatient Diagnostic/X-ray/Lab**	100%	80%	80%	60%	80%	60%	100%	80%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS, and PET Scans)**	100%	80%	80%	60%	80%	60%	100%	80%
Outpatient Surgery Copay or Coinsurance**	100%	80%	80%	60%	80%	60%	100%	80%
Urgent Care**	100%	80%	80%	60%	80%	60%	100%	80%
Emergency Room Copay waived if admitted**	100%	Same as in network	80%	Same as in network	80%	Same as in network	100%	Same as in network
Durable Medical Equipment Copay**	100%	80%	80%	60%	80%	60%	100%	80%
DME Calendar Year Maximum	\$2,000		\$2,000		\$2,000		\$2,000	
Mental Health — Inpatient 30 days per calendar year**	100%	80%	80%	60%	80%	60%	100%	80%
Substance Abuse Rehabilitation**	100%	80%	80%	60%	80%	60%	100%	80%
Lifetime Maximums	\$5,000,000		\$5,000,000		\$5,000,000		\$5,000,000	
PHARMACY**								
Retail Drug Copay	100%	80%	80%	60%	80%	60%	100%	80%
Mail Order Drug Copay (31-60 day supply)	100%	Not covered	80%	Not covered	80%	Not covered	100%	Not covered
Contraceptives	Included	Included	Included	Included	Included	Included	Included	Included

+ This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage copayments indicate what Aetna is required to pay.

*Based upon Treasure guidance available as of the print date.

**Coinsurance applies after the deductible is met where applicable.

NOTE: Payment for Out-of-Network facility care is determined based upon Aetna’s allowable fee schedule. Payment for other Out-of-Network care is determined based upon the negotiated charge that would apply if such services or supplies were received from an In-Network provider. These charges are referred to in your Plan Document as “recognized” changes.

AETNA SMALL GROUP MEDICAL PLANS
Aetna PPO Plan Options+

MEMBER BENEFITS	PPO Plan 101		PPO Plan 102		PPO Plan103 (HSA Compatible*)		PPO Plan 104 (HSA Compatible*)	
	In-Network	Out-of Network	In-Network	Out-of Network	In-Network	Out-of Network	In-Network	Out-of Network
In-Network Coinsurance/ Out-of-Network Coinsurance**	90%	70%	80%	60%	80%	60%	80%	60%
Calendar Year Deductible Individual/Family	\$500/ \$1,000	\$1,000/ \$2,000	\$750/ \$1,500	\$1,500/ \$3,000	\$2,200/ \$4,400	\$3,500/ \$7,000	\$3,000/ \$6,000	\$5,000/ \$10,000
Calendar Year Out of Pocket Individual/Family	\$2,000/ \$4,000	\$4,000/ \$8,000	\$4,000/ \$8,000	\$8,000/ \$16,000	\$3,000/ \$6,000	\$6,000/ \$12,000	\$4,000/ \$8,000	\$7,500/ \$15,000
Hospital Inpatient Copay/ Deductible/Coinsurance per admit**	90% after \$100 copay	70% after \$100 copay	80% after \$500 copay	60% after \$500 copay	80%	60%	80%	60%
Primary Care Physician Office Visit Copay/Coinsurance**	\$15	70%	\$15	60%	80%	60%	80%	60%
Specialist Office Visit Copay/ coinsurance**	\$30	70%	\$40	60%	80%	60%	80%	60%
Routine Physical Exams (Adult/Child)**	\$15	70%	\$15	60%	100% deductible waived	60%	100% deductible waived	60%
Routine OB/GYN**	\$30	70%	\$40	60%	100% deductible waived	60%	100% deductible waived	60%
Outpatient Diagnostic/X-ray/Lab**	90%	70%	80%	60%	80%	60%	80%	60%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS, and PET Scans)**	90%	70%	80%	60%	80%	60%	80%	60%
Outpatient Surgery Copay or Coinsurance**	90% after \$100 copay	70% after \$100 copay	80% after \$150 copay	60% after \$150 copay	80%	60%	80%	60%
Urgent Care**	\$35	70%	\$50	60%	80%	60%	80%	60%
Emergency Room Copay waived if admitted**	\$100	Same as in-network	\$200	Same as in-network	80%	Same as in-network	80%	Same as in-network
Durable Medical Equipment Copay**	90%	50%	80%	50%	80%	60%	80%	60%
DME Calendar Year Maximum	\$2,000		\$2,000		\$2,000		\$2,000	
Mental Health — Inpatient 30 days per calendar year**	90% after \$100 copay	70% after \$100 copay	80% after \$500 copay	60% after \$500 copay	80%	60%	80%	60%
Substance Abuse Rehabilitation**	90% after \$100 copay	70% after \$100 copay	80% after \$500 copay	60% after \$500 copay	80%	60%	80%	60%
Lifetime Maximums	\$5,000,000		5,000,000		\$5,000,000		\$5,000,000	
PHARMACY**								
Triple Tier/Retail Drug Copay	\$10/\$30/\$40	70% after copay	\$10/\$35/\$50	70% after copay	80%	60% Deductible applies	80%	60% Deductible applies
Mail Order Drug Copay (31-60 day supply)	2x retail	Not covered	2x retail	Not covered	80% Deductible applies	Not covered	80% Deductible applies	Not covered
Contraceptives	Included	Included	Included	Included	Included	Included	Included	Included

+ This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage copayments indicate what Aetna is required to pay.

*Based upon Treasury guidance available as of the print date.

**Coinsurance applies after the deductible is met where applicable.

NOTE: Payment for Out-of-Network facility care is determined based upon Aetna's allowable fee schedule. Payment for other Out-of-Network care is determined based upon the negotiated charge that would apply if such services or supplies were received from an In-Network provider. These charges are referred to in your Plan Document as "recognized" charges.

Limitations and Exclusions



These plans do not cover all health care expenses and include exclusions and limitations. Employers and members should refer to their plan documents to determine which health care services are covered and to what extent.

Aetna Primary Care Plan HMO Open Access & Aetna Choice Plan POS

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 or rider(s) purchased.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates.
- Cosmetic surgery.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval.
- Experimental and investigational procedures (except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial).
- Hearing aids.
- Home births.
- Immunizations for travel or work.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services including 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.
- Medical expenses for a pre-existing condition are not covered (full postponement rule) for the first 365 days after the member's enrollment date. Lookback period for determining a pre-existing condition (conditions for which diagnosis, care or treatment was recommended or received) is 180 days prior to the enrollment date. The pre-existing condition limitation period will be reduced by the number of days of prior creditable coverage the member has as of the enrollment date.
- Nonmedically necessary services or supplies.
- Orthotics.
- Over-the-counter medications and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered in the plan documents.
- Treatment of behavioral disorders.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.



Aetna Managed Choice Plan & Aetna Choice Plan PPO

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.
- Dental care and X-rays.
- Donor egg retrieval.
- Experimental and investigational procedures.
- Hearing aids.
- Immunizations for travel or work.
- Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVE, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
- Medical expenses for a pre-existing condition are not covered (full postponement rule) for the first 365 days after the insured's enrollment date. Lookback period for determining a pre-existing condition (conditions for which diagnosis, care or treatment was recommended or received) is 90 days prior to the enrollment date. The pre-existing condition limitation period will be reduced by the number of days of prior creditable coverage the member has as of the enrollment date.
- Nonmedically necessary services or supplies.
- Orthotics.
- Over-the-counter medications and supplies.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling.
- Special duty nursing.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.



For more information about any of these plans, or to receive a quote, please contact your broker or Southeast Region Small Group Sales at 1-888-422-2128.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The Aetna companies that offer, underwrite or administer benefit coverage include Aetna Health Inc. and Aetna Life Insurance Company.

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 arranges for the provision of health care services. However, Aetna itself is not a provider of health care services, and therefore, cannot guarantee any results or outcomes. Consult the plan documents (Schedule of Benefits, Certificate of Coverage, Evidence of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. The availability of a plan or program may vary by geographic service area and by plan design. With the exception of Aetna Rx Home Delivery® service, participating 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. Notice of the change shall be provided, in accordance with applicable state law. Certain primary care providers are affiliated with integrated delivery systems or other provider groups (such as independent practice associations and physician-hospital organizations), and members who select these providers will generally be referred to specialists and hospitals within those systems or groups. However, if a system or group does not include a provider qualified to meet member's medical needs, member may request to have services provided by non-system or non-group providers. Member's request will be reviewed and will require prior authorization from the system or group and/or Aetna to be a covered benefit.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify, or obtain prior approval of coverage for certain services such as non-emergency inpatient hospital care. If your plan covers outpatient prescription drugs, your plan may include 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 not 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 Aetna's website at www.aetna.com, or the Aetna Medication Formulary Guide. Many drugs, including many of those listed on the formulary, are subject to rebate arrangements between Aetna and the manufacturer of the drugs. Rebates received by Aetna from drug manufacturers are not reflected in the cost paid by a member for a prescription drug. In addition, in circumstances where your prescription plan utilizes 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., 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.

Health Savings Account (HSA) services are independently offered and administered by HSA custodians or vendors selected by employers or members.

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

