Aetna POS Medical Plan Summary Chart	Core	In-Network	Out-Of-Network
Deductible			
Single	none	$400	$1,200
Family	none	$1,200	$3,600
Out -Of-Pocket Maximum			
Single	none	$1,750	$6,000
Family	none	$3,500	$12,000
Aggregate	N/A	Yes	Yes
Physician Fees (Primary Care Office Visits) Includes services of an internist, general physician, family practitioner or pediatrician. Also includes dermatologist, allergist and OB/GYN.	$20 Copay	$40 Copay	40% after Deductible
Physician Fees (Specialist)	$20 Copay	$50 Copay	40% after Deductible
Routine Physical Exams			
Routine Adult Physical Exams including immunizations (One exam every 12 months age 18 and over)	$20 Copay	$40 Copay	40% after Deductible
Routine GYN Exams (one visit per calendar year - includes Pap smear and related lab fees)	$20 Copay	$40 Copay	40% after Deductible
Routine Child Exams including immunizations	$20 Copay	$40 Copay	40% after Deductible
Routine Cancer Screening Expenses (includes routine rectal exam/prostate-specific antigen test for covered males age 40 and over)	Plan Pays 100%	Plan Pays 100%	40% after Deductible
Routine Cancer Screening Expenses (colorectal cancer screening for members age 50 and over done in an outpatient setting)	Plan Pays 100%	Plan Pays 100%	40% after Deductible
Routine Mammogram Expenses for covered females age 40 and over	Plan Pays 100%	Plan Pays 100%	40% after Deductible
For Use of Urgent Care Provider - Urgent Care	$50 Copay	$50 Copay	$50 Copay
For Emergency Room Treatment - Emergency Care	$150 Copay	$150 Copay	$150 Copay
Ambulance Expenses	$75 co-pay	$75 Copay	$75 Copay
For Outpatient Hospital Expenses (including surgery)	$150 co-pay	30% after Deductible	40% after Deductible
Physician Fees for Outpatient Surgery	Plan Pays 100%	30% after Deductible	40% after Deductible
Hospital Expenses - Inpatient Coverage	$350	30% after Deductible	40% after Deductible
Pre-Admission Testing Office Visit	$20 Copay	Copay applies for provider type	40% after Deductible
Physician Fees for Routine Eye Exam Expenses (1 exam per 12 months) Non-surgical Office	$20 Copay	$50 Copay	40% after Deductible
Physician Fees for Routine Hearing Exams (1 exam per 24 months) Non-surgical Office	$20 Copay	$50 Copay	40% after Deductible
Other Covered Medical Expenses			
Convalescent / Skilled Nursing Facility Expenses (120 day maximum, prior hospital confinement not required)	$350	30% after Deductible	40% after Deductible
Home Health Care Expenses	Plan Pays 100%	Plan Pays 100%	40% after Deductible

Aetna POS Medical Plan Summary Chart	Core	In-Network	Out-Of-Network
Hospice Care Expenses (Inpatient or Outpatient, no limit or dollar maximum)	Plan Pays 100%	Plan Pays 100%	40% after Deductible
Short-Term Rehabilitation / Outpatient Therapy (Speech, Physical or Occupational) 90 day maximum per year combined	$20 Copay	$50 Copay	40% after Deductible
Chiropractic Care / Spinal Manipulation (Limited to 20 visits per calendar year)	$40 Copay	$40 Copay	40% after Deductible
Durable Medical and Surgical Equipment	Plan Pays 100%	Plan Pays 100%	40% after Deductible
Allergy Testing	$20 Copay	$40 Copay	40% after Deductible
Allergy Serum and Injections - If a physician visit is not included then no Copay applies	$20 Copay	$40 Copay	40% after Deductible
Family Planning			
Maternity - Initial Visit and Post Natal Care Inpatient Care	$20 Copay $350 Copay	$50 Copay 30% after Deductible	40% after Deductible
Vasectomy, Tubal Ligation and Voluntary Abortion	Coverage based on where services are rendered		40% after Deductible
Infertility Treatment Expenses (diagnosis and treatment of the underlying medical condition)	Coverage based on where services are rendered		40% after Deductible
Infertility Expenses includes ovulation inductions and insemination (up to 6 cycles in a lifetime)	Coverage based on where services are rendered		40% after Deductible
For Advanced Reproductive Technology Expenses (ZIFT and GIFT)	No Coverage	No Coverage	No Coverage
Diagnostic Laboratory and X-Ray Expenses			
Outpatient or Independent Lab	Plan Pays 100%	10% - no Deductible	40% after Deductible
Physician office or Stand along facility	$20 Copay	$50 Copay	40% after Deductible
Exception: If the covered person receives the diagnostic X-ray services during a Physician's office visit, the member will only be responsible for the Copay for the Physician's office visit.			
Diagnostic X-Ray For Complex Imaging Services (MRI, CAT scan and PET scan)	Plan Pays 100%	$250 Copay	40% after Deductible

POS Behavioral Health Summary Chart

There is no deductible for Behavioral Health Benefits. The following Anuual Out-of-Pocket Maximums Apply	**In-Network**	**Out-of-Network**
Single	$1,750	$5,000
Family	$3,500	$10,000
Inpatient Treatment	First 15 days at 10%, remaining days at 30%	50%
Outpatient Treatment	30%	50%