

## SOUTH CAROLINA AETNA ADVANTAGE PLAN OPTIONS

| MEMBER BENEFITS  | First Dollar PPO 35  |   |
|--|--|---|
|  | In-Network   | Out-of-Network*                                     |
| Deductible<br>Individual<br>Family   | \$0<br>\$0   | \$7,000<br>\$14,000                                 |
| Coinsurance<br>(Member's Responsibility)   | 35%  | 50% after deductible                                |
| Co-insurance Maximum<br>Individual<br>Family   | \$3,500<br>\$7,000   | \$5,000<br>\$10,000                                 |
| Out-of-Pocket Maximum<br>Individual<br>Family<br>(deductible included)                                   | \$3,500<br>\$7,000   | \$12,000<br>\$24,000                                |
| Lifetime Maximum*  | \$5,000,000  |   |
| Non-specialist Office Visit<br>(General Physician, Family<br>Practitioner, Pediatrician or<br>Internist) | \$35 copay   | 50% after deductible                                |
| Specialist Visit   | \$45 copay   | 50% after deductible                                |
| Hospital Admission   | 35%  | 50% after deductible                                |
| Outpatient Surgery   | 35%  | 50% after deductible                                |
| Emergency Room<br>(after deductible)   | \$100 copay** (waived if admitted)<br>and 35% co-insurance |   |
| Annual Routine Gyn Exam<br>(Annual Pap/Mammogram)  | \$0 copay  | 50% after deductible                                |
| Maternity  | Not covered  | Not covered   |
| Preventive Health<br>(\$200 per exam)  | \$35 copay   | 50% after deductible                                |
| Lab/X-Ray  | 35%  | 50% after deductible                                |
| Skilled Nursing (In lieu of<br>Hospital) (30 days per<br>calendar year*)                                 | 35%  | 50% after deductible                                |
| Physical/Occupational Therapy<br>and Chiropractic Care<br>(\$25 Max -24 visits per<br>calendar year*)    | 35%  | 50% after deductible                                |
| Home Health Care (In lieu<br>of Hospital) (30 visits per<br>calendar year*)                              | 35%  | 50% after deductible                                |
| Durable Medical Equipment<br>(\$2000 per calendar year*)   | 35%  | 50% after deductible                                |
| <b>PHARMACY</b>  |  |   |
| Pharmacy Deductible<br>per Individual<br>(does not apply to generic)*                                    | \$500  | \$500   |
| Generic<br>(Oral Contraceptives included)  | \$15 copay<br>not subject to<br>deductible                 | \$15 copay plus<br>50% not subject<br>to deductible |
| Preferred Brand Name   | \$25 copay<br>after deductible                             | \$25 copay plus<br>50% after<br>deductible          |
| Non-Preferred Brand<br>(Oral Contractives Included)  | \$40 copay<br>after deductible                             | \$40 copay plus<br>50% after<br>deductible          |
| Calendar Year Maximum<br>per Individual*   | Unlimited  | Unlimited   |

\* Maximum applies to combined in and out of network benefits. For a full list of benefit coverage and exclusions refer to plan documents.

\*\* Copay is billed separately and not due at time of service. Copay does not count towards co-insurance or out of pocket max.

\*\*\* Aetna discount available.

+ Payment for out of network facility care is determined based upon Aetna's Allowable Fee Schedule. Payment for other out-of-network facility care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider.

A summary of exclusions is listed on page 17. For a full list of benefit coverage and exclusions refer to the plan documents.

The Aetna Advantage Plans for Individuals and Families are offered, underwritten or administered by Aetna Life Insurance or through an out-of-state blanket trust.

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