PLAN 1

PLATINUM 500 90/50

BENEFIT SUMMARY

Benefit/Feature No Referrals Required	In Network Providers Aetna Choice POS II Online Search: www.aetna.com Aetna One Concierge 1-866-252-3559	Out- of-Network Providers
Deductible (Embedded*) (every Calendar year)	$500/Individual; $1,000/Family	$2,000/Individual; $4,000/Family
Out-of-Pocket Maximum (Embedded*) (every Calendar Year)	$6,850/Individual; $13,700/Family	$14,000/Individual; $38,000/Family
(Out of Pocket Maximum is combined between In-Network and Out-of-Network and **includes deductible, coinsurance, medical copayments and prescription copays/coinsurance** but does not include non covered amounts above the plan's fee schedule or allowable charge, or pre-authorization penalties.)		
Lifetime Maximum Benefit	Unlimited	Unlimited
PHYSICIAN SERVICES		
Office Visit to Primary Care	You pay $30 copay/visit	Plan pays 50%(1) after deductible
Office Visit to Specialist	You pay $60 copay/visit	Plan pays 50%(1) after deductible
Routine Gynecological Care	Plan pays 100%	Plan pays 50%(1) after deductible
Pre-Natal Care	You pay $30 copay/visit (initial visit only)	Plan pays 50%(1) after deductible
Routine Physical	Plan pays 100%	Plan pays 50%(1) after deductible
Well Care (Child & Adult)	Plan pays 100%	Plan pays 50%(1) after deductible
Childhood Immunizations	Plan pays 100%	Plan pays 100%
Inpatient/Outpatient Professional Services	Plan pays 90% after deductible	Plan pays 50%(1) after deductible
HOSPITAL SERVICES		
Inpatient Admission (2)	Plan pays 90% after deductible	Plan pays 50%(1) after deductible
Outpatient Services	Plan pays 90% after deductible	Plan pays 50%(1) after deductible
Outpatient Ambulatory Surgery (2)		
- Physician Charges	Plan pays 90% after deductible	Plan pays 50%(1) after deductible
- Hospital Charges	Plan pays 90% after deductible	Plan pays 50%(1) after deductible
- Free-standing Surgical Center	Plan pays 90% after deductible	Plan pays 50%(1) of a Maximum Allowable of $1,000 per surgery, after the deductible is met*
Urgent Care Center	You pay $75 copay/visit	Plan pays 50%(1) after deductible
Emergency Room Services	Plan pays 90% after deductible **(Out-of-Area True Emergency Admissions are subject to In Network Benefits)**	
Inpatient Rehab & Skilled Nursing (2)	Plan pays 90% after deductible **(60 days per incident maximum)**	Plan pays 50%(1) after deductible **(60 days per incident maximum)**
OTHER SERVICES		
Outpatient Therapies (2)	**Includes Physical, Occupational & Speech** **All Therapies (60 visit combined limit, every plan year)** (This limit does not apply to benefits associated with Autism Spectrum Disorder, developmental delays, or acquired brain injury)	
- Hospital Based	Plan pays 90% after deductible	Plan pays 50%(1) after deductible
- Office Based or Freestanding Facility	You pay $60 copay/visit	Plan pays 50%(1) after deductible
Cardiac Rehabilitation (2)	Plan pays 90% after deductible **(36 visits combined every plan year)**	Plan pays 50%(1) after deductible **(36 visits combined every plan year)**
Laboratory Services		
- Hospital Based	Plan pays 90% after deductible	Plan pays 50%(1) after deductible
- Office Based or Freestanding Facility	Plan pays 90% after deductible	Plan pays 50%(1) after deductible
Diagnostic Services (2)		
- MRIs, MRAs, CT Scans, and PET Scans (2)	Plan pays 90% after deductible	Plan pays 50%(1) after deductible
- All Other Diagnostic Services	Plan pays 90% after deductible	Plan pays 50%(1) after deductible
Durable Medical Equipment (2)	Plan pays 90% after deductible	Plan pays 50%(1) after deductible
Home Health Care (2)	Plan pays 90% after deductible **(60 visits per year/not to exceed 4 hrs per visit)**	Plan pays 50%(1) after deductible **(60 visits per year/not to exceed 4 hrs per visit)**
Chiropractic Care Covered age 18 and older only	You pay $60 copay/visit **(30 visit maximum every plan year)**	Plan pays 50%(1) after deductible **(30 visit maximum every plan year)**
MENTAL DISORDER & SUBSTANCE ABUSE SERVICES		
Inpatient Mental Disorder/Substance Abuse (2)	Plan pays 90% after deductible	Plan pays 50%(1) after deductible
Outpatient Mental Disorder/Substance Abuse (2)		
- Hospital Based	Plan pays 90% after deductible	Plan pays 50%(1) after deductible
- Office Based or Freestanding Facility	You pay $30 copay/visit	Plan pays 50%(1) after deductible

(1) Out-of-Network elective (non-preferred) professional services will be paid based on the 50th percentile of FairHealth. Out-of-Network elective (non-preferred) facility services will be paid based on the NAP Facility Charge Review under the National Advantage Program (NAP). Out-of-Network involuntary (preferred) professional services will be paid based on 125% of Medicare's allowable rate. Out-of-Network involuntary (preferred) facility services will be paid based upon NAP vendor contracts or NAP Facility Charge Review.

(2) Some of these services require precertification. For Network services, your physician should obtain precertification for you, however, you are ultimately responsible for precertification for all services out-of-network, otherwise a penalty of 50% of the Plan's recognized charges, to a maximum of $10,000 will be applied. Refer to Plan Documents for a complete precertification list.

Note: This summary is not intended to be a comprehensive list of services and is not a guarantee of coverage. Once enrolled, you will be supplied with a Plan Document/Summary Plan Description (SPD) that will detail all covered services.

Note: For Texas Residents– Infertility is Not Covered unless your employer has elected the Invitro fertilization rider, only charges for testing to diagnose infertility will be covered. For Texas Residents – If Invitro fertilization rider IS elected, it is covered as specifically listed in the SPD. For Arkansas Residents - Invitro fertilization procedures, including, cryopreservation, is covered with a $15,000 lifetime benefit, see SPD for more details.

*Embedded means you can satisfy the Family "Deductible" or the Family "Maximum Out-of-pocket" by meeting the individual amount for any one (1) covered family Member and then any combination of family Members may satisfy the remaining amount. No more than the individual amount will be credited to the Family amount for any one Covered Person and no Covered Person will be required to meet more than the individual amount each Benefit Year.