

Medical plan options that fit

Small Business Solutions

FOR BUSINESSES WITH 50 OR FEWER ELIGIBLE EMPLOYEES



Florida

†Health benefits plans and health insurance plans are offered and/or underwritten by Aetna Health Inc. and/or Aetna Life Insurance Company (Aetna).

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We want you to know[®]



AETNA PRIMARY CARE[®] PLAN HMO OPEN ACCESS PLAN OPTIONS

Plan Type	Copay Plans		
	FL HMO OA 801	FL HMO OA 802	FL HMO OA 803
MEMBER BENEFITS	In-Network	In-Network	In-Network
Lifetime Maximums	\$5,000,000	\$5,000,000	\$5,000,000
Coinsurance	N/A	N/A	N/A
Calendar Year Deductible Individual/Family	N/A	N/A	N/A
Calendar Year Out-of-Pocket Individual/Family	\$2,000/\$4,000	\$3,000/\$6,000	\$5,000/\$10,000
Primary Care Physician Office Visit	\$15	\$20	\$35
Specialist Physician Office Visit	\$30	\$50	\$70
Outpatient Diagnostic Lab	\$0	\$0	\$0
Outpatient Diagnostic X-ray	\$30	\$50	\$70
Outpatient Diagnostic Complex Imaging (CAT, MRI, MRA/MRS and PET scans)	\$100	\$300	\$500
Emergency Room (copay waived if admitted)	\$100	\$150	\$300
Urgent Care	\$35	\$75	\$150
Hospital – Inpatient Admission	\$500/admit	\$500 per day, day 1-4	\$2,000/admit
Hospital – Outpatient Surgery	\$250	\$500	\$1,000
Preventive Care Services	\$15	\$20	\$35
Mental Health – Inpatient (30 days per calendar year)	\$500/admit	\$500 per day, day 1-4	\$2,000/admit
Substance Abuse Rehabilitation (30 days per calendar year)	\$500/admit	\$500 per day, day 1-4	\$2,000/admit
Durable Medical Equipment	80%	70%	70%
Durable Medical Equipment Calendar Year Maximum	\$2,000	\$2,000	\$2,000
PHARMACY			
Retail (triple tier) (contraceptives included)	\$10 / \$30 / \$50	\$10 / \$35 / \$50	\$15 / \$45 / \$60
Mail-Order Drug (up to a 90-day supply)	2x	2x	2x
Self-Injectable Drugs (maximum copay 2x tier 3 copay)	80%	80%	80%

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, unless otherwise noted.

NOTE: Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify, or obtain prior approval for certain services such as non-emergency hospital care. For a summary list of Limitations and Exclusions, refer to page 11.

FLORIDA AETNA SMALL GROUP MEDICAL PLANS

AETNA PRIMARY CARE® PLAN HMO OPEN ACCESS PLAN OPTIONS

Plan Type	Deductible & Coinsurance Plans		
	FL HMO OA 811	FL HMO OA 812	FL HMO OA 813
MEMBER BENEFITS	In-Network	In-Network	In-Network
Lifetime Maximums	\$5,000,000	\$5,000,000	\$5,000,000
Coinsurance	80%	70%	70%
Calendar Year Deductible Individual/Family	\$500/\$1,000	\$750/\$1,500	\$1,000/\$2,000
Calendar Year Out-of-Pocket Individual/Family	\$4,000/\$8,000	\$4,000/\$8,000	\$5,000/\$10,000
Primary Care Physician Office Visit	\$20, ded waived	\$20, ded waived	\$20, ded waived
Specialist Physician Office Visit	\$50, ded waived	\$50, ded waived	\$50, ded waived
Outpatient Diagnostic Lab	\$0, ded waived	\$0, ded waived	\$0, ded waived
Outpatient Diagnostic X-ray	\$50, ded waived	\$50, ded waived	\$50, ded waived
Outpatient Diagnostic Complex Imaging (CAT, MRI, MRA/MRS and PET scans)	\$200, ded applies	\$200, ded applies	\$300, ded applies
Emergency Room (copay waived if admitted)	\$150, ded waived	\$150, ded waived	\$200, ded waived
Urgent Care	\$75, ded waived	\$75, ded waived	\$75, ded waived
Hospital – Inpatient Admission	80%, ded applies	70%, ded applies	70%, ded applies
Hospital – Outpatient Surgery	80%, ded applies	70%, ded applies	70%, ded applies
Preventive Care Services	\$20, ded waived	\$20, ded waived	\$20, ded waived
Mental Health – Inpatient (30 days per calendar year)	80%, ded applies	70%, ded applies	70%, ded applies
Substance Abuse Rehabilitation (30 days per calendar year)	80%, ded applies	70%, ded applies	70%, ded applies
Durable Medical Equipment	80%, ded applies	70%, ded applies	70%, ded applies
Durable Medical Equipment Calendar Year Maximum	\$2,000	\$2,000	\$2,000
PHARMACY			
Retail (triple tier) (contraceptives included)	\$10 / \$35 / \$50	\$10 / \$45 / \$60	\$10 / \$45 / \$60
Mail-Order Drug (up to a 90-day supply)	2x	2x	2x
Self-Injectable Drugs (maximum copay 2x tier 3 copay)	80%	80%	80%

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, unless otherwise noted.

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FLORIDA AETNA SMALL GROUP MEDICAL PLANS

AETNA PRIMARY CARE® PLAN HMO OPEN ACCESS PLAN OPTIONS

Plan Type	Deductible & Coinsurance Plans			
Plan Options	FL HMO OA 814	FL HMO OA 815	FL HMO OA 816	FL HMO OA 817
MEMBER BENEFITS	In-Network	In-Network	In-Network	In-Network
Lifetime Maximums	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000
Coinsurance	70%	50%	50%	100%
Calendar Year Deductible Individual/Family	\$2,000/\$4,000	\$2,000/\$4,000	\$3,000/\$6,000	\$10,000/\$10,000
Calendar Year Out-of-Pocket Individual/Family	\$5,000/\$10,000	\$5,000/\$10,000	\$6,000/\$12,000	\$10,000/\$10,000*
Primary Care Physician Office Visit	\$25, ded waived	\$20, ded waived	\$35, ded waived	\$35, ded waived
Specialist Physician Office Visit	\$50, ded waived	\$50, ded waived	\$70, ded waived	100%, ded applies
Outpatient Diagnostic Lab	\$0, ded waived	\$0, ded waived	\$0, ded waived	100%, ded applies
Outpatient Diagnostic X-ray	\$50, ded waived	50%, ded waived	50%, ded waived	100%, ded applies
Outpatient Diagnostic Complex Imaging (CAT, MRI, MRA/MRS and PET scans)	\$300, ded applies	50%, ded applies	50%, ded applies	100%, ded applies
Emergency Room (copay waived if admitted)	\$200, ded waived	\$200, ded waived	\$200, ded waived	100%, ded applies
Urgent Care	\$75, ded waived	\$75, ded waived	\$100, ded waived	100%, ded applies
Hospital – Inpatient Admission	70%, ded applies	50%, ded applies	50%, ded applies	100%, ded applies
Hospital – Outpatient Surgery	70%, ded applies	50%, ded applies	50%, ded applies	100%, ded applies
Preventive Care Services	\$25, ded waived	\$20, ded waived	\$35, ded waived	\$35, ded waived
Mental Health – Inpatient (30 days per calendar year)	70%, ded applies	50%, ded applies	50%, ded applies	100%, ded applies
Substance Abuse Rehabilitation (30 days per calendar year)	70%, ded applies	50%, ded applies	50%, ded applies	100%, ded applies
Durable Medical Equipment	70%, ded applies	70%, ded applies	50%, ded applies	100%, ded applies
Durable Medical Equipment Calendar Year Maximum	\$2,000	\$2,000	\$2,000	\$2,000
PHARMACY				
Retail (triple tier) (contraceptives included)	\$10 / \$45 / \$60	\$10 / \$45 / \$60	\$20 / \$50 / \$70	\$20 / \$50 / \$70
Mail-Order Drug (up to a 90-day supply)	2x	2x	2x	2x
Self-Injectable Drugs (maximum copay 2x tier 3 copay)	80%	80%	50%**	80%

*Out-of-Pocket Maximum includes deductible.

**Maximum copay on self-injectable does not apply.

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FLORIDA AETNA SMALL GROUP MEDICAL PLANS

AETNA PRIMARY CARE® PLAN POS OPEN ACCESS PLAN OPTIONS

Plan Type	Copay Plans					
	FL POS OA 801		FL POS OA 802		FL POS OA 803	
Plan Options	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
MEMBER BENEFITS						
Lifetime Maximums	\$5,000,000	\$1,000,000	\$5,000,000	\$1,000,000	\$5,000,000	\$1,000,000
Coinsurance	N/A	70%	N/A	50%	N/A	50%
Calendar Year Deductible Individual/Family	N/A	\$500/ \$1,000	N/A	\$2,000/ \$4,000	N/A	\$2,000/ \$4,000
Calendar Year Out-of-Pocket Individual/Family	\$2,000/ \$4,000	\$4,000/ \$8,000	\$3,000/ \$6,000	\$6,000/ \$12,000	\$5,000/ \$10,000	\$6,000/ \$12,000
Primary Care Physician Office Visit	\$15	70%	\$20	50%	\$35	50%
Specialist Physician Office Visit	\$30	70%	\$50	50%	\$70	50%
Outpatient Diagnostic Lab	\$0	70%	\$0	50%	\$0	50%
Outpatient Diagnostic X-ray	\$30	70%	\$50	50%	\$70	50%
Outpatient Diagnostic Complex Imaging (CAT, MRI, MRA/MRS and PET scans)	\$100	70%	\$300	50%	\$500	50%
Emergency Room (copay waived if admitted)	\$100	Same as In-Network	\$150	Same as In-Network	\$300	Same as In-Network
Urgent Care	\$35	70%	\$75	50%	\$150	50%
Hospital – Inpatient Admission	\$500/admit	70%	\$500 per day, day 1-4	50%	\$2,000/admit	50%
Hospital – Outpatient Surgery	\$250	70%	\$500	50%	\$1,000	50%
Preventive Care Services	\$15	70%	\$20	50%	\$35	50%
Mental Health – Inpatient (30 days per calendar year)	\$500/admit	70%	\$500 per day, day 1-4	50%	\$2,000/admit	50%
Substance Abuse Rehabilitation (30 days per calendar year)	\$500/admit	70%	\$500 per day, day 1-4	50%	\$2,000/admit	50%
Durable Medical Equipment	80%	70%	70%	50%	70%	50%
Durable Medical Equipment Calendar Year Maximum	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000
PHARMACY						
Retail (triple tier) (contraceptives included)	\$10/\$30/\$50	Not Covered	\$10/\$35/\$50	Not Covered	\$15/\$45/\$60	Not Covered
Mail-Order Drug (up to a 90-day supply)	2x		2x		2x	
Self-Injectable Drugs (maximum copay 2x tier 3 copay)	80%		80%		80%	

*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 Documents as “recognized” charges.

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AETNA PRIMARY CARE® PLAN POS OPEN ACCESS PLAN OPTIONS

Plan Type	Deductible & Coinsurance Plans					
	FL POS OA 811		FL POS OA 812		FL POS OA 813	
Plan Options	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
MEMBER BENEFITS						
Lifetime Maximums	\$5,000,000	\$1,000,000	\$5,000,000	\$1,000,000	\$5,000,000	\$1,000,000
Coinsurance	80%	50%	70%	50%	70%	50%
Calendar Year Deductible Individual/Family	\$500/ \$1,000	\$2,000/ \$4,000	\$750/ \$1,500	\$2,000/ \$4,000	\$1,000/ \$2,000	\$2,000/ \$4,000
Calendar Year Out-of-Pocket Individual/Family	\$4,000/ \$8,000	\$6,000/ \$12,000	\$4,000/ \$8,000	\$6,000/ \$12,000	\$5,000/ \$10,000	\$6,000/ \$12,000
Primary Care Physician Office Visit	\$20, ded waived	50%	\$20, ded waived	50%	\$20, ded waived	50%
Specialist Physician Office Visit	\$50, ded waived	50%	\$50, ded waived	50%	\$50, ded waived	50%
Outpatient Diagnostic Lab	\$0, ded waived	50%	\$0, ded waived	50%	\$0, ded waived	50%
Outpatient Diagnostic X-ray	\$50, ded waived	50%	\$50, ded waived	50%	\$50, ded waived	50%
Outpatient Diagnostic Complex Imaging (CAT, MRI, MRA/MRS and PET scans)	\$200, ded applies	50%	\$200, ded applies	50%	\$300, ded applies	50%
Emergency Room (copay waived if admitted)	\$150, ded waived	Same as In-Network	\$150, ded waived	Same as In-Network	\$200, ded waived	Same as In-Network
Urgent Care	\$75, ded waived	50%	\$75, ded waived	50%	\$75, ded waived	50%
Hospital – Inpatient Admission	80%, ded applies	50%	70%, ded applies	50%	70%, ded applies	50%
Hospital – Outpatient Surgery	80%, ded applies	50%	70%, ded applies	50%	70%, ded applies	50%
Preventive Care Services	\$20, ded waived	50%	\$20, ded waived	50%	\$20, ded waived	50%
Mental Health – Inpatient (30 days per calendar year)	80%, ded applies	50%	70%, ded applies	50%	70%, ded applies	50%
Substance Abuse Rehabilitation (30 days per calendar year)	80%, ded applies	50%	70%, ded applies	50%	70%, ded applies	50%
Durable Medical Equipment	80%, ded applies	50%	70%, ded applies	50%	70%, ded applies	50%
Durable Medical Equipment Calendar Year Maximum	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000
PHARMACY						
Retail (triple tier) (contraceptives included)	\$10/\$35/\$50	Not Covered	\$10/\$45/\$60	Not Covered	\$10/\$45/\$60	Not Covered
Mail-Order Drug (up to a 90-day supply)	2x		2x		2x	
Self-Injectable Drugs (maximum copay 2x tier 3 copay)	80%		80%		80%	

*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 Documents as “recognized” charges.

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FLORIDA AETNA SMALL GROUP MEDICAL PLANS

AETNA PRIMARY CARE® PLAN POS OPEN ACCESS PLAN OPTIONS

Plan Type	100% Plans					
	FL POS OA 821		FL POS OA 822		FL POS OA 823	
Plan Options	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
MEMBER BENEFITS						
Lifetime Maximums	\$5,000,000	\$1,000,000	\$5,000,000	\$1,000,000	\$5,000,000	\$1,000,000
Coinsurance	100%	70%	100%	70%	100%	70%
Calendar Year Deductible Individual/Family	\$1,500/ \$4,500	\$2,000/ \$6,000	\$2,000/ \$6,000	\$3,000/ \$9,000	\$3,000/ \$9,000	\$3,000/ \$9,000
Calendar Year Out-of-Pocket Individual/Family	\$1,500/ \$4,500**	\$5,000/ \$15,000**	\$2,000/ \$6,000**	\$6,000/ \$18,000**	\$3,000/ \$9,000**	\$7,000/ \$21,000**
Primary Care Physician Office Visit	\$20, ded waived	70%	\$20, ded waived	70%	\$20, ded waived	70%
Specialist Physician Office Visit	\$50, ded waived	70%	\$50, ded waived	70%	\$50, ded waived	70%
Outpatient Diagnostic Lab	\$0, ded waived	70%	\$0, ded waived	70%	\$0, ded waived	70%
Outpatient Diagnostic X-ray	\$0, ded waived	70%	\$0, ded waived	70%	\$0, ded waived	70%
Outpatient Diagnostic Complex Imaging (CAT, MRI, MRA/MRS and PET scans)	100%, ded applies	70%	100%, ded applies	70%	100%, ded applies	70%
Emergency Room (copay waived if admitted)	\$100, ded waived	Same as In-Network	\$150, ded waived	Same as In-Network	\$200, ded waived	Same as In-Network
Urgent Care	\$75, ded waived	70%	\$75, ded waived	70%	\$75, ded waived	70%
Hospital – Inpatient Admission	100%, ded applies	70%	100%, ded applies	70%	100%, ded applies	70%
Hospital – Outpatient Surgery	100%, ded applies	70%	100%, ded applies	70%	100%, ded applies	70%
Preventive Care Services	\$20, ded waived	70%	\$20, ded waived	70%	\$20, ded waived	70%
Mental Health – Inpatient (30 days per calendar year)	100%, ded applies	70%	100%, ded applies	70%	100%, ded applies	70%
Substance Abuse Rehabilitation (30 days per calendar year)	100%, ded applies	70%	100%, ded applies	70%	100%, ded applies	70%
Durable Medical Equipment	100%, ded applies	70%	100%, ded applies	70%	100%, ded applies	70%
Durable Medical Equipment Calendar Year Maximum	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000
PHARMACY						
Retail (triple tier) (contraceptives included)	\$10/\$30/\$50	Not Covered	\$10/\$35/\$50	Not Covered	\$15/\$45/\$60	Not Covered
Mail-Order Drug (up to a 90-day supply)	2x		2x		2x	
Self-Injectable Drugs (maximum copay 2x tier 3 copay)	80%		80%		80%	

*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 Documents as “recognized” charges.

**Out-of-Pocket Maximum includes deductible.

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NOTE: Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify, or obtain prior approval for certain services such as non-emergency hospital care. For a summary list of Limitations and Exclusions, refer to page 11.

AETNA PRIMARY CARE® PLAN POS OPEN ACCESS PLAN OPTIONS

Plan Type	High-Deductible (HSA-Compatible) Health Plans					
	FL POS OA 831 (HDHP)		FL POS OA 832 (HDHP)		FL POS OA 833 (HDHP)	
Plan Options	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
MEMBER BENEFITS						
Lifetime Maximums	\$5,000,000	\$1,000,000	\$5,000,000	\$1,000,000	\$5,000,000	\$1,000,000
Coinsurance	100%	70%	100%	70%	100%	70%
Calendar Year Deductible Individual/Family	\$1,500/ \$3,000	\$3,000/ \$6,000	\$2,500/ \$5,000	\$4,000/ \$8,000	\$5,000/ \$10,000	\$7,000/ \$14,000
Calendar Year Out-of-Pocket Individual/Family	\$1,500/ \$3,000**	\$5,000/ \$10,000**	\$2,500/ \$5,000**	\$6,000/ \$12,000**	\$5,000/ \$10,000**	\$11,000/ \$22,000**
Primary Care Physician Office Visit	100%, ded applies	70%	100%, ded applies	70%	100%, ded applies	70%
Specialist Physician Office Visit	100%, ded applies	70%	100%, ded applies	70%	100%, ded applies	70%
Outpatient Diagnostic Lab	100%, ded applies	70%	100%, ded applies	70%	100%, ded applies	70%
Outpatient Diagnostic X-ray	100%, ded applies	70%	100%, ded applies	70%	100%, ded applies	70%
Outpatient Diagnostic Complex Imaging (CAT, MRI, MRA/MRS and PET scans)	100%, ded applies	70%	100%, ded applies	70%	100%, ded applies	70%
Emergency Room (copay waived if admitted)	100%, ded applies	Same as In-Network	100%, ded applies	Same as In-Network	100%, ded applies	Same as In-Network
Urgent Care	100%, ded applies	70%	100%, ded applies	70%	100%, ded applies	70%
Hospital – Inpatient Admission	100%, ded applies	70%	100%, ded applies	70%	100%, ded applies	70%
Hospital – Outpatient Surgery	100%, ded applies	70%	100%, ded applies	70%	100%, ded applies	70%
Preventive Care Services	\$0, ded waived	70%	\$0, ded waived	70%	\$0, ded waived	70%
Mental Health – Inpatient (30 days per calendar year)	100%, ded applies	70%	100%, ded applies	70%	100%, ded applies	70%
Substance Abuse Rehabilitation (30 days per calendar year)	100%, ded applies	70%	100%, ded applies	70%	100%, ded applies	70%
Durable Medical Equipment	100%, ded applies	70%	100%, ded applies	70%	100%, ded applies	70%
Durable Medical Equipment Calendar Year Maximum	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000
PHARMACY						
Retail (triple tier) (contraceptives included)	100%, ded applies	Not Covered	100%, ded applies	Not Covered	100%, ded applies	Not Covered
Mail-Order Drug (up to a 90-day supply)	2x		2x		2x	
Self-Injectable Drugs (maximum copay 2x tier 3 copay)	100%, ded applies		100%, ded applies		100%, ded applies	

*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 Documents as “recognized” charges.

**Out-of-Pocket Maximum includes deductible.

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NOTE: Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify, or obtain prior approval for certain services such as non-emergency hospital care. For a summary list of Limitations and Exclusions, refer to page 11.

FLORIDA AETNA SMALL GROUP MEDICAL PLANS

AETNA PRIMARY CARE® PLAN MANAGED CHOICE® OPEN ACCESS PLAN OPTIONS

Plan Options	FL MC OA 801		FL MC OA 811		FL MC OA 813	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
MEMBER BENEFITS						
Lifetime Maximums	\$5,000,000		\$5,000,000		\$5,000,000	
Coinsurance	N/A	70%	80%	50%	70%	50%
Calendar Year Deductible Individual/Family	N/A	\$500/ \$1,000	\$500/ \$1,000	\$2,000/ \$4,000	\$1,000/ \$2,000	\$2,000/ \$4,000
Calendar Year Out-of-Pocket Individual/Family	\$2,000/ \$4,000	\$4,000/ \$8,000	\$4,000/ \$8,000	\$6,000/ \$12,000	\$5,000/ \$10,000	\$6,000/ \$12,000
Primary Care Physician Office Visit	\$15	70%	\$20, ded waived	50%	\$20, ded waived	50%
Specialist Physician Office Visit	\$30	70%	\$50, ded waived	50%	\$50, ded waived	50%
Outpatient Diagnostic Lab	\$0	70%	\$0, ded waived	50%	\$0, ded waived	50%
Outpatient Diagnostic X-ray	\$30	70%	\$50, ded waived	50%	\$50, ded waived	50%
Outpatient Diagnostic Complex Imaging (CAT, MRI, MRA/MRS and PET scans)	\$100	70%	\$200, ded applies	50%	\$300, ded applies	50%
Emergency Room (copay waived if admitted)	\$100	Same as In-network	\$150, ded waived	Same as In-network	\$200, ded waived	Same as In-network
Urgent Care	\$35	70%	\$75, ded waived	50%	\$75, ded waived	50%
Hospital – Inpatient Admission	\$500/admit	70%	80%, ded applies	50%	70%, ded applies	50%
Hospital – Outpatient Surgery	\$250	70%	80%, ded applies	50%	70%, ded applies	50%
Preventive Care Services	\$15	70%	\$20, ded waived	50%	\$20, ded waived	50%
Mental Health – Inpatient (30 days per calendar year)	\$500/admit	70%	80%, ded applies	50%	70%, ded applies	50%
Substance Abuse Rehabilitation (30 days per calendar year)	\$500/admit	70%	80%, ded applies	50%	70%, ded applies	50%
Durable Medical Equipment	80%	70%	80%, ded applies	50%	70%, ded applies	50%
Durable Medical Equipment Calendar Year Maximum	\$2,000		\$2,000		\$2,000	
PHARMACY						
Retail (triple tier) (contraceptives included)	\$10/\$30/\$50	70% after copay	\$10/\$35/\$50	70% after copay	\$10/\$45/\$60	70% after copay
Mail-Order Drug (up to a 90-day supply)	2x	Not Covered	2x	Not Covered	2x	Not Covered
Self-Injectable Drugs (maximum copay 2x tier 3 copay)	80%	Not Covered	80%	Not Covered	80%	Not Covered

*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 Documents as “recognized” charges.

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, unless otherwise noted.

NOTE: Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify, or obtain prior approval for certain services such as non-emergency hospital care. For a summary list of Limitations and Exclusions, refer to page 12.

AETNA PRIMARY CARE® PLAN MANAGED CHOICE® OPEN ACCESS PLAN OPTIONS

Plan Options	FL MC OA 822		FL MC OA 831 (HDHP)		FL MC OA 832 (HDHP)	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
MEMBER BENEFITS						
Lifetime Maximums	\$5,000,000		\$5,000,000		\$5,000,000	
Coinsurance	100%	70%	100%	70%	100%	70%
Calendar Year Deductible Individual/Family	\$2,000/ \$6,000	\$3,000/ \$9,000	\$1,500/ \$3,000	\$3,000/ \$6,000	\$2,500/ \$5,000	\$4,000/ \$8,000
Calendar Year Out-of-Pocket Individual/Family	\$2,000/ \$6,000**	\$6,000/ \$18,000**	\$1,500/ \$3,000**	\$5,000/ \$10,000**	\$2,500/ \$5,000**	\$6,000/ \$12,000**
Primary Care Physician Office Visit	\$20, ded waived	70%	100%, ded applies	70%	100%, ded applies	70%
Specialist Physician Office Visit	\$50, ded waived	70%	100%, ded applies	70%	100%, ded applies	70%
Outpatient Diagnostic Lab	\$0, ded waived	70%	100%, ded applies	70%	100%, ded applies	70%
Outpatient Diagnostic X-ray	\$0, ded waived	70%	100%, ded applies	70%	100%, ded applies	70%
Outpatient Diagnostic Complex Imaging (CAT, MRI, MRA/MRS and PET scans)	100%, ded applies	70%	100%, ded applies	70%	100%, ded applies	70%
Emergency Room (copay waived if admitted)	\$150, ded waived	Same as In-network	100%, ded applies	Same as In-network	100%, ded applies	Same as In-network
Urgent Care	\$75, ded waived	70%	100%, ded applies	70%	100%, ded applies	70%
Hospital – Inpatient Admission	100%, ded applies	70%	100%, ded applies	70%	100%, ded applies	70%
Hospital – Outpatient Surgery	100%, ded applies	70%	100%, ded applies	70%	100%, ded applies	70%
Preventive Care Services	\$20, ded waived	70%	\$0, ded waived	70%	\$0, ded waived	70%
Mental Health – Inpatient (30 days per calendar year)	100%, ded applies	70%	100%, ded applies	70%	100%, ded applies	70%
Substance Abuse Rehabilitation (30 days per calendar year)	100%, ded applies	70%	100%, ded applies	70%	100%, ded applies	70%
Durable Medical Equipment	100%, ded applies	70%	100%, ded applies	70%	100%, ded applies	70%
Durable Medical Equipment Calendar Year Maximum	\$2,000		\$2,000		\$2,000	
PHARMACY						
Retail (triple tier) (contraceptives included)	\$10/\$35/\$50	70% after copay	100%, ded applies	70%	100%, ded applies	70%
Mail-Order Drug (up to a 90-day supply)	2x	Not Covered	2x	Not Covered	2x	Not Covered
Self-Injectable Drugs (maximum copay 2x tier 3 copay)	80%	Not Covered	100%, ded applies	Not Covered	100%, ded applies	Not Covered

*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 Documents as “recognized” charges.

**Out-of-Pocket Maximum includes deductible.

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, unless otherwise noted.

NOTE: Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify, or obtain prior approval for certain services such as non-emergency hospital care. For a summary list of Limitations and Exclusions, refer to page 12.

AETNA PPO AND INDEMNITY PLAN OPTIONS

Plan Options	FL PPO 841		FL IND 800
	In-Network	Out-of-Network*	In-Network/Out-of-Network
MEMBER BENEFITS			
Lifetime Maximums	\$5,000,000		\$1,000,000
Coinsurance	80%	60%	80%
Calendar Year Deductible Individual/Family	\$1,000/\$3,000	\$2,000/\$6,000	\$500/\$1,000
Calendar Year Out-of-Pocket Individual/Family	\$3,000/\$9,000	\$5,000/\$15,000	\$10,000/\$20,000
Primary Care Physician Office Visit	\$25, ded waived	60%	80%, ded applies
Specialist Physician Office Visit	\$50, ded waived	60%	80%, ded applies
Outpatient Diagnostic Lab	80%, ded applies	60%	80%, ded applies
Outpatient Diagnostic X-ray	80%, ded applies	60%	80%, ded applies
Outpatient Diagnostic Complex Imaging (CAT, MRI, MRA/MRS and PET scans)	80%, ded applies	60%	80%, ded applies
Emergency Room (copay waived if admitted)	\$200, ded waived	Same as In-network	80%, ded applies
Urgent Care	\$75, ded waived	60%	80%, ded applies
Hospital – Inpatient Admission	80%, ded applies	60%	80% after \$500/admit, ded applies
Hospital – Outpatient Surgery	80%, ded applies	60%	80%, ded applies
Preventive Care Services	\$25, ded waived	60%	80%, ded waived
Mental Health – Inpatient (30 days per calendar year)	80%, ded applies	60%	80% after \$500/admit, ded applies
Substance Abuse Rehabilitation (30 days per calendar year)	80%, ded applies	60%	80% after \$500/admit, ded applies
Durable Medical Equipment	80%, ded applies	60%	80%, ded applies
Durable Medical Equipment Calendar Year Maximum	\$2,000		\$2,000
PHARMACY			
Retail (triple tier) (contraceptives included)	\$15/\$45/\$60 \$100/\$300 deductible	80% after copay	\$10/\$35/\$50
Mail-Order Drug (up to a 90-day supply)	2x	Not Covered	2x
Self-Injectable Drugs (maximum copay 2x tier 3 copay)	80%	Not Covered	80%

*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 Documents as “recognized” charges.

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, unless otherwise noted.

NOTE: Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify, or obtain prior approval for certain services such as non-emergency hospital care. For a summary list of Limitations and Exclusions, refer to page 12.

Limitations and exclusions

Aetna HMO & Aetna 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.

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.

Limitations and exclusions (continued)

Aetna Managed Choice® & Aetna 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 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 insured'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.
- 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 Regional Small Group Sales Support at 1-888-422-2128.

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits vary by location. Health benefits and health insurance plans contain exclusions and limitations.

Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions.

Investment services are independently offered through JPMorgan Institutional Investors, Inc., a subsidiary of JPMorgan Chase Bank.

Information is believed to be accurate as of the production date however, it is subject to change. For more information about Aetna plans, refer to www.aetna.com.