

AETNA POS EMORYCHOICE

	Core Network	Aetna National Network	Out-of-Network
Outpatient Physician Office Visit			
Routine Preventative Care Injury/Illness (PCP)*	\$20 co-pay	\$40 co-pay	40% after deductible
Allergy Treatment			
With Physician Visit	\$20 co-pay	\$40 co-pay	40% after deductible
No Physician Visit	\$0 co-pay	\$0 co-pay	40% after deductible
Specialists	\$20 co-pay	\$50 co-pay	40% after deductible
Mammograms	\$0 co-pay	\$50 co-pay	40% after deductible
Sigmoidoscopy	\$0 co-pay	\$250 co-pay	40% after deductible
Colonoscopy	\$0 co-pay	\$250 co-pay	40% after deductible
MRI CT scan, Pet scan	\$0 co-pay	\$250 co-pay	40% after deductible
Other Radiology	\$0 co-pay	\$50 co-pay	40% after deductible
Independent Lab Services (Facility and Professional Services)			
Hospital Outpatient	\$0 co-pay	10% not subject to deductible	40% after deductible
Doctor's Office	\$20 co-pay	\$50 co-pay	40% after deductible
Stand-alone Facility	\$20 co-pay	\$50 co-pay	40% after deductible
Independent Lab	\$0 co-pay	10% not subject to deductible	40% after deductible
Outpatient Surgery			
Facility and Physician Services	\$100 co-pay	30% after deductible	40% after deductible
Pre-admission Testing Office Visit	\$20 co-pay	\$50 co-pay	40% after deductible
Inpatient Hospital Facility and Physician Services	\$250 co-pay	30% after deductible	40% after deductible
Second Opinion for Surgery	\$20 co-pay	\$50 co-pay	40% after deductible
Pre Admission Certification- Continued Stay Review Required for all inpatient admissions Employee/provider are responsible for contacting AETNA	100 % reduction for admissions not certified or reviewed by Aetna	100% reduction for admissions not certified or reviewed by Aetna	100 % reduction for admissions not certified or reviewed by Aetna
Skilled Nursing Facility Up to a maximum of 120 visits per calendar year	\$250 co-pay	30% after deductible	40% after deductible
Emergency Room			
Facility	\$100 co-pay	\$100 co-pay	\$100 co-pay (if true emergency)
Physician	\$0 co-pay	\$0 co-pay	40% after deductible
Ambulance	\$75 co-pay	\$75 co-pay	\$75 co-pay
Home Health Care Up to a maximum of 120 visits per calendar year	\$0 co-pay	\$0 co-pay	40% after deductible
Hospice			
Inpatient Facility	\$0 co-pay	\$0 co-pay	40% after deductible
Outpatient setting	\$0 co-pay	\$0 co-pay	40% after deductible
Maternity Initial Visit & Pre- & Post-Natal Care	\$20 co-pay on initial office visit	\$50 co-pay on initial office visit	40% after deductible
Hospital	\$250 co-pay	30% after deductible	40% after deductible
Family Planning			
Office visit including tests and counseling	\$20 co-pay	\$50 co-pay	40% after deductible
Surgical sterilization (vasectomy/tubal ligations)			
Inpatient Facility	\$250 co-pay	30% after deductible	40% after deductible
Outpatient Facility	\$100 co-pay	30% after deductible	40% after deductible
Physician's Services	\$20 co-pay	\$50 co-pay	40% after deductible
Chiropractic Care	\$40 co-pay	\$40 co-pay	40% after deductible
Annual Routine Eye Exam	\$20 eye exam at The Emory Clinic	\$50 co-pay	40% after deductible
Hearing			
\$20 co-pay	\$20 co-pay	\$40 co-pay	40% after deductible
Screening by PCP only	Screening by PCP only	Screening by PCP only	
Out Patient Private Duty Nursing	Not covered	Not covered	Not covered
Chemo/Radiation Therapy	\$20 co-pay	\$50 co-pay	40% after deductible
Durable Medical Equipment	\$0 co-pay	\$0 co-pay	40% after deductible
Out patient Short-term Rehabilitation Maximum of 90 visits per calendar year combined for Speech, Physical and Occupational therapy) Developmental speech therapy not covered	\$20 co-pay	\$50 co-pay	40% after deductible
Prescription Co-pays Administered by Medco	\$12 first tier generic** \$25 second tier \$50 third tier \$70 fourth tier 90-day supply of mail-order maintenance Prescriptions for two co-pays	Same as core	Reimbursement is based on a discounted price plus the co-pay
Mental Health and Substance Abuse Administered by United Behavioral Health			
Inpatient	First 15 days at 10% Remaining days at 30%	First 15 days at 10% Remaining days at 30%	50% up to 30 days per year
Outpatient	30% all visits	30% all visits	50% up to 30 days per year
Lifetime Maximum***	\$1,500,000	\$1,500,000	\$1,500,000
Calendar Year Deductible			
Individual	None	\$350	\$1,200
Family Maximum	None	\$1050	\$3,500
Aggregate	N/A	Yes	Yes
Out-of-Pocket Maximum**** Includes deductible and co-insurance	No	Yes	Yes
Individual	None	\$1,750	\$6,000
Family Maximum	None	\$3,500	\$12,000
Aggregate	None	Yes	Yes

*Routine or preventative care provided by Dermatologist, Allergist, or OB/GYN is covered at the PCP co-payment.

**When a generic is available but the pharmacy dispenses the brand name drug for any reason, you will pay the difference between the brand name drug and the generic PLUS the brand co-payment

*** In-network and out-of-network maximums are combined.