

Aetna Health Options

Plan <i>*OON = Out of Network</i>	FL 18 OAMC 1000 80/50 25/50 Rx1	FL 18 OAMC 2000 70/50 30/60 Rx2	FL 18 OAMC 6600 100/50 25/75 Rx5
Calendar Year Deductible	\$1,000 Ind / \$2,000 Fam-In Network <i>\$3,000 Ind / \$6,000 Fam-OON</i>	\$2,000 Ind / \$4,000 Fam-In Network <i>\$4,000 Ind / \$8,000 Fam-OON</i>	\$6,600 Ind / \$13,200 Fam-In Network <i>\$13,500 Ind / \$27,000 Fam-OON</i>
Coinsurance	20%-In Network / 50%-OON	30%-In Network / 50%-OON	0%-In Network / 50%-OON
Family Physician Office Visit	\$25 Copay-In Network <i>Deductible & Coinsurance-OON</i>	\$30 Copay-In Network <i>Deductible & Coinsurance-OON</i>	\$25 Copay-In Network <i>Deductible & Coinsurance-OON</i>
Specialist Office Visit	\$50 Copay-In Network <i>Deductible & Coinsurance-OON</i>	\$60 Copay-In Network <i>Deductible & Coinsurance-OON</i>	\$75 Copay-In Network <i>Deductible & Coinsurance-OON</i>
Wellness	100% Covered In Network	100% Covered In Network	100% Covered In Network
Physician Services Outside Office	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Urgent Care Center	\$75 Copay-In Network <i>Deductible & Coinsurance-OON</i>	\$100 Copay-In Network <i>Deductible & Coinsurance-OON</i>	Deductible & Coinsurance
Emergency Room	\$500 Copay	\$500 Copay	In Network Deductible & Coinsurance
Inpatient Hospital	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Hospital	Deductible & Coinsurance	Expenses: Deductible & Coinsurance Surgery: \$800 Copay-In Network <i>Deductible & Coinsurance-OON</i>	Deductible & Coinsurance
Ambulatory Surgical Center	Deductible & Coinsurance	\$400 Copay- In Network <i>Deductible & Coinsurance-OON</i>	Deductible & Coinsurance
Independent Diagnostic Testing Facility	Deductible & Coinsurance	Advanced Imaging \$300 Copay / X-Ray \$60 Copay-In Network <i>Deductible & Coinsurance-OON</i>	Deductible & Coinsurance
Freestanding Lab	Deductible & Coinsurance	\$5 Copay-In Network <i>Deductible & Coinsurance-OON</i>	Deductible & Coinsurance
Pharmacy	No Deductible, then \$10/30/60/30% Max Copay \$250 In Network <i>Coinsurance Only</i> <i>(Speciality Not Covered)-OON</i>	No Deductible, then \$10/45/70/30% Max Copay \$250 In Network <i>Coinsurance Only</i> <i>(Speciality Not Covered)-OON</i>	No Deductible, then \$15/50/85/30% Max Copay \$250 In Network <i>Coinsurance Only</i> <i>(Speciality Not Covered)-OON</i>
Out of Pocket Maximum	\$4,500 Ind / \$9,000 Fam-In Network <i>\$6,000 Ind / \$12,000 Fam-OON</i>	\$6,000 Ind / \$12,000 Fam-In Network <i>\$12,000 Ind / \$24,000 Fam-OON</i>	\$7,150 Ind / \$14,300 Fam-In Network <i>\$14,500 Ind / \$29,000 Fam-OON</i>

Prepared by **Combined Insurance Services, Inc.** Please refer to SBC's for complete details.

