

Feature	Aetna Global Benefits - Pre-65/Post-65			
Provider	In Network	Out of Network	Out of Area	Overseas
	Aetna Global Benefits 1-800-231-7729; refer to applicable country code to access this number; if you cannot access the number, call collect at 1-813-775-0190 www.aetnaglobalbenefits.com			
Cost Sharing				
Annual Deductible	\$100 Individual; \$200 Family	\$200 Individual; \$400 Family	\$200 Individual; \$400 Family	\$100 Individual; \$200 Family
Out-of-pocket maximum	\$500 Individual; \$1,000 Family; excludes deductible	\$1,000 Individual; \$2,000 Family; excludes deductible	\$1,000 Individual; \$2,000 Family; excludes deductible	\$500 Individual; \$1,000 Family; excludes deductible
Lifetime coverage limit	Limit does not apply	Limit does not apply	Limit does not apply	Limit does not apply
Policies/Requirements				
Need to file claims	No; except for care received In Network in U.S. and inpatient care received Overseas at AGB Direct Pay facilities	Yes	Yes	Yes; except for inpatient care
Domestic partner benefits	Yes	Yes	Yes	Yes
Access				
Ability to self-refer to OB/GYN	Yes	Yes	Yes	Yes
Ability to self-refer to specialists	Yes	Yes	Yes	Yes
Out-of-area dependent coverage	Yes	Yes	Yes	Yes
Out-of-area participant coverage	Yes	Yes	Yes	Yes
Spending Account				
HRA -- You only	Not Applicable	Not Applicable	Not Applicable	Not Applicable
HRA -- You and spouse	Not Applicable	Not Applicable	Not Applicable	Not Applicable
HRA -- You and child	Not Applicable	Not Applicable	Not Applicable	Not Applicable
HRA -- You and family	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Eligible expenses for reimbursement	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Outpatient Services				
Primary doctor office visit	\$10 copay; limited to non-surgical only	70% covered after deductible is met; limited to non-surgical only	80% covered after deductible is met; limited to non-surgical only	100% covered after deductible is met; limited to non-surgical only
Specialist doctor office visit	\$10 copay; limited to non-surgical only	70% covered after deductible is met; limited to non-surgical only	80% covered after deductible is met; limited to non-surgical only	100% covered after deductible is met; limited to non-surgical only

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	Preventive Care			
Annual physical exam	\$10 copay; age schedules apply	70% covered after deductible is met; age schedules apply	80% covered after deductible is met; age schedules apply	100% covered after deductible is met; age schedules apply
Well-woman exam (includes pap)	\$10 copay; age schedules apply	70% covered after deductible is met; age schedules apply	80% covered after deductible is met; age schedules apply	100% covered after deductible is met; age schedules apply
Mammogram	100% covered; routine mammogram; no age or frequency limit	70% covered; routine mammogram; no age or frequency limit	100% covered; routine mammogram; no age or frequency limit	100% covered; routine mammogram; no age or frequency limit
Pediatric exams	\$10 copay; age schedules apply	70% covered after deductible is met; age schedules apply	80% covered after deductible is met; age schedules apply	100% covered after deductible is met; age schedules apply
Immunizations (child)	\$10 copay; age schedules apply	70% covered after deductible is met; age schedules apply	80% covered after deductible is met; age schedules apply	100% covered after deductible is met; age schedules apply
Colorectal screening	90% covered after deductible is met; limitations apply; check with Plan for details	70% covered after deductible is met; limitations apply; check with Plan for details	80% cov after ded is met; limitations apply; check with Plan for details	100% cov after ded is met; limitations apply; check with Plan for details
Cancer screenings	90% covered after deductible is met	70% covered after deductible is met	80% covered after deductible is met	100% covered after deductible is met
Cardiovascular screenings	90% covered after deductible is met	70% covered after deductible is met	80% covered after deductible is met	100% covered after deductible is met
Allergy tests and treatments	90% covered after deductible is met	70% covered after deductible is met	80% covered after deductible is met	100% covered after deductible is met
	Outpatient Care			
Outpatient surgery	90% covered after deductible is met	70% covered after deductible is met	80% covered after deductible is met	100% covered after deductible is met
Outpatient laboratory services	90% covered after deductible is met	70% covered after deductible is met	80% covered after deductible is met	100% covered after deductible is met
Outpatient physical therapy	90% covered after deductible is met; must be medically necessary	70% covered after deductible is met; must be medically necessary	80% covered after deductible is met; must be medically necessary	100% covered after deductible is met; must be medically necessary
Outpatient X-ray	90% covered after deductible is met	70% covered after deductible is met	80% covered after deductible is met	100% covered after deductible is met
Outpatient occupational therapy	90% covered after deductible is met; must be medically necessary	70% covered after deductible is met; must be medically necessary	80% covered after deductible is met; must be medically necessary	100% covered after deductible is met; must be medically necessary
Outpatient speech therapy	90% covered after deductible is met; must be medically necessary	70% covered after deductible is met; must be medically necessary	80% covered after deductible is met; must be medically necessary	100% covered after deductible is met; must be medically necessary

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Outpatient cardiac rehabilitation	90% covered after deductible is met; must be medically necessary	70% covered after deductible is met; must be medically necessary	80% covered after deductible is met; must be medically necessary	100% covered after deductible is met; must be medically necessary
Family Planning/Maternity Care				
Office visit: pre/postnatal	\$10 copay; limited to non-surgical only	70% covered after deductible is met	80% covered after deductible is met	100% covered after deductible is met
In-hospital delivery services	90% covered after deductible is met	70% covered after deductible is met	80% covered after deductible is met	100% covered after deductible is met
Newborn nursery services	90% covered after deductible is met	70% covered after deductible is met	80% covered after deductible is met	100% covered after deductible is met
Fertility services	Covered; check with Plan for details	Covered; check with Plan for details	Covered; check with Plan for details	Covered; check with Plan for details
In vitro fertilization	Covered; limited to \$25,000 per lifetime; check with Plan for details	Covered; limited to \$25,000 per lifetime; check with Plan for details	Covered; limited to \$25,000 per lifetime; check with Plan for details	Covered; limited to \$25,000 per lifetime; check with Plan for details
Artificial insemination	Covered; limited to six attempts per lifetime; check with Plan for details	Covered; limited to six attempts per lifetime; check with Plan for details	Covered; limited to six attempts per lifetime; check with Plan for details	Covered; limited to six attempts per lifetime; check with Plan for details
Female tubal ligation	90% covered after deductible is met	70% covered after deductible is met	80% covered after deductible is met	100% covered after deductible is met
Male vasectomy	90% covered after deductible is met	70% covered after deductible is met	80% covered after deductible is met	100% covered after deductible is met
Hearing				
Hearing evaluations	Not covered	Not covered	Not covered	Not covered
Hearing aids	Not covered	Not covered	Not covered	Not covered
Vision				
Routine vision exams	Not covered	Not covered	Not covered	Not covered
Regular lenses and frames	Not covered	Not covered	Not covered	Not covered
Contact lenses	Not covered	Not covered	Not covered	Not covered
Dental				
Dental implants	Not covered	Not covered	Not covered	Not covered
Accidental injury to teeth	90% covered after deductible is met	70% covered after deductible is met	80% covered after deductible is met	100% covered after deductible is met
Surgical removal of tumors, cysts and impacted teeth	90% covered after deductible is met	70% covered after deductible is met	80% covered after deductible is met	100% covered after deductible is met
Inpatient Services				
Hospital copay	90% covered; after deductible is met	70% covered; after deductible is met	80% covered; after deductible is met	100% covered after deductible is met
Hospital semi-private room	90% covered after plan deductible	70% covered after plan deductible	80% covered after plan deductible	100% covered after deductible is met
Inpatient lab and X-ray	90% covered; after deductible is met	70% covered; after deductible is met	80% covered; after deductible is met	100% covered after deductible is met
Inpatient surgery	90% covered; after deductible is met	70% covered; after deductible is met	80% covered; after deductible is met	100% covered after deductible is met

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Inpatient physician and surgeon services	90% covered; after deductible is met	70% covered; after deductible is met	80% covered; after deductible is met	100% covered after deductible is met
Emergency Care				
Emergency room (not followed by admission)	90% covered; emergency; 50% covered after deductible is met for non-emergency	70% covered; emergency; 50% covered after deductible is met for non-emergency	80% covered; emergency; 50% covered after deductible is met for non-emergency	100% covered
Urgent care clinic visit	\$10 copay	100% covered after deductible is met	100% covered after deductible is met	100% covered after deductible is met
Ambulance services	90% covered after deductible is met; in and out-of-network and out-of-area combined			100% covered after deductible is met
Prescription Drug Coverage				
Annual prescription deductible	Not applicable	Not applicable	Not applicable	Not applicable
Prescription drug website	Same as medical plan	Same as medical plan	Same as medical plan	Same as medical plan
Prescription drug member services	Same as medical plan	Same as medical plan	Same as medical plan	Same as medical plan
Prescription drug vendor	Same as medical plan	Same as medical plan	Same as medical plan	Same as medical plan
Annual Rx out-of-pocket maximum	Not applicable	Not applicable	Not applicable	Not applicable
Retail				
Retail generic	\$5 copay; 31 day supply	70% covered after deductible is met; 31 day supply	80% covered after deductible is met; 31 day supply	100% covered after deductible is met; 31 day supply
Retail formulary brand	\$15 copay; 31 day supply; formulary does not apply	70% covered after deductible is met; 31 day supply; formulary does not apply	80% covered after deductible is met; 31 day supply; formulary does not apply	100% covered after deductible is met; 31 day supply; formulary does not apply
Retail nonformulary brand	Not covered; AGB has no formulary	Not covered; AGB has no formulary	Not covered; AGB has no formulary	Not covered; AGB has no formulary
Mail Order				
Mail order generic	One retail copay for each month's supply; up to a 12-month supply depending on prescription and physician's recommendation	Not covered	Not covered	Not covered

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Mail order formulary brand	One retail copay for each mon supply; ltd to 12-month supply depending on prescription and physician's recommendation; formulary does not apply	Not covered	Not covered	Not covered
Mail order nonformulary brand	Not covered; AGB has no formulary	Not covered; AGB has no formulary	Not covered; AGB has no formulary	Not covered; AGB has no formulary
Other				
Oral contraceptives	Retail and mail order available; applicable prescription drug copay applies	Retail available only; applicable prescription drug coinsurance and medical deductible apply	Retail available only; applicable prescription drug coinsurance and medical ded apply	Retail available only; applicable Rx coinsurance and medical ded apply
Fertility drugs	Applicable prescription drug copay applies	Applicable prescription drug coinsurance and medical deductible apply	Applicable prescription drug coinsurance and medical deductible apply	Applicable prescription drug coinsurance and medical deductible apply
Retail injectable drugs	Applicable prescription drug copay or office visit copay applies; check with Plan for details	Applicable coinsurance and deductible apply; check with Plan for details	Applicable coinsurance and deductible apply; check with Plan for details	Applicable coinsurance and deductible apply; check with Plan for details
Mental Health				
Mental Health: Combined with substance abuse	No	No	No	No
Mental Health: Outpatient coverage	90% covered after deductible is met	70% covered after deductible is met	80% covered after deductible is met	100% covered after deductible is met
Mental Health: Inpatient coverage	90% covered after deductible is met	70% covered after deductible is met	80% covered after deductible is met	100% covered after deductible is met
Substance Abuse				
Detox: Outpatient coverage	90% covered after deductible is met	70% covered after deductible is met	80% covered after deductible is met	100% covered after deductible is met
Detox: Inpatient coverage	90% covered after deductible is met	70% covered after deductible is met	80% covered after deductible is met	100% covered after deductible is met
Rehab: Outpatient coverage	90% covered after deductible is met	70% covered after deductible is met	80% covered after deductible is met	100% covered after deductible is met
Rehab: Inpatient coverage	90% covered after deductible is met	70% covered after deductible is met	80% covered after deductible is met	100% covered after deductible is met

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Alternative Care				
Chiropractic	\$10 copay; limited to non-surgical only; must be medically necessary	70% covered after deductible is met; must be medically necessary	80% covered after deductible is met; must be medically necessary	100% covered after deductible is met; must be medically necessary
Acupuncture	\$10 copay; limited to 20 visits per calendar year; acupressure not covered	70% covered after deductible is met; limited to 20 visits per calendar year; acupressure not covered	80% covered after deductible is met; limited to 20 visits per calendar year; acupressure not covered	100% covered after deductible is met; limited to 20 visits per calendar year; acupressure not covered
Care Management Programs				
Heart disease care management	No	No	No	No
Hypertension care management	No	No	No	No
Diabetes care management	No	No	No	No
Asthma care management	No	No	No	No
Prenatal care management	No	No	No	No
Cancer care management	No	No	No	No
Smoking cessation program	No	No	No	No
Weight control program	No	No	No	No
Other				
Noncustodial home health care	90% covered after deductible is met; limitations apply; check with Plan for details	70% covered after deductible is met; limitations apply; check with Plan for details	80% covered after deductible is met; limitations apply; check with Plan for details	100% covered after deductible is met; limitations apply; check with Plan for details
Hospice care	90% covered after deductible is met; limitations apply; check with Plan for details	70% covered after deductible is met; limitations apply; check with Plan for details	80% covered after deductible is met; limitations apply; check with Plan for details	100% covered after deductible is met; limitations apply; check with Plan for details
Prescribed care in noncustodial skilled nursing facility	90% covered after deductible is met; limitations apply; check with Plan for details	70% covered after deductible is met; limitations apply; check with Plan for details	80% covered after deductible is met; limitations apply	100% covered after deductible is met; limitations apply; check with Plan for details
Durable medical equipment	90% covered after deductible is met	70% covered after deductible is met	80% covered after deductible is met	100% covered after deductible is met
Prosthetic devices	90% covered after deductible is met	70% covered after deductible is met	80% covered after deductible is met	100% covered after deductible is met