

PPO 7500

WITH UNLIMITED PRIMARY CARE VISITS PLUS DENTAL

SOUTH CAROLINA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network*
Deductible Individual Family	\$7,500 \$15,000	\$10,000 \$20,000
Coinsurance (Member's responsibility)	20% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	<i>\$0 once out-of-pocket max. is satisfied</i>	
Coinsurance Maximum Individual Family	\$2,500 \$5,000	\$2,500 \$5,000
Out-of-Pocket Maximum Individual Family	\$10,000 \$20,000	\$12,500 \$25,000
	<i>Includes deductible</i>	
Non-Specialist Office Visit <i>Unlimited visits</i> General Physician, Family Practitioner, Pediatrician or Internist	\$30 copay deductible waived	50% after deductible
Specialist Visit <i>Unlimited visits</i>	20% after deductible	50% after deductible
Hospital Admission	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Urgent Care Facility	\$50 copay deductible waived	50% after deductible
Emergency Room	\$150 copay** (waived if admitted); deductible applies	
Annual Routine Gyn Exam <i>No waiting period</i> Annual Pap/Mammogram	\$0 copay deductible waived	50% after deductible
Maternity	Not covered <i>Except for pregnancy complications</i>	
Preventive Health — Routine Physical <i>No waiting period</i>	\$0 copay deductible waived	50% after deductible
	<i>Includes lab and X-rays</i>	
Lab/X-Ray (Non-preventive)	20% after deductible	50% after deductible
Skilled Nursing — in lieu of hospital <i>30 days per calendar year*</i>	20% after deductible	50% after deductible
Physical/Occupational Therapy <i>24 visits per calendar year*</i>	20% after deductible	50% after deductible
Home Health Care — in lieu of hospital <i>30 visits per calendar year*</i>	20% after deductible	50% after deductible
Durable Medical Equipment <i>Aetna will pay up to \$2,000 per calendar year*</i>	20% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network*
Pharmacy Deductible per individual	Not Applicable	Not Applicable
Generic	\$15 copay	\$15 copay plus 50%
Preferred Brand	Not covered	Not covered
Non-Preferred Brand	Not covered	Not covered
Self-Injectables	Not covered	Not covered

- * Maximum applies to combined in and out-of-network benefits.
- ** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.
- + For important information on your costs and how Aetna pays for out-of-network care, read "What you need to know about your out-of-network costs."

This material is for information only. A summary of exclusions is listed in the Aetna Advantage Plan brochure. For a full list of benefit coverage and exclusions refer to the plan documents. Plans may be subject to medical underwriting or other restrictions. Rates and benefits vary by location. 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. Health insurance plans contain exclusions and limitations. Information is believed to be accurate as of the production date; however, it is subject to change.

Aetna Advantage Plans for Individuals, Families and the Self-Employed are underwritten by Aetna Life Insurance Company directly and/or through an out-of-state blanket trust or Aetna Health Inc. (together, "Aetna") In some states, individuals may qualify as a business group of one and may be eligible for guaranteed issue, small group health plans. To the extent permitted by law, these plans are medically underwritten and you may be declined coverage in accordance with your health condition.

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INDIVIDUAL DENTAL PPO MAX PLAN

SOUTH CAROLINA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	Preferred	Non-Preferred
Annual Deductible per Member (Does not apply to Diagnostic and Preventive Services)	\$25; \$75 family maximum	\$25; \$75 family maximum
Annual Maximum Benefit	Unlimited	Unlimited
DIAGNOSTIC SERVICES		
Oral exams		
Periodic oral exam	100% deductible waived	100% deductible waived
Comprehensive oral exam	100% deductible waived	100% deductible waived
Problem-focused oral exam	100% deductible waived	100% deductible waived
X-rays		
Bitewing — single film	100% deductible waived	100% deductible waived
Complete series	100% deductible waived	100% deductible waived
PREVENTIVE SERVICES		
Adult cleaning	100% deductible waived	100% deductible waived
Child cleaning	100% deductible waived	100% deductible waived
Sealants — per tooth	Not covered*	Not covered
Fluoride application — with cleaning	100% deductible waived	100% deductible waived
Space maintainers	Not covered*	Not covered
BASIC SERVICES		
Amalgam fillings — 2 surfaces	100% after deductible	100% after deductible
Resin fillings — 2 surfaces	Not covered*	Not covered
Oral Surgery		
Extraction — exposed root or erupted tooth	Not covered*	Not covered
Extraction of impacted tooth — soft tissue	Not covered*	Not covered
MAJOR SERVICES		
Complete upper denture	Not covered*	Not covered
Partial upper denture (resin based)	Not covered*	Not covered
Crown — Porcelain with noble metal	Not covered*	Not covered
Pontic — Porcelain with noble metal	Not covered*	Not covered
Inlay — Metallic (3 or more surfaces)	Not covered*	Not covered
Oral Surgery		
Removal of impacted tooth — partially bony	Not covered*	Not covered
Endodontic Services		
Bicuspid root canal therapy	Not covered*	Not covered
Molar root canal therapy	Not covered*	Not covered
Periodontic Services		
Scaling & root planing — per quadrant	Not covered*	Not covered
Osseous surgery — per quadrant	Not covered*	Not covered
ORTHODONTIC SERVICES	Not covered*	Not covered

Participating dentists may offer discounted rates on additional services such as tooth whitening. Discounts for non-covered services may not be available in all states.

Nonpreferred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

This list of covered services is representative. A summary of exclusions is listed in the Aetna Advantage Plan brochure. For a full list of benefit coverage and exclusions refer to the plan documents.

All products not available in all counties.

This material is for information only. Dental insurance plans contain exclusions and limitations. Not all dental 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. Information is believed to be accurate as of the production date; however, it is subject to change.

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To the extent permitted by law, these plans are medically underwritten and you may be declined coverage in accordance with your health condition.

* Discounts for non-covered services may not be available in all states.

