Coverage Period: 10/01/2025 - 09/30/2026

aetna : University of Southern California Postdoctoral Scholar Benefit Program
OA Managed Choice® POS

Coverage for: Individual + Family | Plan Type: POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://www.aetna.com/sbcsearch/getpolicydocs?u=081400-080020-012504 or by calling 1-888-982-3862. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual $1,000 / Family $3,000. Out-of-Network: Individual $10,000 / Family $30,000.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See http://www.aetna.com/docfind or call 1-888-982-3862 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/visit	50% coinsurance	None
	Specialist visit	$10 copay/visit	50% coinsurance	None
	Preventive care/ screening/ immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/advancedcontrolaetnaca	Generic drugs	Copay/prescription: $10 (retail), $20 (mail order)	50% coinsurance (retail)	Covers 30 day supply (retail), 31-90 day supply (mail order). $250 maximum copay for each 30 day supply. Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Copay/prescription for preferred insulin: $25 for each 30 day supply.
	Preferred brand drugs	Copay/prescription: $25 (retail), $50 (mail order)	50% coinsurance (retail)	
	Non-preferred brand drugs	50% copay up to maximum/prescription: $100 (retail & mail order)	50% coinsurance (retail)	
	Specialty drugs	Copay/prescription: 20%	Not covered	All prescriptions must be filled through the Aetna Specialty Pharmacy Network. $150 maximum copay for each 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance	None
	Physician/surgeon fees	10% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance after $100 copay/visit	10% coinsurance after $100 copay/visit	Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
	Urgent care	$50 copay/visit	50% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $10 copay/visit; other outpatient services: no charge	Office & other outpatient services: 50% coinsurance	None
	Inpatient services	10% coinsurance	40% coinsurance	Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of $400 for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	10% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	120 visits/calendar year out-of-network. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	$10 copay/visit	50% coinsurance	None
	Habilitation services	No charge	50% coinsurance	None
	Skilled nursing care	10% coinsurance	50% coinsurance	60 days/calendar year. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	50% coinsurance	50% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	10% coinsurance	40% coinsurance for inpatient; 50% coinsurance for outpatient	Penalty of $400 for failure to obtain pre-authorization for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	1 routine eye exam/24 months.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture - 20 visits/calendar year for disease, injury & chronic pain.
- Chiropractic care - Limited to in-network providers.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, including artificial insemination.
- Private-duty nursing - 70- 8 hour shifts/calendar year.
- Routine eye care (Adult) - 1 routine eye exam/24 months.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-800-482-4833 (TTY), http://www.insurance.ca.gov.

- For more information on your rights to continue coverage, contact the plan at 1-888-982-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete

information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general toll free number at 1-888-982-3862. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-800-482-4833 (TTY), http://www.insurance.ca.gov.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-Help (4357), 1-800-482-4833(TTY), www.insurance.ca.gov

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:

Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,060**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:

Primary care provider office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Diabetic supplies *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$10
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$830**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:

Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$60
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$260**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-888-982-3862.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Discrimination is Against the Law

Aetna complies with applicable California and Federal civil rights laws and does not discriminate on the basis of race, color, national origin, ethnic group, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, medical condition, genetic information, or sex (consistent with 45 CFR § 92.101(a)(2) and California 2 CCR § 14025). Aetna does not exclude people or treat them less favorably because of race, color, national origin, ethnic group, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, medical condition, genetic information, or disability.

Aetna:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
    - Qualified sign language interpreters
    - Information written in other languages.

If you need reasonable medications, appropriate auxiliary aids and services, or language assistance services, call 1-800-872-3862 (TTY: 711) or the number on the back of your ID card.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ethnic group, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, medical condition, genetic information, or disability, by action or inaction, you can file a grievance with:

Civil Rights Coordinator
Attn: 1557 Coordinator
CVS Pharmacy, Inc.
1 CVS Drive, MC 2332, (HMO customers: P.O. Box 14032 Lexington, KY 40512-4032)
Woonsocket, RI 02895
Phone: 1-800-648-7817, TTY: 711
Email: CRCoordinator@aetna.com

You can file a grievance in person, by mail, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Please visit https://www.aetna.com/individuals-families/member-rights-resources/complaints- grievances-appeals.html#california for information about how to file a complaint or grievance with the California Department of Insurance or California Department of Managed Health Care (for HMO enrollees).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. This notice is available at Aetna's website: https://www.aetna.com/

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of companies offering and administering health and dental plans and other products such as life, disability, and long-term care insurance. In California, this includes Aetna's wholly-owned subsidiaries Aetna Life Insurance Company, Aetna Health of California Inc., Aetna Better Health of California Inc., Aetna Dental of California Inc., and Health and Human Resource Center Inc., and its other affiliates licensed in California. Aetna's ultimate parent is CVS Health Corporation ("CVS Health").

TTY:**711**

English	**To access language services at no cost to you, call 1-888-982-3862.**
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-888-982-3862 ይደውሉ::.
Arabic	للحصول علىخدمات لغوية دونتكلفة،الرجاء الاتصالعلى الرقم 1-888-982-3862
Armenian	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-888-982-3862 հեռախոսահամարով:
Carolinian (Kapasal Falawasch)	ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-888-982-3862.
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-888-982-3862.
Chinese Traditional	如欲使用免費語言服務，請致電 1-888-982-3862.
Cushitic-Oromo	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf, bilbili 1-888-982-3862.
French	Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862.
French Creole (Haitian)	Pou jwenn sèvis lang gratis, rele 1-888-982-3862.
German	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an.
Greek	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-982-3862.
Gujarati	તમારે કોઇ જાતના ખર્ચ વગિ ભાષાની સેાિઓની પહોંચ માટે, કોલ કરો 1-888-982-3862.
Hindi	आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-888-982-3862 पर कॉल करें।.
Hmong	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-888-982-3862.
Italian	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-982-3862.
Japanese	言語サービスを無料でご利用いただくには、1-888-982-3862 までお電話ください。
Karen	လၢတၢ်ကမၤနှ ဂၢ် က ၢ်စ အတၢ်မၤစၢၤ အတၢ်ဖံးတၢ်မၤတဖၢ်လၢ တအၢ်ဒံးအပၤလၢကဘၢ်ဟ်အၤအဂၢ်ဘၢ်နှ် ကံး 1-888-982-3862 တကၢ်.
Korean	무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오.
Laotian	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕ່ໍກັບທ່ານ, ໃຫ້ໂທຫາ 1-888-982-3862.
Mon-Khmer Cambodian	ដ ើម្បីទទួលបានដរោកម្មភាសាដ លឥតគិតថ្លៃម្រែរាប់ដរោកអ្នកប្រ ម្ដដៅទូរស័ព្ទដៅកាន់ដលខ 1-888-982-3862 ។
Navajo	T'áá ni nizaad k'ehjí bee níká a'doowol doo bą́ą́h ílínígóó kojį' hólne' 1-888-982-3862.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-982-3862.

Persian-Farsi	تماس بگیرید 1-888-982-3862 برای دسترسی به خدمات زبان به طور رایگان، با شماره
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-982-3862.
Portuguese	Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਨਿਾਂ ਬਸਿ ਿੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਰਿਨ ਲਈ, 1-888-982-3862 'ਤੇ ਫ਼ੋਨ ਰਿ। .
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862.
Samoan	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-888-982-3862.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite 1-888-982-3862.
Spanish	Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862.
Syriac-Assyrian	ܟܐ ܢ 1-888-982-3862. ܗܘܒܩܐ ܬܠܦܘ ܢ ܟܠ ܝܠܚܝܘܬܐ ܕܡܢܝܢܐ ܠܡܢܬܐ ܡܢܚܐܝܬ، ܡܫܒܚܐ ܢ :
Tagalog	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862.
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-888-982-3862.
Ukrainian	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-982-3862.
Vietnamese	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, gọi số 1-888-982-3862.

University of Southern California Postdoctoral Scholar Benefit Program

Supplemental Information **Coverage for:** Individual + Family | **Plan Type:** POS

How is the overall deductible or out-of-pocket limit met?	Individual **deductible** and **out-of-pocket limit** payments apply to the family **deductible** and **out-of-pocket limit**.	The family **deductible** and family **out-of-pocket limit** are cumulative for all family members. The family **deductible** and **out-of-pocket limit** can be met by a combination of family members; however no single individual within the family will be subject to more than the individual **deductible** or **out-of-pocket limit** amount.

How your out-of-network care is reimbursed:

We cover the cost of services based on whether doctors are "in-network" or "out-of-network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

You may choose a **provider** (doctor or hospital) in our **network**. You may choose to visit an out-of-network **provider**. If you choose a doctor who is out-of-network, your Aetna health **plan** may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "**allowed**" **amount**.

Professional Services: 105% of Medicare	Facility Services: 140% of Medicare

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna **plan** "recognizes." Your doctor may bill you for the dollar amount that your **plan** doesn't "recognize." You must also pay any **copayments**, **coinsurance** and **deductibles** under your **plan**. No dollar amount above the "recognized charge" counts toward your **deductible** or **out-of-pocket limit**. To learn more about how we pay out-of-network benefits, visit **Aetna.com**. Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's **network** of health care **providers**. Go to **Aetna.com** and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna member site.

This applies when you *choose* to get care out-of-network. When you have no choice (for example: emergency room visit after a car accident or for other **emergency services**), we will pay the bill as if you got care in-network. You pay cost sharing and **deductibles** for your in-network level of benefits. Contact Aetna if your health care **provider** asks you to pay more. You are not responsible for any outstanding **balance billed** by your **providers** for **emergency services** beyond your cost sharing and **deductibles**.

Other important information about your plan:

This **plan** does not cover all health care expenses and includes exclusions and limitations. Members should refer to their **plan** documents to determine which

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health care services are covered and to what extent.

Additional information regarding your **plan** is available in the Disclosure Document on **Aetna.com**.

Information includes:

- "Knowing what is covered" which describes how we review a request for coverage for a service or supply
- "**Prescription drug** benefit" which describes procedures we use to manage **prescription drug** benefits. These procedures include how to obtain a list of covered drugs and the exception policy for receiving coverage of a drug that is not on a closed formulary

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and **health insurance plans** contain exclusions and limitations. 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. You may be responsible for the health care **provider's** full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the **plan**. **Providers** are independent contractors and are not agents of Aetna. **Provider** participation may change without notice. We do not provide care or guarantee access to health services.

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 by you or your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your **plan** documents
- 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 with respect to the treatment of cancer or other life-threatening disease or condition
- Home births
- Immunizations for travel or work except where **medically necessary** or indicated
- Implantable drugs and certain injectable drugs including injectable infertility drugs
- Long-term rehabilitation therapy
- Non-**medically necessary** services or supplies
- Orthotics except diabetic orthotics
- Outpatient **prescription drugs** (except for treatment of diabetes), unless covered by a prescription **plan** rider and over-the-counter medications (except as provided in a hospital) and supplies
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling or **prescription drugs**
- Therapy or rehabilitation other than those listed as covered

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In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

We consider your personal information to be private. We have policies and procedures in place to protect your personal information from unlawful use and disclosure. For a summary of our policy, go to **Aetna.com**. You'll find the Privacy Notices link at the bottom of the page.

Plan features and availability may vary by location and group size.

Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	Aetna Life Insurance Company
NAME OF PLAN	OA Managed Choice® POS
1. Type of Policy	Large Employer Group Policy
2. Type of Plan	Point of service (POS)
3. Areas of Colorado Where Plan is Available	Plan is available throughout Colorado.

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits and Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
4. Annual Deductible Type	EMBEDDED DEDUCTIBLE INDIVIDUAL: The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met. FAMILY: The maximum amount that the family will pay for the year. The family deductible can be met by 2 or more individuals.
5. Out-of-Pocket Type	EMBEDDED OUT-OF-POCKET INDIVIDUAL: The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met. FAMILY: The maximum amount that the family will pay for the year. The family out-of-pocket can be met by 3 or more individuals.
6. What is included in the In-Network Out-of-Pocket Maximum?	Deductible, copayments, coinsurance
7. Is pediatric dental coverage included in this plan?	No, the plan does not include pediatric dental.
8. What cancer screenings are covered?	Prostate Cancer Screening, Cervical Cancer Screening, Breast Cancer Screening, Colorectal Cancer Screening – age and frequency schedules may apply.

USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, refer to your certificate of coverage for details.
10. Does the plan have a binding arbitration clause?	No	

Questions: Call 1-888-982-3862, TDD 1-800-628-3323 (hearing impaired only) or visit **Aetna.com.**

If you are not satisfied with the resolution of your complaint or grievance, contact: Colorado Division of Insurance
Consumer Services, Life and Health Section
1560 Broadway, Suite 850, Denver, CO 80202
Call 303-894-7490 (in state, toll free: 800-930-3745)
Email: **dora_insurance@state.co.us**

Colorado Network Access Plan Disclosure:
Aetna maintains and makes available to interested parties upon request a managed care network access plan on its business premises. The managed care network access plan demonstrates the managed care network contains an adequate number of accessible acute care hospitals, primary care providers, and specialists available to provide covered health care services. Among other things, the access plan describes Aetna's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of plan enrollees.

This document is available in other languages. Do you need this in another language? Call us.
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-888-982-3862.

Si necesita asistencia lingüistica en español, llámenos al número que figura en su tarjeta de identificación (ID) médica.
Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-888-982-3862.