

Small Business Solutions

Medical Plan Options

Georgia



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GEORGIA AETNA SMALL GROUP MEDICAL PLANS

HMO PLAN OPTIONS

PLAN OPTIONS	HMO Open Access Plan A 2005	HMO Open Access Plan B 2005	HMO Open Access Plan C 2005	HMO Plan D 2005	HMO Plan E 2005
MEMBER BENEFITS					
In-Network/Out-of-Network Coinsurance	90%	90%	80%	80%	80%
Calendar Year Deductible Individual/Family	N/A	N/A	N/A	N/A	\$500/\$1,000
Calendar Year Out-of-Pocket Individual/Family	\$1,500/\$3,000	\$2,000/\$4,000	\$3,000/\$6,000	\$4,000/\$8,000	\$4,000/\$8,000
Hospital Inpatient Copay/Deductible/Coinsurance	\$100 per day 5 day max	\$500 per admit	80%	\$1,500 per admit	80%
Primary Physician Office Visit	\$15	\$20	\$30	\$35	\$40
Specialist Office Visit	\$25	\$40	\$50	\$50	\$60
Outpatient Diagnostic Lab/X-Ray	\$0/\$25	\$0/\$40	\$0/\$50	\$0/\$50	\$0/\$60
Outpatient Complex Imaging (CAT, MRI, MRA/MRS, PET scans)	\$100	\$150	\$200	\$200	\$200
Outpatient Surgery Copay/Coinsurance	\$100	\$250	80%	\$500	80%
Urgent Care	\$35	\$50	\$75	\$75	\$75
Emergency Room (Copay waived if admitted)	\$100	\$100	\$150	\$200	\$250
Durable Medical Equipment	90%	90%	80%	80%	80%
Durable Medical Equipment Calendar Year Maximum	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000
Mental Health Inpatient (30 days per calendar year)	\$100 per day 5 day max	\$500 per admit	80%	\$1,500 per admit	80%
Substance Abuse Rehabilitation	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Lifetime Maximum	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000
PHARMACY					
Triple Tier Copay	\$10/\$20/\$35	\$10/\$30/\$45	\$10/\$30/\$45	\$10/\$35/\$50	\$30/\$45/\$60
Mail Order Drug Copay (31-90 day supply)	2.5x retail	2.5x retail	2.5x retail	2.5x retail	2.5x retail
Contraceptives	Included	Included	Included	Included	Included

This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage copayments indicate what Aetna is required to pay, unless otherwise noted.

NOTE: Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify, or obtain prior approval for certain services such as non-emergency hospital care. For a summary list of Limitations and Exclusions, refer to page 7.

POS PLAN OPTIONS

PLAN OPTIONS	POS Open Access Plan A 2005		POS Open Access Plan B 2005		POS Open Access Plan C 2005		POS Plan D 2005	
	In-Network	Out-of-Network**	In-Network	Out-of-Network**	In-Network	Out-of-Network**	In-Network	Out-of-Network**
MEMBER BENEFITS								
In-Network/Out-of-Network Coinsurance	90%	70%	90%	70%	80%	60%	80%	50%
Calendar Year Deductible Individual/Family	N/A	\$500/ \$1,000	N/A	\$500/ \$1,000	N/A	\$1,000/ \$2,000	\$500/ \$1,000	\$1,500/ \$3,000
Calendar Year Out-of-Pocket Individual/Family	\$1,500/ \$3,000	\$3,000/ \$6,000	\$2,000/ \$4,000	\$3,000/ \$6,000	\$3,000/ \$6,000	\$4,000/ \$8,000	\$4,000/ \$8,000	\$8,000/ \$16,000
Hospital Inpatient Copay/Deductible/Coinsurance*	\$100 per day 5 day max	70%	\$500 per admit	70%	80%	60%	80%	50%
Primary Physician Office Visit*	\$15	70%	\$20	70%	\$30	60%	\$40	50%
Specialist Office Visit*	\$25	70%	\$40	70%	\$50	60%	\$60	50%
Outpatient Diagnostic Lab/X-Ray*	\$0/\$25	70%	\$0/\$40	70%	\$0/\$50	60%	\$0/\$60	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS, PET scans)	\$100	70%	\$150	70%	\$200	60%	\$200	50%
Outpatient Surgery Copay/Coinsurance*	\$100	70%	\$250	70%	80%	60%	80%	50%
Urgent Care	\$35	70%	\$50	70%	\$75	60%	\$75	50%
Emergency Room (Copay waived if admitted)*	\$100	Same as In-Network	\$100	Same as In-Network	\$150	Same as In-Network	\$200	Same as In-Network
Durable Medical Equipment*	90%	70%	90%	70%	80%	60%	80%	50%
Durable Medical Equipment Calendar Year Maximum	\$5,000		\$5,000		\$5,000		\$5,000	
Mental Health Inpatient (30 days per calendar year)*	\$100 per day 5 day max	70%	\$500 per admit	70%	80%	60%	80%	50%
Substance Abuse Rehabilitation	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Lifetime Maximum	\$5,000,000		\$5,000,000		\$5,000,000		\$5,000,000	
PHARMACY								
Triple Tier Copay	\$10/\$20/\$35	Not Covered	\$10/\$30/\$45	Not Covered	\$10/\$30/\$45	Not Covered	\$30/\$45/\$60	Not Covered
Mail Order Drug Copay (31-90 day supply)	2.5x retail	Not Covered	2.5x retail	Not Covered	2.5x retail	Not Covered	2.5x retail	Not Covered
Contraceptives	Included	Not Covered	Included	Not Covered	Included	Not Covered	Included	Not Covered

This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage copayments indicate what Aetna is required to pay, unless otherwise noted.

* Where applicable, coinsurance applies after the out-of-network deductible is met.

** Payment for Out-of-Network facility care is determined based upon Aetna's allowable fee schedule. Payment for other Out-of-Network care is determined based upon the negotiated charge that would apply if such services or supplies were received from an In-Network provider. These charges are referred to in your Plan Documents as "recognized" charges.

NOTE: Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify, or obtain prior approval for certain services such as non-emergency hospital care. For a summary list of Limitations and Exclusions, refer to page 7.

GEORGIA AETNA SMALL GROUP MEDICAL PLANS

HSA-COMPATIBLE PLAN OPTIONS

PLAN OPTIONS	POS Open Access HSA- Compatible Plan E 2005		POS Open Access HSA- Compatible Plan F 2005	
	In-Network	Out-of-Network **	In-Network	Out-of-Network**
MEMBER BENEFITS				
In-Network/Out-of-Network Coinsurance	100%	80%	100%	80%
Calendar Year Deductible Individual/Family	\$2,200/ \$4,400	\$3,500/ \$7,000	\$5,000/ \$10,000	\$7,000/ \$14,000
Calendar Year Out-of-Pocket Individual/Family	\$2,200/ \$4,400	\$5,000/ \$10,000	\$5,000/ \$10,000	\$8,500/ \$17,000
Hospital Inpatient Copay/Deductible/Coinsurance*	100%	80%	100%	80%
Primary Physician Office Visit*	100%	80%	100%	80%
Specialist Office Visit*	100%	80%	100%	80%
Outpatient Diagnostic Lab/X-Ray*	100%	80%	100%	80%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS, PET scans)	100%	80%	100%	80%
Outpatient Surgery Copay/Coinsurance*	100%	80%	100%	80%
Urgent Care	100%	80%	100%	80%
Emergency Room (Copay waived if admitted)*	100%	Same as In-Network	100%	Same as In-Network
Durable Medical Equipment*	100%	80%	100%	80%
Durable Medical Equipment Calendar Year Maximum	\$5,000		\$5,000	
Mental Health Inpatient (30 days per calendar year)*	100%	80%	100%	80%
Substance Abuse Rehabilitation	Not Covered	Not Covered	Not Covered	Not Covered
Lifetime Maximum	\$5,000,000		\$5,000,000	
PHARMACY				
Triple Tier Copay	Discount Card Available	Discount Card Available	Discount Card Available	Discount Card Available
Mail Order Drug Copay (31-90 day supply)	Not Covered	Not Covered	Not Covered	Not Covered
Contraceptives	Not Covered	Not Covered	Not Covered	Not Covered

This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage copayments indicate what Aetna is required to pay, unless otherwise noted.

* Where applicable, coinsurance applies after the out-of-network deductible is met.

** Payment for Out-of-Network facility care is determined based upon Aetna's allowable fee schedule. Payment for other Out-of-Network care is determined based upon the negotiated charge that would apply if such services or supplies were received from an In-Network provider. These charges are referred to in your Plan Documents as "recognized" charges.

NOTE: Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify, or obtain prior approval for certain services such as non-emergency hospital care. For a summary list of Limitations and Exclusions, refer to page 7.

PPO PLAN OPTIONS

PLAN OPTIONS	PPO Plan A 2005		PPO Plan B 2005		PPO Plan C 2005		PPO Plan D 2005	
MEMBER BENEFITS	In-Network	Out-of-Network**	In-Network	Out-of-Network**	In-Network	Out-of-Network**	In-Network	Out-of-Network**
In-Network/Out-of-Network Coinsurance	90%	70%	80%	60%	80%	60%	80%	60%
Calendar Year Deductible Individual/Family	\$300/ \$900	\$600/ \$1,800	\$500/ \$1,000	\$1,000/ \$2,000	\$1,000/ \$3,000	\$2,000/ \$6,000	\$2,000/ \$6,000	\$4,000/ \$12,000
Calendar Year Out-of-Pocket Individual/Family	\$1,000/ \$3,000	\$2,000/ \$6,000	\$2,000/ \$4,000	\$4,000/ \$8,000	\$3,000/ \$9,000	\$6,000/ \$18,000	\$3,000/ \$9,000	\$6,000/ \$18,000
Hospital Inpatient Copay/Deductible/Coinsurance*	90%	70%	80% after \$100 copay	60%	80%	60%	80%	60%
Primary Physician Office Visit*	\$15	70%	\$20	60%	\$25	60%	\$40	60%
Specialist Office Visit*	\$25	70%	\$20	60%	\$35	60%	\$60	60%
Outpatient Diagnostic Lab/X-Ray*	90%	70%	80%	60%	80%	60%	80%	60%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS, PET scans)	90%	70%	80%	60%	80%	60%	80%	60%
Outpatient Surgery Copay/Coinsurance*	90%	70%	80%	60%	80%	60%	80%	60%
Urgent Care*	\$50	70%	80%	60%	\$50	60%	\$50	60%
Emergency Room (Copay waived if admitted)*	\$100	Same as In-Network	80% after \$75 copay	Same as In-Network	\$150	Same as In-Network	\$150	Same as In-Network
Durable Medical Equipment*	90%	70%	80%	60%	80%	60%	80%	60%
Durable Medical Equipment Calendar Year Maximum	\$5,000		\$5,000		\$5,000		\$5,000	
Mental Health Inpatient (30 days per calendar year)*	90%	70%	80% after \$100 copay	60%	80%	60%	80%	60%
Substance Abuse Rehabilitation	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Lifetime Maximum	\$5,000,000		\$5,000,000		\$5,000,000		\$5,000,000	
PHARMACY								
Triple Tier Copay	\$10/\$30/\$40	\$10/\$30/\$40	\$10/\$20/\$35	\$10/\$20/\$35	\$10/\$35/\$45	\$10/\$35/\$45	\$30/\$45/\$60	\$30/\$45/\$60
Mail Order Drug Copay (31-90 day supply)	2.5x retail	2.5x retail	2.5x retail	2.5x retail	2.5x retail	2.5x retail	2.5x retail	2.5x retail
Contraceptives	Included	Included	Included	Included	Included	Included	Included	Included

This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage copayments indicate what Aetna is required to pay, unless otherwise noted.

* Coinsurance applies after the out-of-network deductible is met.

** Payment for Out-of-Network facility care is determined based upon Aetna's allowable fee schedule. Payment for other Out-of-Network care is determined based upon the negotiated charge that would apply if such services or supplies were received from an In-Network provider. These charges are referred to in your Plan Documents as "recognized" charges.

NOTE: Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify, or obtain prior approval for certain services such as non-emergency hospital care. For a summary list of Limitations and Exclusions, refer to page 7.

GEORGIA AETNA SMALL GROUP MEDICAL PLANS

PPO PLAN OPTIONS

PLAN OPTIONS	PPO Plan E First Dollar 2005 – \$500/\$1,000		PPO Plan F Basic Hospital 2005		PPO HSA-Compatible Plan G 2005		PPO HSA-Compatible Plan H 2005	
MEMBER BENEFITS	In-Network	Out-of-Network**	In-Network	Out-of-Network**	In-Network	Out-of-Network**	In-Network	Out-of-Network**
In-Network/Out-of-Network Coinsurance	80%	60%	75%	60%	100%	80%	100%	80%
Calendar Year Deductible Individual/Family	\$1,000/ \$3,000	\$1,500/ \$4,500	\$2,000/ \$6,000		\$2,500/ \$5,000	\$4,000/ \$8,000	\$5,000/ \$10,000	\$7,000/ \$14,000
Calendar Year Out-of-Pocket Individual/Family	\$2,000/ \$6,000	\$3,000/ \$9,000	\$4,000/ \$12,000		\$2,500/ \$5,000	\$6,000/ \$12,000	\$5,000/ \$10,000	\$8,500/ \$17,000
Hospital Inpatient Copay/Deductible/Coinsurance*	80%	60%	75% after \$500 copay	60% after \$1,000 copay	100%	80%	100%	80%
Primary Physician/ Specialist Office Visit*	80%	60%	\$25/limited to 3 visits per calendar year	60%/limited to 3 visits	100%	80%	100%	80%
Outpatient Diagnostic Lab/X-Ray*	80%	60%	Not Covered	Not Covered	100%	80%	100%	80%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS, PET scans)	80%	60%	Not Covered	Not Covered	100%	80%	100%	80%
Outpatient Surgery Copay/Coinsurance*	80%	60%	75% after \$150 copay	60% after \$150 copay	100%	80%	100%	80%
Urgent Care*	80%	60%	Not Covered	Not Covered	100%	80%	100%	80%
Emergency Room (Copay waived if admitted)*	80%	Same as In-Network	75% after \$100 copay	Same as In-Network	100%	Same as In-Network	100%	Same as In-Network
Durable Medical Equipment*	80%	60%	Not Covered	Not Covered	100%	80%	100%	80%
Durable Medical Equipment Calendar Year Maximum		\$5,000		N/A		\$5,000		\$5,000
Mental Health Inpatient (30 days per calendar year)*	80%	60%	Not Covered	Not Covered	100%	80%	100%	80%
Substance Abuse Rehabilitation	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Lifetime Maximum		\$5,000,000		\$2,000,000		\$5,000,000		\$5,000,000
PHARMACY								
Triple Tier Copay	\$15/\$30/\$45	\$15/\$30/\$45	Discount Card Available		100%	80%	100%	80%
Mail Order Drug Copay (31-90 day supply)	2.5x retail	2.5x retail	Not Covered	Not Covered	2.5x retail	2.5x retail	2.5x retail	2.5x retail
Contraceptives	Included	Included	Not Covered	Not Covered	Included	Included	Included	Included

This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage copayments indicate what Aetna is required to pay, unless otherwise noted.

* Coinsurance applies after the out-of-network deductible is met.

** Payment for Out-of-Network facility care is determined based upon Aetna's allowable fee schedule. Payment for other Out-of-Network care is determined based upon the negotiated charge that would apply if such services or supplies were received from an In-Network provider. These charges are referred to in your Plan Documents as "recognized" charges.

NOTE: Some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify, or obtain prior approval for certain services such as non-emergency hospital care. For a summary list of Limitations and Exclusions, refer to page 7.

Limitations and Exclusions

These plans do not cover all health care expenses and include exclusions and limitations. Employers and members should refer to their plan documents to determine which health care services are covered and to what extent.

Aetna HMO & Aetna POS

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.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates.
- Cosmetic surgery.
- Custodial care.
- Dental care and dental X-rays.
- 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).
- Hearing aids.
- Home births.
- Immunizations for travel or work.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents.

- Medical expenses for a pre-existing condition are not covered (full postponement rule) for the first 365 days after the member's enrollment date. Lookback period for determining a pre-existing condition (conditions for which diagnosis, care or treatment was recommended or received) is 180 days prior to the enrollment date. The pre-existing condition limitation period will be reduced by the number of days of prior creditable coverage the member has as of the enrollment date.
- Nonmedically necessary services or supplies.
- Orthotics.
- Over-the-counter medications and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered in the plan documents.
- Treatment of behavioral disorders.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna PPO

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 purchased.

- All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents.
- Charges related to any eye surgery mainly to correct refractive errors.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and X-rays.
- Donor egg retrieval.

- Experimental and investigational procedures.
- Hearing aids.
- Immunizations for travel or work.
- Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
- Medical expenses for a pre-existing condition are not covered (full postponement rule) for the first 365 days after the insured's enrollment date. Lookback period for determining a pre-existing condition (conditions for which diagnosis, care or treatment was recommended or received) is 180 days prior to the enrollment date. The pre-existing condition limitation period will be reduced by the number of days of prior creditable coverage the member has as of the enrollment date.
- Nonmedically necessary services or supplies.
- Orthotics.
- Over-the-counter medications and supplies.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling.
- Special duty nursing.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The Aetna companies that offer, underwrite or administer benefits coverage include Aetna Health Inc. and Aetna Life Insurance Company.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna arranges for the provision of healthcare/dental services. However, Aetna itself is not a provider of healthcare/dental services and therefore, cannot guarantee any results or outcomes. Consult the plan documents (Schedule of Benefits, Certificate of Coverage, Evidence of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. The availability of a plan or program may vary by geographic service area and by plan design. With the exception of Aetna Rx Home Delivery® service, all participating physicians, hospitals and other health care providers are independent contractors and are neither employees nor agents of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law. Certain primary care providers are affiliated with integrated delivery systems or other provider groups (such as independent practice associations and physician-hospital organizations), and members who select these providers will generally be referred to specialists and hospitals within those systems or groups. However, if a system or group does not include a provider qualified to meet member's medical needs, member may request to have services provided by non-system or non-group providers. Member's request will be reviewed and will require prior authorization from the system or group and/or Aetna to be a covered benefit.

Health benefit and insurance plans contain exclusions and some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify, or obtain prior approval of coverage for certain services such as non-emergency inpatient hospital care. If your plan covers outpatient prescription drugs, your plan may include a Preferred Drug List (formulary). A preferred drug list is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally not limited to the drugs listed on the Preferred Drug List. The medications listed on the Preferred Drug List are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the Preferred Drug List, and information about other pharmacy programs such as precertification and step therapy, please refer to Aetna's website at www.aetna.com, or the Preferred Drug List. Many drugs, including many of those listed on the Preferred Drug List are subject to rebate arrangements between Aetna and the manufacturer of the drugs. Aetna receives rebates from the manufacturers of many drugs, including many that are on the Preferred Drug List. These rebates do not reduce the amount you pay for an individual prescription drug. However, they help control the overall costs of prescription drug coverage. Your pharmacy benefit provides coverage for many drugs that are not on this list. Also, in some cases, if you need to pay a percentage of the cost of the drug or an amount to meet a deductible, your costs may be higher for a "preferred drug" than they would be for a "nonpreferred drug." You can find out more about the terms and limitations on your plan by reading your plan documents. You can also contact Member Services.

Aetna Health Savings Accounts (HSA) are administered by Aetna Life Insurance Company. HSA fees, interest rates and investment options are subject to change without notice. Investment options are not insured by Aetna or the FDIC and may result in loss of principal. This document is not intended to provide tax or investment advice. Please consult your independent financial advisor before opening an HSA or making an investment selection.

While this material is believed to be accurate as of the print date, it is subject to change.