

Aetna HMO Benefits Plan – Benefit Copay Sheet

Type of Service or Supply	Benefit Level*
Out-of-Pocket Maximums	No lifetime maximum
Inpatient Hospital Services	
Room and Board	Covered in full – no copay
X-Ray and Lab Tests	Covered in full – no copay
Private Duty Nurse	Covered in full if medically necessary – no copay
Special Care Units	Covered in full – no copay
Maternity Care	Covered in full – no copay
Well-Baby Care	Covered in full – no copay
Skilled Nursing Facilities	Covered in full – no copay
Birth Facilities	Covered in full – no copay
Hospice Care	Covered in full – no copay
Surgery and Anesthesia	
Inpatient Surgery	Covered in full – no copay
Outpatient Surgery	Covered in full – no copay
Outpatient Treatments	
Office Visit Copays: Primary Care Physician	Copay applies per visit
Specialists	Copay applies per visit with referral
Ob/Gyn	Copay applies per visit – no referral
Doctor's Home Visits	Copay applies per visit
X-Ray and Lab Tests	Covered in full
Cardiac, Rehabilitation, Chemotherapy, Dialysis or Radiation	Copay applies per visit
Physical, Speech, and Occupational Therapy	Covered in full – 60 visits per condition, per calendar year/copay applies per visit
Licensed Chiropractor	Copay applies per visit – 20 visits per year (Jan. through Dec.)
Routine Examinations	Covered in full – copay applies per visit
Routine Well-Baby Care	Covered in full – copay applies per visit
Immunizations	Covered in full – copay applies per visit
Eye Examinations (no hardware)	Covered in full – copay applies per visit
Hearing Examinations	Covered in full – copay applies per visit
Home Health Care	Covered in full – no copay
Podiatry (nonroutine)	Covered in full – copay applies per visit
Mental and Nervous Conditions	
Inpatient Treatment	35 days per year (Jan. through Dec.) covered in full – no copay
Outpatient Treatment	30 visits per year (Jan. through Dec.) covered in full – copay applies per visit
Alternate Care Facilities	Covered in full – for acute residential treatment only
Treatment of Alcohol and Drug Abuse	
Inpatient Treatment	28 days per occurrence covered in full – no copay
Outpatient Treatment	60 visits per year (Jan. through Dec.) covered in full – no copay
Emergency Detoxification	Covered in full – no copay
Other Services	
Infertility Services: Diagnosis	Covered in full – copay applies per visit
Treatment	Covered with limitations – copay applies per visit
Medical Equipment	Covered under home care
Durable Medical Equipment	Covered when medically necessary – copay applies
Informed Health Line	24-hour/7-day-a-week access to medical professionals via an 800 number
Ambulance Services	Covered when medically necessary – no copay

Prosthetic Devices	Covered with limitations – copay applies
Emergency Care	Covered in full – copay/waived if admitted
Dental Services: TMJ	Not covered
Oral Surgery	Not covered – except bony impactions
Wigs in connection with treatment of disease by radiation or chemicals	\$500/year

*See materials distributed by State Health Benefits Program for copay amounts