



PLAN DESIGN & BENEFIT OVERVIEW
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|--|---|
| Medical Deductible | \$0 | \$100 per person per calendar year Medical and Hospital combined (except for a per person per calendar year \$50 Home Health Care and \$100 DME deductible) |
| Hospital Deductible | \$50 per confinement per person Up to a calendar year maximum of \$240 per family. | Combined with medical deductible |
| Member Coinsurance | Covered 100% | Allowance Schedule |
| Coinsurance Limit | Not applicable | Not applicable |
| Lifetime Maximum | Unlimited | Unlimited |
| Maximum Out of Pocket (copayment/coinsurance) | Not applicable | Not applicable |
| PCP/ Referral Requirement | None | None |
| MEDICAL SERVICES | IN-NETWORK | OUT-OF-NETWORK |
| Preventive Care Physical exams, eye exams, well woman, immunizations, diagnostic screenings | No copayment | Allowance Schedule |
| Routine Well Child Exams/Immunizations | No copayment | Allowance Schedule |
| PCP Office Visits | \$15 copayment | Allowance Schedule |
| Specialist Office Visit | \$15 copayment | Allowance Schedule |
| Second Surgical Opinion | \$15 copayment | Allowance Schedule |
| INPATIENT HOSPITAL SERVICES | IN-NETWORK | OUT-OF-NETWORK |
| Inpatient Coverage (Semi-private room and board) | \$50 per confinement per person up to a calendar year maximum of \$240 per family | Allowance Schedule |
| Inpatient Obstetrical Care (includes delivery, postpartum care and routine newborn nursery care) | No copayment | Allowance Schedule |
| Surgery, Surgical Assistant, Anesthesia, Oxygen | No copayment | Allowance Schedule |
| Pre-Admission Testing | \$15 copayment | Allowance Schedule |
| OUTPATIENT HOSPITAL SERVICES | IN-NETWORK | OUT-OF-NETWORK |
| Ambulatory/Outpatient Surgery | No copayment | Allowance Schedule |



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| EMERGENCY MEDICAL CARE | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| Urgent Care Services | \$15 copayment | \$15 copayment |
| Emergency Room | \$100 copayment | \$100 copayment |
| Emergency Use of Land Ambulance | No copayment | No copayment |
| Emergency Use of Air Ambulance | No copayment | No copayment |
| MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE SERVICES | IN-NETWORK | OUT-OF-NETWORK |
| Inpatient (Semi-private room and board) | \$50 per confinement per person up to a calendar year maximum of \$240 per family | Allowance Schedule |
| Outpatient | \$15 copayment | Allowance Schedule |
| DURABLE MEDICAL EQUIPMENT (DME) | IN-NETWORK | OUT-OF-NETWORK |
| Deductible, Copayment/Coinsurance (e.g. hospital beds, oxygen, oxygen equipment, wheelchairs, PAP devices and supplies, diabetic pumps and supplies, catheters, artificial arms, legs, eyes, ears) | No copayment. Subject to allowed amount AFTER \$100 deductible* per person per calendar year | 50% of allowed amount AFTER \$100 deductible* per person per calendar year plus any amount billed above the allowed amount |
| HOME HEALTHCARE | IN-NETWORK | OUT-OF-NETWORK |
| Home Health Care Deductible | No copayment | \$50 deductible |
| Home Health Care Visits One visit equals up to 4 hours of care | No copayment 200 visits per calendar year | 25% coinsurance 40 visits per calendar year |
| Home Infusion Therapy | No copayment | 25% coinsurance |

***DME \$100 deductible not applicable to Positive Airway Pressure (PAP) devices, PAP supplies, insulin pump and insulin pump supplies**



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| ADDITIONAL BENEFITS | IN-NETWORK | OUT-OF-NETWORK |
|--|--|--|
| Hospice Care | No copayment | Allowance Schedule |
| Diagnostic Procedures X-rays, Radium and Radionuclide MRI/MRA, PET/CAT scans Laboratory tests | \$15 copayment | Allowance Schedule |
| Allergy Office Visit | \$15 copayment | Allowance Schedule |
| Allergy Testing/Treatment | No copayment | Allowance Schedule |
| Physical/Occupational Therapy | \$15 copayment | Allowance Schedule |
| Speech/Language Therapy | \$15 copayment | Allowance Schedule |
| Cardiac Rehabilitation | \$15 copayment | Allowance Schedule |
| Chemotherapy/Radiation Therapy | No copayment | Allowance Schedule |
| Kidney Dialysis | No copayment | Allowance Schedule |
| Ear Coverage Treatment for disease and injury of the ears | \$15 copayment | Allowance Schedule |
| Chiropractic Care Unlimited visits. Pre-certification required after 20 th visit | \$15 copayment | Allowance Schedule |
| Podiatric Services Routine Services, such as removal of corns are not covered | \$15 copayment | Allowance Schedule |
| Family Planning Services Vasectomy Tubal Ligation | \$15 copayment \$15 copayment No copayment | Allowance Schedule Allowance Schedule Allowance Schedule |
| Infertility Care | No copayment | Allowance Schedule |
| Advanced Reproductive Technologies in-Vitro fertilization ZIFT/GIFT/ICIS (3 cycles per lifetime) | No copayment | Allowance Schedule |