

# PLAN 5 - Classic 5000 Deductible



Benefit/Feature	In Network Providers		Out- of-Network Providers
	Aetna Choice POS II		
<b>No Referrals Required</b>			
<b>Deductible (Embedded*)</b> (every Calendar year)	\$5,000/Individual; \$10,000/Family		\$10,000/Individual; \$20,000/Family
<b>Out-of-Pocket Maximum (Embedded*)</b> (every Calendar Year)	\$7,350/Individual; \$14,700/Family		\$20,000/Individual; \$40,000/Family
(Out of Pocket Maximum is combined between In-Network and Out-of-Network and <b>includes deductible, coinsurance, medical copayments and prescription copays/coinsurance</b> but does not include non covered amounts above the plan's fee schedule or allowable charge, or pre-authorization penalties.)			
<b>Lifetime Maximum Benefit</b>	Unlimited		Unlimited
<b>PHYSICIAN SERVICES</b>			
<b>Office Visit to Primary Care</b>	You pay \$45 copay/visit		Plan pays 50%(1) after deductible
<b>Office Visit to Specialist</b>	You pay \$90 copay/visit		Plan pays 50%(1) after deductible
<b>Pre-Natal Care</b>	You pay \$45 copay/visit (initial visit only)		Plan pays 50%(1) after deductible
<b>Routine Physical</b>	Plan pays 100%		Plan pays 50%(1) after deductible
<b>Well Care (Child &amp; Adult)</b>	Plan pays 100%		Plan pays 50%(1) after deductible
<b>Childhood Immunizations</b>	Plan pays 100%		Plan pays 50%(1) after deductible
<b>Inpatient/Outpatient Professional Services</b>	Plan pays 70% after deductible		Plan pays 50%(1) after deductible
<b>HOSPITAL SERVICES</b>			
<b>Inpatient Admission <sup>(2)</sup></b>	Plan pays 70% after deductible		Plan pays 50%(1) after deductible
<b>Outpatient Services</b>	Plan pays 70% after deductible		Plan pays 50%(1) after deductible
<b>Outpatient Ambulatory Surgery <sup>(2)</sup></b>			
- Physician Charges	Plan pays 70% after deductible		Plan pays 50%(1) after deductible
- Hospital Charges	Plan pays 70% after deductible		Plan pays 50%(1) after deductible
- Free-standing Surgical Center	Plan pays 70% after deductible		Plan pays 50%(1) after deductible
<b>Urgent Care Center</b>	You pay \$90 copay/visit		You pay \$90 copay/visit
<b>Emergency Room Services</b>	Plan pays 70% after deductible (Out-of-Area True Emergency Admissions are subject to In Network Benefits)		
<b>Inpatient Rehab &amp; Skilled Nursing <sup>(2)</sup></b>	Plan pays 70% after deductible (120 days per year)		Plan pays 50%(1) after deductible (120 days per year)
<b>OTHER SERVICES</b>			
<b>Outpatient Therapies <sup>(2)</sup></b>	<b>Includes Physical, Occupational &amp; Speech</b>		
	<b>All Therapies (60 visit combined limit, every plan year)</b> (This limit does not apply to benefits associated with Autism Spectrum Disorder, developmental delays, or acquired brain injury)		
- Hospital Based	Plan pays 70% after deductible		Plan pays 50%(1) after deductible
- Office Based	You pay \$90 copay/visit		Plan pays 50%(1) after deductible
<b>Laboratory Services</b>	Plan pays 70% after deductible		Plan pays 50%(1) after deductible
<b>Diagnostic Services <sup>(2)</sup></b>			
- MRIs, MRAs, CT Scans, and PET Scans <sup>(2)</sup>	Plan pays 70% after deductible		Plan pays 50%(1) after deductible
- All Other Diagnostic Services	Plan pays 70% after deductible		Plan pays 50%(1) after deductible
<b>Durable Medical Equipment <sup>(2)</sup></b>	Plan pays 70% after deductible		Plan pays 50%(1) after deductible
<b>Home Health Care <sup>(2)</sup></b>	Plan pays 70% after deductible (120 visits per year/not to exceed 4 hrs per visit)		Plan pays 50%(1) after deductible (120 visits per year/not to exceed 4 hrs per visit)
<b>Chiropractic Care</b> Covered age 18 and older only	You pay \$90 copay/visit (20 visit maximum every plan year)		Plan pays 50%(1) after deductible (20 visit maximum every plan year)
<b>MENTAL DISORDER &amp; SUBSTANCE ABUSE SERVICES</b>			
<b>Inpatient Mental Disorder/Substance Abuse <sup>(2)</sup></b>	Plan pays 70% after deductible		Plan pays 50%(1) after deductible
<b>Outpatient Mental Disorder/Substance Abuse <sup>(2)</sup></b>			
- Hospital Based	Plan pays 70% after deductible		Plan pays 50%(1) after deductible
- Office Based or Freestanding Facility	You pay \$45 copay/visit		Plan pays 50%(1) after deductible

(1) For all Out-of-Network elective and non-emergent Hospital services the Plan will not pay more than Plan's Allowable Charge which will be based on 50% of Recognized Charges for both inpatient & outpatient services.

(2) Some of these services require pre-authorization. For Network services, your physician should obtain pre-authorization for you, however, you are ultimately responsible for pre-authorization for all services (in or out-of-network), otherwise a penalty of 50% of the Plan's allowable amount, to a maximum of \$2,500 will be applied.

**Note:** This summary is not intended to be a comprehensive list of services and is not a guarantee of coverage. Once enrolled, you will be supplied with a Plan Document/Summary Plan Description (SPD) that will detail all covered services.

\*Embedded means you can satisfy the Family "Deductible" or the Family "Maximum Out-of-Pocket" with any combination of family members satisfying the amount. However, no one individual may meet more than the individual amount. In-network and out-of-network Deductibles and Out-of-Pocket Maximums are tracked separately, such that Covered Services applied to one will not apply to the other.

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