PLAN 8 - Value 7350 Deductible

TD CONSORTIUM BENEFITS TRUST

Benefit/Feature No Referrals Required	In Network Providers Aetna Choice POS II	Out- of-Network Providers
Deductible (Embedded*) (every Calendar year)	$7,350/Individual; $14,700/Family	$14,700/Individual; $29,400/Family
Out-of-Pocket Maximum (Embedded*) (every Calendar Year)	$7,350/Individual; $14,700/Family	Unlimited
(Out of Pocket Maximum is combined between In-Network and Out-of-Network and **includes deductible, coinsurance, medical copayments and prescription copays/coinsurance** but does not include non covered amounts above the plan's fee schedule or allowable charge, or pre-authorization penalties.)		
Lifetime Maximum Benefit	Unlimited	Unlimited
PHYSICIAN SERVICES		
Office Visit to Primary Care	Plan pays 100% after deductible	Plan pays 60%(1) after deductible
Office Visit to Specialist	Plan pays 100% after deductible	Plan pays 60%(1) after deductible
Pre-Natal Care	Plan pays 100% after deductible (initial visit only)	Plan pays 60%(1) after deductible
Routine Physical	Plan pays 100%	Plan pays 60%(1) after deductible
Well Care (Child & Adult)	Plan pays 100%	Plan pays 60%(1) after deductible
Childhood Immunizations	Plan pays 100%	Plan pays 60%(1) after deductible
Inpatient/Outpatient Professional Services	Plan pays 100% after deductible	Plan pays 60%(1) after deductible
HOSPITAL SERVICES		
Inpatient Admission (2)	Plan pays 100% after deductible	Plan pays 60%(1) after deductible
Outpatient Services	Plan pays 100% after deductible	Plan pays 60%(1) after deductible
Outpatient Ambulatory Surgery (2)		
- Physician Charges	Plan pays 100% after deductible	Plan pays 60%(1) after deductible
- Hospital Charges	Plan pays 100% after deductible	Plan pays 60%(1) after deductible
- Free-standing Surgical Center	Plan pays 100% after deductible	Plan pays 60%(1) after deductible
Urgent Care Center	Plan pays 100% after deductible	Plan pays 100% after deductible
Emergency Room Services	Plan pays 100% after deductible (Out-of-Area True Emergency Admissions are subject to In Network Benefits)	
Inpatient Rehab & Skilled Nursing (2)	Plan pays 100% after deductible (120 days per year)	Plan pays 60%(1) after deductible (120 days per year)
OTHER SERVICES		
Outpatient Therapies (2)	**Includes Physical, Occupational & Speech** **All Therapies (60 visit combined limit, every plan year)** (This limit does not apply to benefits associated with Autism Spectrum Disorder, developmental delays, or acquired brain injury)	
- Hospital Based	Plan pays 100% after deductible	Plan pays 60%(1) after deductible
- Office Based	Plan pays 100% after deductible	Plan pays 60%(1) after deductible
Laboratory Services	Plan pays 100% after deductible	Plan pays 60%(1) after deductible
Diagnostic Services (2)		
- MRIs, MRAs, CT Scans, and PET Scans (2)	Plan pays 100% after deductible	Plan pays 60%(1) after deductible
- All Other Diagnostic Services	Plan pays 100% after deductible	Plan pays 60%(1) after deductible
Durable Medical Equipment (2)	Plan pays 100% after deductible	Plan pays 60%(1) after deductible
Home Health Care (2)	Plan pays 100% after deductible (120 visits per year/not to exceed 4 hrs per visit)	Plan pays 60%(1) after deductible (120 visits per year/not to exceed 4 hrs per visit)
Chiropractic Care Covered age 18 and older only	Plan pays 100% after deductible (20 visit maximum every plan year)	Plan pays 60%(1) after deductible (20 visit maximum every plan year)
MENTAL DISORDER & SUBSTANCE ABUSE SERVICES		
Inpatient Mental Disorder/Substance Abuse (2)	Plan pays 100% after deductible	Plan pays 60%(1) after deductible
Outpatient Mental Disorder/Substance Abuse (2)		
- Hospital Based	Plan pays 100% after deductible	Plan pays 60%(1) after deductible
- Office Based or Freestanding Facility	Plan pays 100% after deductible	Plan pays 60%(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 60% 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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V6.7.20

This is a self-insured plan administered by Aetna.

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