



Summary of Benefits
PPO 80/50 \$500 Deductible

	<u>In-Network</u> Cost to Covered Person	<u>Out-of-Network</u> Cost to Covered Person*
Member Coinsurance for Eligible Expenses	20%	50%
Annual deductible ⁽¹⁾		
Individual	\$500	\$1,500
Family	\$1,000	\$3,000
Annual Out-of-pocket Maximum ^{(2) (3)}		
Individual (includes deductible)	\$2,000	\$6,000
Family (includes deductible)	\$4,000	\$12,000
Lifetime Maximum Benefit	Unlimited	
Physician Care		
General Practitioner (PCP) Office Visit	\$20 copay	Deductible, then 50%
Specialist Office Visit	\$40 copay	Deductible, then 50%
Lab Tests & X-rays Major	Deductible, then 20%	Deductible, then 50%
Lab Tests & X-rays Minor	Covered in full	Deductible, then 50%
Office Surgery	Deductible, then 20%	Deductible, then 50%
Allergy Injections	Deductible, then 20%	Deductible, then 50%
Urgent Care	\$75 copay	\$75 copay
Child Hearing Exam	Covered in full	Deductible, then 50%
Childhood Immunizations	Covered in full	Deductible, then 50%
Preventive Care (All Ages)		
Physician services;	Covered in full	Deductible, then 50%
History	Covered in full	Deductible, then 50%
Physical Exam	Covered in full	Deductible, then 50%
Development Assessment for Children	Covered in full	Deductible, then 50%
Anticipatory Guidance for Children	Covered in full	Deductible, then 50%
Laboratory Test, X-rays, blood pressure and other services for the early detection of diseases when ordered by a Physician	Covered in full	Deductible, then 50%
Annual Pap Exam & Lab	Covered in full	Deductible, then 50%
Prostate Cancer Screening	Covered in full	Deductible, then 50%
Mammography	Covered in full	Deductible, then 50%
Maternity Care		
Office visits (prenatal)	Covered in full	Deductible, then 50%
Hospitalization	Deductible, then 20%	Deductible, then 50%
o Vision Exam - Routine (Limited to 1 visit per year)	Covered in full	Deductible, then 50%
o Adult hearing exam (Limited to 1 visit per year)	Covered in full	Deductible, then 50%

This is brief summary of benefits. Details of your benefits are subject to the terms, conditions and limitations of the Group Health Insurance Contract.

	<u>In-Network Cost to Covered Person</u>	<u>Out-of-Network Cost to Covered Person*</u>
Hospitalization Inpatient Services		
Semi-private Hospital Room & Board	Deductible, then 20%	Deductible, then 50%
Physician & Surgeon Services	Deductible, then 20%	Deductible, then 50%
Lab, X-ray and other facility charges	Deductible, then 20%	Deductible, then 50%
Inpatient Rehabilitation	Deductible, then 20%	Deductible, then 50%
Hospital Outpatient Surgery	Deductible, then 20%	Deductible, then 50%
Hospital Outpatient services	Deductible, then 20%	Deductible, then 50%
Emergency Room	\$250 copay, then 20%	\$250 copay, then 20%
Ambulance		
Ground transportation	Deductible, then 20%	Deductible, then 20%
Air transportation	Deductible, then 20%	Deductible, then 20%
Mental or Emotional Illness or Disorders & Chemical Dependency		
Inpatient Mental or Emotional Illness Disorder	Deductible, then 20%	Deductible, then 50%
Inpatient Chemical Dependency	Deductible, then 20%	Deductible, then 50%
Outpatient Mental or Emotional Illness Disorder	\$20 copay	Deductible, then 50%
Outpatient Chemical Dependency	\$20 copay	Deductible, then 50%
Office Visits Related to Mental or Emotional Disorder	\$20 copay	Deductible, then 50%
Office Visits Related to Chemical Dependency	\$20 copay	Deductible, then 50%
Serious mental illness - Inpatient	Deductible, then 20%	Deductible, then 50%
Serious mental illness - Outpatient	\$20 copay	Deductible, then 50%
Rehabilitation Services		
Inpatient rehabilitation services	Deductible, then 20%	Deductible, then 50%
Outpatient rehabilitation services (35 visits per calendar year)	\$40 copay	Deductible, then 50%
Durable Medical Equipment		
	Deductible, then 50%	Deductible, then 50%
Skilled Nursing Facility		
25 day maximum per calendar year	Deductible, then 20%	Deductible, then 50%
Home Health Care		
60 visits per calendar year maximum benefit.	Deductible, then 20%	Deductible, then 50%
Hospice Service		
	Covered in full	Deductible, then 50%
Organ Transplant		
	Deductible, then 20%	Deductible, then 50%
Manipulative Services		
\$500 Calendar Year maximum benefit.	Deductible, then 20%	Deductible, then 50%

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Acupressure/Acupuncture 10 visits per calendar year maximum benefit.	Deductible, then 20%	Deductible, then 50%
Temporomandibular Joint Dysfunction (TMJ)	Deductible, then 20%	Deductible, then 50%

- (1) Co-pays do not count toward the Calendar Year deductible.
(2) Deductibles apply to OOP maximum.
(3) Co-pays apply to OOP maximum
Pre-Authorization. There is a \$500 penalty for failure to obtain pre-authorization.
Penalty payments do not apply toward the deductible or out-of-pocket maximum.

The following are subject to Pre-Authorization prior to obtaining services:

- DME
- Inpatient admissions
- Inpatient rehabilitation
- Organ transplants
- Skilled nursing Facilities
- Home health care
- Providers visit <http://www.aetna.com/docfind/custom/mymeritain/>

*All out of network benefits are subject to usual and customary charges.

Schedule of Benefits

**Prescription Drugs
Traditional Plan - Option - No deductible**

Retail - 34 day supply

- Generic		\$3
- Brand Preferred		\$35
- Brand Non-Preferred		\$60

- Specialty Drugs Preferred	15%	
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- Specialty Drugs Non-Preferred	50%	
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Mail Order Pharmacy - 90 day supply

- Generic		\$6
- Brand Preferred		\$70
- Brand Non-Preferred		\$180

