



Summary of Benefits PPO 70/50 \$2,500 Deductible

	<u>In-Network</u> <u>Cost to Covered Person</u>	<u>Out-of-Network</u> <u>Cost to Covered Person*</u>
Member Coinsurance for Eligible Expenses	30%	50%
Annual deductible ⁽¹⁾		
Individual	\$2,500	\$5,000
Family	\$5,000	\$10,000
Annual Out-of-pocket Maximum ^{(2) (3)}		
Individual (includes deductible)	\$6,600	\$13,200
Family (includes deductible)	\$13,200	\$26,400
Lifetime Maximum Benefit	Unlimited	
Physician Care		
General Practitioner (PCP) Office Visit	\$35 copay	Deductible then 50%
Specialist Office Visit	\$60 copay	Deductible then 50%
Lab Tests & X-rays Major	Deductible, then 30%	Deductible then 50%
Lab Tests & X-rays Minor	Covered in full	Deductible then 50%
Office Surgery	Deductible then 30%	Deductible then 50%
Allergy Injections	Deductible then 30%	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 30%	Deductible then 50%
Vision Exam - Routine (Limited to 1 visit per year)	Covered in full	Deductible then 50%
Adult hearing exam (Limited to 1 visit per year)	Covered in full	Deductible then 50%

	<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 30%	Deductible then 50%
Physician & Surgeon Services	Deductible then 30%	Deductible then 50%
Lab, X-ray and other facility charges	Deductible then 30%	Deductible then 50%
Inpatient Rehabilitation	Deductible then 30%	Deductible then 50%
Hospital Outpatient Surgery	Deductible then 30%	Deductible then 50%
Hospital Outpatient services	Deductible then 30%	Deductible then 50%
Emergency Room	\$200 copay, then 30%	\$200 copay, then 30%
Ambulance		
Ground transportation	Deductible then 30%	Deductible then 30%
Air transportation	Deductible then 30%	Deductible then 30%
Mental or Emotional Illness or Disorders & Chemical Dependency		
Inpatient Mental or Emotional Illness Disorder	Deductible then 30%	Deductible then 50%
Inpatient Chemical Dependency	Deductible then 30%	Deductible then 50%
Outpatient Mental or Emotional Illness Disorder	\$35 copay	Deductible then 50%
Outpatient Chemical Dependency	\$35 copay	Deductible then 50%
Office Visits Related to Mental or Emotional Disorder	\$35 copay	Deductible then 50%
Office Visits Related to Chemical Dependency	\$35 copay	Deductible then 50%
Serious mental illness - Inpatient	Deductible then 30%	Deductible then 50%
Serious mental illness - Outpatient	\$35 copay	Deductible then 50%
Rehabilitation Services		
Inpatient rehabilitation services	Deductible then 30%	Deductible then 50%
Outpatient rehabilitation services (35visits per calendar year)	\$60 copay	Deductible then 50%
Durable Medical Equipment		
	Deductible then 50%	Deductible then 50%
Skilled Nursing Facility		
25 day maximum per calendar year	Deductible then 30%	Deductible then 50%
Home Health Care		
60 visits per calendar year maximum benefit.	Deductible then 30%	Deductible then 50%
Hospice Service		
	Covered in full	Deductible then 50%
Organ Transplant		
	Deductible then 30%	Deductible then 50%
Manipulative Services		
\$500 Calendar Year maximum benefit.	Deductible then 30%	Deductible then 50%

	<u>In-Network Cost to Covered Person</u>	<u>Out-of-Network Cost to Covered Person*</u>
Acupressure/Acupuncture		
10 visits per calendar year maximum benefit.	Deductible then 30%	Deductible then 50%
Temporomandibular Joint Dysfunction (TMJ)		
	Deductible then 30%	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.