General Provisions		
Benefit	**AETNA Providers**	**All Other Providers**
Aither Advocate Phone Number	833.420.1910	
Benefit Period	01/01-12/31	
Deductible - Embedded Individual Family	 $7,000 $14,000	 $14,000 $28,000
Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. In Network and Out of Network deductibles are separate and do NOT cross accumulate towards each other.		
Member Pays - payment based on the plan allowance	20% coinsurance	50% coinsurance
Total Maximum Out-of-Pocket - Embedded (includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses. Once met, there is no cost sharing for covered services for the rest of the plan year). Individual Family	 $10,000 $20,000	 $20,000 $40,000
The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. In Network and Out of Network Out-of-Pocket Maximums are separate and do NOT cross accumulate towards each other.		

Physician Office Services			
Services rendered in a physicians office	**Plan Provisions**	**Patient Responsibility**	**Patient Responsibility**
Primary Care Physician/Provider (office, home, virtual, phone)		$30 copayment	Deductible then 50%
Specialty Care Physician/ Provider (office, home, virtual, phone)		$60 copayment	Deductible then 50%
Lab & X-ray Services including ultrasounds		$35 copay per visit	Deductible then 50%
Advanced Imaging (MRI/MRA, CT Scans, PET Scans, Nuclear Medicine)	Precertification required	Deductible then 20%	Deductible then 50%
Injections (Physician & Medication)	Precertification required if greater than $1,500	Included in office visit copay	Deductible then 50%
Office Surgery		Included in office visit copay	Deductible then 50%
Walk-In Retail / Convenience Clinics		$30 copayment	Deductible then 50%
Allergy Injections		$60 copayment	Deductible then 50%

Preventive Care			
Service	**Plan Provisions**	**Patient Responsibility**	**Patient Responsibility**
Routine Pediatric/Adolescent Physical Exams		No Cost Share	Not Covered
Routine Adult Physical Exams		No Cost Share	Not Covered
Adult, Pediatric and Adolescent Immunizations		No Cost Share	Not Covered
Mammograms, Annual Routine		No Cost Share	Not Covered
Routine Gynecological Exams, including a Pap Test		No Cost Share	Not Covered
Preventive Contraceptive Management		No Cost Share	Not Covered
Routine Screening Services		No Cost Share	Not Covered
Routine Colonoscopy		No Cost Share	Not Covered
Preventive/Well Care is covered as defined in the Patient Protection and Affordable Care Act, as amended and as described by the Health Resources and Services Administration (HRSA)			

Diagnostic Testing (Independent Laboratory & Freestanding Imaging Facility)			
Service	**Plan Provisions**	**Patient Responsibility**	**Patient Responsibility**
Lab & X-ray Services and Diagnostic Tests		$35 copay per visit	Deductible then 50%
Advanced Imaging (MRI/MRA, CT Scans, PET Scans, Nuclear Medicine)	Precertification required	Deductible then 20%	Deductible then 50%
Sleep Study (Freestanding Facility)		Not covered	Not covered
Sleep Study (Home)		Not covered	Not covered

Emergency Services			
Service	**Plan Provisions**	**Patient Responsibility**	**Patient Responsibility**
Emergency Room (Including Facility, ER Physician, Radiologist, & Pathologist)		Deductible then, $250 copay and 20% coinsurnace	Deductible then, $250 copay and 20% coinsurnace
Urgent Care Office Visit Charge		$75 copay per visit	Deductible then 50%
Ambulance and other medically necessary transportation		Deductible then 20%	Deductible then 50%
Non Emergent Air Ambulance		Not covered	Not covered

Surgery			
Service	**Plan Provisions**	**Patient Responsibility**	**Patient Responsibility**

Surgery Facility	Precertification required	Deductible then 20%	Deductible then 50%
Surgeon	Precertification required	Deductible then 20%	Deductible then 50%
Assistant Surgeon	Precertification required	Deductible then 20%	Deductible then 50%
Anesthesiologist	Precertification required	Deductible then 20%	Deductible then 50%
Pathologist/Radiologist	Precertification required	Deductible then 20%	Deductible then 50%
Cochlear Implants		Not covered	Not covered
Bariatric Surgery		Not covered	Not covered
Gender Dysphoria		Not covered	Not covered
Abortion		Not covered	Not covered
Preadmission Testing		Deductible then 20%	Deductible then 50%

Medical Inpatient Services (Hospital, Medical Rehabilitation, Skilled Nursing Facility)

Service	Plan Provisions	Patient Responsibility	Patient Responsibility
Inpatient Facility	Precertification required	Deductible then 20%	Deductible then 50%
Inpatient Physician	Precertification required	Deductible then 20%	Deductible then 50%
Inpatient Physician Services (Including pathology & radiology services)	Precertification required	Deductible then 20%	Deductible then 50%
Inpatient Surgery (Includes Surgeon, Assistant, Anesthesiologist, Radiologist, Pathologist)	Precertification required	Deductible then 20%	Deductible then 50%
Gender Dysphoria		Not covered	Not covered
Bariatric Surgery		Not covered	Not covered
Transplant Services		Not covered	Not covered
Post Hospitalization Medical Rehab Facility	Precertification required	Deductible then 20%	Deductible then 50%
Skilled Nursing Facility		Not covered	Not covered

Medical Outpatient Hospital Services

Service	Plan Provisions	Patient Responsibility	Patient Responsibility
Outpatient Hospital Facility	Precertification required	Deductible then 20%	Deductible then 50%
Outpatient Hospital Observation (Emergent only)	Precertification required if greater than 23 hours	Deductible then 20%	Deductible then 50%
Lab & X-ray Services and Diagnostic Tests		Deductible then 20%	Deductible then 50%
Advanced Imaging (MRI/MRA, CT Scans, PET Scans, Nuclear Medicine)	Precertification required	Deductible then 20%	Deductible then 50%
Chemotherapy	Precertification required	Deductible then 20%	Deductible then 50%
Radiation Therapy	Precertification required	Deductible then 20%	Deductible then 50%
Infusion Therapy	Precertification required if greater $1,500	Deductible then 20%	Deductible then 50%
Cardiac Rehabilitation	Limit 36 visits per plan year	Deductible then 20%	Deductible then 50%
Physical, Speech, and Occupational Therapy	Limit 20 visits per year PT, OT, & ST combined Precertification required after 6 visits	$75 copay per visit	Deductible then 50%
Pulmonary Rehab/Respiratory Therapy	Limit 20 visits per year Precertification required after 6 visits	Deductible then 20%	Deductible then 50%
Applied Behavior Analysis for Autism Spectrum Disorder	Precertification required after 6 visits Limit 20 visits per plan year	$75 copay per visit	Deductible then 50%

Maternity Services

Service	Plan Provisions	Patient Responsibility	Patient Responsibility
Prenatal Care - Physician Office Visits		No Cost Share	Not Covered
Inpatient Hospital (Mom)		Deductible then 20%	Deductible then 50%
Hospital Nursery (Newborn)		Deductible then 20%	Deductible then 50%
Physician - Global Delivery		Deductible then 20%	Deductible then 50%
Physician - Newborn		Deductible then 20%	Deductible then 50%
Nurse Midwife		Deductible then 20%	Deductible then 50%
Birthing Center		Deductible then 20%	Deductible then 50%
Lactation Counseling & Equipment		No Cost Share	Not Covered
Dependent Daughter Maternity		Deductible then 20%	Deductible then 50%

***Precertification required if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean section.**

Therapy and Rehabilitation Services - Office

Service	Plan Provisions	Patient Responsibility	Patient Responsibility
Acupuncture Treatment		Not covered	Not covered
Applied Behavior Analysis for Autism Spectrum Disorder	Precertification required after 6 visits Limit 20 visits per plan year	$75 copay per visit	Deductible then 50%
Biofeedback		Not covered	Not covered
Cardiac Rehabilitation	Limit 36 visits per plan year	Deductible then 20%	Deductible then 50%
Chemotherapy	Precertification required	Deductible then 20%	Deductible then 50%
Chiropractic Care/Spinal Manipulations	Limit 10 visits per plan year	$60 copayment	Deductible then 50%
Dialysis	Precertification required	Deductible then 20%	Deductible then 50%
Holistic or Homeopathic Medicine		Not covered	Not covered
Hyperbaric Treatment		Not covered	Not covered
Infusion Therapy	Precertification required if greater than $1,500	Deductible then 20%	Deductible then 50%
Infusion Specialty Medications	Precertification required if greater than $1,500	Deductible then 20%	Deductible then 50%

Massage Therapy		Not covered	Not covered
Physical, Speech, and Occupational Therapy	Precertification required after 6 visits Limit 20 visits per year PT, OT, & ST combined	$75 copay per visit	Deductible then 50%
Pulmonary Rehab/Respiratory Therapy	Limit 20 visits per year Precertification required after 6 visits	Deductible then 20%	Deductible then 50%
Radiation Therapy	Precertification required	Deductible then 20%	Deductible then 50%
Mental Health Services			
Service	**Plan Provisions**	**Patient Responsibility**	**Patient Responsibility**
Office Visit - Mental Health		$30 copayment	Deductible then 50%
Inpatient Mental Health Services (Facility)	Precertification required	Deductible then 20%	Deductible then 50%
Inpatient Mental Health Services (Physician)		Deductible then 20%	Deductible then 50%
Inpatient Lab, X-ray, Diagnostic Testing		Deductible then 20%	Deductible then 50%
Outpatient Mental Health Services (Facility)		Partial Day Program - Deductible then 20%	Deductible then 50%
Outpatient Mental Health Services (Physician)		$30 copayment	Deductible then 50%
Mental Health Residential Treatment (Facility & Physician)	Precertification required	Deductible then 20%	Deductible then 50%
Mental Health Partial Hospitalization (Facility & Physician)	Precertification required	Deductible then 20%	Deductible then 50%
Substance Abuse			
Service	**Plan Provisions**	**Patient Responsibility**	**Patient Responsibility**
Office Visit - Substance Abuse		$30 copayment	Deductible then 50%
Inpatient Detox (Facility)	Precertification required	Deductible then 20%	Deductible then 50%
Inpatient Detox (Physician)		Deductible then 20%	Deductible then 50%
Inpatient Lab, X-ray, Diagnostic Testing		Deductible then 20%	Deductible then 50%
Outpatient Hospital Detox Services (Facility)		Partial Day Program - Deductible then 20%	Deductible then 50%
Outpatient Hospital Detox Services (Physician)		$30 copayment	Deductible then 50%
Inpatient Substance Abuse Rehab (Facility)	Precertification required	Deductible then 20%	Deductible then 50%
Inpatient Substance Abuse Rehab (Physician)		Deductible then 20%	Deductible then 50%
Outpatient Hospital Substance Abuse (Facility)		Partial Day Program - Deductible then 20%	Deductible then 50%
Outpatient Hospital Substance Abuse (Physician)		$30 copayment	Deductible then 50%
Substance Abuse Residential Treatment (Facility & Physician)	Precertification required	Deductible then 20%	Deductible then 50%
Substance Abuse Partial Hospitalization (Facility & Physician)	Precertification required	Deductible then 20%	Deductible then 50%
Other Treatments/Services			
Service	**Plan Provisions**	**Patient Responsibility**	**Patient Responsibility**
Assisted Fertilization Procedures		Not covered	Not covered
Biofeedback		Not covered	Not covered
Dental Services Related to Accidental Injury		Not covered	Not covered
Dental Oral Surgery		Not covered	Not covered
Diabetic Supplies		Deductible then 20%	Deductible then 50%
Durable Medical Equipment and Prosthetics	Precertification required if greater than $2,500	Deductible then 20%	Deductible then 50%
Genetic Counseling		Not covered	Not covered
Genetic Testing		Not covered	Not covered
Glaucoma, Cataract Surgery and Lenses		Not covered	Not covered
Hearing Aids & Exams		Not covered	Not covered
Home Health Care	Precertification required - Limited to 20 visits per Calendar Year.	Deductible then 20%	Deductible then 50%
Hospice	Precertification required	Deductible then 20%	Deductible then 50%
Infertility Diagnosis		Not covered	Not covered
Medical Supplies		Deductible then 20%	Deductible then 50%
Nutritional Counseling		$30 Copay PCP $60 Copay Specialist	Deductible then 50%
Private Duty Nursing		Not covered	Not covered
Prostate Exam		No cost share	Not Covered
Sexual Function		Not covered	Not covered
Temporomandibular Joint Disorder (TMJ)		Not covered	Not covered
Wigs (hair loss due to cancer treatment or alopecia related to a medical condition)		Not covered	Not covered
Prescription Drugs			
Prescription Drug Deductible **Individual** **Family**		N/A (No pharmacy deductible)	
Shared with Medical?		N/A (No pharmacy deductible)	
Prescription Drug Out of Pocket Maximum **Individual** **Family**		$10,000 $20,000	
Shared with Medical?		Yes - shared	
Retail – 30 Day Supply			
Preferred Generic		$10 copayment	
Preferred Brand		$40 copayment	
Non-Preferred Brand		$80 copayment	
Specialty Drugs		25% coinsurance	
Mail Order – 90 Day Supply			
Preferred Generic		$30 copayment	
Preferred Brand		$120 copayment	
Non-Preferred Brand		$240 copayment	
Specialty Drugs		25% coinsurance	