

# PLAN 3

## AR SILVER 2500

### BENEFIT SUMMARY



Benefit/Feature  No Referrals Required	In Network Providers Aetna Choice POS II Online Search: <a href="http://www.aetna.com">www.aetna.com</a> Aetna One Concierge 1-866-252-3559	Out- of-Network Providers
<b>Deductible (Embedded*)</b> (every Calendar year)	\$2,500/Individual; \$5,000/Family	\$7,500/Individual; \$15,000/Family
<b>Out-of-Pocket Maximum (Embedded*)</b> (every Calendar Year)	\$9,200/Individual; \$18,400/Family	\$24,000/Individual; \$72,000/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 \$30 copay/visit	Plan pays 75% <sup>(1)</sup> after deductible
<b>Office Visit to Specialist</b>	You pay \$60 copay/visit	Plan pays 75% <sup>(1)</sup> after deductible
<b>Routine Gynecological Care</b>	Plan pays 100%	Plan pays 75% <sup>(1)</sup> after deductible
<b>Pre-Natal Care</b>	You pay \$30 copay/visit (initial visit only)	Plan pays 75% <sup>(1)</sup> after deductible
<b>Routine Physical</b>	Plan pays 100%	Plan pays 75% <sup>(1)</sup> after deductible
<b>Well Care</b> (Child & Adult)	Plan pays 100%	Plan pays 75% <sup>(1)</sup> after deductible
<b>Childhood Immunizations</b>	Plan pays 100%	Plan pays 100%
<b>Inpatient/Outpatient Professional Services</b>	Plan pays 70% after deductible	Plan pays 50% <sup>(1)</sup> after deductible
<b>HOSPITAL SERVICES</b>		
<b>Inpatient Admission</b> <sup>(2)</sup>	Plan pays 70% after deductible	Plan pays 50% <sup>(1)</sup> after deductible
<b>Outpatient Services</b>	Plan pays 70% after deductible	Plan pays 50% <sup>(1)</sup> after deductible
<b>Outpatient Ambulatory Surgery</b> <sup>(2)</sup> - Physician Charges - Hospital Charges - Free-standing Surgical Center	Plan pays 70% after deductible Plan pays 70% after deductible Plan pays 70% after deductible	Plan pays 50% <sup>(1)</sup> after deductible Plan pays 50% <sup>(1)</sup> after deductible Plan pays 50% <sup>(1)</sup> of a Maximum Allowable of \$1,000 per surgery, after the deductible is met*
<b>Urgent Care Center</b>	You pay \$75 copay/visit	Plan pays 75% <sup>(1)</sup> after deductible
<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</b> <sup>(2)</sup>	Plan pays 70% after deductible (60 days per incident maximum)	Plan pays 50% <sup>(1)</sup> after deductible (60 days per incident maximum)
<b>OTHER SERVICES</b>		
<b>Outpatient Therapies</b> <sup>(2)</sup>  - Hospital Based - Office Based or Freestanding Facility	<b>Includes Physical, Occupational &amp; Speech 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)	
	Plan pays 70% after deductible You pay \$30 copay/visit	Plan pays 50% <sup>(1)</sup> after deductible Plan pays 75% <sup>(1)</sup> after deductible
<b>Cardiac Rehabilitation</b> <sup>(2)</sup>	Plan pays 70% after deductible (36 visits combined every plan year)	Plan pays 50% <sup>(1)</sup> after deductible (36 visits combined every plan year)
<b>Laboratory Services</b> - Hospital Based - Office Based or Freestanding Facility	Plan pays 70% after deductible Plan pays 70% after deductible	Plan pays 50% <sup>(1)</sup> after deductible Plan pays 50% <sup>(1)</sup> after deductible
<b>Diagnostic Services</b> <sup>(2)</sup> - MRIs, MRAs, CT Scans, and PET Scans <sup>(2)</sup> - All Other Diagnostic Services	Plan pays 70% after deductible Plan pays 70% after deductible	Plan pays 50% <sup>(1)</sup> after deductible Plan pays 50% <sup>(1)</sup> after deductible
<b>Durable Medical Equipment</b> <sup>(2)</sup>	Plan pays 70% after deductible	Plan pays 50% <sup>(1)</sup> after deductible
<b>Home Health Care</b> <sup>(2)</sup>	Plan pays 70% after deductible (60 visits per year/not to exceed 4 hrs per visit)	Plan pays 50% <sup>(1)</sup> after deductible (60 visits per year/not to exceed 4 hrs per visit)
<b>Chiropractic Care</b> Covered age 18 and older only	You pay \$30 copay/visit (30 visit maximum every plan year)	Plan pays 75% <sup>(1)</sup> after deductible (30 visit maximum every plan year)
<b>MENTAL DISORDER &amp; SUBSTANCE ABUSE SERVICES</b>		
<b>Inpatient Mental Disorder/Substance Abuse</b> <sup>(2)</sup>	Plan pays 80% after deductible	Plan pays 60% <sup>(1)</sup> after deductible
<b>Outpatient Mental Disorder/Substance Abuse</b> <sup>(2)</sup> - Hospital Based - Office Based or Freestanding Facility	Plan pays 70% after deductible You pay \$30 copay/visit	Plan pays 50% <sup>(1)</sup> after deductible Plan pays 75% <sup>(1)</sup> after deductible
<p><b>(1)</b> Out-of-Network elective (non-preferred) professional services will be paid based on the 50th percentile of FairHealth. Out-of-Network elective (non-preferred) facility services will be paid based on the NAP Facility Charge Review under the National Advantage Program (NAP). Out-of-Network involuntary (preferred) professional services will be paid based on 125% of Medicare's allowable rate. Out-of-Network involuntary (preferred) facility services will be paid based upon NAP vendor contracts or NAP Facility Charge Review.</p> <p><b>(2)</b> Some of these services require precertification. For Network services, your physician should obtain precertification for you, however, you are ultimately responsible for precertification for all services out-of-network, otherwise a penalty of 50% of the Plan's recognized charges, to a maximum of \$10,000 will be applied. Refer to Plan Documents for a complete precertification list.</p> <p><b>Note:</b> 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.</p> <p><b>Note:</b> For Arkansas Residents - Invitro fertilization procedures, including, cryopreservation, is covered with a \$15,000 lifetime benefit, see SPD for more details.</p> <p>*Embedded means you can satisfy the Family "Deductible" or the Family "Maximum Out-of-pocket" by meeting the individual amount for any one (1) covered family Member and then any combination of family Members may satisfy the remaining amount. No more than the individual amount will be credited to the Family amount for any one Covered Person and no Covered Person will be required to meet more than the individual amount each Benefit Year.</p>		