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Learning Care Group

Basic Plan 2021

Highlights	Aetna Open Access Aetna Select Plan Aetna Premier Care Network Plus Preferred Benefits In-Network Provider
Coinsurance (Out-of-Pocket) Plan Member	80% after deductible
Deductible 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: Individual $2,000 / Family $6,000
Out-of-Pocket Maximum: 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. **Not included:** Premiums, balance-billing charges & health care this plan doesn't cover.	In-Network: Individual $5,000 / Family $12,500
Lifetime Maximum	Unlimited
PCP Office Visit (Non surgical, excluding Mental Health, Alcohol and Drug Abuse)	$25 copay
Specialist Office Visit (Non surgical, excluding Mental Health, Alcohol and Drug Abuse)	$50 copay
Preventive care /screening /immunizations *You may have to pay for services that are not preventive	100%
Other Physicians: (non-office visits)	80% after deductible
Outpatient Surgery	80% after deductible

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X-Ray & Lab Tests	80% after deductible
Hospital Inpatient Coverage: Outpatient Coverage:	 80% after deductible 80% after deductible
Emergency Room	$350 copay/visit for emergency use $500 copay/visit for non-emergency use.
Urgent Care Facility	$85 copay
Ambulance	80% after deductible
Acupuncture	100%, after $50 copay 30 visits maximum per year for chronic pain
Private Room Limit	Semiprivate
Mental Health & Substance Abuse: Inpatient Coverage: Outpatient Coverage:	 80% after deductible $25 copay
Skilled Nursing Facility Benefit maximum is a combined limit for preferred and nonpreferred services.	80% after deductible Up to 120 days per calendar year.
Home Health Care: Benefit maximum is a combined limit for preferred and nonpreferred services.	80% after deductible 120 visits maximum per year for private duty nursing, home heatlh care combined
Short Term Rehabilitation:	100%, after $50 copay 100 visits maximum for speech therapy, physical therapy, occupational therapy combined.

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Habilitative physical, occupational and speech therapy (PT/OT/ST)	100%, no deductible, no copay
Spinal Manipulation:	80% after deductible 30 visits maximum per calendar year.
Durable Medical Equipment	80% after deductible
Preventive Prenatal Maternity Visits	100% deductible waived
Prescription Drug **Benefits not provided by Aetna**	Generic-$15 copay Preferred Brand-$45 copay Non-Preferred Brand-$80 copay Specialty-25% coinsurance up to $250
Routine Exams Children: 7 exams 1st 12 months of life, 3 exams in the 13th-24th months of life, 3 exams in the 25th-36th months of life, 1 exam per calendar year thereafter Includes immunizations. Adults: 1 exam per calendar year. Includes immunizations.	100% deductible waived
Routine Mammograms No age or frequency limits	100% deductible waived
Routine Digital Rectal Exam (DRE) & Prostate Antigen Test (PSA) No age or frequency limits	100% deductible waived
Routine Ob/Gyn Exam 1 Pap smear and gynecological exam per calendar year	100% deductible waived
Routine Eye Exam	Not Covered
Flu Shot Vaccine	100% deductible waived
Routine Hearing Exam 1 exam per 24 months	$50 copay

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Hearing Aid $3,000 maximum every 2 years for Hearing Aids	80% after deductible
Family Planning & Infertility- **Tubal Ligaton**	100% deductible waived
Family Planning & Infertility- **Vasectomy**	80% after deductible for vasectomy
Basic Infertility Benefit	Includes coverage for the diagnosis and treatment of the underlying cause of infertility. Excludes GIFT, ZIFT, in vitro fertilization, and reverse sterilization.

What's Not Covered?

This plan does not cover all health care expenses and contains exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally *not covered.*

1. All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents;
2. Charges related to any eye surgery mainly to correct refractive errors;
3. Cosmetic surgery, including breast reduction;
4. Custodial care;
5. Dental care and X-rays;
6. Donor egg retrieval;
7. Experimental and investigational procedures;
8. Immunizations for travel or work;
9. Nonmedically necessary services or supplies;
10. Over-the-counter medications and supplies;
11. Reversal of sterilization;
12. Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and
13. Special duty nursing.

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Basic Plan 2021

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	Preferred Benefits In-Network Provider

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