

## 2021 ENHANCED MEDICAL PLAN BENEFIT SUMMARY

Administered by Aetna - P. O. Box 981106, El Paso, TX 79998-1106, (800) 238-6716, [www.aetna.com](http://www.aetna.com)

<b>PLAN PROVISIONS</b>	<b>NETWORK BENEFITS</b>	<b>NON-NETWORK BENEFITS *</b>
Deductible	\$250 Single; \$500 Family	\$500 Single; \$1,000 Family
Coinsurance	90% Plan; 10% Member	70% Plan; 30% Member
Out-of-Pocket Maximum <b>(O-P-M)</b>	\$3,000 Single; \$6,000 Family	\$4,500 Single; \$9,000 Family
Lifetime Maximum Policy Benefit	<b>NONE</b>	<b>NONE</b>
	<b>YOU PAY:</b>	<b>YOU PAY:</b>
Physician Office Services	Subject to deductible then coinsurance of 10% until O-P-M reached	Deductible then coinsurance of 30% until O-P-M reached
Specialist Physician Office Services	Subject to deductible then coinsurance of 10% until O-P-M reached	Deductible then coinsurance of 30% until O-P-M reached
Well Baby/Child Care	100% paid by Plan	Deductible then coinsurance of 30% until O-P-M reached
Comprehensive Physical Exams, Routine	100% paid by Plan	Deductible then coinsurance of 30% until O-P-M reached
Obstetrical Office Visits (Pre & Post Natal)	100% paid by Plan	Deductible then coinsurance of 30% until O-P-M reached
Allergy Services – Testing, Serum, Injections	Deductible then coinsurance of 10% until O-P-M reached	Deductible then coinsurance of 30% until O-P-M reached
Professional Fees for Surgical/Medical Services	Subject to deductible then coinsurance of 10% until O-P-M reached	Deductible then coinsurance of 30% until O-P-M reached
Inpatient Hospital Services	Subject to deductible then coinsurance of 10% until O-P-M reached	<b>With Prior Notification</b> - Deductible then coinsurance of 30%
Emergency Care	Subject to deductible then coinsurance of 10% until O-P-M	Deductible then coinsurance of 30% until O-P-M
Emergency Ambulance Services	100% of Eligible Expenses paid by Plan	Covered as Network Benefit
Urgent Care Services	Subject to deductible then co-insurance of 10% until O-P-M reached	Deductible then coinsurance of 30% until O-P-M reached
CVS Minute Clinics Non-CVS Minute Clinics	100% paid by Plan 10%; after deductible is met	Deductible then coinsurance of 30%
Outpatient Hospital & Alternate Facility Services	Deductible then coinsurance of 10% until O-P-M reached.	Deductible then coinsurance of 30% until O-P-M reached.
Outpatient Mental Health & Substance Abuse Services	Subject to deductible then coinsurance of 10% until O-P-M reached	Deductible then coinsurance of 30% until O-P-M reached

Inpatient Mental Health & Substance Abuse	Subject to deductible then coinsurance of 10% until O-P-M reached	Deductible then coinsurance of 30% until O-P-M reached
Prosthetic Devices & Durable Medical Equipment	Subject to Deductible then coinsurance of 10% <b>over \$1,000 requires prior approval</b> ; Maximum \$2,500 (except diabetic DME items)	Deductible then coinsurance of 30%; <b>over \$1,000 requires prior approval</b> ; Maximum \$2,500 (except diabetic DME items)
Outpatient Rehabilitation Services (Limitations Apply)	Subject to deductible then coinsurance of 10% until O-P-M reached	Deductible then coinsurance of 30% until O-P-M reached
Prescription Benefit – Retail Pharmacy	Tier I - \$10 Tier II – 25% (min \$50 – max \$100) Tier III – 40% (min \$100 –max \$150)	Deductible then coinsurance of 30%
Prescription Benefit – Mail Order 90-Day Supply	Tier I - \$25 (includes CVS retail stores) Tier II – 25% (min \$125 – max \$225) Tier III –40% (min \$225 – max \$325)	Not Covered

\*Subject to UCR and balance billing