Manatee YourChoice Health Plan

In-Network – Aetna POSII (Open Access)

2020 Levels of Reimbursement

	Ultimate Plan	Best Plan	Better Plan	Basic Plan
Preventive & Wellness Exams				
Adult Annual Exam & Immunizations	No Co-pay	No Co-pay	No Co-pay	No Co-pay
Child Annual Exam & Immunizations	No Co-pay	NA	No Co-pay	NA
Child Preventive Dental Program (Prophylaxis, Radiology, Restorative)	No Co-pay	NA	No Co-pay	NA
Physician Services and Other Benefit				
Deductible	None	$250	$500	$1,000
Coinsurance* (after Deductible)	None	20%	25%	50%
Annual Individual Out-of-Pocket (after Copay & Deductible, except Inpatient)	$1,400	$1,800	$2,400	$5,000
Primary Care and Specialty Physicians				
Office Visit	$25 Co-pay	$25 Co-pay	Ded. & Coin.	Ded. & Coin.
Lab, X-ray, & Imaging	No co-pay	Ded. & Coin.	Ded. & Coin.	Ded. & Coin.
Alternative Care Benefits- Nutritional Therapy				
Maximum Annual Benefit per Service	20 Visits per calendar year**			
Copay per Visit	$0-visits 1-5 $25/visit beyond	$0-visits 1-5 $25/visit beyond	$0-visits 1-5 $25/visit beyond	$0-visits 1-5 $25/visit beyond
Alternative Care Benefits - Physical Therapy, Occupational Therapy, Speech Therapy				
Maximum Annual Benefit per Service	20 Visits per calendar year**. **Note: The 20 visits per calendar year include the max 5 visits per calendar year allowed at an outpatient hospital/facility.**			
PT Copay per Visit	$0-visits 1-5 $25/visit beyond	Ded. & Coin.	Ded. & Coin.	Ded. & Coin.
OT & ST Copay per Visit	$25/visit	Ded. & Coin.	Ded. & Coin.	Ded. & Coin.
Alternative Care Benefits- All Other				
Maximum Annual Benefit per Service Copay per Visit	20 Visits per therapy per calendar year**: Chiropractic, Acupuncture, Massage			
Copay per Visit	$25.00 per visit	Ded. & Coin.	Ded. & Coin.	Ded. & Coin.
Hospital Benefits – Inpatient (Facility Only)				
Deductible **per** Confinement	None	$250	$250	$1,000
Coinsurance	None	20%	25%	50%
Maximum out of Pocket **after Deductible, per confinement**	None	$1,000	$1,200	$3,000
Emergency Room	$100 Copay	$150 Copay + Ded. & Coin.	$200 Copay + Ded. & Coin.	$300 Copay + Ded. & Coin.

*Coinsurance is the percentage of the cost for a covered service. A coinsurance of 20% means 80% of the covered cost is the Plan's responsibility and 20% is the member's responsibility (80%/20%, 75%/25%, 50%/50%).

** 20 Visits per calendar year is for in-network and out-of-network combined

Out of Network Benefits

2020 Levels of Reimbursement

	Ultimate Plan	Best Plan	Better Plan	Basic Plan
Preventive & Wellness Exams				
Adult Annual Exam & Immunizations	Ded. & Coin.	Ded. & Coin.	Ded. & Coin.	Ded. & Coin.
Child Annual Exam & Immunizations	Ded. & Coin.	NA	Ded. & Coin.	NA
Child Preventive Dental Program (Prophylaxis, Radiology, Restorative)	Ded. & Coin.	NA	Ded. & Coin.	NA
Physician Services and Other Benefit				
Deductible	$500	$750	$1,000	$2,000
Coinsurance* (after Deductible)	20%	20%	25%	50%
Annual Individual Out-of-Pocket (after Deductible)	$2,800	$5,000	$7,200	$10,000
Primary Care and Specialty Physicians				
Office Visit	Ded. & Coin.	Ded. & Coin.	Ded. & Coin.	Ded. & Coin.
Lab, X-ray, & Imaging	Ded. & Coin.	Ded. & Coin.	Ded. & Coin.	Ded. & Coin.
Alternative Care Benefits- Nutritional Therapy				
Maximum Annual Benefit per Service	Not Covered	Not Covered	Not Covered	Not Covered
Alternative Care Benefits - Physical Therapy, Occupational Therapy, Speech Therapy				
Maximum Annual Benefit per Service	20 Visits per calendar year**. **Note: The 20 visits per calendar year include the maximum 5 visits per calendar year allowed at an outpatient hospital/facility.**			
Cost per visit	Ded. & Coin.	Ded. & Coin.	Ded. & Coin.	Ded. & Coin.
Alternative Care Benefits- All Other				
Maximum Annual Benefit per Service Copay per Visit	20 Visits per therapy per calendar year**: Chiropractic & Massage. **Acupuncture not covered**			
Cost per visit	Ded. & Coin.	Ded. & Coin.	Ded. & Coin.	Ded. & Coin.
Hospital Benefits – Inpatient (Facility Only)				
Deductible **per** Confinement	$250	$750	$1,000	$2,000
Coinsurance	20%	20%	25%	50%
Maximum out of Pocket **after Deductible, per confinement**	$2,550	$2,450	$2,600	$3,000
Emergency Room	$100 Copay	$150 Copay + Ded. & Coin.	$200 Copay + Ded. & Coin.	$300 Copay + Ded. & Coin.

*Coinsurance is the percentage of the cost for a covered service. A coinsurance of 20% means 80% of the covered cost is the Plan's responsibility and 20% is the member's responsibility (80%/20%, 75%/25%, 50%/50%).

** 20 Visits per calendar year is for in-network and out-of-network combined.