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| **Effective January 1, 2014** | **U.S. Network** **Aetna Open Choice PPO**  | **Out-of-Network** |
| **General** |
| **A plan year is a calendar year, January 1 through December 31** |
| Medical Deductible (per person) | $1,000 per plan year |
| **Medical Out-of-pocket limits (Office visit co-payments and dental services do not accrue toward the out of pocket limits)** |
| Medical out-of-pocket limits per person | $5,000 per plan year  |
| **Office visits** |
| Office visits for Illness or Specialist | 100% after $20 co-pay | 75% after deductible  |
| Routine annual physicals and defined preventive services\*  | 100% |
| Ob/GYN (well woman) exam – one per plan year\* | 100% |
| **Laboratory and X-rays** |
| All services; (unless covered under defined preventive services above)  | 75% after deductible  |
| **Emergency room related** |
| [Emergency Room](http://intranet.worldbank.org/WBSITE/INTRANET/UNITS/HR/0%2C%2CcontentMDK%3A20377365~currentSitePK%3A328635~pagePK%3A64207891~piPK%3A64207885~theSitePK%3A328635%2C00.html) | 75% after deductible  |
| [Ambulance Services](http://intranet.worldbank.org/WBSITE/INTRANET/UNITS/HR/0%2C%2CcontentMDK%3A20386767~currentSitePK%3A328635~pagePK%3A64207891~piPK%3A64207885~theSitePK%3A328635%2C00.html) | 75% after deductible  |
| **Inpatient** |
| Hospital costs including anesthesia | 75% after deductible  |
| Surgery (physician) |
| Hospice |
| **Outpatient** |
| Hospital costs including anesthesia | 75% after deductible  |
| Surgery (physician) |
| Hospice |
| **Chemotherapy and Radiation Therapy** |
| Chemotherapy and Radiation Therapy:Does not include oral or injectable medications purchased through pharmacy benefit | 100%, no deductibleIn-office/facility administrationonly |
| **Maternity** |
| Maternity not covered under Sponsored Plan  |
| **Mental Health and Substance Abuse** |
| Inpatient hospitalization for mental health or substance abuse | 75% after deductible  | 75% after deductible  |
| Outpatient facility, including day treatment programs |
| Office visits | 100% after $20 co-pay  |
| **Nursing and Home Health Care** |
| Skilled Nursing Facility – (e.g., Rehabilitation Center) *Maximum 60 days per condition per plan year* | 75% after deductible  |
| Convalescent Care *Maximum 60 days per condition per plan year* |
| Visiting Nurse –*Maximum 120 days per condition per plan*  |
| Private Duty Nursing – *Contact Insurance Administrator for authorization* |
| **Short Term Rehabilitation** |
| Physical, occupational or speech therapy – *Restorative service after illness or accident. 60 visits PT, OT, ST combined per condition per plan year. Visits over 60 review for medical necessity.* | 100% after $20 co-pay  | 75% after deductible  |
| Physical, occupational or speech therapy – *For diagnosis of Development Delay a maximum 60 visits PT, OT, ST combined, per year, per child* |
| Chiropractor (30 visit limit per year)  |
| Acupuncture (30 visit limit per year)  | Currently no providers  |
| **Durable Medical Equipment** |
| [Durable Medical Equipment](http://intranet.worldbank.org/WBSITE/INTRANET/UNITS/HR/0%2C%2CcontentMDK%3A20342793~currentSitePK%3A328635~pagePK%3A64207891~piPK%3A64207885~theSitePK%3A328635%2C00.html):Rentals *Purchases only if approved by Insurance Administrator* | 75% after deductible  |
| **Vision Care** |
| Routine eye exams, one per plan year, including refraction.  | 100% after $20 co-pay | 75% after deductible  |
| Frames, lenses, contacts | Up to $200 reimbursement every two plan years |
| **Hearing Aids** |
| Hearing Aids | Maximum reimbursement $4,000 every five plan years |
| **Oral Surgery** |
| Gingivectomy, gingioplasty, alveoplasty, vestibuloplasty, osseous surgery, implant surgery, oral surgery | 75% after deductible  |
| **Dental services are not covered under the Sponsored Parent plan** |

\*Defined preventive care serviceswill be provided at 100% when an In Network physician or facility is used.

Defined preventive services are determined by gender and age and recommendations may change from

time to time. Always check the most recent recommendations with your Insurance Administrator and discuss

them with your doctor.

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| **Prescription drugs –**  | **US Network**  | **All other**  |
| Annual Deductible per person | $100 | Prescriptions purchased outside of the U.S.networkare covered under your medical benefit 80% after medical deductible  |
| Out-of-pocket limits per person | $1,000 per plan year |
| Generics (retail, mail order, Specialty) | 100% |
| Preferred Brand-name (retail)  |  80% after deductible |
| Preferred Brand-name (mail order) |  80%no deductible |
| Non Preferred Brand-name (retail) |  70% after deductible |
| Non Preferred Brand-name (mail order) |  70% no deductible |
| SPECIALTY Drugs  | 80%after deductible |