THE CHILDREN'S CARE NETWORK

Effective Date: January 1, 2023

	MEDICAL - AETNA				
Plan Name	**OA HMO $5,500**	**OA POS Managed Choice $6,850**	**OA POS Managed Choice $3,000 HSA**	**OA POS Managed Choice $2,500**	**OA POS Managed Choice $500**
Network	**Health Network Only**	**Open Access Managed Choice POS - GA**	**Open Access Managed Choice POS - GA**	**Open Access Managed Choice POS - GA**	**Open Access Managed Choice POS - GA**
Deductible Accumulation	**Calendar Year**	**Calendar Year**	**Calendar Year**	**Calendar Year**	**Calendar Year**
IN NETWORK	**Embedded**	**Embedded**	**Embedded**	**Embedded**	**Embedded**
Deductibles (Indv/Fam)	$5,500 / $11,000	$6,850 / $13,700	$3,000 / $6,000	$2,500 / $5,000	$500 / $1,500
Preventive Care	No Charge	No Charge	No Charge	No Charge	No Charge
Primary Care Visit	$35 Copay	$40 Copay	20% after deductible	$30 Copay	$25 Copay
Specialist Visit	$75 Copay	$80 Copay	20% after deductible	$60 Copay	$50 Copay
X-Ray	No Charge	30% after deductible	20% after deductible	20% after deductible	20% after deductible
Complex Imaging	$250 Copay	30% after deductible	20% after deductible	20% after deductible	20% after deductible
Outpatient Facility	30% after deductible	30% after deductible	20% after deductible	20% after deductible	20% after deductible
Inpatient Visit	30% after deductible	30% after deductible	20% after deductible	20% after deductible	20% after deductible
Urgent Care	$100 Copay	$75 Copay	20% after deductible	$75 Copay	$75 Copay
Emergency Room	30% after deductible	$300 Copay then 30%	20% after deductible	$250 Copay then 20%	$200 Copay then 20%
Out-of-Pocket Max (Individual/Family)	$7,900 / $15,800	$7,900 / $15,800	$6,900 / $13,800	$7,900 / $15,800	$7,900 / $15,800
PHARMACY	**Advanced Control Plan**	**Advanced Control Plan**	**Advanced Control Plan**	**Advanced Control Plan**	**Advanced Control Plan**
Deductible (Indv/Fam)	Integrated with Medical	$250 / $750	Integrated with Medical	$250 / $750	$200 / $400
Tier I	$10 Copay	$20 Copay	$15 Copay after deductible	$20 Copay	$20 Copay
Tier II	$55 Copay	$45 Copay after deductible	$40 Copay after deductible	$45 Copay after deductible	$45 Copay after deductible
Tier III	$100 Copay after deductible	$75 Copay after deductible	$85 Copay after deductible	$75 Copay after deductible	$75 Copay after deductible
Specialty	25% up to max $350 after deductible	25% up to max $350 after deductible	25% up to max $350 after deductible	25% up to max $350 after deductible	25% up to max $350 after deductible
OUT OF NETWORK		**Embedded**	**Embedded**	**Embedded**	**Embedded**
Deductibles (Indv/Fam)	Not Covered	$10,000 / $20,000	$10,500 / $21,000	$7,500 / $22,500	$5,000 / $15,000
Coinsurance		40%	40%	40%	40%
Out-of-Pocket Max (Indv/Fam)		$20,000 / $40,000	$20,500 / $41,000	$23,500 / $47,000	$15,000 / $30,000
RATES - with Dental/Vision/VB Move	**OA HMO $5,500 RATES**	**OA POS Managed Choice $6,850 RATES**	**OA POS Managed Choice $3,000 HSA RATES**	**OA POS Managed Choice $2,500 RATES**	**OA POS Managed Choice $500 RATES**
Employee	$691.72	$780.39	$764.28	$848.80	$921.26
Employee + Spouse	$1,452.69	$1,638.89	$1,604.85	$1,782.56	$1,934.75
Employee + Child(ren)	$1,348.87	$1,521.77	$1,490.15	$1,655.17	$1,796.48
Family	$2,237.88	$2,524.74	$2,472.28	$2,746.06	$2,980.50

Embedded - The individual out-of-pocket is the most any individual will pay, even if enrolled with other family members

Non-Embedded - The entire family deductible & out-of-pocket must be met, even if only by one family member

On Out of Network services, the member may be responsible for any amount over the allowed amount (balance bill)

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	DENTAL - AETNA	
	HIGH PLAN	**LOW PLAN**
IN NETWORK		
Deductibles (Individual / Family)	$50 / $150	$50 / $150
Preventive Care	0%	0%
Basic Procedures (extractions, fillings, etc.)	20% after deductible	20% after deductible
Major Procedures (crowns, dentures, etc.)	50% after deductible	N/A
Child Orthodontia	50% with lifetime max of $1,000	N/A
OUT OF NETWORK	**BASED ON MAXIMUM 90th UCR**	**BASED ON MAXIMUM ALLOWED CHARGE**
Deductibles (Individual / Family)	$50 / $150	$50 / $150
Preventive Care	0%	0%
Basic Procedures (extractions, fillings, etc.)	20% after deductible	20% after deductible
Major Procedures (crowns, dentures, etc.)	50% after deductible	N/A
Child Orthodontia	50% with lifetime max of $1,000	N/A
COMBINED CALENDAR YEAR MAX BENEFIT		
Calendar Year Maximum Benefit	$1,500	$1,500
Orthodontia Lifetime Maximum	$1,000	N/A
MONTHLY RATES	**HIGH PLAN RATE**	**LOW PLAN RATE**
Employee	$31.40	$15.06
Employee + Spouse	$72.40	$34.58
Employee + Child(ren)	$73.35	$39.32
Family	$116.60	$61.92

If you utilize a non-participating dentist, you may be responsible for the difference between the carrier's reimbursement schedule and the amount the dentist charged (balance bill).

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Effective Date: January 1, 2023

	VISION - AETNA	
PLAN FEATURES	**IN NETWORK**	**OUT OF NETWORK**
Vision Exam	$10 Copay	Reimbursed up to $32
Lenses		
Single	$10 Copay	Reimbursed up to $25
Bifocal	$10 Copay	Reimbursed up to $40
Trifocal	$10 Copay	Reimbursed up to $64
Elective Contact Lenses	$130 Allowance	Reimbursed up to $104
Frames	$130 allowance then 20% off the remainder	Reimbursed up to $65
Frequency (Months)		
Exam	12 months	
Lenses	12 months	
Frames	24 months	
Contacts	12 months	

MONTHLY RATES	RATE
Employee	$6.21
Employee + Spouse	$11.80
Employee + Child(ren)	$12.42
Family	$18.27

If you utilize a non-participating provider, you may be responsible for the difference between the carrier's reimbursement schedule and the amount the dentist charged (balance bill).