Pequot Open Plan

The chart in this section explains your health care options for the Pequot Open Plan in effect as of January 1, 2022.

The amounts shown in this comparison reflect what you pay.	**Benefits**
Annual Deductible **(applies to annual out-of-pocket maximum)** • Team Member • Team Member + Child or Spouse • Family	 $1,250 $2,500 $3,750
Annual Out-of-Pocket Maximum**	**Includes deductibles, coinsurance and copays**
(penalties for lack of pre-certification and non-covered expenses do not apply) • Team Member • Team Member + Child or Spouse • Family	 $3,750 $7,500 $11,250
Pre-Certification Penalty	
(for failure to pre-certify medically necessary procedures) (Expenses will not apply to out-of-pocket.)	20%, up to the first $5,000 of covered expenses or zero reimbursement, depending on the network
Routine Physicals (one per plan year)	no cost to you, no deductible*
Annual Gynecological Exam (One routine exam and Pap smear per plan year, 16 years and older)	no cost to you, no deductible*
Routine Mammogram • Ages 20 to 40 years: One routine mammogram every 24 months • Ages 40 and older: One every 12 months	 no cost to you, no deductible*
Routine Colonoscopy (Age 50 and older: One every five years)	no cost to you, no deductible*
Routine Immunizations (Up to age 19); and *Routine Immunizations* (Age 19 and older) as recommended by the Advisory Committee on Immunization Practices (ACIP)**	no cost to you, no deductible*
Routine Pediatric Care	no cost to you, no deductible*
Hospital Services	10% after deductible
Pre-Natal and Post-Natal Care	10% after deductible
Birthing Facility Fee	10% after deductible
Physician Office Visits (does not include charges for telephone calls between patient and physician, when there is a charge for such calls)	$25 copay per visit, no deductible
Urgent Care (hospital-based) – Urgent Care visit charge only; for other services performed see that section.	$50 copay per visit, no deductible
Walk-In Center (non-hospital-associated) – office visit only; for other services performed see that	

section.	
	$25 copay per visit, no deductible
X-rays, Ultrasounds, CT and PET Scans, RIs, and SPECTs	10% after deductible
Restorative Physical and Occupational Therapy	$25 copay per visit, no deductible
Chiropractic Care	$25 copay per visit, no deductible Maximum 25 visits per year
Acupuncture, when deemed medically necessary (maximum $500 per plan year)	$25 copay per visit, no deductible
Cardiac Rehabilitation (Up to 60 visits per year)	$25 copay per visit, no deductible
Speech Therapy (must be physician approved)	$25 copay per visit, no deductible
Allergy Testing and Injections	10% after deductible
Chemotherapy	10% after deductible
Contraceptive Management (16 years and older)	10% after deductible
Diagnostic Procedures (performed in a hospital or for outpatient surgical care)	10% after deductible
Laboratory Tests (outpatient)	covered 100%*
Ambulatory Surgical Facility Fee	10% after deductible
Pre-Admission Testing	10% after deductible
Second Surgical Opinion	$25 copay, no deductible
Inpatient Care • Room and Board Limited to 120 days per calendar year (semi-private room) • Inpatient physician services • Miscellaneous inpatient services and supplies	$250 copay per admission plus 10%, after deductible
Skilled Nursing Facility • Medical care only; no custodial care • Limited to 365 days maximum per confinement	10% after deductible $250 copay unless transferred directly from inpatient
Anesthesia Services	10% after deductible
Assistant Surgical Services	10% after deductible
Cast and Dressing Services	10% after deductible
Elective Surgery • With Pre-certification	10% after deductible
• Without Pre-certification, if deemed medically necessary	10% after 20% pre-certification penalty, up to first $5,000 of covered expenses, after deductible
Emergency Surgery	10% after deductible
Maternity Surgery (including physician attendance)	10% after deductible
Ambulance for Emergency	20%, no deductible
Durable Medical Equipment (Some items may require precertification)	10% after deductible
Emergency Room Services	

(at a hospital emergency room for sudden or serious illness or accident) – ER visit charge only; for other services performed see that section.	$100 copay per visit, no deductible
Home Health (when skilled services are required)	
• Combined with special duty nursing, limited to 120 days per calendar year	10% after deductible
• Physician House Calls	Not covered
Hospice Care	10% after deductible
Accident-Related Dental Services	10% after deductible

- Hearing aids: Maximum of $2000 paid every 36 months.
- Wigs: $100 and 1 wig every 3 years

** Ask Provider to send to a network Laboratory*
**For annual physicals and preventive screenings covered under the Affordable Care Act.*
*** The annual out-of-pocket maximum includes deductibles, coinsurance and copays for medical and prescription drugs.*
Expenses incurred in the last quarter of the year do not carry over to the next year.
**http://www.immunize.org/catg.d/p2011.pdf

Deductible
The annual deductible is the amount you and each covered family member must pay each plan year for covered medical and prescription drug expenses before the plan begins to pay benefits. After you satisfy the annual deductible requirement, the plan reimburses a percentage of covered expenses.

Certain services, such as child immunizations provided by network physicians, are not subject to the deductible. For more information, see "Your Health Care Options at a Glance" in the *Your Medical Plan* section. Amounts you pay as copays do not count toward your deductible.
A family deductible is met when the accumulation of all individual family member's deductibles combined, not exceeding each member's individual deductible, meet the total family deductible amount. A new deductible applies each year.

Out-of-Pocket Maximum
The out-of-pocket maximum limits the amount you and your family pay for covered medical expenses each year. Essentially, the out-of-pocket maximum protects you against having to pay extraordinary medical bills in a given year.

Once your share of covered expenses reaches the out-of-pocket maximum, the plan pays 100% of the eligible charges for any additional covered expenses for the rest of the plan year.

The annual out-of-pocket maximum includes deductibles, coinsurance and copays for medical and prescription drugs.

The following expenses do not count toward your out-of-pocket maximum:

- Penalty for non-certified hospital stays and non-certified outpatient services requiring pre-certification
- Maximum Allowable Amount
- Dental coinsurance
- Vision care expenses
- Expenses not covered by the plan