ABC IMAGING OF WASHINGTON DC GROUP HEALTH PLAN
PPO MEDICAL COVERAGE SUMMARY

In-Network Providers will submit claims to Continental Benefits on the patient's behalf.
Out-of-Network claims must be filed no later than 12 months after the claim was incurred or the claim will be denied.

TopCare
Powered by:
COMPASS

If you need a medical procedure/diagnostic imaging and/or surgery, our Health Pro can help you through the process. Contact your Health Pro at (844) 657-0900 for more information and assistance in selecting a provider. Normal benefits will be paid as described below.

Submit Medical Claims to: Continental Benefits; PO Box 3610, Brandon, FL 33809-3610
Electronic Claims Submission for Medical Claims: Payer ID # 35245
For a list of Preferred Providers: www.aetna.com/asa
Submit Pharmacy Claims to: Envolve Health., https://pharmacy.envolvehealth.com/members.html;
Member Services: (844) 406-8066 Pharmacy Help Desk: (844)-406-8099
Electronic Claims Submission for Pharmacy Claims: RxBIN: 008019; Rx Grp: 251000

Pre-Certification: American Health Holdings – (800) 641-5566

Inpatient Hospital admissions (including Mental Illness and Substance Abuse admissions); Skilled Nursing Facility and Rehabilitation Facility admissions; Routine and high risk maternity (routine only if inpatient stay exceeds 48/96 hours); Long term acute care; Outpatient surgeries including, but not limited to, back surgeries, hysterectomy, transplants, sleep apnea surgeries, etc.; Non-emergency CT Scan, MRI, PET Scan, capsule endoscopy and genetic testing, including BRCA; Dialysis; Chemotherapy; Radiation therapy; Hyperbaric oxygen; Home Health Care; Durable Medical Equipment, limited to electric/motorized scooters or wheelchairs.

Pre-Certification Penalty: $500 penalty if Pre-Certification is not obtained. The penalty will be assessed to the provider if the services are rendered by an in-network provider and Pre-Certification is not obtained. If services are rendered by an out-of-network provider, the penalty will be assessed to the Participant if Pre-Certification is not obtained.

MEDICAL PLAN DEDUCTIBLES AND MAXIMUMS

Benefits and cost sharing accumulate on a Plan Year basis from 12/1 through 11/30 each year.

TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule. The Deductible applies to all services prior to benefit payment, except for Copay services and where noted	OUT-OF-NETWORK PROVIDER The Allowable Expense is limited to the Maximum Allowable Charge or other amount determined by the Plan Administrator. The Deductible applies to all services prior to benefit payment, except where noted
DEDUCTIBLE	Per Plan Year (Carryover does not apply) In-network and out-of-network deductibles are not combined. The Deductible is embedded.	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family
MEDICAL OUT-OF-POCKET MAXIMUM	Per Plan Year (Carryover does not apply) Includes medical deductible, coinsurance, Copays and prescription drug out-of-pocket expenses. In-network and out-of-network Out-of-Pocket Maximums are not combined. The Out-of-Pocket Maximum is embedded.	$6,350 Individual $12,700 Family	$15,000 Individual $30,000 Family
ANNUAL/LIFETIME MAXIMUM		Unlimited	

Radiologist, Anesthesiologists, Pathologists and Emergency Care: If you have a covered surgical procedure or inpatient stay at a Participating Hospital or facility, services by the associated physician, radiologist, anesthesiologist or pathologist, will be payable at the in-network benefit level. Emergency care and associated professional fees (E.g. anesthesiologist, pathologist, radiologist, etc.) rendered in a Hospital Emergency room will be payable at the in-network benefit level when rendered by either a non-preferred or Preferred Provider. The treatment must be for an Emergency as defined in the Plan. Follow-up care will be payable according to the Coverage Summary.

TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule. The Deductible applies to all services prior to benefit payment, except for Copay services and where noted	OUT-OF-NETWORK PROVIDER The Allowable Expense is limited to the Maximum Allowable Charge or other amount determined by the Plan Administrator. The Deductible applies to all services prior to benefit payment, except where noted
ACUPUNCTURE	Maximum of 12 visits per Plan Year.	100% after deductible	80% after deductible
ALLERGY CARE			
-Office Visit		$30 Copay per visit	80% after deductible
-Treatment (Injections)		100%, deductible waived after office visit copay	80% after deductible
-Serum		100%, deductible waived after office visit copay	80% after deductible
-Laboratory & Scratch Testing		Refer to Laboratory benefit	Refer to Laboratory benefit
AMBULANCE	Ground or Air ambulance is covered if Medically Necessary.		
-Emergency		100% after deductible	Same as in-network
-Non-Emergency		100% after deductible	80% after deductible
ANESTHESIA			
-Inpatient		100% after deductible	80% after deductible
-Outpatient		100% after deductible	80% after deductible
-Office		100% after deductible	80% after deductible
AUTISM SPECTRUM DISORDERS	Covered when Medically Necessary. Visit maximums do not apply to Participants aged 2 through 10 years.	Covered as described under type of service rendered	Covered as described under type of service rendered
BIOFEEDBACK		Not covered	Not covered
CARDIAC REHABILITATION	Maximum of 36 visits per Plan Year.		
-Office		$30 Copay per visit	80% after deductible
-Any Other Place of Service		$30 Copay per visit	80% after deductible
CHEMOTHERAPY	Pre-Certification required. Penalty listed above applies if not obtained.		
-Outpatient Hospital		100% after deductible	80% after deductible
-Office		100% after deductible	80% after deductible
-Any Other Place of Service		100% after deductible	80% after deductible
CHIROPRACTOR	Maximum of 20 visits per Plan Year	$30 Copay per visit	80% after deductible
COGNITIVE REHABILITATION	Maximum of 20 visits per Plan Year	$30 Copay per visit	80% after deductible

TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule. The Deductible applies to all services prior to benefit payment, except for Copay services and where noted	OUT-OF-NETWORK PROVIDER The Allowable Expense is limited to the Maximum Allowable Charge or other amount determined by the Plan Administrator. The Deductible applies to all services prior to benefit payment, except where noted
DENTAL CARE COVERED UNDER MEDICAL PLAN	Routine care is not covered.		
-Accidental Injury to Teeth	Treatment must be completed within 12 months of the accident.	100% after deductible	100% after deductible
-Dental Oral Surgery		Not covered	Not covered
-Anesthesia and Facility Services	Covered for a child under 5 years of age, a patient that is severely disabled or has one or more medical conditions that necessitate admission to a Hospital or Alternate Facility and general anesthesia for dental treatment.	Covered as described under type of service rendered	Covered as described under type of service rendered
DIABETIC TREATMENT			
-Education		$30 Copay per visit	80% after deductible
-Supplies and Equipment	Refer to the Prescription Drug benefit for additional benefits available	100% after deductible	80% after deductible
DIAGNOSTIC X-RAYS AND IMAGING TESTS	Pre-Certification required on genetic testing. Penalty listed above applies if not obtained.		
-Independent Facility		100% after deductible	80% after deductible
-Outpatient Hospital		100% after deductible	80% after deductible
-Physician's Office		100%, deductible waived after office visit copay	80% after deductible
HIGH TECH IMAGING ***(SUCH AS MRI, MRA, PET AND CAT SCANS)***	Pre-Certification required on non-emergent imaging. Penalty listed above applies if not obtained.		
-Independent Facility		$150 Copay per visit	80% after deductible
-Outpatient Hospital		$150 Copay per visit	80% after deductible
-Physician's Office		$150 Copay per visit	80% after deductible
DIALYSIS OR HEMODIALYSIS	Pre-Certification required. Penalty listed above applies if not obtained.		
-Outpatient Hospital		100% after deductible	80% after deductible
-Office		100% after deductible	80% after deductible
-Any Other Place of Service		100% after deductible	80% after deductible

TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule. The Deductible applies to all services prior to benefit payment, except for Copay services and where noted	OUT-OF-NETWORK PROVIDER The Allowable Expense is limited to the Maximum Allowable Charge or other amount determined by the Plan Administrator. The Deductible applies to all services prior to benefit payment, except where noted
DURABLE MEDICAL EQUIPMENT (DME) ***Including, but not limited to:***	Pre-Certification required on DME limited to electric/motorized scooters or wheelchairs. Penalty listed above applies if not obtained.		
-Durable Medical Equipment	Benefits limited to single purchase of a type of DME (including repair/replacement) every three years or as needed to accommodate growth in young children	100% after deductible	80% after deductible
-Disposable Medical Supplies	Excluded except as needed for the effective use of covered Durable Medical Equipment. Covers ostomy supplies.	100% after deductible	80% after deductible
-Prosthetics (Internal)		100% after deductible	80% after deductible
-Prosthetics (External)		100% after deductible	80% after deductible
-Foot Orthotics		Not covered	Not covered
-Orthotics (Braces)		100% after deductible	80% after deductible
ENTERAL FORMULA		Not covered	Not covered
FAMILY PLANNING SERVICES			
-Elective Sterilization Procedures			
Tubal Ligation		100%, deductible waived	80% after deductible
Vasectomy		Covered as described under type of service rendered	Covered as described under type of service rendered
-Contraceptive Devices		100%, deductible waived	80% after deductible
-Contraceptive Management Office Visit		100%, deductible waived	80% after deductible
-Infertility Treatment	The Plan covers Medically Necessary diagnostic testing and treatment of the Sickness or Injury that is the underlying cause of infertility and artificial insemination (1 visit/plan year to a maximum of $2,500) Other advanced assisted reproductive procedures are not covered.	Covered as described under type of service rendered	Covered as described under type of service rendered

TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule. The Deductible applies to all services prior to benefit payment, except for Copay services and where noted	OUT-OF-NETWORK PROVIDER The Allowable Expense is limited to the Maximum Allowable Charge or other amount determined by the Plan Administrator. The Deductible applies to all services prior to benefit payment, except where noted
GENDER REASSIGNMENT SERVICES	Covered per guidelines in the plan document.	Covered as described under type of service rendered	Covered as described under type of service rendered
GENETIC TESTING AND COUNSELING	Covered when Medically Necessary.		
-Genetic Testing		Refer to diagnostic testing and laboratory benefits.	Refer to diagnostic testing and laboratory benefits.
-Genetic Counseling		100% after deductible	80% after deductible
HEARING AIDS AND EXAMS	Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years. Limited to $5,000 in eligible expenses per Plan Year.	100% after deductible	80% after deductible
HOME HEALTH CARE	Pre-Certification required. Penalty listed above applies if not obtained. Maximum of 60 visits per Plan Year.	100% after deductible	80% after deductible
HOSPICE CARE			
-Inpatient		100% after deductible	80% after deductible
-Home		100% after deductible	80% after deductible
HOSPITAL FACILITY			
Inpatient Hospital	Pre-Certification required. Penalty listed above applies if not obtained.	$500 copay per admission, then 100% after deductible	$500 copay per admission, then 80% after deductible
Outpatient Hospital			
-Emergency Room for a medical Emergency		100% after deductible	100% after deductible
-Emergency Room for non-Emergency care		100% after deductible	100% after deductible
-Outpatient Surgical Center	Pre-Certification required on certain surgical procedures. Penalty listed above applies if not obtained.	$250 Copay per admission, then 100% after deductible	$250 Copay per admission, then 80% after deductible
INFUSION THERAPY		100% after deductible	80% after deductible
LABORATORY	Pre-Certification required on genetic testing. Penalty listed above applies if not obtained.		
-Independent Facility		100% after deductible	80% after deductible
-Outpatient Hospital		100% after deductible	80% after deductible
-Physician's Office		100%, deductible waived after office visit copay	80% after deductible

TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule. The Deductible applies to all services prior to benefit payment, except for Copay services and where noted	OUT-OF-NETWORK PROVIDER The Allowable Expense is limited to the Maximum Allowable Charge or other amount determined by the Plan Administrator. The Deductible applies to all services prior to benefit payment, except where noted
MASSAGE THERAPY (When rendered by a Licensed Massage Therapist)		Not covered	Not covered
MATERNITY CARE-MOTHER -Inpatient Hospital or Birthing Center -Physician for Prenatal Care and Delivery	Post-Certification required if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean section. Penalty listed above applies if not obtained.	$500 copay per admission, then 100% after deductible 100% after deductible; routine prenatal care covered at 100%, deductible waived	$500 copay per admission, then 80% after deductible 80% after deductible
MENTAL ILLNESS SERVICES -Inpatient -Inpatient Physician -Outpatient -Office	Pre-Certification required on inpatient admissions. Penalty listed above applies if not obtained. Includes coverage for residential care.	100% after deductible 100% after deductible 100% after deductible $30 Copay per visit	80% after deductible 80% after deductible 80% after deductible 80% after deductible
MODIFIED FOOD PRODUCT		Not covered	Not covered
NEWBORN CARE (Prior to Discharge) -Hospital -Physician	Post-Certification required if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean section. Penalty listed above applies if not obtained.	100% after deductible; however if length of stay is the same as mother's length of stay benefits will be paid at 100%, deductible waived 100% after deductible	80% after deductible; however if length of stay is the same as mother's length of stay benefits will be paid at 80%, deductible waived 80% after deductible
NUTRITIONAL COUNSELING		100% after deductible	80% after deductible
OBESITY TREATMENT		Not covered	Not covered

TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule. The Deductible applies to all services prior to benefit payment, except for Copay services and where noted	OUT-OF-NETWORK PROVIDER The Allowable Expense is limited to the Maximum Allowable Charge or other amount determined by the Plan Administrator. The Deductible applies to all services prior to benefit payment, except where noted
OCCUPATIONAL THERAPY	Maximum of 30 visits per Plan Year combined for occupational, physical and speech therapies.		
-Office		$30 Copay per visit	80% after deductible
-Any Other Place of Service		$30 Copay per visit	80% after deductible
ORGAN TRANSPLANTS Guidelines apply – Refer to your Plan Document for more information on this benefit	Pre-Certification required. Penalty listed above applies if not obtained. Travel, lodging and meals are not covered.	Covered as described under type of service rendered	Covered as described under type of service rendered
PHYSICAL THERAPY	Maximum of 30 visits per Plan Year combined for occupational, physical and speech therapies.		
-Office		$30 Copay per visit	80% after deductible
-Any Other Place of Service		$30 Copay per visit	80% after deductible
PHYSICIAN			
-Inpatient		100% after deductible	80% after deductible
-Office/Clinic (PCP)		$30 Copay per visit	80% after deductible
Consultation (Specialist)			
-Inpatient		100% after deductible	80% after deductible
-Outpatient		100% after deductible	80% after deductible
-Office/Clinic		$30 Copay per visit	80% after deductible
Second Medical Opinion		$30 Copay per visit	80% after deductible
POST-COCHLEAR IMPLANT AURAL THERAPY	Maximum of 30 visits per Plan Year.	$30 Copay per visit	80% after deductible
PREADMISSION TESTING		Refer to Laboratory and Diagnostic Tests benefits	Refer to Laboratory and Diagnostic Tests benefits
PREVENTATIVE/WELL CARE	Preventative/Well Care is covered as defined in the Patient Protection and Affordable Care Act, as amended.		
-Physician Office Services		100%, deductible waived	80% after deductible
-Lab, X-ray or other preventive tests		100%, deductible waived	80% after deductible
-Immunizations		100%, deductible waived	80% after deductible
-Women's Preventive Care	Covered as described by the Health Resources and Services Administration (HRSA)	100%, deductible waived	80% after deductible
-Mammograms (Routine) Includes coverage for routine 3D mammograms		100%, deductible waived	80% after deductible
-Routine Vision Exam		Not covered	Not covered
-Routine Hearing Screening		Not covered	Not covered

TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule. The Deductible applies to all services prior to benefit payment, except for Copay services and where noted	OUT-OF-NETWORK PROVIDER The Allowable Expense is limited to the Maximum Allowable Charge or other amount determined by the Plan Administrator. The Deductible applies to all services prior to benefit payment, except where noted
PRIVATE DUTY NURSING		Not covered	Not covered
RADIATION THERAPY	Pre-Certification required. Penalty listed above applies if not obtained.		
-Outpatient Hospital		100% after deductible	80% after deductible
-Office		100% after deductible	80% after deductible
-Any Other Place of Service		100% after deductible	80% after deductible
REHABILITATION FACILITY	Pre-Certification required. Penalty listed above applies if not obtained. Maximum of 60 days per Plan Year combined with Skilled Nursing Facility.	100% after deductible	80% after deductible
RESPIRATORY THERAPY	Maximum of 20 visits per Plan Year		
-Outpatient Hospital		$30 Copay per visit	80% after deductible
-Any Other Place of Service		$30 Copay per visit	80% after deductible
SLEEP STUDIES AND TREATMENT	Must be Medically Necessary treatment of documented sleep apnea.	100% after deductible	80% after deductible
SPEECH THERAPY	Maximum of 30 visits per Plan Year combined for occupational, physical and speech therapies.		
-Office		$30 Copay per visit	80% after deductible
-Any Other Place of Service		$30 Copay per visit	80% after deductible
SKILLED NURSING FACILITY	Pre-Certification required. Penalty listed above applies if not obtained. Maximum of 60 days per Plan Year combined with Rehabilitation Facility.	100% after deductible	80% after deductible
SUBSTANCE ABUSE TREATMENT	Pre-Certification required on inpatient admissions. Penalty listed above applies if not obtained. Includes coverage for residential care.		
-Detoxification		100% after deductible	80% after deductible
-Inpatient Rehabilitation		100% after deductible	80% after deductible
-Inpatient Physician		100% after deductible	80% after deductible
-Outpatient		100% after deductible	80% after deductible
-Office		$30 Copay per visit	80% after deductible

TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule. The Deductible applies to all services prior to benefit payment, except for Copay services and where noted	OUT-OF-NETWORK PROVIDER The Allowable Expense is limited to the Maximum Allowable Charge or other amount determined by the Plan Administrator. The Deductible applies to all services prior to benefit payment, except where noted
SURGERY (Refer to Hospital Facility, Surgery Center or Anesthesia for benefits related to surgery) Surgeon	Pre-Certification required on certain surgical procedures. Penalty listed above applies if not obtained. Elective abortions are covered.		
-Inpatient		100% after deductible	80% after deductible
-Outpatient		100% after deductible	80% after deductible
-Office		100% after deductible	80% after deductible
Assistant Surgeon		100% after deductible	80% after deductible
Second Surgical Opinion		$30 Copay per visit	80% after deductible
SURGERY CENTER (Freestanding Surgical Facility)	Pre-Certification required on certain surgical procedures. Penalty listed above applies if not obtained.	$250 Copay per admission, then 100% after deductible	$250 Copay per admission, then 80% after deductible
TEMPOROMANDIBULAR JOINT DISORDER (TMJ)	Maximum limit of $3,000 per Plan Year.	Covered as described under type of service rendered	Covered as described under type of service rendered
TOBACCO CESSATION	Except for services covered as described under Preventative/Well Care the Patient Protection and Affordable Care Act.	Not covered	Not covered
URGENT CARE FACILITY		Facility: $75 Copay per visit All other services: 100% after deductible	80% after deductible
WIGS		Not covered	Not covered

PRESCRIPTION DRUG EXPENSE BENEFIT

TYPE OF PROGRAM	IMPORTANT PROVISIONS	IN-NETWORK BENEFITS
PRESCRIPTION DEDUCTIBLE		None
PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM	Per Plan Year	$6,350 Individual $12,700 Family Combined with the Medical Out-of-Pocket Maximum The Out-of-Pocket Maximum is embedded.
RETAIL	Up to 31-day supply	$ 10.00 Copay – Tier 1 $ 35.00 Copay – Tier 2 $ 60.00 Copay – Tier 3
MAIL ORDER MAINTENANCE DRUGS	Up to a 90-day supply	$ 25.00 Copay – Tier 1 $ 87.50 Copay – Tier 2 $150.00 Copay – Tier 3
SPECIALTY DRUGS		See Benefits above
DIABETIC SUPPLIES AND INSULIN		See Benefits above
Prior authorization may be required for some drugs. **Drugs purchased at out-of-network pharmacies are not covered.** Certain preventive drugs, including oral contraceptives are covered in full, not subject to deductible. See www.healthcare.gov for more information. Contact your Pharmacy Benefit Manager for prescription drug coverage inquiries. Your Pharmacy Benefit Manager's contact information is located on your Benefit Identification Card.		

Note: This Coverage Summary is intended to be a general description of benefits only. Some limitations, conditions, or exclusions may apply. The benefits listed above are subject to change at any time. If there is a discrepancy between this overview and the Plan Document, the Plan Document will prevail. Services must be Medically Necessary treatment of Sickness or Injury, unless otherwise stated. The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make it Medically Necessary even though it is not specifically listed as an exclusion. All of the facts and circumstances surrounding the claim must be considered.