



Aexcel Plus Open Choice (PPO Medical) - Local 77 Traditional Plan

Schedule of Benefits

Prepared exclusively for:

Employer:	The City of Seattle
Contract number:	ASC-100290
	Schedule of Benefits 7A
Plan effective date:	January 1, 2019
Plan issue date:	March 21, 2019

These benefits are not insured with Aetna but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Aetna medical benefits plan.

Schedule of benefits

This schedule of benefits lists the **deductibles** and **copayments/payment percentage**, if any, that apply to the services you receive under this plan. You should review this schedule to become familiar with your **deductibles** and **copayments/payment percentage** and any limits that apply to the services.

How to read your schedule of benefits

- When we say:
 - “In-network coverage”, we mean you get care from **network providers**.
 - “Out-of-network coverage”, we mean you can get care from **out-of-network providers**.
 - “Other health care coverage”, we mean you can get care from an **out-of-network provider** when you could not reasonably get the services and supplies needed from a **network provider**. This includes when you get care from **out-of-network providers** during your **stay** in a **network hospital**.
- The **deductibles** and **copayments/payment percentage** listed in the schedule of benefits below reflect the **deductibles** and **copayment/payment percentage** amounts under your plan.
- Any **payment percentage** listed in the schedule of benefits reflects the plan **payment percentage**. This is the amount the Plan pays. You are responsible to pay any **deductibles, copayments**, and the remaining **payment percentage**.
- You are responsible for full payment of any health care services you receive that are not a **covered benefit**.
- This plan has maximums for specific **covered benefits**. For example, these could be visit, day or dollar maximums. They are combined maximums between **network providers** and **out-of-network providers** unless we state otherwise.
- At the end of this schedule you will find detailed explanations about your:
 - **Deductible**
 - **Maximum out-of-pocket limits**
 - Maximums

Important note:

All **covered benefits** are subject to the Calendar Year **deductible** and **copayment/payment percentage** unless otherwise noted in the schedule of benefits below.

We are here to answer any questions. Contact Member Services by logging onto your Aetna member website at www.aetna.com or at the toll-free number on your ID card.

This schedule of benefits replaces any schedule of benefits previously in effect under your plan of benefits. Keep this schedule of benefits with your booklet.

Schedule of Benefits

This schedule of benefits lists the **deductibles** and **copayments/payment percentage**, if any, that apply to the services you receive under this plan. You should review this schedule to become familiar with your **deductibles** and **copayments/payment percentage** and any limits that apply to the services.

Important Information about Your Cost Share as it Applies to Aexcel Designated Network Specialists, Non-Designated Network Specialists and All Other Network Providers

This plan provides access to covered services and supplies through a network of health care providers. The plan is designed to lower your out-of-pocket costs when you use **network providers** for **covered expenses**. Your cost-sharing will generally be lower when you use **network providers**.

*In addition to the **network providers** described above, this plan provides access to **covered expenses** through designated network of specialty **physicians** that are unique to your plan. These **network providers** are shown as **Aexcel designated specialists and non-designated specialists** and all other network providers. Your cost sharing will be lower when you use the **Aexcel designated network specialists**. The **Aexcel designated network specialists, non-designated network specialists**, and "all other network provider groups" are identified in the printed **directory** and the on-line version of the **directory** via provider search at www.aetna.com. Please be sure to look at the appropriate **directory** that applies to your plan, since different **Aetna** plans use different networks of providers. Your plan includes different benefit levels based upon the type of **network provider** that you use (designated, non-designated or all other network provider) or if you choose to see an **out-of-network** provider. The Aexcel designated specialists include 12 medical specialties which are listed below.*

The *Aexcel* medical specialties include:

- Cardiology
- Cardiothoracic surgery
- Gastroenterology
- General surgery
- Neurology
- Neurosurgery
- Obstetrics and Gynecology
- Orthopedics
- Otolaryngology/ENT
- Plastic surgery
- Urology
- Vascular surgery

Important Notes:

1. **Aexcel Designated Network Specialists** can be found in the paper **directory** with an asterisk and on the on-line version of the **directory** via provider search with a blue star.
2. If you obtain covered services and supplies from an **Aexcel designated network specialist**, separate cost sharing applies to these types of providers. If your **PCP** is also an **Aexcel designated network specialist** or a **non-designated network specialist**, in this situation, you will be subject to the applicable **specialist copay** (if any) that applies to these types of providers and *not* the **copay** that applies to **PCP's** under this Plan. The cost sharing amounts are described later in this *Schedule of Benefits*.

Important Note:

If you live in an area with an "Aexcel" network, for maximum savings, you must select an Aexcel designated network specialist for specialty care in these Aexcel specialties. If you select a non-designated network specialist for your specialty care, your out-of-pocket expenses will be higher than if you selected an Aexcel designated network specialist in that same specialty or certain benefits may not be covered under this Plan. *Carefully read the details on cost-sharing provided later in this Schedule of Benefits.*

	IN-NETWORK COVERAGE			OUT-OF-NETWORK COVERAGE
Eligible health services	Aexcel Designated Network Specialists	Non-Designated Network Specialists	All Other Network Providers	Out-of-Network Providers
Services performed by a specialist listed in one of the Aexcel medical specialty categories listed above	80% per visit	60% per visit	80% per visit	60% per visit

Plan features	Deductible/Maximums		
	In-network coverage*	Out-of-network coverage*	Other health care*
Deductible			
You have to meet your Calendar Year deductible before this plan pays for benefits.			
Individual	\$100 per Calendar Year	\$150 per Calendar Year	\$100 per Calendar Year
Family	\$300 per Calendar Year	\$450 per Calendar Year	\$300 per Calendar Year
Common Accident Deductible			
Common Accident Deductible	\$100	\$150	\$100

Deductible waiver			
The Calendar Year in-network deductible is waived for all of the following eligible health services :			
<ul style="list-style-type: none"> • Preventive care and wellness • Family planning services - female contraceptives 			
Maximum out-of-pocket limit			
Maximum out-of-pocket limit per Calendar Year.			
Individual	\$300 per Calendar Year	\$1,350 per Calendar Year	\$300 per Calendar Year
Family	\$900 per Calendar Year	\$4,050 per Calendar Year	\$900 per Calendar Year

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Preventive care and wellness			

Routine physical exams			
Performed at a physician's office	100% per visit No deductible applies.	Not Covered	100% per visit No deductible applies.
Covered persons through age 21:	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.	Not Covered	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.
Covered persons age 22 and over but less than 65: Maximum visits per 12 months	1 visit	Not Covered	1 visit
Covered persons age 65 and over: Maximum visits per 12 months	1 visit	Not Covered	1 visit

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Preventive care immunizations			
Performed in a facility or at a physician's office	100% per visit No deductible applies	Not Covered	100% per visit No deductible applies
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your physician or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.	Not Covered	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your physician or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.
Well woman preventive visits routine gynecological exams (including pap smears)			
Performed at a physician's , obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit No deductible applies	Not Covered	100% per visit No deductible applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.	Not Covered	Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.
Maximum visits per Calendar Year	1 visit	Not Covered	1 visit

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Preventive screening and counseling services			
Office visits <ul style="list-style-type: none"> • Obesity and/or healthy diet counseling • Misuse of alcohol and/or drugs • Use of tobacco products • Sexually transmitted infection counseling • Genetic risk counseling for breast and ovarian cancer 	100% per visit No deductible applies	Not Covered	100% per visit No deductible applies
Obesity and/or healthy diet counseling maximums:			
Maximum visits per 12 months (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*	Not Covered	26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.			
Misuse of alcohol and/or drugs maximums:			
Maximum visits per 12 months	5 visits*	Not Covered	5 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.			
Use of tobacco products maximums:			
Maximum visits per 12 months	8 visits*	Not Covered	8 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.			
Sexually transmitted infection counseling maximums:			
Maximum visits per 12 months	2 visits*	Not Covered	2 visits*
*Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.			
Genetic risk counseling for breast and ovarian cancer maximums:			
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations	Not Covered	Not subject to any age or frequency limitations

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Routine cancer screenings (applies whether performed at a physician's, specialist office or facility)			
Routine cancer screenings	100% per visit No deductible applies.	Not covered	100% per visit No deductible applies.
Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.	Not Applicable	Subject to any age, family history, and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.
Lung cancer screening maximums	1 screening every 12 months*	Not Applicable	1 screening every 12 months*
*Important note: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the <i>Outpatient diagnostic testing</i> section.			
Prenatal care Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)			
Preventive care services only	100% per visit No deductible applies	60% (of the recognized charge) per visit	100% per visit No deductible applies
Important note: You should review the <i>Maternity and related newborn care</i> sections. They will give you more information on coverage levels for maternity care under this plan.			

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Comprehensive lactation support and counseling services			
Lactation counseling services – facility or office visits	100% per visit No deductible applies	80% (of the recognized charge) per visit	100% per visit No deductible applies
Lactation counseling services maximum visits per 12 months either in a group or individual setting	6 visits*	6 visits*	6 visits*
*Important note: Any visits that exceed the lactation counseling services maximum are covered under Physician services office visits.			
Breast feeding durable medical equipment			
Breast pump supplies and accessories	100% per item No deductible applies	80% (of the recognized charge) per item	100% per item No deductible applies
Important note: See the <i>Breast feeding durable medical equipment</i> section of the booklet for limitations on breast pump and supplies.			
Family planning services – female contraceptives			
Counseling services			
Female contraceptive counseling services office visit	100% per visit No deductible applies	60% (of the recognized charge) per visit	100% per visit No deductible applies
Contraceptive counseling services maximum visits per 12 months either in a group or individual setting	2 visits*	2 visits*	2 visits*
*Important note: Any visits that exceed the contraceptive counseling services maximum are covered under Physician services office visits.			
Devices			
Female contraceptive device provided, administered, or removed, by a physician during an office visit	100% per item No deductible applies	80% (of the recognized charge) per item	100% per item No deductible applies

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Female voluntary sterilization			
Inpatient	100% per admission No deductible applies	60% (of the recognized charge) per admission	100% per admission No deductible applies
Outpatient	100% per visit No deductible applies	60% (of the recognized charge) per visit	100% per visit No deductible applies
Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Physicians and other health professionals			
Physicians and specialists office visits (non-surgical)			
Physician services			
Office hours visits (non-surgical) non preventive care	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit
Immunizations that are not considered preventive care			
Immunizations that are not considered preventive care	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Specialist			
Specialist office visits			
Office hours visits (non-surgical)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit
Physician surgical services			
Physicians and specialists office visits			
Performed at a physician's office	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit
Performed at a specialist's office	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit

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Alternatives to physician office visits			
Walk-in clinic visits			
Preventive Care Services			
Immunizations	100% per visit No deductible applies	Not Covered	100% per visit No deductible applies
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your physician or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.	Not Covered	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your physician or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.
All non preventive care services for which cost sharing is not shown above			
All other services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit

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Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Hospital and other facility care			
Hospital care			
Inpatient hospital	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission	80% (of the recognized charge) per admission
Alternatives to hospital stays			
Outpatient surgery and physician surgical services			
	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit
Home health care			
Outpatient	90% (of the negotiated charge) per visit	90% (of the recognized charge) per visit	90% (of the recognized charge) per visit
Maximum visits per Calendar Year	130 Limited to: 1 intermittent visit per day provided by a participating home health care agency ; 1 visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge	130 Limited to: 1 intermittent visit per day provided by a participating home health care agency ; 1 visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge	130 Limited to: 1 intermittent visit per day provided by a participating home health care agency ; 1 visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge
Hospice care			
Inpatient facility	90% (of the negotiated charge) per admission	90% (of the recognized charge) per admission	90% (of the recognized charge) per admission
Maximum days per lifetime	Unlimited	Unlimited	Unlimited

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Hospice care			
Outpatient	90% (of the negotiated charge) per visit	90% (of the recognized charge) per visit	90% (of the recognized charge) per visit
Outpatient private duty nursing			
Outpatient private duty nursing	90% (of the negotiated charge) per visit	90% (of the recognized charge) per visit	90% (of the recognized charge) per visit
Skilled nursing facility			
Inpatient facility	80% (of the negotiated charge) per admission	80% (of the recognized charge) per admission	80% (of the recognized charge) per admission
Maximum days per Calendar Year	90 days	90 days	90 days
Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Emergency services and urgent care			
Emergency services			
Hospital emergency room	80% (of the negotiated charge) per visit	Paid the same as in-network coverage	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit
Important Note: As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (deductible, copayment, and payment percentage , as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the member's ID number is on the bill.			
Urgent care			
Urgent medical care (at a non- hospital free standing facility)	80% (of the negotiated charge) per visit	80% (of the recognized charge) per visit	80% (of the recognized charge) per visit

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Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Specific conditions			
Autism spectrum disorder			
Autism spectrum disorder treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
All other coverage for diagnosis and treatment, including behavioral therapy, will continue to be provided the same as any other illness under this plan			
Birth center			
Inpatient	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission	80% (of the recognized charge) per admission
Diabetic equipment, supplies and education			
Diabetic equipment, supplies and education	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Family planning services - other			
Voluntary sterilization for males			
Outpatient	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit
Abortion			
Outpatient	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit
Maternity and related newborn care			
Inpatient	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission	80% (of the recognized charge) per admission

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Delivery services and postpartum care services			
Performed in a facility or at a physician's office	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit
Other prenatal care services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Mental health treatment - inpatient			
Inpatient mental health treatment	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission	80% (of the recognized charge) per admission
Inpatient residential treatment facility			
Coverage is provided under the same terms, conditions as any other illness .			
Mental health treatment - outpatient			
Outpatient mental health treatment	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit
Coverage is provided under the same terms, conditions as any other illness .			
Substance related disorders treatment - inpatient			
Inpatient substance abuse detoxification during a hospital confinement	80% (of the negotiated charge) per admission	80% (of the recognized charge) per admission	80% (of the recognized charge) per admission
Inpatient substance abuse rehabilitation during a hospital confinement			
Inpatient residential treatment facility during a hospital confinement			
Coverage is provided under the same terms, conditions as any other illness .			

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Substance related disorders treatment - outpatient: detoxification and rehabilitation			
Outpatient substance abuse treatment Coverage is provided under the same terms, conditions as any other illness .	80% (of the negotiated charge) per visit	80% (of the recognized charge) per visit	80% (of the recognized charge) per visit
Oral and maxillofacial treatment (mouth, jaws and teeth)			
Orthodontic treatment directly related to an orthognathic surgical procedure	80% (of the negotiated charge) per visit	80% (of the recognized charge) per visit	80% (of the recognized charge) per visit
Orthodontic treatment directly related to an orthognathic surgical procedure Lifetime Maximum	\$10,000	\$10,000	\$10,000
All other Oral and maxillofacial treatment (mouth, jaws and teeth)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit
Reconstructive breast surgery			
Reconstructive breast surgery	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Reconstructive surgery and supplies			
Reconstructive surgery	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

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Eligible health services	Network Institute of Excellence (IOE) facility	Network Non-IOE facility	Out-of-network coverage*	Other health care
Transplant services facility and non-facility				
Inpatient hospital transplant services	80% (of the negotiated charge) per transplant	60% (of the negotiated charge) per transplant	60% (of the recognized charge) per transplant	60% (of the recognized charge) per transplant
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Eligible health services				
	In-network coverage*	Out-of-network coverage*	Other health care	
Treatment of infertility				
Basic infertility				
Basic infertility	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	
Eligible health services				
	In-network coverage*	Out-of-network coverage*	Other health care	
Specific therapies and tests				
Outpatient diagnostic testing				
Diagnostic complex imaging services				
	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit	
Diagnostic lab work				
	80% (of the negotiated charge) per visit.	60% (of the recognized charge) per visit.	80% (of the recognized charge) per visit.	
Diagnostic radiological services				
	80% of the negotiated charge per visit.	60% of the recognized charge per visit.	80% of the recognized charge per visit.	

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Chemotherapy			
	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Outpatient infusion therapy			
	90% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit

Outpatient radiation therapy			
	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Short-term rehabilitation services			
Outpatient Physical, Massage, Occupational, Speech, Cardiac and Pulmonary Therapies			
	80% (of the negotiated charge) per visit	80% (of the recognized charge) per visit	80% (of the recognized charge) per visit

Maximum visits per Calendar Year	30 visits	30 visits	30 visits

Habilitation therapy services			
	80% (of the negotiated charge) per visit	80% (of the recognized charge) per visit	80% (of the recognized charge) per visit

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Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Other services			
Acupuncture			
Acupuncture	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit
Maximum visits per Calendar Year	12	12	12
Ambulance service			
Ground, air or water ambulance	80% (of the negotiated charge) per trip	80% (of the recognized charge) per trip	80% (of the recognized charge) per trip
Clinical trial therapies (experimental or investigational)			
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Clinical trials (routine patient costs)			
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Durable medical equipment (DME)			
DME	80% (of the negotiated charge) per item	80% (of the recognized charge) per item	80% (of the recognized charge) per item
Hearing aids and exams			
Hearing aid exams	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Hearing aids	100% (of the negotiated charge) per item	100% (of the recognized charge) per item	100% (of the recognized charge) per item
Maximum per 36 month period	\$1,000 per ear	\$1,000 per ear	\$1,000 per ear

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Non-preventive hearing exams			
For adults and children	80% (of the negotiated charge) per visit	80% (of the recognized charge) per visit	80% (of the recognized charge) per visit

Maximum	One exam in any 12 consecutive month period.
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Nutritional supplements			
Nutritional supplements	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Prosthetic devices			
Prosthetic devices Foot Orthotics	80% (of the negotiated charge) per item	60% (of the recognized charge) per item	80% (of the recognized charge) per item
Other Prosthetic Devices	80% (of the negotiated charge) per item	80% (of the recognized charge) per item	80% (of the recognized charge) per item
Foot Orthotics Lifetime Maximum Benefit	\$500	\$500	\$500

Spinal manipulation			
Spinal manipulation	80% (of the negotiated charge) per visit	80% (of the recognized charge) per visit	80% (of the recognized charge) per visit
Maximum visits per Calendar Year	10	10	10

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Eligible health services	In-network coverage*	Out-of-network coverage*
Outpatient prescription drugs		
Plan features	Deductible/Copayment/Payment Percentage/Maximums	
Deductible waiver		
The Calendar Year deductible is waived for all prescription drugs .		
Deductible and copayment/payment percentage waiver for risk reducing breast cancer prescription drugs		
The Calendar Year deductible and the per prescription copayment/payment percentage will not apply to risk reducing breast cancer prescription drugs when obtained at a network pharmacy . This means that such risk reducing breast cancer prescription drugs will be paid at 100%.		
Deductible and copayment/payment percentage waiver for tobacco cessation prescription and over-the-counter drugs		
The Calendar Year deductible and the per prescription copayment/payment percentage will not apply to the first two 90-day treatment regimens for tobacco cessation prescription drugs and OTC drugs when obtained at a network pharmacy . This means that such prescription drugs and OTC drugs will be paid at 100%. Your Calendar Year deductible and any prescription copayment/payment percentage will apply after those two regimens have been exhausted.		
Deductible and copayment/payment percentage waiver for contraceptives		
The Calendar Year deductible and the per prescription copayment/payment percentage will not apply to female contraceptive methods when obtained at a network pharmacy . This means that the following will be paid at 100%:		
<ul style="list-style-type: none"> Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drugs for that method paid at 100%. 		
The Calendar Year deductible and the per prescription copayment/payment percentage continue to apply to prescription drugs that have a generic equivalent or generic alternative available within the same therapeutic drug class obtained at a network pharmacy unless you are granted a medical exception.		
Outpatient prescription drug maximum out-of-pocket limit		
Outpatient prescription drug maximum out-of-pocket limit per Calendar Year		
Individual	\$1,200 per Calendar Year	
Family	\$3,600 per Calendar Year	

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Generic prescription drugs (including specialty drugs)		
Per prescription copayment/payment percentage		
For each fill up to a 34 day supply filled at a retail pharmacy	\$15 copayment per supply Payment percentage is 100% (of the negotiated charge) No Calendar Year deductible applies	Not covered
More than a 34 day supply but less than a 91 day supply filled at a mail order pharmacy	\$30 copayment per supply Payment percentage is 100% (of the negotiated charge) No Calendar Year deductible applies	Not covered
Lifetime Maximum for Smoking Cessation Aids or Drugs	One 90 day supply	Not covered
Brand-name prescription drugs (including specialty drugs)		
Per prescription copayment/payment percentage		
For each fill up to a 34 day supply filled at a retail pharmacy	\$15 copayment per supply Payment percentage is 100% (of the negotiated charge) No Calendar Year deductible applies	Not covered
More than a 34 day supply but less than a 91 day supply filled at a mail order pharmacy	\$30 copayment per supply Payment percentage is 100% (of the negotiated charge) No Calendar Year deductible applies	Not covered
Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a pharmacy	100% per prescription or refill No deductible applies	Not covered
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna member website at	

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	www.aetna.com or calling the number on your ID card.	
Risk reducing breast cancer prescription drugs		
Risk reducing breast cancer prescription drugs filled at a pharmacy	100% per prescription or refill No deductible applies	Not covered
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.	
Tobacco cessation prescription and over-the-counter drugs		
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy	\$0 per prescription or refill No deductible applies	Not covered
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.	
If you or your prescriber requests a covered brand-name prescription drug when a covered generic prescription drug equivalent is available, you will be responsible for the cost difference between the generic prescription drug and the brand-name prescription drug , plus the cost sharing that applies to the brand-name prescription drug .		

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General coverage provisions

This section provides detailed explanations about the:

- **Deductible**
- **Maximum out-of-pocket limits**
- **Maximums**

that are listed in the first part of this schedule of benefits.

Deductible provisions

Eligible health services applied to the out-of-network **deductibles** will be applied to satisfy the in-network **deductibles**. **Eligible health services** applied to the in-network **deductibles** will be applied to satisfy the out-of-network **deductibles**.

The **deductible** may not apply to certain **eligible health services**. You must pay any applicable **copayments/payment percentage** for **eligible health services** to which the **deductible** does not apply.

Individual

This is the amount you owe for in-network and out-of-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. This Calendar Year **deductible** applies separately to you and each of your covered dependents. After the amount you pay for **eligible health services** reaches the Calendar Year **deductible**, this plan will begin to pay for **eligible health services** for the rest of the Calendar Year.

Family

This is the amount you and your covered dependents owe for in-network and out-of-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. After the amount you and your covered dependents pay for **eligible health services** reach this family Calendar Year **deductible**, this plan will begin to pay for **eligible health services** that you and your covered dependents incur for the rest of the Calendar Year.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

- The combined **eligible health services** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

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Common Accident Deductible

This limit applies when two or more family members are injured in the same accident. The common accident deductible limit places a limit on your **deductible** expenses when covered expenses are applied toward the separate Calendar Year **deductibles**. When this occurs, and all covered expenses related to the accident in that Calendar Year exceed the common accident deductible limit, your plan will then pay the excess amount based on the plan **payment percentage**. The added benefit will be reduced by any family deductible limit benefit amount paid for the same covered expenses.

Deductible carryover

Any amounts that you paid for **eligible health services** in the last three months of a Calendar Year that apply toward that year's Calendar Year **deductibles** will also count toward the following year's Calendar Year **deductibles**.

Copayments

Copayment

As it applies to in-network coverage, this is a specified dollar amount or percentage that must be paid by you at the time you receive **eligible health services** from a **network provider**.

Payment percentage

The specific percentage the plan pays for a health care service listed in the schedule of benefits.

Maximum out-of-pocket limits provisions

Eligible health services applied to the **out-of-network maximum out-of-pocket limit** will be applied to satisfy the in-network **maximum out-of-pocket limit** and **eligible health services** applied to the in-network **maximum out-of-pocket limit** will be applied to satisfy the out-of-network **maximum out-of-pocket limit**.

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments/payment percentage** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit** each of you must meet your **maximum out-of-pocket limit** separately.

Individual

Once the amount of the **copayments/payment percentage** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** or **recognized charge** for **covered benefits** that apply toward the limit for the rest of the Calendar Year for that person.

Family

Once the amount of the **copayments/payment percentage** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** or **recognized charge** for such **covered benefits** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

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To satisfy this family **maximum out-of-pocket limit** for the rest of the Calendar Year, the following must happen:

- The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members. The family **maximum out-of-pocket limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **maximum out-of-pocket limit** amount in a Calendar Year.

The **maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the **maximum out-of-pocket limit** does not apply to a covered benefit, your **copayment/payment percentage** for that covered benefit will not count toward satisfying the **maximum out-of-pocket limit** amount.

Certain costs that you incur do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services
- Any out of pocket costs for outpatient **prescription drugs**
- As it applies to out-of-network coverage: Charges, expenses or costs in excess of the **recognized charge**
- Out-of-Network expenses incurred for physical, occupational, speech, and neurodevelopmental therapies.

Maximum provisions

Eligible health services applied to the **out-of-network** maximum will not be applied to satisfy the network maximum and **eligible health services** applied to the network maximum will not be applied to satisfy the **out-of-network** maximum.

Calculations; determination of recognized charge; determination of benefits provisions

Your financial responsibility for the costs of services will be calculated on the basis of when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than one Calendar Year. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet.

General coverage provisions

This section provides detailed explanations about the:

- Outpatient **prescription drug maximum out-of-pocket limits**

Outpatient prescription drug maximum out-of-pocket limits provisions

The outpatient **prescription drug maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments/payment percentage** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual and family outpatient **prescription drug maximum out-of-pocket limit**. As to the individual outpatient **prescription drug maximum out-of-pocket limit** each of you must meet your outpatient **prescription drug maximum out-of-pocket limit** separately.

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Individual

Once the amount of the **copayments/payment percentage** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets the individual outpatient **prescription drug maximum out-of-pocket limit**, this plan will pay 100% of the **covered benefits** that apply toward the limit for the rest of the Calendar Year for that person.

Family

Once the amount of the **copayments/payment percentage** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets this family outpatient **prescription drug maximum out-of-pocket limit**, this plan will pay 100% of such **covered benefits** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

To satisfy this family outpatient **prescription drug maximum out-of-pocket limit** for the rest of the Calendar Year, the following must happen:

- The family outpatient **prescription drug maximum out-of-pocket limit** is a cumulative outpatient **prescription drug maximum out-of-pocket limit** for all family members. The family **maximum out-of-pocket limit** can be met by a combination of family members with no single individual within the family contributing more than the individual outpatient **prescription drug maximum out-of-pocket limit** amount in a Calendar Year.

The outpatient **prescription drug maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the outpatient **prescription drug maximum out-of-pocket limit** does not apply to a covered benefit, your **copayment/payment percentage** for that covered benefit will not count toward satisfying the outpatient **prescription drug maximum out-of-pocket limit** amount.

Certain costs that you incur do not apply toward the outpatient **prescription drug maximum out-of-pocket limit**. These include:

- All costs for non-covered services

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