Aexcel Plus Open Choice (PPO Medical) - Most City Traditional Plan
Schedule of Benefits

Prepared exclusively for:

Employer:	The City of Seattle
Contract number:	ASC-100290
	Schedule of Benefits 2A
Plan effective date:	January 1, 2020
Plan issue date:	December 16, 2020

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 secure 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	70% 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	$400 per Calendar Year	$1,000 per Calendar Year	$400 per Calendar Year
Family	$1,200 per Calendar Year	$3,000 per Calendar Year	$1,200 per Calendar Year
Common Accident Deductible			
Common Accident Deductible	$400	$1,000	$400

Maximum out-of-pocket limit			
Maximum out-of-pocket limit per Calendar Year.			
Individual	$1,000 per Calendar Year	$2,000 per Calendar Year	$1,000 per Calendar Year
Family	$3,000 per Calendar Year	$6,000 per Calendar Year	$3,000 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 cancer screenings (applies whether performed at a physician's, specialist office or facility)			
Mammograms	80% (of the **negotiated charge**) per test	60% (of the **recognized charge**) per test	80% (of the **recognized charge**) per test
Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: • 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.	Subject to any age, family history, and frequency guidelines as set forth in the most current: • 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.	Subject to any age, family history, and frequency guidelines as set forth in the most current: • 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.
Prenatal care **Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)**			
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
Important note: You should review the *Maternity and related newborn care* sections. They will give you more information on coverage levels for maternity care under this plan.			
Breast feeding durable medical equipment			

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Breast pump supplies and accessories	100% (of the **negotiated charge**) per item No **deductible** applies	Not covered	80% (of the **recognized charge**) per item No **deductible** applies
Important note: See the *Breast feeding durable medical equipment* section of the booklet for limitations on breast pump and supplies.			
Family planning services – female contraceptives			
Counseling services			
Female contraceptive counseling services office visit	80% (of the balance of the **negotiated charge**) per visit thereafter	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Contraceptive counseling services maximum visits per Calendar Year 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	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item	80% (of the **recognized charge**) per item
Female voluntary sterilization			
Inpatient	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission	80% (of the **recognized charge**) per admission
Outpatient	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
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
***Telemedicine Consultations**			

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**The plan may utilize one or more telemedicine vendors. To obtain information regarding potential cost share when utilizing a telemedicine vendor, contact member services at the number on your ID card.*			
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
Alternatives to physician office visits			
Walk-in clinic visits			
Walk-in clinic non-emergency visit *(includes coverage for immunizations)*	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
	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 secure member website at www.aetna.com or calling the number on your ID card.	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 secure member website at www.aetna.com or calling the number on your ID card.	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 secure member website at www.aetna.com or calling the number on your ID card.

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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**	$200 then the plan pays 80% (of the balance of the **negotiated charge**) per admission No **deductible** applies	$200 then the plan pays 60% (of the balance of the **recognized charge**) per admission thereafter No **deductible** applies	$200 then the plan pays 80% (of the balance of the **recognized charge**) per admission No **deductible** applies
Outpatient **hospital**	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Alternatives to hospital stays			
Outpatient surgery and physician surgical services			
(performed at a hospital or other outpatient facility)	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	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	130 Limited to: 3 intermittent visits 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: 3 intermittent visits 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: 3 intermittent visits 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

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Hospice care			
Inpatient facility	$200 then the plan pays 80% (of the balance of the **negotiated charge**) per admission	$200 then the plan pays 60% (of the balance of the **recognized charge**) per admission	$200 then the plan pays 80% (of the balance of the **recognized charge**) per admission
Maximum days per lifetime	Unlimited	Unlimited	Unlimited

Hospice care			
Outpatient	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
	Part-time or intermittent nursing care by an **R.N.** or **L.P.N.** for up to 8 hours a day Part-time or intermittent home health aide services to care for you up to 8 hours a day	Part-time or intermittent nursing care by an **R.N.** or **L.P.N.** for up to 8 hours a day Part-time or intermittent home health aide services to care for you up to 8 hours a day	Part-time or intermittent nursing care by an **R.N.** or **L.P.N.** for up to 8 hours a day Part-time or intermittent home health aide services to care for you up to 8 hours a day
Outpatient private duty nursing			
Outpatient private duty nursing	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Skilled nursing facility			
Inpatient facility	$200 then the plan pays 80% (of the balance of the **negotiated charge**) per admission No **deductible** applies	$200 then the plan pays 60% (of the balance of the **recognized charge**) per admission No **deductible** applies	$200 then the plan pays 80% (of the balance of the **recognized charge**) per admission No **deductible** applies
Maximum days per Calendar Year	90	90	90

Eligible health services	**In-network coverage***	**Out-of-network coverage***	**Other health care**
Emergency services and urgent care			
Emergency services			
Hospital emergency room	$150 then the plan pays 80% (of the balance of the **negotiated charge**) per visit	Paid the same as in-network coverage.	Paid the same as in-network coverage.

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	No **deductible** applies		
Non-emergency care in a **hospital** emergency room	$150 then the plan pays 60% (of the balance of the **negotiated charge**) per visit No **deductible** applies.	$150 then the plan pays 60% (of the balance of the **recognized charge charge**) per visit No **deductible** applies	$150 then the plan pays 60% (of the balance of the **recognized charge charge**) per visit No **deductible** applies

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.
- A separate hospital emergency room **copayment/payment percentage** will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room **copayment/payment percentage** will be waived and your inpatient **copayment/payment percentage** will apply.

Urgent care

Urgent medical care (at a non-**hospital** free standing facility)	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
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			
Birthing center			
Inpatient	$200 then the plan pays 80% (of the balance of the **negotiated charge**) per admission No **deductible** applies	$200 then the plan pays 60% (of the balance of the **recognized charge**) per admission	$200 then the plan pays 80% (of the balance of the **recognized charge**) per admission No **deductible** applies
*The per admission **copayment** and/or **deductible** amount for newborns will be waived for nursery charges for the duration of the newborn's initial facility stay. The nursery charges waiver will not apply for non-routine facility stays.*			
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
Jaw joint disorder treatment			

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Jaw joint disorder treatment	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Non-Surgical Lifetime Maximum per Benefi	$5,000	$5,000	$5,000
Surgical Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Maternity and related newborn care			
Inpatient	$200 then the plan pays 80% (of the balance of the **negotiated charge**) per admission No **deductible** applies	$200 then the plan pays 60% (of the balance of the **recognized charge**) per admission No **deductible** applies	$200 then the plan pays 80% (of the balance of the **recognized charge**) per admission No **deductible** applies
*The per admission **copayment** and **deductible** amount for newborns will be waived for nursery charges for the duration of the newborn's initial routine facility stay. The nursery charges waiver will not apply for non-routine facility stays.*			
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 Inpatient **residential treatment facility** Coverage is provided under the same terms, conditions as any other **illness**.	$200 then the plan pays 80% (of the balance of the **negotiated charge**) per admission No **deductible** applies	$200 then the plan pays 60% (of the balance of the **recognized charge**) per admission No **deductible** applies	$200 then the plan pays 80% (of the balance of the **recognized charge**) per admission No **deductible** applies
Mental health treatment - outpatient			
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** includes **telemedicine**	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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consultation Coverage is provided under the same terms, conditions as any other **illness**.			
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** includes **telemedicine** cognitive behavior therapy consultation	80% (of the **negotiated charge**) per visit	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Other outpatient mental health treatment (includes skilled behavioral health services in the home) **Partial hospitalization treatment** **Intensive outpatient program** The cost share doesn't apply to in-network peer counseling support services	80% (of the **negotiated charge**) per visit	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Substance related disorders treatment - inpatient			
Inpatient **substance abuse detoxification** during a **hospital** confinement Inpatient **substance abuse** rehabilitation during a **hospital** confinement Inpatient **residential treatment facility** during a **hospital** confinement	$200 then the plan pays 80% (of the balance of the negotiated charge) per admission No **deductible** applies	$200 then the plan pays 60% (of the balance of the **recognized charge**) per admission No **deductible** applies	$200 then the plan pays 80% (of the balance of the recognized charge) per admission No **deductible** applies

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Coverage is provided under the same terms, conditions as any other **illness**.			
Substance related disorders treatment - outpatient: detoxification and rehabilitation			
Outpatient **substance abuse** office visits to a **physician** or **behavioral health provider** (includes **telemedicine** consultation) 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
Outpatient **substance abuse** office visits to a **physician** or **behavioral health provider** includes **telemedicine** cognitive behavioral therapy consultations 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
Other outpatient **substance abuse** services **Partial hospitalization treatment** **Intensive outpatient program** The cost share doesn't apply to in-network peer counseling support 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* Institute of Quality (IOQ) Facility	In-network coverage* Non-IOQ Facility	Out-of-network coverage*
Obesity surgery			
Inpatient **hospital** (includes surgical procedure and acute **hospital** services)	$200 then the plan pays 80% (of the balance of the **negotiated charge**) per admission No **deductible** applies	Not covered	$200 then the plan pays 80% (of the balance of the **recognized charge**) per admission No **deductible** applies
Outpatient obesity surgery			
	80% (of the **negotiated charge**) per visit	Not covered	80% (of the **recognized charge**) per visit

Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
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
Accidental injury treatment Maximum Benefit	$600 per occurrence	$600 per occurrence	$600 per occurrence
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			

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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

Eligible health services	Network (IOE facility)	Network (Non-IOE facility)	Out-of-network coverage*	Other health care
Transplant services facility and non-facility				
Inpatient **hospital** transplant services	$200 then the plan pays 80% (of the balance of the **negotiated charge**) per transplant	$200 then the plan pays 60% (of the balance of the **negotiated charge**) per transplant	$200 then the plan pays 60% (of the balance of the **recognized charge**) per transplant	$200 then the plan pays 60% (of the balance 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
Outpatient comprehensive infertility services			
	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Maximum per lifetime**	$10,000	$10,000	$10,000
As used for this benefit, "lifetime" is defined to include covered benefits paid under this plan or another plan underwritten and/or administered by **Aetna or any **Aetna** affiliate, with the same policyholder			
Eligible health services	**In-network coverage***	**Out-of-network coverage***	**Other health care**
Specific therapies and tests			
Outpatient diagnostic testing			

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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.
Chemotherapy			
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			
	80% (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, Cardiac and Pulmonary Therapies			
	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Short-term rehabilitation services maximum	First 25 visits per year regardless of medical necessity; thereafter medical necessity applies.	First 25 visits per year regardless of medical necessity; thereafter medical necessity applies.	First 25 visits per year regardless of medical necessity; thereafter medical necessity applies.
Outpatient Speech Therapy			
	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit

Habilitation therapy services

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

	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
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	60% (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	80% (of the **negotiated charge**) per item	80% (of the **recognized charge**) per item	80% (of the **recognized charge**) per item

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	No **deductible** applies.	No **deductible** applies.	No **deductible** applies
Maximum per 36 month period	$1,000 per ear	$1,000 per ear	$1,000 per ear

Non-preventive hearing exams			
For adults and children	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit

Maximum	One exam in any 12 consecutive month period.

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	80% (of the **negotiated charge**) per item	60% (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	60% (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%:

- 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 31 day supply filled at a **retail pharmacy**	**Copayment** is the greater of $10 or 30% (of the **negotiated charge**) but will be no more than $100 per supply **Payment percentage** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered
More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	**Copayment** is the greater of $20 or 30% (of the **negotiated charge**) but will be no more than $200 per supply **Payment percentage** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered
Brand-name prescription drugs (including specialty drugs)		
Per prescription copayment/payment percentage		
For each fill up to a 31 day supply filled at a **retail pharmacy**	**Copayment** is the greater of $10 or 40% (of the **negotiated charge**) but will be no more than $100 per supply **Payment percentage** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered
More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	**Copayment** is the greater of $20 or 40% (of the **negotiated charge**) but will be no more than $200 per supply **Payment percentage** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered

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Generic prescription drugs for smoking cessation, asthma and antihyperlipidemic (including specialty drugs)		
Per prescription copayment/payment percentage		
For each fill up to a 31 day supply filled at a **retail pharmacy**	**Copayment** is the greater of $5 or 10% (of the **negotiated charge**) but will be no more than $100 per supply **Payment percentage** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered
More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	**Copayment** is the greater of $10 or 10% (of the **negotiated charge**) but will be no more than $200 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 for smoking cessation, asthma and antihyperlipidemic (including specialty drugs)		
Per prescription copayment/payment percentage		
For each fill up to a 31 day supply filled at a **retail pharmacy**	**Copayment** is the greater of $10 or 20% (of the **negotiated charge**) but will be no more than $100 per supply **Payment percentage** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered
More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	**Copayment** is the greater of $20 or 20% (of the **negotiated charge**) but will be no more than $200 per supply **Payment percentage** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered

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Generic Diabetic supplies, drugs and insulin		
Per prescription copayment/payment percentage		
For each fill up to a 31 day supply filled at a **retail pharmacy**	$5 **copayment** per supply **Payment percentage** is 100% (of the **negotiated charge** No Calendar Year **deductible** applies	Not covered
More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$10 **copayment** per supply **Payment percentage** is 100% (of the **negotiated charge** No Calendar Year **deductible** applies	Not covered
Brand-name Diabetic supplies, drugs and insulin		
Per prescription copayment/payment percentage		
For each fill up to a 31 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 31 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

Proton Pump Inhibitors and Non-Sedating Antihistamines		
Monthly Maximum Benefit paid by plan (applies to covered prescription strength and over-the-counter equivalent versions. See your Booklet for details.	$20	Not covered

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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**.

Per Admission Deductible

Separate **deductibles** may apply per facility. These **deductibles** are in addition to any other **deductibles** applicable under this plan. They may apply to each **stay** or they may apply on a per day basis up to a per admission maximum amount.

Eligible health services applied to the per admission **deductible** cannot be applied to any other **deductible** required in this plan. Likewise, **eligible health services** applied to this plan's other **deductibles** cannot be applied to meet the per admission **deductible**.

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**.

Per Admission Copayment

A per admission **copayment** is an amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility.

Separate **copayments** may apply per facility. These **copayments** are in addition to any other **copayments** applicable under this plan. They may apply to each **stay** or they may apply on a per day basis up to a per admission maximum amount.

The per admission **copayment** amount is equal to a facility's **semi-private room rate** for one day. However, for the **stay** of a well newborn baby (starting at birth), the per admission **copayment** amount will not exceed the **hospital**'s actual **room and board** charge on the first day of the **stay**.

Payment percentage

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

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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.

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 non-emergency use of the emergency room
- 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.

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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** 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.

Individual

Once the amount of the **copayments** 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** 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.

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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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