Open Access Aetna Select Medical Plan
Consumer Plus Choice

Schedule of Benefits

Prepared exclusively for:

Employer:	Katy Independent School District
Contract number:	ASA-724976
Schedule of Benefits 4A	
Plan effective date:	January 1, 2020
Plan issue date:	December 16, 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:
  - "Designated network coverage", we mean you get care from **network providers** at the lowest cost share.
  - "Non-designated network coverage", we mean you can get care from **network providers** at the higher cost share.
- The **deductibles** and **copayments/payment percentage** listed in the schedule of benefits below reflect the **deductibles** and **copayment/payment percentage** amounts under your plan.
- You are responsible to pay any **deductibles**, **copayments** and **payment percentage**. The **payment percentage** listed in the schedule of benefits reflects the plan **payment percentage**. This is the **payment percentage** amount the plan pays. You are responsible for paying any 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.
- 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.

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** on your secure member website 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** with a blue star **on your secure member website** at www.aetna.com.
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	
Eligible health services	**Aexcel Designated Network Specialists**	**Non-Designated Network Specialists**
Services performed by a specialist listed in one of the Aexcel medical specialty categories listed above	80% (of the **negotiated charge**) per visit	65% (of the **negotiated charge**) per visit
All Other Network Providers	80% (of the **negotiated charge**) per visit	

Plan features	Deductible/Maximums	
	Designated- network coverage*	**Non-designated- network coverage***
Deductible		
You have to meet your Calendar Year **deductible** before this plan pays for benefits.		
Individual	$1,750 per Calendar Year	$2,250 per Calendar Year
Family	$3,500 per Calendar Year	$4,000 per Calendar Year
Deductible waiver		
The Calendar Year in-network **deductible** is waived for all of the following **eligible health services:** • Preventive care and wellness • Family planning services - female contraceptives		
Maximum out-of-pocket limit		
Maximum out-of-pocket limit per Calendar Year		
Individual	$4,500 per Calendar Year	$6,000 per Calendar Year
Family	$9,000 per Calendar Year	$10,500 per Calendar Year
Annual HealthFund amount		
Individual	$0 per Calendar Year	
Employee and Spouse	$0 per Calendar Year	
Employee and Child(ren)	$0 per Calendar Year	
Family	$0 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*
Preventive care and wellness	
Routine physical exams	
Performed at a **physician's**, **PCP** office	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.
Covered persons age 22 and over but less than 65: Maximum visits per Calendar Year	1 visit
Covered persons age 65 and over: Maximum visits per Calendar Year	1 visit
Preventive care immunizations	
Performed in a facility or at a **physician's** office	100% per visit No **deductible** applies
	Subject to any age and visit 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's secure 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**, **PCP**, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit No **deductible** applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
Maximum visits per Calendar Year	1 visit

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

Preventive screening and counseling services	
Office visits • 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
Obesity and/or healthy diet counseling maximums:	
Maximum visits per Calendar Year (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)*
*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 Calendar Year	Unlimited 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 Calendar Year	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 Calendar Year	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

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

Routine cancer screenings (applies whether performed at a physician's, PCP, specialist office or facility)	
Routine cancer screenings	100% per visit No **deductible** applies
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.
Lung cancer screening maximums	1 screening every 12 months*
Important note: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* 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
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.	
Comprehensive lactation support and counseling services	
Lactation counseling services – facility or office visits	100% per visit No **deductible** applies
Lactation counseling services maximum per Calendar Year either in a group or individual setting	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

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

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	100% per visit No **deductible** applies	
Contraceptive counseling services maximum visits per Calendar Year either in a group or individual setting	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	
Female voluntary sterilization		
Inpatient	100% per admission No **deductible** applies	
Outpatient	100% per visit No **deductible** applies	
	Network benefit level	
Eligible health services	**Designated-network coverage***	**Non-designated network coverage***
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	80% (of the **negotiated charge**) per visit

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

Immunizations that are not considered preventive care		
Immunizations that are not considered preventive care	100% (of the **negotiated charge**) per visit	100% (of the **negotiated charge**) per visit
Specialist		
Specialist office visits		
Office hours visits (non-surgical)	80% (of the **negotiated charge**) per visit	65% (of the **negotiated charge**) per visit
Physician surgical services		
Physicians and **specialists** office visits		
Performed at a **physician's**, **PCP** office	80% (of the **negotiated charge**) per visit	80% (of the **negotiated charge**) per visit
Performed at a **specialist's** office	80% (of the **negotiated charge**) per visit	65% (of the **negotiated charge**) per visit
Alternatives to physician office visits		
Walk-in clinic visits		
Walk-in clinic non-emergency visit *(includes coverage for immunizations.)*	100% (of the **negotiated charge**) per visit No **deductible** applies	100% (of the **negotiated charge**) 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.	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.

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

	Network benefit level	
Eligible health services	**Designated- network coverage***	**Non-designated- network coverage***
Hospital and other facility care		
Hospital care		
Inpatient **hospital**	80% (of the balance of the **negotiated charge**) per admission	$500 then the plan pays 65% (of the balance of the **negotiated charge**) per admission
Alternatives to hospital stays		
Outpatient surgery and physician surgical services		
Performed in the outpatient department of a **hospital**	80% (of the **negotiated charge**) per visit	65% (of the **negotiated charge**) per visit
Performed in an Ambulatory Surgical Center	80% (of the **negotiated charge**) per visit	80% (of the **negotiated charge**) per visit
Home health care		
Outpatient	80% (of the **negotiated charge**) per visit	80% (of the **negotiated charge**) per visit
Maximum visits per Calendar Year	100 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.	100 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.
Hospice care		
Inpatient facility	80% (of the **negotiated charge**) per admission	80% (of the **negotiated charge**) per admission
Maximum days per lifetime	Unlimited	Unlimited

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

Hospice care		
Outpatient	80% (of the **negotiated charge**) per visit	80% (of the **negotiated 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
Outpatient private duty nursing		
Outpatient private duty nursing	80% (of the **negotiated charge**) per visit	80% (of the **negotiated charge**) per visit
Maximum visits/shifts per Calendar Year	70 shifts Up to eight hours equal one shift.	70 shifts Up to eight hours equal one shift.
Skilled nursing facility		
Inpatient facility	80% (of the **negotiated charge**) per admission	80% (of the **negotiated charge**) per admission
Maximum days per Calendar Year	60	60
Eligible health services	**In-network coverage***	**Out-of-network coverage***
Emergency services and urgent care		
Emergency services		
Hospital emergency room	$250 then the plan pays 70% (of the balance of the **negotiated charge**) per visit	Paid the same as in-network coverage
Non-emergency care in a **hospital** emergency room	Not covered	Not covered

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.

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

- 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	Not covered

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

	Network benefit level	
Eligible health services	**Designated- network coverage***	**Non-designated- network coverage***
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.
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.
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	80% of the **negotiated charge**) per admission	$500 then the plan pays 65% (of the balance of the **negotiated charge**) per admission
Family planning services - other		
Voluntary sterilization for males		
Performed in an Ambulatory Surgical Center	80% (of the **negotiated charge**) per visit	80% (of the **negotiated charge**) per visit
Outpatient - All other	80% (of the **negotiated charge**) per visit	65% (of the **negotiated charge**) per visit
Abortion		
Performed in an Ambulatory Surgical Center	80% (of the **negotiated charge**) per visit	80% (of the **negotiated charge**) per visit
Outpatient - All other	80% (of the **negotiated charge**) per visit	65% (of the **negotiated charge**) per visit
Maternity and related newborn care		
Inpatient	80% (of the **negotiated charge**) per admission	$500 then the plan pays 65% (of the balance of the **negotiated charge**) per admission

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

Delivery services and postpartum care services		
Performed in a facility or at a **physician's** office	80% (of the **negotiated charge**) per visit	65% (of the **negotiated 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.
Mental health treatment - inpatient		
Inpatient mental health treatment Inpatient **residential treatment facility** Coverage is provided under the same terms, conditions as any other **illness**.	80% (of the **negotiated charge**) per admission	80% (of the **negotiated charge**) per admission
Mental health treatment - outpatient		
Outpatient mental health treatment 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 **negotiated charge**) per visit
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** includes **telemedicine** cognitive behavioral therapy consultation	80% (of the **negotiated charge**) per visit	80% (of the **negotiated charge**) per visit

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

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	65% (of the **negotiated 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 Coverage is provided under the same terms, conditions as any other **illness**.	80% (of the **negotiated charge**) per admission	80% (of the **negotiated charge**) per admission
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 **negotiated charge**) per visit

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

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 **negotiated 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	65% (of the **negotiated charge**) per visit
Oral and maxillofacial treatment (mouth, jaws and teeth)		
Oral and maxillofacial treatment (mouth, jaws and teeth)	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 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.
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.

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

Eligible health services	Network (IOE facility)	Network (Non-IOE facility)
Transplant services facility and non-facility		
Inpatient **hospital** transplant services	80% (of the **negotiated charge**) per transplant	Not covered
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.	Not covered
Eligible health services	**Network (IOQ Facility)**	**Network (Non-IOQ Facility)**
Obesity treatment		
Institutes of Quality Bariatric Surgery (Inpatient)	80% (of the **negotiated charge**	Not Covered
Institutes of Quality Bariatric Surgery (Outpatient)	80% (of the **negotiated charge**	Not Covered
Precertification may be required		
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.	Not Covered
	Network benefit level	
Eligible health services	**Designated- network coverage***	**Non-designated- network coverage***
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.

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

Outpatient comprehensive infertility services		
	80% (of the **negotiated charge**) per visit	65% (of the **negotiated charge**) per visit
Maximum number of ovulation induction cycles with menotropins per lifetime**	6	6
Maximum number of Intrauterine insemination cycles per lifetime**	6	6
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		
	Network benefit level	
Eligible health services	**Designated- network coverage***	**Non-designated- network coverage***
Specific therapies and tests		
Outpatient diagnostic testing		
Diagnostic complex imaging services		
Performed in the outpatient department of a **hospital**	80% (of the **negotiated charge**) per visit	65% (of the **negotiated charge**) per visit
Performed at an outpatient facility other than the **hospital** outpatient department	80% (of the **negotiated charge**) per visit	80% (of the **negotiated charge**) per visit
Diagnostic lab work		
Performed in the outpatient department of a **hospital**	80% (of the **negotiated charge**) per visit	65% (of the **negotiated charge**) per visit
Performed at an outpatient facility other than the **hospital** outpatient department	80% (of the **negotiated charge**) per visit	80% (of the **negotiated charge**) per visit

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

Diagnostic radiological services		
Performed in the outpatient department of a **hospital**	80% (of the **negotiated charge**) per visit	65% (of the **negotiated charge**) per visit
Performed at an outpatient facility other than the **hospital** outpatient department	80% (of the **negotiated charge**) per visit	80% (of the **negotiated charge**) per visit
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.
Outpatient infusion therapy		
	80% (of the **negotiated charge**) per visit	65% (of the **negotiated 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.
Short-term cardiac and pulmonary rehabilitation services		
Cardiac rehabilitation		
Cardiac rehabilitation	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.
Pulmonary rehabilitation		
Pulmonary rehabilitation	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		
Short-term rehabilitation services (outpatient physical, occupational, speech therapies) combined with Habilitation therapy services (outpatient physical, occupational, speech therapies)		
	80% (of the **negotiated charge**) per visit	65% (of the **negotiated charge**) per visit
Outpatient physical, speech, and occupational therapies maximum		
Maximum visits per Calendar Year	60 visits	60 visits

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

	Network benefit level	
Eligible health services	**Designated network coverage***	**Non-designated network coverage***
Other services		
Acupuncture		
Acupuncture	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.
Ambulance service		
Ground, air or water **ambulance**	80% (of the **negotiated charge**) per trip	80% (of the **negotiated 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.
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.
Durable medical equipment (DME)		
DME	80% (of the **negotiated charge**) per item	80% (of the **negotiated charge**) per item
Non-preventive hearing exams		
For adults and children	100% (of the **negotiated charge**) per visit No **deductible** applies	100% (of the **negotiated charge**) per visit No **deductible** applies
Maximum for children	One exam in any 12 consecutive month period.	
Maximum for adults	One exam in any 24 consecutive month period.	
Prosthetic devices		
Prosthetic devices	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.

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

Spinal manipulation		
Spinal manipulation	80% (of the **negotiated charge**) per visit	80% (of the **negotiated charge**) per visit
Maximum visits per Calendar Year	20	20
Vision care		
Routine vision care		
Routine vision exams (including refraction)		
Performed by a legally qualified ophthalmologist or optometrist	100% (of the **negotiated charge**) per visit No **deductible** applies	100% (of the **negotiated charge**) per visit No **deductible** applies
Maximum visits per 12 consecutive month period for dependent children to age 18	1 visit	1 visit
Maximum visits per 24 consecutive month period for adults	1 visit	1 visit

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

Eligible health services*	
Outpatient prescription drugs	
Family planning services - female contraceptives	
Female contraceptives that are **generic prescription drugs**: • Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches	100% per **prescription** or refill No **deductible** applies
Female contraceptives that are **brand-name prescription drugs**: • Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches	100% per **prescription** or refill No **deductible** applies
Female contraceptive generic devices and brand-name devices	100% per **prescription** or refill No **deductible** applies
Preventive care drugs and supplements	
Preventive care drugs and supplements filled at a **pharmacy**	100% per **prescription** or refill No **deductible** applies

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

Risk reducing breast cancer prescription drugs	
Risk reducing breast cancer **prescription drugs** filled at a **pharmacy**	100% per **prescription** or refill No **deductible** applies
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 secure 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** for each 90 day supply	$0 per **prescription** or refill No **deductible** applies
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below. 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 secure member website at www.aetna.com or calling the number on your ID card.

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

General coverage provisions

This section provides detailed explanations about the:

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

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

Deductible provisions

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 **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 **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.

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. Not more than two per admission **copayments** will apply for each facility type during a Calendar Year.

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

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.

Maximum out-of-pocket limits provisions

Eligible health services that are subject to the **maximum out-of-pocket limit** include **prescription drug eligible health services** provided under the medical plan or the outpatient **prescription drug** plan provided by your Employer.

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** 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** 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
- All costs for non-emergency use of the emergency room
- Any out of pocket costs for Obesity surgery

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

Calculations; 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.

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