



Open Choice PPO HDHP

Schedule of benefits

If this is an ERISA plan, you have certain rights under this plan. Please contact your employer for additional information.

Prepared exclusively for:

Policyholder: El Camino Hospital
Policyholder number: GP-0181066
Schedule of Benefits: 1A
Open Choice PPO HDHP

Group policy effective date: January 1, 2022
Plan effective date: January 1, 2022
Plan issue date: February 20, 2025
Plan revision effective date: January 1, 2025

Underwritten by Aetna Life Insurance Company in the state of California.

Schedule of benefits

This schedule of benefits lists the **deductibles** and **copayments/coinsurance** that apply to the services you receive under this plan. You should review this schedule to become familiar with your **deductibles** and **copayments/coinsurance** 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/coinsurance** listed in the schedule of benefits below reflect the **deductibles** and **copayment/coinsurance** amounts under your plan.
- You are responsible to pay any **deductibles, copayments, and coinsurance**.
- The **coinsurance** listed in the schedule of benefits reflects the plan **coinsurance** percentage. This is the **coinsurance** amount the plan pays. You are responsible for paying any remaining **coinsurance**.
- 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/coinsurance** 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.

The coverage described in this schedule of benefits will be provided under **Aetna Life Insurance Company’s group policy**. This schedule of benefits replaces any schedule of benefits previously in effect under the **group policy**. Keep this schedule of benefits with your booklet-certificate.

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	\$3,300 per Calendar Year	\$6,000 per Calendar Year	\$3,300 per Calendar Year	
Family	\$6,600 per Calendar Year	\$12,000 per Calendar Year	\$6,600 per Calendar Year	
Deductible waiver				
The Calendar Year deductible is waived for all of the following eligible health services :				
• Preventive care and wellness • Family planning services - female contraceptives				
Deductible waiver provision for preventive prescription drugs				
Deductible waiver provision for preventive prescription drugs . No deductible will apply to preventive covered prescription drug expenses for those prescription drugs used to treat:				
The prevention of conditions relating to:				
• Hypertension • Heart disease • Diabetic complications • Asthmatic episodes • Conditions resulting from osteoporosis • Stroke • Various pediatric conditions, such as vitamins and fluoride deficiency, and maternal and fetal problems during pregnancy.				
Maximum out-of-pocket limit				
Maximum out-of-pocket limit per Calendar Year.				
Individual	\$5,000 per Calendar Year	\$10,000 per Calendar Year	\$5,000 per Calendar Year	
Family	\$10,000 per Calendar Year	\$20,000 per Calendar Year	\$10,000 per Calendar Year	

*See *How to read your schedule of benefit and important note* at the beginning of this schedule of benefits

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

Routine physical exams			
Performed at a physician's office	100% per visit No deductible applies	60% (of the recognized charge) per visit	100% per visit No deductible applies
Covered persons through age 21: Maximum age and visit limits per 12 months	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 secure member website at www.aetna.com or calling the number on the back of your ID card.	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 secure member website at www.aetna.com or calling the number on the back of your ID card.	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 secure member website at www.aetna.com or calling the number on the back of your ID card.
Covered persons age 22 and over but less than 65: Maximum visits per 12 months	1 visit	1 visit	1 visit
Covered persons age 65 and over: Maximum visits per 12 months	1 visit	1 visit	1 visit

**See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits*

Preventive care immunizations			
Performed in a facility or at a physician's office	100% per visit No deductible applies	60% (of the recognized charge) per visit	100% per visit No deductible applies
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your physician or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of 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 the back of 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 the back of your ID card.
Well woman preventive visits routine gynecological exams (including pap smears)			
Performed at a physician's , obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit No deductible applies	60% (of the recognized charge) per visit	100% per visit No deductible applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.
Maximum visits per Calendar Year	1 visit	1 visit	1 visit

**See How to read your schedule of benefits, important note about your cost sharing and important notice 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	60% (of the recognized charge) per visit	100% per visit No deductible applies
Obesity and/or healthy diet counseling maximums:			
Maximum visits per 12 months (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*	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)*	26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.			
Misuse of alcohol and/or drugs maximums:			
Maximum visits per 12 months	5 visits*	5 visits*	5 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.			
Use of tobacco products maximums:			
Maximum visits per 12 months	8 visits*	8 visits*	8 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.			
Genetic risk counseling for breast and ovarian cancer maximums:			
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations	Not subject to any age or frequency limitations	Not subject to any age or frequency limitations

*See *How to read your schedule of benefits, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

Routine cancer screenings (applies whether performed at a physician's, specialist office or facility)			
Routine cancer screenings	100% per visit No deductible applies	60% (of the recognized charge) per visit	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 secure member website at www.aetna.com or calling the number on the back of 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 secure member website at www.aetna.com or calling the number on the back of 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 secure member website at www.aetna.com or calling the number on the back of your ID card.
Lung cancer screening maximums	1 screening every 12 months*	1 screening every 12 months*	1 screening every 12 months*
*Important note: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the <i>Outpatient diagnostic testing</i> section.			

*See *How to read your schedule of benefits, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

Prenatal care			
Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)			
Preventive care services only (includes participation in the California Prenatal Screening Program)	100% per visit No deductible applies	60% (of the recognized charge) per visit	100% per visit No deductible applies
Important note: You should review the <i>Maternity and related newborn care</i> sections. They will give you more information on coverage levels for maternity care under this plan.			
Comprehensive lactation support and counseling services			
Lactation counseling services – facility or office visits	100% per visit No deductible applies	60% (of the recognized charge) per visit	100% per visit No deductible applies
Lactation counseling services maximum visits per 12 months either in a group or individual setting	6 visits*	6 visits*	6 visits*
*Important note: Any visits that exceed the lactation counseling services maximum are covered under Physician services office visits.			
Breast feeding durable medical equipment			
Breast pump supplies and accessories	100% per item No deductible applies	60% (of the recognized charge) per item	100% per item No deductible applies
Important note: See the <i>Breast feeding durable medical equipment</i> section of the booklet-certificate for limitations on breast pump and supplies.			
Family planning services – female contraceptives			
Female contraceptive education and counseling services office visit	100% per visit No deductible applies	60% (of the recognized charge) per visit	100% per visit No deductible applies

*See *How to read your schedule of benefits, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

Devices			
Female contraceptive device provided, administered, or removed, by a physician during an office visit and follow up services	100% per item No deductible applies	60% (of the recognized charge) per item	100% per item No deductible applies
Female voluntary sterilization			
Inpatient	100% per admission No deductible applies	60% (of the recognized charge) per admission	100% per admission No deductible applies
Outpatient	100% per visit No deductible applies	60% (of the recognized charge) per visit	100% per visit No deductible applies
Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
2. 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 consultation by a physician	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit
Telemedicine consultation by a specialist	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit

**See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits*

Immunizations when not part of the physical exam			
Immunizations when not part of the physical exam	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
Walk-in clinic visits			
Not all preventive care services are available at all walk-in clinics . The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from a network physician .			
	Network Benefit Level		Out-of-network benefit level
Description	Designated network coverage	Non-designated network coverage	Out-of-network coverage
Non-emergency services	100% (of the negotiated charge) per visit after deductible	80% (of the negotiated charge) per visit after deductible	60% (of the recognized charge) per visit after deductible
Preventive care immunizations	100% (of the negotiated charge) per visit, no deductible applies	100% (of the negotiated charge) per visit, no deductible applies	60% (of the recognized charge) per visit after deductible

**See How to read your schedule of benefits, important note about your cost sharing and important notice at the beginning of this schedule of benefits*

Immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician
Preventive screening and counseling services	100% (of the negotiated charge) per visit, no deductible applies	100% (of the negotiated charge) per visit, no deductible applies	60% (of the recognized charge) per visit after deductible
Preventive screening and counseling limits	See the <i>Preventive care services</i> section of the SOB	See the <i>Preventive care services</i> section of the SOB	See the <i>Preventive care services</i> section of the SOB
Important Note: Designated network provider A network provider listed in the directory under <i>Best Results for your plan</i> as a provider for your plan. Non-designated network provider A provider listed in the directory under the <i>All other results</i> tab as a provider for your plan. See the <i>Contact us</i> section if you have questions. You will pay less cost share when you use a designated network walk-in clinic provider. Non-designated network walk-in clinic providers are available to you, but the cost share will be at a higher level when these providers are used.			

*See *How to read your schedule of benefits, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
3. Hospital and other facility care			
Hospital care			
Inpatient hospital	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission	80% (of the recognized charge) per admission
Alternatives to hospital stays			
Outpatient surgery and physician surgical services			
	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit
Home health care			
Outpatient	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	Not Applicable	120 Limited to: 3 intermittent visits per day provided by a participating home health care agency ; 1 visit equals at least 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 14 days of discharge	Not Applicable
Hospice care			
Inpatient facility	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission	80% (of the recognized charge) per admission
Maximum days per lifetime	Unlimited	Unlimited	Unlimited

*See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

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
Maximum visits/shifts per <i>Calendar Year</i>	120 shifts Up to eight hours equal one shift.	120 shifts Up to eight hours equal one shift.	120 shifts Up to eight hours equal one shift.
Skilled nursing facility			
Inpatient facility	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission	80% (of the recognized charge) per admission
Maximum days per Calendar Year	100	100	100
Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care

*See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

4. Emergency services and urgent care

Emergency services

Hospital emergency room	80% (of the negotiated charge) per visit	Paid the same as in-network coverage	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not Covered	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 coinsurance**) as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by this plan. If the **provider** bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, and we will resolve any payment dispute with the **provider** over that amount. Make sure the member's ID number is on the bill.

Urgent care

Urgent medical care (at a non- hospital free standing facility)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit
Non-urgent use of urgent care provider (at a non- hospital free standing facility)	Not covered	Not covered	Not covered

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

5. Specific conditions

Behavioral health

Mental health treatment - inpatient

Inpatient mental health treatment	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission	80% (of the recognized charge) per admission
Inpatient residential treatment facility Inpatient mental health treatment			

*See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

Mental health treatment - outpatient			
Outpatient mental health treatment office visits to a physician or behavioral health provider (includes telemedicine consultation)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit
All other outpatient mental health treatment as described in your booklet-certificate (includes skilled behavioral health services in the home) Partial hospitalization treatment Intensive outpatient program	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit

**See How to read your schedule of benefit, important note about your cost sharing and important notice at the beginning of this schedule of benefits*

Substance related disorders treatment - inpatient			
Inpatient substance abuse detoxification	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission	80% (of the recognized charge) per admission
Inpatient substance abuse rehabilitation			
Inpatient residential treatment facility			
Substance related disorders treatment - outpatient			
Outpatient substance abuse office visits to a physician or behavioral health provider (includes telemedicine consultation)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit
All other outpatient substance abuse services (as described in your booklet-certificate)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit
Partial hospitalization treatment			
Intensive outpatient program			
Birth center and physician services			
Inpatient	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission	80% (of the recognized charge) per admission
Diabetic equipment, supplies and education			
Diabetic equipment, supplies and education	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Family planning services - other			
Voluntary sterilization for males			
Outpatient	100% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit
Termination of pregnancy			

*See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

Inpatient	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.) per visit
Outpatient	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.
Physician's office	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.
Jaw joint disorder treatment			
Jaw joint 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
Maternity and related newborn care			
Inpatient	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission	80% (of the recognized charge) per admission
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.
Pregnancy complications			
	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission	80% (of the recognized charge) per admission

**See How to read your schedule of benefit, important note about your cost sharing and important notice at the beginning of this schedule of benefits*

Gender reassignment counseling, surgery and injectable hormone replacement therapy		
	In-network coverage	Out-of-network coverage
Gender reassignment counseling, surgery and injectable hormone replacement therapy, including office visits and outpatient services	Covered based on type of service and where it is received.	Covered based on type of service and where it is received.

Obesity surgery			
Inpatient hospital (includes surgical procedure and acute hospital services)	80% (of the negotiated charge) per admission	Not covered	80% (of the recognized charge) per admission
Outpatient obesity surgery			
	80% (of the negotiated charge) per visit	Not covered	80% (of the recognized 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	Covered according to the type of benefit and the place where the service is received
Reconstructive surgery and supplies			
Reconstructive surgery	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

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	80% (of the negotiated charge) per transplant	60% (of the negotiated charge) per transplant	60% (of the recognized charge) per transplant	60% (of the recognized charge) per transplant

*See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

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				
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 number of ovulation induction cycles with menotropins per lifetime**	6	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				
Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care	
6. Specific therapies and tests				
Outpatient diagnostic testing				
Diagnostic complex imaging services				
	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit	
Diagnostic lab work				
	80% (of the negotiated charge) per visit.	60% (of the recognized charge) per visit.	80% (of the recognized charge) per visit.	
Diagnostic radiological services				
	80% (of the negotiated charge) per visit.	60% (of the recognized charge) per visit.	80% (of the recognized charge) per visit.	
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	

*See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

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

Short-term rehabilitation services			
Outpatient Physical and Occupational Therapies			
	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit
Outpatient Speech Therapy			
	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	80% (of the recognized charge) per visit

Spinal manipulation			
Spinal manipulation	80% (of the negotiated charge) per visit	Not covered	80% (of the recognized charge) per visit

*See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

Habilitation therapy services			
Outpatient physical and occupational 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
Outpatient speech 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

Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
7. 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	20	20	20

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

*See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

Durable medical equipment (DME)			
DME	80% (of the negotiated charge) per item	Not covered	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	60% (of the recognized charge) per item	80% (of the recognized charge) per item
Hearing aids	One per ear every 36 month consecutive period	One per ear every 36 month consecutive period	One per ear every 36 month consecutive 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.
Osteoporosis			
Physician's 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
Prosthetic and orthotic devices			
Prosthetic and orthotic 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	Covered according to the type of benefit and the place where the service is received

**See How to read your schedule of benefit, important note about your cost sharing and important notice at the beginning of this schedule of benefits*

Vision care			
Routine vision exams (including refraction)			
Performed by a licensed ophthalmologist or optometrist	100% (of the negotiated charge) per visit No deductible applies.	Not covered	80% (of the recognized charge) per visit No deductible applies.
Maximum visits per 24 consecutive month period	1 visit	Not covered	1 visit
All other outpatient services for which cost sharing is not shown above			
All other outpatient 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
Eligible health services	In-network coverage*	Out-of-network coverage*	
8. Outpatient prescription drugs			
Plan features	Deductible/Copayment/Coinsurance/Maximums		
Deductible and copayment/coinsurance waiver for risk reducing breast cancer prescription drugs			
The Calendar Year deductible and the per prescription copayment/coinsurance 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/coinsurance waiver for contraceptives			
The Calendar Year deductible and the per prescription copayment/coinsurance 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 drug for that method paid at 100%. We will cover brand-name emergency contraceptive “Ella” until such time as a generic equivalent is approved by the FDA. At that time, only a generic equivalent will be covered.			
The Calendar Year deductible and the per prescription copayment/coinsurance 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.			

*See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

Deductible waiver for preventive prescription drugs

No **deductible** will apply to preventive covered **prescription drug** expenses for those **prescription drugs** used for:

The prevention of conditions relating to:

- Hypertension
- Heart disease
- Diabetic complications
- Asthmatic episodes
- Conditions resulting from osteoporosis
- Stroke
- Various pediatric conditions, such as vitamins and fluoride deficiency, and maternal and fetal problems during pregnancy

Partial fill dispensing for Schedule II controlled substances, such as opioids

Partial fill dispensing allows less than the entire prescription to be filled at a **pharmacy**. You will pay a prorated amount of your cost share based on the size of the supply.

Important note:

- Review the How to access out-of-network pharmacies section of the booklet-certificate for more information on how these pharmacies are subject to higher out-of-pocket costs.

Generic prescription drugs

Per prescription copayment/coinsurance

For each fill up to a 30 day supply filled at a retail pharmacy	\$5 copayment per supply Coinsurance is 100% (of the negotiated charge)	Coinsurance is 100% (of the recognized charge) but will be no more than \$5 per supply
More than a 31 day supply but less than a 91 day supply filled at a mail order pharmacy	\$10 copayment per supply Coinsurance is 100% (of the negotiated charge)	Not Covered

Brand-name prescription drugs

Per prescription copayment/coinsurance

For each fill up to a 30 day supply filled at a retail pharmacy	\$20 copayment per supply Coinsurance is 100% (of the negotiated charge)	Coinsurance is 100% (of the recognized charge) but will be no more than \$5 per supply
More than a 31 day supply but less than a 91 day supply filled at a mail order pharmacy	\$40 copayment per supply Coinsurance is 100% (of the negotiated charge)	Not Covered

*See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

Orally administered anti-cancer prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	\$0 copayment per supply Coinsurance is 100% (of the negotiated charge)	Coinsurance is 100% (of the recognized charge) but will be no more than \$5 per supply
More than a 31 day supply but less than a 91 day supply filled at a mail order pharmacy	\$0 copayment per supply Coinsurance is 100% (of the negotiated charge)	Not Covered
Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a pharmacy	100% per prescription or refill	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.

*See *How to read your schedule of benefit, important note about your cost sharing and important notice* 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	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.
Family planning services - female contraceptives		
If your provider recommends a particular service or FDA-approved item based on a determination of medical necessity , that service or item will be covered without cost sharing, regardless of whether it is generic or brand-name. We will defer to the determination made by your provider . Medical necessity may include considerations such as severity of side effects, differences in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the item or service, as determined by your provider .		
Female contraceptives that are generic prescription drugs : • Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches	\$0 per prescription or refill No deductible applies	Paid according to the type of drug per the schedule of benefits, above
Female contraceptives that are brand-name prescription drugs : • Oral drugs • Injectable drugs • Vaginal rings	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above

*See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

• Transdermal contraceptive patches		
Tobacco cessation prescription and over-the-counter drugs		
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy	\$0 per prescription or refill No deductible applies	Paid according to the type of drug per the schedule of benefits, above
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 tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card. Coverage for tobacco cessation prescription drugs is not subject to any precertification requirements.	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.
If you or your prescriber requests a covered brand-name prescription drug when a covered generic prescription drug equivalent is available, you will be responsible for the cost difference between the generic prescription drug and the brand-name prescription drug , plus the cost sharing that applies to brand-name prescription drugs .		

*See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

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 that are subject to the deductible include prescription drug eligible health services provided under the medical plan prescription drug plan .
Eligible health services applied to the out-of-network deductibles will not be applied to satisfy the in-network deductibles . Eligible health services applied to the in-network deductibles will not 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/coinsurance 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.

See How to read your schedule of benefit, important note about your cost sharing and important notice at the beginning of this schedule of benefit

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**. As it applies to in-network coverage, if **Aetna** compensates **network providers** on the basis of the reasonable amount, your percentage copayment is based on this amount.

Coinsurance

The specific percentage you and the plan have to pay 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 outpatient **prescription drug** plan.

Eligible health services applied to the **out-of-network maximum out-of-pocket limit** will not 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 not 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/coinsurance** 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/coinsurance** 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/coinsurance** 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.

See How to read your schedule of benefit, important note about your cost sharing and important notice at the beginning of this schedule of benefit

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/coinsurance** 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
- All costs incurred for non-urgent use of an **urgent care provider**

Maximum provisions

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

Outpatient prescription drug maximum out-of-pocket limits provisions

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

See How to read your schedule of benefit, important note about your cost sharing and important notice at the beginning of this schedule of benefit