Preferred Provider Organization (PPO) Medical Plan with Aetna HealthFund
Kent County Levy Court

PPO HRA $5000/$10,000 RX $10/$25/$75
Schedule of Benefits

Prepared exclusively for:

Employer:	Delaware Valley Health Trust
Contract number:	721185
Control number**:**	108430 – Plans D and E Schedule of Benefits 1B
Plan effective date:	July 1, 2018
Plan issue date:	August 20, 2018

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

Schedule of benefits

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

How to read your schedule of benefits

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

Important note:
All **covered benefits** are subject to the Plan 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 Navigator® 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.

Plan features	Deductible/Maximums		
	In-network coverage*	**Out-of-network coverage***	**Other health care***
Deductible			
You have to meet your Plan Year **deductible** before this plan pays for benefits.			
Individual	$5,000 per Plan Year	$5,000 per Plan Year	$5,000 per Plan Year
Family	$10,000 per Plan Year	$10,000 per Plan Year	$10,000 per Plan Year
Deductible waiver			
The Plan 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 Plan Year.			
Individual	$7,150 per Plan Year	$10,000 per Plan Year	$7,150 per Plan Year
Family	$14,300 per Plan Year	$20,000 per Plan Year	$14,300 per Plan Year
Precertification covered benefit reduction			
This only applies to out-of-network coverage. The booklet contains a complete description of the **precertification** program. You will find details on **precertification** requirements in the *Medical necessity and precertification requirements* section. Failure to **precertify** your **eligible health services** when required will result in the following benefits reduction: • A $200 benefit reduction will be applied separately to each type of **eligible health services** or • The **eligible health services** will not be covered. The additional percentage or dollar amount of the **recognized charge** which you may pay as a penalty for failure to obtain **precertification** is not a **covered benefit**, and will not be applied to the **deductible** amount or the **maximum out-of-pocket limit**, if any.			
Annual HealthFund amount			
Individual	$5,000 per Plan Year		
Family	$10,000 per Plan Year		

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

Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Preventive care and wellness			
Routine physical exams			
Performed at a **physician's** office	100% per visit No **deductible** applies.	80% (of the **recognized charge**) per visit	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 Navigator® secure member website at www.aetna.com or calling the number on 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 Navigator® secure member website at www.aetna.com or calling the number on 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 Navigator® secure 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 Plan Year	1 visit	1 visit	1 visit
Covered persons age 65 and over: Maximum visits per Plan Year	1 visit	1 visit	1 visit

*See *How to read your schedule of benefits* 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	80% (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 Navigator® secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® 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**, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit No **deductible** applies	80% (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 Plan Year	1 visit	1 visit	1 visit

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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	80% (of the **recognized charge**) per visit	100% per visit No **deductible** applies
Obesity and/or healthy diet counseling maximums:			
Maximum visits per Plan 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)*	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 Plan Year	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 Plan Year	8 visits*	8 visits*	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 Plan Year	2 visits*	2 visits*	2 visits*
*Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.			

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

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
Routine cancer screenings (applies whether performed at a physician's, specialist office or facility)			
Routine cancer screenings	100% per visit No **deductible** applies.	80% (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 Navigator® secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.
Lung cancer screening maximums	1 screening every Plan Year*	1 screening every Plan Year*	1 screening every Plan Year*
***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	Physician's or Specialist copay then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge**) per visit	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	80% (of the **recognized charge**) per visit	100% per visit No **deductible** applies
Lactation counseling services maximum visits per 12 months either in a group or individual setting	6 visits*	6 visits*	6 visits*
***Important note:** Any visits that exceed the lactation counseling services maximum are covered under **Physician** services office visits.			
Breast feeding durable medical equipment			
Breast pump supplies and accessories	100% per item No **deductible** applies	80% (of the **recognized charge**) per item	100% per item No **deductible** applies
Important note: See the *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	80% (of the **recognized charge**) per visit	100% per visit No **deductible** applies
Contraceptive counseling services maximum visits per 12 months either in a group or individual setting	2 visits*	2 visits*	2 visits*
***Important note:**			

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

Any visits that exceed the contraceptive counseling services maximum are covered under **Physician** services office visits.			
Devices			
Female contraceptive device provided, administered, or removed, by a **physician** during an office visit	100% per item No **deductible** applies	80% (of the **recognized charge**) per item	100% per item No **deductible** applies
Female voluntary sterilization			
Inpatient	100% per admission No **deductible** applies	80% (of the **recognized charge**) per admission	100% per admission No **deductible** applies
Outpatient	100% per visit No **deductible** applies	80% (of the **recognized charge**) per visit	100% per visit No **deductible** applies
Eligible health services	**In-network coverage***	**Out-of-network coverage***	**Other health care**
Physicians and other health professionals			
Physicians and **specialists** office visits (non-surgical)			
Physician services			
Office hours visits (non-surgical) non preventive care	$10 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies
Complex imaging, lab work and radiological services performed during a **physician's** office visit	$10 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies
Allergy injections			
Performed at a **physician's** or **specialist** office when you do not see the **physician**	100% (of the **negotiated charge**) per visit	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Allergy testing, treatment and injections			
Performed at a **physician's** or **specialist** office	100% (of the **negotiated charge**) per visit	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit

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Immunizations that are not considered preventive care			
Immunizations that are not considered preventive care	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Specialist			
Specialist office visits			
Office hours visits (non-surgical)	$20 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies
Complex imaging, lab work and radiological services performed during a **specialist** office visit	$20 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies
Physician surgical services			
Physicians and **specialists** office visits			
Performed at a **physician's** office	100% (of the **negotiated charge**) per visit	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Performed at a **specialist's** office	100% (of the **negotiated charge**) per visit	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit

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Alternatives to physician office visits			
Walk-in clinic visits			
Preventive Care Services			
Immunizations	100% per visit No **deductible** applies	80% (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 Navigator® secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.
All non preventive care services for which cost sharing is not shown above			
All other services	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies

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Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Hospital and other facility care			
Hospital care			
Inpatient **hospital**	100% (of the **negotiated charge**) per admission	80% (of the **recognized charge**) per admission	80% (of the **recognized charge**) per admission
Alternatives to hospital stays			
Outpatient surgery and physician surgical services			
	100% (of the **negotiated charge**) per visit	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Home health care			
Outpatient	100% (of the **negotiated charge**) per visit	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Maximum visits per Plan Year	100	100	100
Hospice care			
Inpatient facility	100% (of the **negotiated charge**) per admission	80% (of the **recognized charge**) per admission	80% (of the **recognized charge**) per admission
Maximum days per lifetime	Unlimited	Unlimited	Unlimited
Hospice care			
Outpatient	100% (of the **negotiated charge**) per visit	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Outpatient private duty nursing			
Outpatient private duty nursing	100% (of the **negotiated charge**) per visit	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Maximum visits/shifts per Plan Year	30 shifts Up to eight hours equal one shift.	30 shifts Up to eight hours equal one shift.	30 shifts Up to eight hours equal one shift.
Skilled nursing facility			
Inpatient facility	100% (of the **negotiated charge**) per admission	80% (of the **recognized charge**) per admission	80% (of the **recognized charge**) per admission
Maximum days per Plan Year	120	120	120

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Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Emergency services and urgent care			
Emergency services			
Hospital emergency room	$150 then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **deductible** applies	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 **payment percentage**), as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by this plan. If the **provider** bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, and we will resolve any payment dispute with the **provider** over that amount. Make sure the member's ID number is on the bill. ▪ A separate hospital emergency room **copayment/payment percentage** will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room **copayment/payment percentage** will be waived and your inpatient **copayment/payment percentage** will apply.			
Urgent care			
Urgent medical care (at a non-**hospital** free standing facility)	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge)** per visit	$50 then the plan pays 80% (of the balance of the **recognized charge**) per visit thereafter No **deductible** applies
Non-urgent use of **urgent care provider** (at a non-**hospital** free standing facility)	Not covered	Not covered	Not covered
A separate urgent care **deductible** or **copayment**/**payment percentage** will apply for each visit to an **urgent care provider**.			

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Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Specific conditions			
Birthing center			
Inpatient	100% (of the **negotiated charge**) per admission	80% (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	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Abortion			
Outpatient	100% (of the **negotiated charge**) per visit	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Maternity and related newborn care			
Inpatient	100% (of the **negotiated charge**) per admission	80% (of the **recognized charge**) per admission	80% (of the **recognized charge**) per admission
Delivery services, non-preventive prenatal care and postpartum care services			
Performed in a facility or at a **physician's** office	100% (of the **negotiated charge**) per visit	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Other non-preventive 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.

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Mental health treatment - inpatient			
Inpatient mental health treatment Inpatient **residential treatment facility** Coverage is provided under the same terms, conditions as any other **illness**.	100% (of the **negotiated charge**) per admission	80% (of the **recognized charge**) per admission	80% (of the **recognized charge**) per admission
Mental health treatment - outpatient			
Outpatient mental health treatment	$10 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies
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**.	100% (of the **negotiated charge**) per admission	80% (of the **recognized charge**) per admission	80% (of the **recognized charge**) per admission
Substance related disorders treatment - outpatient: detoxification and rehabilitation			
Outpatient **substance abuse** treatment	$10 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies

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Obesity surgery			
Inpatient **hospital** (includes surgical procedure and acute **hospital** services)	100% (of the **negotiated charge**) per admission	80% (of the **recognized charge**) per admission	80% (of the **recognized charge**) per admission
Outpatient obesity surgery			
	100% (of the **negotiated charge**) per visit	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Oral and maxillofacial treatment (mouth, jaws and teeth)			
Oral and maxillofacial treatment (mouth, jaws and teeth)	100% (of the **negotiated charge**) per visit	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Reconstructive breast surgery			
Reconstructive breast **surgery**	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Reconstructive surgery and supplies			
Reconstructive **surgery**	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

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	100% (of the **negotiated charge**) per transplant	80% (of the **negotiated charge**) per transplant	80% (of the **recognized charge**) per transplant	80% (of the **recognized charge**) per transplant
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

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Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Treatment of infertility			
Basic infertility			
Basic **infertility**	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Eligible health services	**In-network coverage***	**Out-of-network coverage***	**Other health care**
Specific therapies and tests			
Outpatient diagnostic testing			
Diagnostic complex imaging services			
	100% (of the **negotiated** charge) per visit	80% (of the **recognized** charge) per visit	80% (of the **recognized** charge) per visit
Diagnostic lab work			
	100% (of the **negotiated** charge) per visit.	80% (of the **recognized** charge) per visit.	80% (of the **recognized** charge) per visit.
Diagnostic radiological services			
	100% of the **negotiated charge** per visit.	80% of the **recognized charge** per visit.	80% of the **recognized 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.	Covered according to the type of benefit and the place where the service is received.
Outpatient infusion 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.
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.

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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			
Short-term rehabilitation services (outpatient physical, occupational therapies) combined with Habilitation therapy services (outpatient physical, occupational therapies)			
	$20 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies
Short-term rehabilitation services (outpatient speech therapies) combined with Habilitation therapy services (outpatient speech therapies)			
	$20 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies
Outpatient Physical and Occupational Therapies Maximum			
Maximum visits per Plan Year	30 visits	30 visits	30 visits
Outpatient Speech Therapy Maximum			
Maximum visits per Plan Year	30 visits	30 visits	30 visits

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Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Other services			
Acupuncture			
Acupuncture (as a form of anesthesia in connection with a covered surgical procedure)	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
Ambulance service			
Emergency	100% (of the **negotiated charge**) per trip	100% (of the **negotiated charge**) per trip	100% (of the **negotiated charge**) per trip
Non-Emergency	100% (of the **negotiated charge**) per trip	80% (of the **recognized charge**) per trip	80% (of the **recognized charge**) per trip
Clinical trial therapies (experimental or investigational)			
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Clinical trials (routine patient costs)			
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Durable medical equipment (DME)			
DME	100% (of the **negotiated charge**) per item	80% (of the **recognized charge**) per item	80% (of the **recognized charge**) per item
Injectable drugs			
Injectable drugs and the administration of those drugs*	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.
* Certain injectable drugs may be covered under the Outpatient Prescription Drug coverage.			
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

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Hearing aids (Covered for children to age 24)	100% (of the **negotiated charge**) per item	80% (of the **recognized charge**) per item	80% (of the **recognized charge**) per item
Maximum per 3 years per ear	$1,000	$1,000	$1,000
Prosthetic devices			
Prosthetic devices	100% (of the **negotiated charge**) per item	80% (of the **recognized charge**) per item	80% (of the **recognized charge**) per item
Spinal manipulation			
Spinal manipulation	100% (of the **negotiated charge**) per visit	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Maximum visits per Plan Year	30	30	30
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	80% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies
Maximum visits per 24 consecutive month period	1 visit	1 visit	1 visit

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

Eligible health services	In-network coverage*
Outpatient prescription drugs	
Plan features	**Deductible/Copayment/Payment Percentage/Maximums**
Deductible waiver	
The plan year **deductible** is waived for all **prescription drugs**.	
Deductible and copayment/payment percentage waiver for risk reducing breast cancer prescription drugs	
The Plan Year **deductible** and the per **prescription copayment/payment percentage** will not apply to risk reducing breast cancer **prescription drugs** when obtained at a **network pharmacy**. This means that such risk reducing breast cancer **prescription drugs** will be paid at 100%.	
Deductible and copayment/payment percentage waiver for tobacco cessation prescription and over-the-counter drugs	
The Plan Year **deductible** and the per **prescription copayment/payment percentage** will not apply to two 90-day treatment regimens for tobacco cessation **prescription drugs** and OTC drugs when obtained at a **network pharmacy**. This means that such **prescription drugs** and OTC drugs will be paid at 100%.	
Deductible and copayment/payment percentage waiver for contraceptives	
The Plan Year **deductible** and the per **prescription copayment/payment percentage** will not apply to female contraceptive methods when obtained at a **network pharmacy**. This means that the following will be paid at 100%: • Certain over-the-counter (OTC) and generic contraceptive **prescription drugs** and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. If a **generic prescription drug** or device is not available for a certain method, you may obtain certain **brand-name prescription drugs** for that method paid at 100%. The Plan Year **deductible** and the per **prescription copayment/payment percentage** continue to apply to **prescription drugs** that have a generic equivalent or generic alternative available within the same **therapeutic drug class** obtained at a **network pharmacy** unless you are granted a medical exception.	

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Generic prescription drugs (including specialty drugs)		
Per prescription copayment/payment percentage		
For each fill up to a 34 day supply filled at a **retail pharmacy**	$10 **copayment** per supply **Payment percentage** is 100% (of the **negotiated charge**) No Plan Year **deductible** applies	$10 **copayment** per supply **Payment percentage** is 80% (of the **recognized charge**) No Plan Year **deductible** applies
More than a 34 day supply but less than a 91 day supply filled at a **retail pharmacy**	$20 **copayment** per supply **Payment percentage** is 100% (of the **negotiated charge**) No Plan Year **deductible** applies	$20 **copayment** per supply **Payment percentage** is 80% (of the **recognized charge**) No Plan Year **deductible** applies
More than a 34 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$20 **copayment** per supply **Payment percentage** is 100% (of the **negotiated charge**) No Plan Year **deductible** applies	Not covered
Preferred brand-name prescription drugs (including specialty drugs)		
Per prescription copayment/payment percentage		
For each fill up to a 34 day supply filled at a **retail pharmacy**	$25 **copayment** per supply **Payment percentage** is 100% (of the **negotiated charge**) No Plan Year **deductible** applies	$25 **copayment** per supply **Payment percentage** is 80% (of the **recognized charge**) No Plan Year **deductible** applies
More than a 34 day supply but less than a 91 day supply filled at a **retail pharmacy**	$50 **copayment** per supply **Payment percentage** is 100% (of the **negotiated charge**) No Plan Year **deductible** applies	$50 **copayment** per supply **Payment percentage** is 80% (of the **recognized charge**) No Plan Year **deductible** applies
More than a 34 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$50 **copayment** per supply **Payment percentage** is 100% (of the **negotiated charge**) No Plan Year **deductible** applies	Not covered

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Non-preferred brand-name prescription drugs (including specialty drugs)		
Per prescription copayment/payment percentage		
For each fill up to a 34 day supply filled at a **retail pharmacy**	$75 **copayment** per supply **Payment percentage** is 100% (of the **negotiated charge**) No Plan Year **deductible** applies	$75 **copayment** per supply **Payment percentage** is 80% (of the **recognized charge**) No Plan Year **deductible** applies
More than a 34 day supply but less than a 91 day supply filled at a **retail pharmacy**	$150 **copayment** per supply **Payment percentage** is 100% (of the **negotiated charge**) No Plan Year **deductible** applies	$150 **copayment** per supply **Payment percentage** is 80% (of the **recognized charge**) No Plan Year **deductible** applies
More than a 34 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$150 **copayment** per supply **Payment percentage** is 100% (of the **negotiated charge**) No Plan Year **deductible** applies	Not covered
Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a **pharmacy**	100% per **prescription** or refill No **deductible** applies	Covered For specific cost share, reference the out of network *Per prescription copayment/payment percentage* under the *generic and brand name* prescription drug section
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 Navigator® secure member website at www.aetna.com or calling the number on your ID card.	

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Risk reducing breast cancer prescription drugs		
Risk reducing breast cancer **prescription drugs** filled at a **pharmacy**	100% per **prescription** or refill No **deductible** applies	Covered For specific cost share, reference the out of network *Per prescription copayment/payment percentage* under the *generic and brand name* prescription drug section
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 Navigator® 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**	$0 per **prescription** or refill No **deductible** applies	Covered For specific cost share, reference the out of network *Per prescription copayment/payment percentage* under the *generic and brand name* prescription drug section
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.	

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If you or your **prescriber** requests a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost difference between **the generic prescription drug** and the **brand-name prescription drug**, plus the cost sharing that applies to the **brand-name prescription drug**.

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General coverage provisions

This section provides detailed explanations about the:

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

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

Deductible provisions

Eligible health services applied to the out-of-network **deductibles** will 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/payment percentage** for **eligible health services** to which the **deductible** does not apply.

For purposes of the Plan Year **deductible** provision below, an individual means an employee enrolled for self only coverage with no dependent coverage and a family means an employee enrolled with one or more dependents. The family **deductible** can be met by one family member, or a combination of family members. For purposes of the Plan Year **deductible** provision below:

- The individual **deductible** applies to a person who is enrolled for self only coverage with no dependent coverage
- The family **deductible** applies to a person who is enrolled with one or more dependents. The family **deductible** can be met by one family member, or a combination of family members.

Individual
This is the amount you owe for in-network and out-of-network **eligible health services** each Plan Year before the plan begins to pay for **eligible health services**. After the amount you pay for **eligible health services** reaches this individual Plan Year **deductible**, this plan will begin to pay for **eligible health services** for the rest of the Plan Year.

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

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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 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/payment percentage** and **deductibles** for **eligible health services** during the Plan 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 Plan 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 Plan 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 Plan 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 Plan Year for all covered family members.

To satisfy this family **maximum out-of-pocket limit** for the rest of the Plan 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 Plan 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
- All costs incurred for non-urgent use of an **urgent care provider**
- As it applies to out-of-network coverage: Charges, expenses or costs in excess of the **recognized charge**

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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 Plan Year. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet.

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 benefits* at the beginning of this schedule of benefits