Open Access Aetna Select Medical Plan

Schedule of Benefits

Prepared exclusively for:

Employer:	City of La Porte
Contract number:	ASA-870576
	Schedule of Benefits 3A
Plan effective date:	January 1, 2020
Plan issue date:	December 30, 2019

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

Schedule of benefits

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

How to read your schedule of benefits

- When we say:
  - "In-network coverage", we mean you get care from **network providers**.
- 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.
- At the end of this schedule you will find detailed explanations about your:
  - **Deductible**
  - **Maximum out-of-pocket limits**

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

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

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

Plan features	Deductible/Maximums
	In-network coverage*
Deductible	
You have to meet your Calendar Year **deductible** before this plan pays for benefits.	
Individual	$500 per Calendar Year
Family	$1,500 per Calendar Year
Deductible waiver	
The Calendar Year in-network **deductible** is waived for all of the following **eligible health services:** • Preventive care and wellness • Family planning services - female contraceptives	
Maximum out-of-pocket limit	
Maximum out-of-pocket limit per Calendar Year.	
Individual	$3,500 per Calendar Year
Family	$10,500 per Calendar Year

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

Eligible health services	In-network coverage*
Preventive care and wellness	
Routine physical exams	
Performed at a **physician's**, **PCP** office	100% per visit No **deductible** applies
Covered persons through age 21:	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.
Covered persons age 22 and over but less than 65: Maximum visits per 12 months	1 visit
Covered persons age 65 and over: Maximum visits per 12 months	1 visit
Preventive care immunizations	
Performed in a facility or at a **physician's** office	100% per visit No **deductible** applies
	Subject to any age and visit limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.
Well woman preventive visits routine gynecological exams (including pap smears)	
Performed at a **physician's**, **PCP**, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit No **deductible** applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
Maximum visits per Calendar Year	1 visit

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

Preventive screening and counseling services	
Office visits • Obesity and/or healthy diet counseling • Misuse of alcohol and/or drugs • Use of tobacco products • Sexually transmitted infection counseling • Genetic risk counseling for breast and ovarian cancer	100% per visit No **deductible** applies
Obesity and/or healthy diet counseling maximums:	
Maximum visits per 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)*
*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*
*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*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	
Sexually transmitted infection counseling maximums:	
Maximum visits per 12 months	2 visits*
*Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.	
Genetic risk counseling for breast and ovarian cancer maximums:	
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations

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

Routine cancer screenings (applies whether performed at a physician's, PCP, specialist office or facility)	
Routine cancer screenings	100% per visit No **deductible** applies
Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.
Lung cancer screening maximums	1 screening every 12 months*
Important note: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.	
Prenatal care **Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)**	
Preventive care services only	100% per visit No **deductible** applies
Important note: You should review the *Maternity and related newborn care* sections. They will give you more information on coverage levels for maternity care under this plan.	
Comprehensive lactation support and counseling services	
Lactation counseling services – facility or office visits	100% per visit No **deductible** applies
Lactation counseling services maximum per 12 months either in a group or individual setting	6 visits*
***Important note:** Any visits that exceed the lactation counseling services maximum are covered under **Physician** services office visits.	

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Breast feeding durable medical equipment	
Breast pump supplies and accessories	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
Contraceptive counseling services maximum visits per 12 months either in a group or individual setting	2 visits*
***Important note:** Any visits that exceed the contraceptive counseling services maximum are covered under **Physician** services office visits.	
Devices	
Female contraceptive device provided, administered, or removed, by a **physician** during an office visit	100% per item No **deductible** applies
Female voluntary sterilization	
Inpatient	100% per admission No **deductible** applies
Outpatient	100% per visit No **deductible** applies

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Eligible health services	In-network coverage*
Physicians and other health professionals	
Physicians and **specialists** office visits (non-surgical)	
Physician services	
Office hours visits (non-surgical) non preventive care	$25 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
***Telemedicine Consultations**	
**The plan may utilize one or more telemedicine vendors. To obtain information regarding potential cost share when utilizing a telemedicine vendor, contact member services at the number on your ID card.*	
Allergy injections	
Performed at a **physician's**, **PCP** or **specialist** office when you do not see the **physician**	80% (of the **negotiated charge**) per visit
Immunizations that are not considered preventive care	
Immunizations that are not considered preventive care	Covered according to the type of benefit and the place where the service is received.
Specialist	
Specialist office visits	
Office hours visits (non-surgical)	$40 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Physician surgical services	
Physicians and **specialists** office visits	
Performed at a **physician's**, **PCP** office	$25 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Performed at a **specialist's** office	$40 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies

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Alternatives to physician office visits	
Walk-in clinic visits	
Walk-in clinic non-emergency visit *(includes coverage for immunizations)*	100% (of the **negotiated charge**) per visit No **deductible** applies
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.

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Eligible health services	In-network coverage*
Hospital and other facility care	
Hospital care	
Inpatient **hospital**	$150 per day copay for the first 5 days of confinement then the plan pays 100% (of the balance of the **negotiated charge**) per admission
Alternatives to hospital stays	
Outpatient surgery and physician surgical services	
	$100 then the plan pays 80% (of the balance of the **negotiated charge**) per visit thereafter
Home health care	
Outpatient	80% (of the **negotiated charge**) per visit
Maximum visits per Calendar Year	120 Limited to: 3 intermittent visits per day provided by a participating home health care agency; 1 visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge
Hospice care	
Inpatient facility	80% (of the **negotiated charge**) per admission
Maximum days per lifetime	Unlimited
Hospice care	
Outpatient	80% (of the **negotiated charge**) per visit
	Part-time or intermittent nursing care by an **R.N.** or **L.P.N.** for up to 8 hours a day Part-time or intermittent home health aide services to care for you up to 8 hours a day

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Outpatient private duty nursing	
Outpatient private duty nursing	80% (of the **negotiated charge**) per visit
Maximum visits/shifts per Calendar Year	70 shifts Up to eight hours equal one shift.
Skilled nursing facility	
Inpatient facility	80% (of the **negotiated charge**) per admission
Maximum days per Calendar Year	100

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Eligible health services	In-network coverage*	Out-of-network coverage*
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
Non-emergency care in a **hospital** emergency room	Not covered	Not covered
Important Note: ▪ As **out-of-network providers** do not have a contract with us the **provider** may not accept payment of your cost share, (**deductible, copayment** and **payment percentage**), as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by this plan. If the **provider** bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, and we will resolve any payment dispute with the **provider** over that amount. Make sure the member's ID number is on the bill. ▪ 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)	$40 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	Not covered
Non-urgent use of **urgent care provider** (at a non-**hospital** free standing facility)	Not covered	Not covered
A separate urgent care **copayment**/payment percentage will apply for each visit to an **urgent care provider**.		

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Eligible health services	In-network coverage*
Specific conditions	
Autism spectrum disorder	
Autism spectrum disorder treatment	Covered according to the type of benefit and the place where the service is received
All other coverage for diagnosis and treatment, including behavioral therapy, will continue to be provided the same as any other **illness** under this plan	
Birthing center	
Inpatient	$150 per day copay for the first 5 days of confinement then the plan pays 100% (of the balance of the **negotiated charge**) per admission
Family planning services - other	
Voluntary sterilization for males	
Outpatient	80% (of the **negotiated charge**) per visit
Maternity and related newborn care	
Inpatient	$150 per day copay for the first 5 days of confinement then the plan pays 100% (of the balance of the **negotiated 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
Other prenatal care services	Covered according to the type of benefit and the place where the service is received.
Mental health treatment - inpatient	
Inpatient mental health treatment Inpatient **residential treatment facility** Coverage is provided under the same terms, conditions as any other **illness**.	$150 per day copay for the first 5 days of confinement then the plan pays 80% (of the balance of the **negotiated charge**) per admission

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Mental health treatment - outpatient	
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** includes **telemedicine** consultation Coverage is provided under the same terms, conditions as any other **illness**.	$40 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** includes **telemedicine** cognitive behavior therapy consultation	$40 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Other outpatient mental health treatment (includes skilled behavioral health services in the home) **Partial hospitalization treatment** **Intensive outpatient program** The cost share doesn't apply to in-network peer counseling support services	80% (of the **negotiated charge**) per visit

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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**.	$150 per day copay for the first 5 days of confinement then the plan pays 100% (of the balance of the **negotiated charge**) per admission

Substance related disorders treatment - outpatient: detoxification and rehabilitation	
Outpatient **substance abuse** office visits to a **physician** or **behavioral health provider** includes **telemedicine** consultation Coverage is provided under the same terms, conditions as any other **illness**.	$40 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Outpatient **substance abuse** office visits to a **physician** or **behavioral health provider** includes **telemedicine** cognitive behavioral therapy consultations Coverage is provided under the same terms, conditions as any other **illness**.	$40 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies

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Other outpatient **substance abuse** services (includes skilled behavioral health services in the home) **Partial hospitalization treatment** **Intensive outpatient program** The cost share doesn't apply to in-network peer counseling support services	80% (of the **negotiated charge**) per visit

Oral and maxillofacial treatment (mouth, jaws and teeth)	
Oral and maxillofacial treatment (mouth, jaws and teeth)	80% (of the **negotiated charge**) per visit
Reconstructive breast surgery	
Reconstructive breast **surgery**	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

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Eligible health services	Network (IOE facility)	Network (Non-IOE facility)
Transplant services facility and non-facility		
Inpatient **hospital** transplant services	$150 per day copay for the first 5 days of confinement then the plan pays 80% (of the balance of the **negotiated charge**) per transplant	Not covered
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.	Not covered

Eligible health services	In-network coverage*
Treatment of infertility	
Basic infertility	
Basic **infertility**	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*
Specific therapies and tests	
Outpatient diagnostic testing	

Diagnostic complex imaging services	
	80% (of the **negotiated** charge) per visit
Diagnostic lab work	
	80% (of the **negotiated charge**) per visit.

Diagnostic radiological services	
	80% (of the **negotiated charge**) per visit.
Chemotherapy	
Chemotherapy	Covered according to the type of benefit and the place where the service is received
Outpatient infusion therapy	
Performed in a **physician's** office	$40 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Performed in a person's home	80% (of the **negotiated charge**) per visit.
Performed in the outpatient department of a **hospital**	80% (of the **negotiated charge**) per visit.
Performed at an outpatient facility other than the outpatient department of a **hospital**	80% (of the **negotiated charge**) per visit.
Outpatient radiation therapy	
	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
Pulmonary rehabilitation	
Pulmonary rehabilitation	Covered according to the type of benefit and the place where the service is received

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

Maximum visits per Calendar Year	60

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Eligible health services	In-network coverage*
Other services	

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

Ambulance service	
Ground, air or water **ambulance**	80% (of the **negotiated charge**) per visit

Clinical trial therapies (experimental or investigational)	
Clinical trial therapies	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

Durable medical equipment (DME)	
DME	80% (of the **negotiated charge**) per item

Non-preventive hearing exams	
For adults and children	100% (of the **negotiated charge**) per visit thereafter No **deductible** applies.
Maximum	One exam in any 24 consecutive month period.

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

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Spinal manipulation	
Spinal manipulation	$40 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Maximum visits per Calendar Year	20

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General coverage provisions

This section provides detailed explanations about the:

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

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

Deductible provisions

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

Individual

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

Family

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

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

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

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

Copayments

Copayment

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

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Per Admission Copayment

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

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

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

Payment percentage

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

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.

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

Individual

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

Family

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

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

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

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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**

Calculations; determination of benefits provisions

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

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.

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