AETNA HEALTH INC.
(DISTRICT OF COLUMBIA)

SCHEDULE OF BENEFITS

Open Access Health Network Only
GOVERNMENT OF THE DISTRICT OF COLUMBIA
Contract Holder Group Agreement Effective Date: January 01, 2014
Contract Holder Number: 0866123

BENEFITS

Benefit	Maximums
Maximum Out-of-Pocket Limit	
Does not apply to Prescription Drug Benefits	
Individual Limit	$3,500 per calendar year
Family Limit	$9,400 per calendar year
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 limit.	
Member must demonstrate the Copayment amounts that have been paid during the year.	
Maximum Benefit	Unlimited per Member per lifetime

OUTPATIENT BENEFITS

Benefit	Copayment
Primary Care Physician Services	
Adult Physical Examination including Immunizations	$0 per visit
Visits are subject to the following visit maximum:	
Adults 21-65 years old: 1 visit per 3 Exams / Year period	
Adults over 65 years old: 1 visit per 12 Months period	
Copayment for immunizations waived if office visit charge is not made.	

Well Child Physical Examination including Immunizations	$0 per visit
Copayment for immunizations waived if office visit charge is not made.	
Office Hours Visits	$10 per visit
After-Office Hours and Home Visits	$15 per visit
E-visit by a Primary Care Physician	$10 per visit
Specialist Physician Services	
Office Visits	$20 per visit
E-visit by a Specialist	$20 per visit
Walk In Clinic Visit	$10 per visit
Routine Gynecological Exam(s) 1 visit(s) per 365 day period	
Performed at a Primary Care Physician Office	$0 per visit
Performed at a Specialist Office	$0 per visit
Prenatal Visit(s) by the attending Obstetrician	$0 per visit
Outpatient Facility Visits	$0 per visit
Diagnostic X-Ray Testing	$0 per visit
Complex Imaging Services, including, but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT); and Positron Emission Tomography (PET)	$0 per visit

Annual and Screening Mammograms are not subject to the Deductible or Copayment.

Mammography (Diagnostic)	$0 per visit

Annual and Screening Mammograms are not subject to the Deductible or Copayment.

Diagnostic Laboratory Testing	$0 per visit

Routine and Medically Necessary Pap Smears are not subject to the Deductible or Copayment.

Outpatient Emergency Services	
Hospital Emergency Room or Outpatient Department	$50 per visit
Urgent Care Facility	$20 per visit
Ambulance	$0 per trip
Outpatient Mental Disorder Visits	

	$10 per visit
Outpatient Substance Abuse Visits Detoxification	$10 per visit/day
Outpatient Substance Abuse Visits Rehabilitation: Unlimited visits per calendar year	$10 per visit/day
Outpatient Surgery	$50 per visit
Outpatient Home Health Visits Limited to 3 intermittent visit(s) per day provided by a Participating home health care agency; 1 visit equals a period of 4 hours or less.	$0 per visit
Outpatient Hospice Care Visits	$0 per visit
Injectable Medications	$20 per prescription or refill

INPATIENT BENEFITS

Benefit	Copayment
Acute Care	$100 per admission
Mental Disorders	
	$100 per admission
During a Residential Treatment Facility Confinement	$100 per admission (waived if a Member is transferred from a Hospital to a Residential Treatment Facility)
Substance Abuse Detoxification and Rehabilitation During a Hospital Confinement	$100 per admission
During a Residential Treatment Facility Confinement	$100 per admission (waived if a Member is transferred from a Hospital to a Residential Treatment Facility)
Maternity	$100 per admission.
	See Specialist Physician Services for Prenatal care and delivery services.
Skilled Nursing Facility	$100 per admission (waived if a Member is transferred from a Hospital to a Skilled Nursing Facility)
Maximum of 60 days per calendar year	
Hospice Care	$0 per admission (waived if a Member is transferred from a Hospital to a Hospice Care facility)

Physicians Visits During Inpatient Confinement	
Office Hours Visits	**$10 per visit**
Specialist Physician Services	
Office Visits	**$20 per visit**
Transplant	
Transplant Facility Expense Services Inpatient Care	
When provided at an Institute of Excellence™ (IOE) facility:	**$100 per admission**
When provided at a non-Institute of Excellence facility:	
No benefit is provided.	**N/A**

ADDITIONAL BENEFITS

Benefit	Copayment
Eye Examination by a Specialist (including refraction) as per schedule in the Certificate	**$20 per visit**
Subluxation	**$20 per visit**
20 visits per calendar year	
Durable Medical Equipment (DME)	**50% (of the cost) per item**
Prosthetics	**0% (of the cost) per item**

Subscriber Eligibility: **Eligible for benefits as defined by the Contract Holder and agreed to by HMO.**

Dependent Eligibility: **A dependent unmarried child of the Subscriber as described in the Eligibility and Enrollment section of the Certificate who is:**

i. **under 26 years of age; or**

ii. **under 26 years of age, dependent on a parent or guardian Member, and attending a recognized college or university, trade or secondary school on a full-time basis; or**

iii. **chiefly dependent upon the Subscriber for support and maintenance, and is 19 years of age or older but incapable of self-support due to mental or physical incapacity, either of which commenced prior to: 26, or if a student, 26.**

Termination of Coverage:	**Coverage of the Subscriber and the Subscriber's dependents who are Members, if any, will terminate on the earlier of the date the Group Agreement terminates or at the end of the month following the date on which the Subscriber ceased to meet the eligibility requirements.** **Coverage of Covered Dependents will cease at the end of the month following the date on which the dependent ceased to meet the eligibility requirements.**