Preferred Provider Organization (PPO) Medical Plan

Schedule of Benefits

Prepared exclusively for:

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Schedule of Benefits	1A
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Underwritten by Aetna Life Insurance Company in the state of Pennsylvania.

Schedule of benefits

This schedule of benefits lists the **deductibles** and **copayments/coinsurance**, 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/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	$300 per Calendar Year	$800 per Calendar Year	$300 per Calendar Year
Family	$900 per Calendar Year	$2,400 per Calendar Year	$900 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 • Nutritional supplements			
Maximum out-of-pocket limit			
Maximum out-of-pocket limit per Calendar Year.			
Individual	$2,500 per Calendar Year	$3,000 per Calendar Year	$2,500 per Calendar Year
Family	$7,500 per Calendar Year	$9,000 per Calendar Year	$7,500 per Calendar Year
Precertification covered benefit reduction			
This only applies to out-of-network coverage. The booklet-certificate 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 $400 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.			

*See *How to read your schedule of benefits and important note* 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 No **deductible** applies to childhood immunizations	100% per visit No **deductible** applies	60% (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's 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's 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's 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 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* at the beginning of this schedule of benefits

Preventive care immunizations			
Performed in a facility or at a **physician's** office No **deductible** applies to childhood immunizations	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 your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.	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.

Well woman preventive visits routine gynecological exams (including pap smears and cytology tests)			
Routine physical exams			
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 No **deductible** applies	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* 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.			
Sexually transmitted infection counseling maximums:			
Maximum visits per 12 months	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.	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's 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's 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's secure member website at www.aetna.com or calling the number on 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 *Outpatient diagnostic testing* section.			

*See *How to read your schedule of benefits* 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	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 *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	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 *Breast feeding durable medical equipment* section of the booklet-certificate 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	60% (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:** Any visits that exceed the contraceptive counseling services maximum are covered under **Physician** services office visits.			

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

Devices			
Female contraceptive device provided, administered, or removed, by a **physician** during an office visit	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**
Physicians and other health professionals			
Physicians and **specialists** office visits (non-surgical)			
Physician services			
Office hours visits (non-surgical) non preventive care	$30 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies
Telemedicine consultation by a **physician**	$30 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	Not Covered	80% (of the **recognized charge**) per visit No **deductible** applies
Maximum visits per day	1	Not Covered	1
Telemedicine consultation by a **specialist**	$40 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	Not Covered	80% (of the **recognized charge**) per visit No **deductible** applies
Maximum visits per day	1	Not Covered	1

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Allergy injections			
Performed at a **physician's** or **specialist** office when you do not see the **physician**	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized 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.	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)	$40 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies

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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
Alternatives to physician office visits			
Walk-in clinic visits			
Walk-in clinic non-emergency visit *(includes coverage for immunizations)*	$30 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	Not covered	80% (of the **recognized 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 secure member website at www.aetna.com or calling the number on your ID card.	Not applicable	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 secure member website at www.aetna.com or calling the number on your ID card.

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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**	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	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	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	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	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 benefits* 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 *Calendar Year*	70 shifts Up to eight hours equal one shift.	70 shifts Up to eight hours equal one shift.	70 shifts Up to eight hours equal one shift.
Skilled nursing facility			
Inpatient facility	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission	80% (of the **recognized charge**) per admission
Maximum days per Calendar Year	120	120	120

*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
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	50% (of the **negotiated charge**) per visit after the **deductible**	50% (of the **recognized charge**) per visit after the **deductible**	50% (of the **recognized charge**) per visit after the **deductible**
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 the back of 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/coinsurance** 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/coinsurance** will be waived and your inpatient **copayment/coinsurance** will apply.			
Urgent care			
Urgent medical care (at a non-**hospital** free standing facility)	$35 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge)** per visit	$35 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/coinsurance** will apply for each visit to an **urgent care provider**.			

*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
Specific conditions			
Autism spectrum disorder			
Autism spectrum disorder treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Autism spectrum disorder diagnosis and testing	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
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	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
There is no limit in the number of visits to an autism service **provider** for treatment of autism spectrum disorders.			
Birthing center			
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	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Abortion			
Outpatient	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
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

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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.
Mental health treatment - inpatient			
Inpatient mental health treatment Inpatient **residential treatment facility** Coverage is provided under the same terms, conditions as any other **illness**.	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission	80% (of the **recognized charge**) per admission
Mental health treatment - outpatient			
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** includes **telemedicine** consultation Coverage is provided under the same terms, conditions as any other **illness**.	$40 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit 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	100% (of the **negotiated charge**) per visit No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies

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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**.	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission	80% (of the **recognized 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	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies
Other outpatient **substance abuse** services **Partial hospitalization treatment** **Intensive outpatient program** The cost share doesn't apply to in-network peer counseling support services	100% (of the **negotiated charge**) per visit No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies

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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 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	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
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			
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

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

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

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			
	$40 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter. No **deductible** applies	60% (of the **recognized charge**) per visit.	80% (of the **recognized charge**) per visit. No **deductible** applies
Outpatient Speech Therapy			
	$40 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter. No **deductible** applies	60% (of the **recognized charge**) per visit.	80% (of the **recognized charge**) per visit. No **deductible** applies

Spinal manipulation			
Spinal manipulation	$40 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies
Habilitation therapy services			
	$40 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit No **deductible** applies

*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
Other services			

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

Ambulance service			
Ground, air or water **ambulance**	80% (of the **negotiated charge**) per trip	60% (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

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Durable medical equipment (DME)			
DME	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item	80% (of the **recognized charge**) per item
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.

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

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Eligible health services	In-network coverage*	Out-of-network coverage*
Outpatient prescription drugs		
Plan features	**Deductible/Copayment/Coinsurance/Maximums**	
Deductible waiver		
The Calendar Year **deductible** is waived for all **prescription drugs**.		
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 tobacco cessation prescription and over-the-counter drugs		
The Calendar Year **deductible** and the per **prescription copayment/coinsurance** 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/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 drugs** for that method paid at 100%. 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.		
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.		

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

Generic prescription drugs (including specialty 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**) No Calendar Year **deductible** applies	$20 **deductible** per supply **Coinsurance** is 60% (of the **recognized charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **retail pharmacy**	$40 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	$40 **deductible** per supply **Coinsurance** is 60% (of the **recognized charge**) No Calendar Year **deductible** applies
More than a 30 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**) No Calendar Year **deductible** applies	Not covered
Preferred brand-name prescription drugs (including specialty drugs)		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	$30 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	$30 **deductible** per supply **Coinsurance** is 60% (of the **recognized charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **retail pharmacy**	$60 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	$60 **deductible** per supply **Coinsurance** is 60% (of the **recognized charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$60 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered

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Non-preferred brand-name prescription drugs (including specialty drugs)		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	$50 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	$50 **deductible** per supply **Coinsurance** is 60% (of the **recognized charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **retail pharmacy**	$100 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	$100 **deductible** per supply **Coinsurance** is 60% (of the **recognized charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$100 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered
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**) No Calendar Year **deductible** applies	$0 **deductible** per supply **Coinsurance** is 60% (of the **recognized charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **retail pharmacy**	$0 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	$0 **deductible** per supply **Coinsurance** is 60% (of the **recognized charge**) No Calendar Year **deductible** applies
More than a 30 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**) No Calendar Year **deductible** applies	Not covered

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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 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 secure member website at www.aetna.com or calling the number on your ID card.
Risk reducing breast cancer prescription drugs		
Risk reducing breast cancer **prescription drugs** filled at a **pharmacy**	100% 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 preventive care drugs and supplements, contact Member Services by logging onto your secure member website at www.aetna.com or calling the number on your ID card.	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your secure member website at www.aetna.com or calling the number on your ID card.

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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 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 secure member website at www.aetna.com or calling the number on your ID card.	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 secure member website at www.aetna.com or calling the number on your ID card.

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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 be applied to satisfy the in-network **deductibles**. **Eligible health services** applied to the in-network **deductibles** will 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.

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**.

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

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 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 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.

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.

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

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 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**

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 benefits* at the beginning of this schedule of benefits.