Schedule of benefits

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Third Party Administrative Services provided by Aetna Life Insurance Company

Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles**, **copayments** or **payment percentage**, if any apply to the **covered services** you receive under the plan. You should review this schedule to become aware of these and any limits that apply to these services.

How your cost share works

- The **deductibles** and **copayments**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
  - For the **covered services** under your medical plan, you will be responsible for the dollar amount
  - For pharmacy benefits where a percentage cost share acts like a **copayment**, you will be responsible for the percentage amount
- **Payment percentage** amounts, if any, listed in the schedule below are what the plan will pay for **covered services**.
- Sometimes your cost share shows a combination of your dollar amount **copayment** that you will be responsible for and the **payment percentage** that your plan will pay.
- You are responsible to pay any **deductibles**, **copayments** and remaining **payment percentage**, if they apply and before the plan will pay for any **covered services**.
- This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits. They may be:
  - Based on a rolling, 12 month period starting with the date of your most recent visit under this plan

  See the schedule for more information about limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.

For examples of how cost share and **deductible** work, go to the *Using your Aetna benefits* section under Individuals & Families at https://www.aetna.com/

Important note:
Covered services are subject to the **deductible**, **maximum out-of-pocket**, limits, **copayment** or **payment percentage** unless otherwise stated in this schedule.

Under this plan, you will:

1. Pay your **copayment**
2. Then pay any remaining **deductible**
3. Then pay your **payment percentage**

Your **copayment** does not apply to any **deductible**.

How your deductible works

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **copayment** or **payment percentage** you pay when you get **covered services** from a **network provider**. This schedule shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **covered services**. You will continue to pay **copayments** or **payment percentage**, if any, for **covered services** after you meet your **deductible**.

How your PCP or physician office visit cost share works

You will pay the **PCP** cost share when you get **covered services** from the **PCP** you select. You will pay a higher cost share when you get **covered services** from a **PCP** that is not your **PCP**. If you did not select a **PCP**, you will pay a higher cost share for **covered services** from any **PCP**, network **physician** or **specialist**.

How your maximum out-of-pocket works

This schedule shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of that year.

Contact us

We are here to answer questions. See the *Contact us* section in your booklet.

This schedule replaces any schedule of benefits previously in use. Keep it with your booklet.

Plan features

Deductible

You have to meet your **deductible** before this plan pays for benefits.

Deductible type	In-network
Individual	$250 per year
Family	$500 per year

Deductible waiver

There is no in-network **deductible** for the following **covered services**:

- Preventive care
- Family planning services – female contraceptives

Deductible and cost share waiver for contraceptives (birth control)

The **prescription** drug **deductible** and per **prescription** cost share will not apply to female contraceptive methods when obtained at a network pharmacy. This means they will be paid at 100%. This includes certain OTC and generic contraceptive **prescription** drugs and devices for each of the methods identified by the FDA. If a **generic prescription drug** is not available, the **brand-name prescription drug** for that method will be paid at 100%.

The **prescription** drug **deductible** and cost share will apply to **prescription** drugs that have a generic equivalent or alternative available within the same therapeutic drug class obtained at a network pharmacy unless we approve a medical exception. A therapeutic drug class is a group of drugs or medications that have a similar or identical mode of action or are used for the treatment of the same or similar disease or injury.

Maximum out-of-pocket limit

Excludes the **deductible**.

Maximum out-of-pocket type	In-network
Individual	$2,000 per year
Family	$4,000 per year

General coverage provisions

This section explains the **deductible, maximum out-of-pocket limit** and limitations listed in this schedule.

Deductible provisions

In-network **covered services** will apply only to the in-network **deductible**.

The **deductible** may not apply to some **covered services**. You still pay the **copayment** or **payment percentage**, if any, for these **covered services**.

Individual deductible

You pay for **covered services** each year before the plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. After the amount paid reaches the individual **deductible**, this plan starts to pay for **covered services** for the rest of the year.

Family deductible

You pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this family **deductible**, this plan starts to pay for **covered services** for the rest of the year. To satisfy this family **deductible** for the rest of the year, the combined **covered services** that you and each of your covered dependents incur toward the individual **deductible** must reach this family **deductible** in a year. When this happens in a year, the individual **deductibles** for you and your covered dependents are met for the rest of the year.

Copayment

This is a flat fee you pay for certain visits or **covered services**. A copay can be a dollar amount or percentage. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Payment Percentage

This is the percentage of the bill you pay after you meet your **deductible**. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **payment percentage** and **deductible**, if any, for **covered services**. **Covered services** that are subject to the **maximum out-of-pocket limit** include those provided under the medical plan and the outpatient **prescription** drug plan.

Individual maximum out-of-pocket limit

- This plan may have 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.
- After you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the year for that person.

Family maximum out-of-pocket limit

After you or your covered dependents meet the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the remainder of the year for all covered family members. The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members.

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

- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit** amount.

Certain costs that you have do not apply toward the **maximum out-of-pocket limit**. These include:

- Amounts paid toward the **deductible**
- **Copayments**

- Out-of-pocket costs for outpatient expenses including **prescription** drugs
- All costs for non-covered services which are identified in the booklet and the schedule
- Costs for non-emergency use of the emergency room

- Costs for non-urgent use of an urgent care **provider**

Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of **covered services** on 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 year. Decisions regarding when benefits are covered are subject to the terms and conditions of the booklet.

Covered services

Acupuncture

Description	In-network
Acupuncture	Covered based on type of service and where it is received

Ambulance services

Description	In-network
Emergency services	100% per trip, no **deductible** applies
Description	**In-network**
Non-emergency services	100% per trip, no **deductible** applies

Autism spectrum disorder

Description	In-network
Diagnosis and testing	Covered based on type of service and where it is received
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	Covered based on type of service and where it is received

Behavioral health

Mental health disorders treatment

Coverage provided is the same as for any other illness

Description	In-network
Inpatient services-**room and board** including **residential treatment facility**	80% per admission after **deductible**

Description	In-network
Outpatient office visit to a **physician** or **behavioral health provider**	$25 then the plan pays 100% per visit, no **deductible** applies
Physician or **behavioral health provider telemedicine** consultation	$25 then the plan pays 100% per visit, no **deductible** applies
Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on type of service and **provider** from which it is received

Description	In-network
Other outpatient services including: • 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% per visit after **deductible**

Substance related disorders treatment

Includes **detoxification**, rehabilitation and **residential treatment facility**

Coverage provided is the same as for any other illness

Description	In-network
Inpatient services-**room and board** during a **hospital stay**	80% per admission after **deductible**

Description	In-network
Outpatient office visit to a **physician** or **behavioral health provider**	$25 then the plan pays 100% per visit, no **deductible** applies
Physician or **behavioral health provider telemedicine** consultation	$25 then the plan pays 100% per visit, no **deductible** applies
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on type of service and **provider** from which it is received

Description	In-network
Other outpatient services including: • 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% per visit after **deductible**

Clinical trials

Description	In-network
Experimental or investigational therapies	Covered based on type of service and where it is received
Routine patient costs	Covered based on type of service and where it is received

Durable medical equipment (DME)

Description	In-network
DME	80% per item after **deductible**

Emergency services

Description	In-network	Out-of-network
Emergency room	$100 then the plan pays 100% per visit, no **deductible** applies	Paid same as in-network
Non-emergency care in a **hospital** emergency room	Not covered	Not covered

Emergency services important note:

- **Out-of-network providers** do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill.
- In the case of a surprise bill from an out-of-network provider, where you had no control of their participation in your **covered services**, you will pay the same cost share you would have if the **covered services** were received from a **network provider**. The cost share will be based on the median contracted rate. Contact us immediately if you receive such a bill.
- If you are admitted to the **hospital** for an inpatient **stay** right after you visit the emergency room, you will not pay your emergency room cost share if you have one. You will pay the inpatient **hospital** cost share, if any.

Hospital care

Description	In-network
Inpatient services - **room and board**	80% after **deductible**

Infertility services

Basic infertility

Description	In-network
Treatment of basic **infertility**	Covered based on type of service and where it is received

Maternity and related newborn care

Includes complications

Description	In-network
Inpatient services – **room and board**	80% per admission after **deductible**
Services performed in **physician** or **specialist** office or a facility	80% per visit after **deductible**
Other services and supplies	80% after **deductible**

Maternity and related newborn care important note:
Any cost share collected applies only to the delivery and postpartum care services provided by an OB, GYN or OB/GYN. Review the *Maternity* section of the booklet. It will give you more information about coverage for maternity care under this plan.

Nutritional support

Description	In-network
Nutritional support	Covered based on type of service and where it is received

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	In-network
Treatment of mouth, jaws and teeth	Covered based on type of service and where it is received

Outpatient prescription drugs

Generic prescription drugs

Description	In-network
30 day supply at a **retail pharmacy**	$10, no **deductible** applies
90 day supply at a **mail order pharmacy**	$30, no **deductible** applies

Preferred brand-name prescription drugs

Description	In-network
30 day supply at a **retail pharmacy**	$30, no **deductible** applies
90 day supply at a **mail order pharmacy**	$90, no **deductible** applies

Non-preferred brand-name prescription drugs

Description	In-network
30 day supply at a **retail pharmacy**	$45, no **deductible** applies
90 day supply at a **mail order pharmacy**	$135, no **deductible** applies

Generic and Preferred Brand-name diabetic supplies, and insulin

Description	In-network
30 day supply at a **retail pharmacy**	$0, no **deductible** applies
90 day supply at a **mail order pharmacy**	$0, no **deductible** applies

Outpatient prescription drug important note:
If you or your **provider** 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 drug and the brand-name drug, plus the cost share that applies to the brand-name drug.

Outpatient surgery

Description	In-network
At **hospital** outpatient department	$100 then the plan pays 80% per visit, no **deductible** applies

Physician and specialist services

Physician services-general or family practitioner

Description	In-network
Physician office hours (not-surgical, not preventive)	$25 then the plan pays 100% per visit, no **deductible** applies
Physician surgical services	$25 then the plan pays 100% per visit, no **deductible** applies

Description	In-network
Physician telemedicine consultation	$25 then the plan pays 100% per visit, no **deductible** applies

Description	In-network
Physician visit during inpatient **stay**	80% per visit after **deductible**

Specialist

Description	In-network
Specialist office hours (not surgical, not preventive)	$25 then the plan pays 100% per visit, no **deductible** applies
Specialist surgical services	$25 then the plan pays 100% per visit, no **deductible** applies

Description	In-network
Complex imaging, lab and radiology services during **physician** office visit	80% per visit, no **deductible** applies
Complex imaging, lab and radiology services during **specialist** office visit	80% per visit, no **deductible** applies

Specialist

Description	In-network
Specialist telemedicine consultation	$25 then the plan pays 100% per visit, no **deductible** applies

All other services not shown above	
Description	**In-network**
All other services	80% per visit after **deductible**

Preventive care

Description	In-network
Breast feeding counseling and support	100% per visit, no **deductible** applies
Breast feeding counseling and support limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 every 1 year Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 1 year to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies
Counseling for alcohol or drug misuse visit limit	5 visits/12 months
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no **deductible** applies
Counseling for sexually transmitted infection visit limit	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no **deductible** applies
Counseling for tobacco cessation visit limit	8 visits/12 months
Family planning services (female contraception counseling)	100% per visit, no **deductible** applies
Family planning services (female contraception counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting
Immunizations	100%, no **deductible** applies
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Routine physical exam	100% per visit, no **deductible** applies
Routine physical exam limits	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 for children and adolescents

	Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months
Well woman GYN exam	100% per visit, no **deductible** applies
Well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

Prosthetic devices

Description	In-network
Prosthetic devices	80% per item after **deductible**

Reconstructive surgery and supplies

Including breast **surgery**

Description	In-network
Surgery and supplies	Covered based on type of service and where it is received

Routine cancer screenings

Description	In-network
Colonoscopy	100% per visit, no **deductible** applies
Digital rectal examination (DRE)	100% per visit, no **deductible** applies
Double contrast barium enema (DCBE)	100% per visit, no **deductible** applies
Fecal occult blood test (FOBT)	100% per visit, no **deductible** applies
Mammogram	100% per visit, no **deductible** applies
Prostate specific antigen (PSA) test	100% per visit, no **deductible** applies
Sigmoidoscopy	100% per visit, no **deductible** applies
Cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section
Lung cancer screening	100% per visit, no **deductible** applies
Limit	1 screening every 12 months Screenings that exceed this limit are covered as outpatient diagnostic testing

Short-term rehabilitation services

Cardiac Rehabilitation

Description	In-network
Cardiac rehabilitation	Covered based on type of service and where it is received

Pulmonary Rehabilitation

Description	In-network
Pulmonary	Covered based on type of service and where it is received

Cognitive Rehabilitation

Description	In-network
Cognitive Rehabilitation	Covered based on type of service and where it is received

Physical and occupational therapies

Description	In-network
At the **physician** office	$25 then the plan pays 100% per visit, no **deductible** applies
At facility that is not a **hospital**	$25 then the plan pays 100% per visit, no **deductible** applies
At **hospital** outpatient department	$25 then the plan pays 100% per visit, no **deductible** applies

Speech therapy (ST)

Description	In-network
At the **physician** office	$25 then the plan pays 100% per visit, no **deductible** applies
At facility that is not a **hospital**	$25 then the plan pays 100% per visit, no **deductible** applies
At **hospital** outpatient department	$25 then the plan pays 100% per visit, no **deductible** applies

Physical therapy

Description	In-network
Visit limit per year	25

Occupational therapy

Description	In-network
Visit limit per year	25

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network
At a Physician's Office	80% per visit, no deductible applies
At facility that is not a **hospital**	80% per visit after **deductible**
At **hospital** outpatient department	80% per visit after **deductible**

Diagnostic lab work

Description	In-network
At a Physician's Office	80% per visit, no deductible applies
At facility that is not a **hospital**	80% per visit after **deductible**
At **hospital** outpatient department	80% per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	In-network
At a Physician's Office	80% per visit, no deductible applies
At facility that is not a **hospital**	80% per visit after **deductible**
At **hospital** outpatient department	80% per visit after **deductible**

Therapies

Chemotherapy

Description	In-network
Chemotherapy services	Covered based on type of service and where it is received

Gene-based, cellular and other innovative therapies (GCIT)

Description	In-network (GCIT-designated facility/provider)	Out-of-network (Including **providers** who are otherwise part of Aetna's network but are not GCIT-designated facilities/**providers**)
Services and supplies	Covered based on type of service and where it is received	Not covered
Gene therapy products, **prescription** drugs	$25 then the plan pays 100% per visit, no **deductible** applies	Not covered

Infusion therapy

Outpatient services

Description	In-network
	100% per visit after **deductible**

Radiation therapy

Description	In-network
Radiation therapy	Covered based on type of service and where it is received

Respiratory therapy

Description	In-network
Respiratory therapy	Covered based on type of service and where it is received

Transplant services

Description	In-network (IOE facility)
Inpatient services and supplies	100% per transplant after **deductible**
Physician services	Covered based on type of service and where it is received

Urgent care services

At a freestanding facility or **provider** that is not a **hospital**
A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

Description	In-network	Out-of-network
Urgent care facility	$50 then the plan pays 100% per visit, no **deductible** applies	Not covered
Non-urgent use of an urgent care facility or **provider**	Not covered	Not covered

Walk-in clinic

Not all preventive care services are available at a **walk-in clinic**. All services are available from a network **physician**.

Description	In-network
Non-emergency services	$25 then the plan pays 100% per visit, no **deductible** applies
Preventive immunizations	100% per visit, no **deductible** applies
Immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**