Health Maintenance Organization (HMO)
Schedule of benefits

If this is an ERISA plan, you have certain rights under this plan. If the contract holder is a church group or a government group, this may not apply. Please contact the contract holder for additional information.

Schedule of benefits

This schedule of benefits lists the **deductibles**, **copayments** or **coinsurance**, if any that apply to the **eligible health services** you get under this plan. You should read this schedule to become aware of these and any limits that apply to the services.

How to read your schedule of benefits

- You must pay any **deductibles**, **copayments** or **coinsurance**, if they apply.
- You must pay the full amount of any health care service you get that is not a **covered benefit**.
- This plan has limits for some **covered benefits**. For example, these could be visit, day or dollar limits.

Important note:
All **covered benefits** are subject to the plan year **deductible**, **out-of-pocket maximum**, limits, **copayment** or **coinsurance** unless otherwise noted in this schedule of benefits below.

How your deductible works

This schedule of benefits shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **eligible health services**. You will continue to pay **copayments** or **coinsurance**, if any, for **eligible health 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 receive **eligible health services** from any **PCP**.

How your maximum out-of-pocket limit works

This schedule of benefits 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 **eligible health services** for the remainder of that year.

How to contact us for help

We are here to answer your questions.

- Log onto your **Aetna®** member website at https://www.aetna.com/
- Call the phone number on your ID card

Aetna Health Inc's HMO agreement provides the coverage described in this schedule of benefits**.** This schedule replaces any schedule of benefits previously in use. Keep it with your certificate.

Plan features – deductible and maximum out-of-pocket

Deductible

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

Deductible	In-network coverage
Individual	$1,500 per year
Family	$3,000 per year

Deductible waiver

The in-network **deductible** is waived for all of the following **eligible health services**:

- Preventive care and wellness
- Family planning services - female contraceptives

The plan year **deductible** is waived for all of the following **eligible health services when obtained at an out-of-network service provider**:

- Routine gynecological exams
- Routine mammography
- Well baby/child exams (including immunizations)

Maximum out-of-pocket limit

Maximum out-of-pocket limit	In-network coverage
Individual	$8,150 per year
Family	$16,300 per year

General coverage provisions

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

Deductible provisions

- Your **deductible** may apply to **eligible health services** provided under the medical plan and the outpatient **prescription drug** plan.
- The **deductible** may not apply to certain **eligible health services**. You must pay any applicable cost share for **eligible health services** to which the **deductible** does not apply.

Individual deductible

You pay for **eligible health services** each year before the plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. Once you have reached the **deductible**, this plan will begin to pay for **eligible health services** for the rest of the year.

Family deductible

You pay for **eligible health services** each year before the plan begins to pay. After the amount paid for **eligible health services** reaches your family **deductible**, this plan will begin to pay for **eligible health services** for the rest of the year.

To satisfy this family **deductible** for the rest of the year, the combined **eligible health services** that you and each of your covered dependents incur towards 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.

Maximum out-of-pocket limits provisions

- **Eligible health services** that are subject to the **maximum out-of-pocket limit** may include **covered benefits** provided under the medical plan and the outpatient **prescription drug** plan.
- 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.

Individual maximum out-of-pocket limit
Once you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered benefits** that apply toward the limit for the rest of the year for that person.

Family maximum out-of-pocket limit
Once you or your covered dependents meet the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered benefits** that apply toward the limit for the remainder of the year for all covered family members.

To satisfy this family **maximum out-of-pocket limit** for the rest of the 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** 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 benefit**, your cost share 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
- Any out of pocket costs for non-emergency use of the emergency room
- Any out of pocket costs incurred for non-urgent use of an urgent care **provider**
- [Amounts received from a third-party **copay** assistance program, like a manufacturer coupon or rebate, for a **specialty prescription drug**]

Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of 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 certificate.

1. Preventive care and wellness

Description	In-network coverage
Preventive care and wellness	0% **coinsurance**, no **deductible** applies
Routine gynecological exams	0% **coinsurance**, no **deductible** applies
Routine mammography	0% **coinsurance**, no **deductible** applies

Preventive care and wellness includes

- **Routine physical exams** - Performed at a **physician** office
- **Preventive care immunizations** - Performed at a facility or at a **physician** office
- **Well woman preventive visits** - **routine gynecological exams (including pap smears)** - Performed at a **physician**, obstetrician (OB), gynecologist (GYN) or OB/GYN office
- **Preventive screening and counseling services** - Includes 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 - Office visits
- **Routine cancer screenings** - Applies whether performed at a **physician**, **specialist** office or facility
- **Prenatal care services** - Provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN
- **Comprehensive lactation support and counseling services** - Facility or office visits
- **Breast feeding durable medical equipment** - Breast pump supplies and accessories
- **Family planning services –** Female contraceptive counseling services office visit, devices, voluntary sterilization

Preventive care and wellness benefit limitations

Routine physical exams

- 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
- High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to one every 36 months

Preventive care immunizations

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.**

Well woman preventive visits - routine gynecological exams (including pap smears)

Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive screening and counseling services
Limitations are per 12 months unless stated below:

Description	Limit
Obesity and/or healthy diet	Unlimited visits from age 0-22, 26 visits every 12 months age 22 or older, of which up to 10 visits may be used for healthy diet counseling
Misuse of alcohol and/or drugs	5 visits every 12 months
Use of tobacco products	8 visits every 12 months
Sexually transmitted infection	2 visits every 12 months
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations

Routine cancer screenings
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
- The comprehensive guidelines supported by the Health Resources and Services Administration

Lung cancer screenings that exceed the cancer-screening limit are covered under the *Outpatient diagnostic testing* section.

Prenatal care services
Review the *Maternity and related newborn care* section of your certificate. It will give you more information on coverage levels for maternity care under this plan.

Comprehensive lactation support and counseling services

- Lactation counseling services limited to 6 visits per 12 months either in a group or individual setting
- Any visits that exceed the lactation counseling services maximum are covered under **physician** services office visits

Breast feeding durable medical equipment
See the *Breast feeding durable medical equipment* section of the certificate for limitations on breast pump and supplies.

Family planning services
Contraceptive counseling services limited to 2 visits per 12 months in either a group or individual setting

2. Physicians and other health professionals

Physician services

Description	In-network coverage
Office hours visits (non-surgical) non preventive care	10% **coinsurance**, no **deductible** applies
Telemedicine consultation by a **physician**	Covered based on the type of service and where it is received
Telemedicine visit limit per day	None

Specialist office visits

Description	In-network coverage
Office hours visit (non-surgical)	10% **coinsurance**, no **deductible** applies

Telemedicine

Description	In-network coverage
Telemedicine consultation by a **specialist**	Covered based on the type of service and where it is received
Visit limit per day	None

Allergy injections

Description	In-network coverage
Without **physician**, or **specialist** office visit	10% **coinsurance**, after **deductible**

Allergy testing and treatment

Description	In-network coverage
Performed at a **physician** or **specialist** office visit	10% **coinsurance**, after **deductible**

Immunizations that are not considered preventive care

Description	In-network coverage
Immunizations that are not considered preventive care	Covered based on the type of service and where it is received

Medical injectables

Description	In-network coverage
Performed at a **physician** or **specialist** office	10% **coinsurance**, after **deductible**

Physician surgical services

Description	In-network coverage
Inpatient surgical services	10% **coinsurance**, after **deductible**
Performed at a **physician** or **specialist** office	10% **coinsurance**, after **deductible**

Alternatives to physician office visits

Walk-in clinic visits

Description	In-network coverage
Walk-in clinic non-emergency visit	$0 **copay**, no **deductible** applies
Preventive care immunizations	0% **coinsurance**, no **deductible** applies

Preventive screening and counseling services at a walk-in clinic

Includes obesity and/or healthy diet counseling, use of tobacco products

Description	In-network coverage
Preventive screening and counseling services	0% **coinsurance**, no **deductible** applies
Telemedicine consultation for preventative screening and counseling services through a **walk-in-clinic**	Covered based on the type of service and where it is received

Limitations

- 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**
- Refer to the *Preventive care and wellness section* earlier in this schedule of benefits for limits that may apply to these types of services

Important note:
Not all preventive care services are available at **walk-in clinics**. The types of services offered will vary by the **provider** and location of the clinic. These services may also be obtained from a network **physician**.

3. Hospital and other facility care

Hospital care

Description	In-network coverage
Inpatient **hospital**	$250 **copay** + 10% **coinsurance**, after **deductible**

Alternatives to hospital stays

Outpatient surgery

Description	In-network coverage
Performed in **hospital** outpatient department	$500 **copay**, after **deductible**
Performed in facility other than **hospital** outpatient department	$500 **copay**, after **deductible**
Physician services	$0 **copay**, after **deductible**

Home health care

Description	In-network coverage
Outpatient	10% **coinsurance**, after **deductible**
Visit limit per year	Coverage is limited to 90 visits per episode

Important note:
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 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

Description	In-network coverage
Inpatient services	$250 **copay** + 10% **coinsurance**, after **deductible**
Outpatient services	10% **coinsurance**, after **deductible**

Skilled nursing facility

Description	In-network coverage
Inpatient facility	$250 **copay** + 10% **coinsurance**, after **deductible**
Day limit per year	Coverage is limited to 60 days per year

4. Emergency services and urgent care

A separate **hospital** emergency room or urgent care cost share will apply for each visit to an emergency room or an urgent care **provider**.

Description	In-network coverage
Hospital emergency room	$650 **copay**, after **deductible**
Non-emergency care in a **hospital** emergency room	Not covered

Important note:

- **Out-of-network providers** do not have a contract with us. The **provider** may not accept payment of your cost share (**deductible**, **copayment/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.
- If you are admitted to a **hospital** as an inpatient right after a visit to an emergency room and you have an emergency room **copay**, your **copay** will be waived.

Description	In-network coverage
Urgent medical care at a free standing facility that is not a **hospital**	$50 **copay**, no **deductible** applies
Non-urgent use of urgent care **provider** at a free standing facility that is not a **hospital**	Not covered

5. Pediatric dental care

Coverage is limited to covered persons through the end of the month in which the person turns 19

Description	In-network coverage
Type A services	0% **coinsurance**, after **deductible**
Type B services	30% **coinsurance**, after **deductible**
Type C services	50% **coinsurance**, after **deductible**
Orthodontic services	50% **coinsurance**, after **deductible**

Dental emergency maximum benefit: For covered dental care services provided for a dental emergency by an **out-of-network dental provider**, the plan pays a benefit at the in-network level of coverage up to the dental emergency maximum of $75. Any charges above the emergency maximum are not covered.

Dental benefits are subject to the plan's **deductible** and **maximum out-of-pocket limit**, if any and as explained in this schedule of benefits.

Diagnostic and preventive care (type A services)

Visits and images

- Office visits during regular office hours, for oral examination (limited to: 2 visits every 12 months)
- Comprehensive oral evaluation (limited to: 2 visits every 12 months)
- Comprehensive periodontal evaluation (limited to: 2 visits every 12 months)
- Problem-focused examination (limited to: 2 visits every 12 months)
- Detailed and extensive oral evaluation – problem focused, by report
- Prophylaxis (cleaning) (limited to: 2 treatments per year)
- Topical application of fluoride (limited to: 2 courses of treatment every 12 months)
- Topical fluoride varnish (limited to: 2 courses of treatment every 12 months)
- Sealants, per tooth (limited to: 1 application every 3 years for permanent molars only)
- Preventive resin restoration in a moderate to high caries risk patient-permanent tooth (limited to: 1 application every 3 years for permanent molars only)
- Bitewing images (limited to: 2 sets per year)
- Complete image series, including bitewings if **medically necessary** (limited to: 1 set every 3 years)
- Panoramic images (limited to: 1 set every 3 years)
- Vertical bitewing images (limited to: 2 sets per year)
- Periapical images
- Cephalometric radiographic image
- Oral/facial photographic images
- Interpretation of diagnostic image
- Intra-oral, occlusal view, maxillary or mandibular
- Diagnostic models
- Emergency palliative treatment per visit

Space maintainers

- Fixed (unilateral)
- Fixed- bilateral, maxillary
- Fixed-bilateral, mandibular

- Removable (unilateral)
- Removable-bilateral, maxillary
- Removable-bilateral, mandibular
- Re-cementation of space maintainer
- Removal of fixed space maintainer

Basic restorative care (type B services)

Visits and images

- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Consultation (by other than the treating provider)
- Therapeutic drug injection, by report
- Infiltration of a sustained release therapeutic when provided as part of an eligible dental service (but only for an oral surgery, periodontal or endodontic procedure)

Images and pathology

- Upper or lower jaw, extra-oral
- Therapeutic drug injection, by report

Oral surgery

- Extractions
  - Extraction, erupted tooth or exposed root
  - Coronal remnants
  - Coronectomy
  - Removal of residual tooth roots
  - Surgical removal of erupted tooth requiring removal of bone and/or resectioning of tooth
  - Surgical access of an unerupted tooth
- Impacted teeth
  - Removal of tooth (soft tissue)
  - Removal of impacted teeth
    - Removal of tooth (partially bony)
    - Removal of tooth (completely bony)
    - Removal of tooth (completely bony with unusual surgical complications)
- Incision and drainage of abscess
- Other surgical procedures
  - Alveoplasty, in conjunction with extractions – per quadrant
  - Alveoplasty, in conjunction with extractions – 1 to 3 teeth or tooth spaces – per quadrant
  - Alveoplasty, not in conjunction with extraction – per quadrant
  - Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces – per quadrant
  - Excision of hyperplastic tissue
  - Excision of periocoronal gingiva
  - Removal of exostosis
  - Tooth reimplantation
  - Transplantation of tooth or tooth bud
  - Placement of device to facilitate eruption of impacted tooth
  - Frenectomy (frenulectomy)
  - Suture of small wound, less than 5 cm

- Collection and application of autologous blood product (limited to 1 every 3 years)

Periodontics

- Occlusal adjustment (other than with an appliance or by restoration)
- Root planing and scaling, per quadrant (limited to 4 separate quadrants every 2 years)
- Root planing and scaling – 1 to 3 teeth per quadrant (limited to once per site every 2 years)
- Periodontal maintenance procedures following active therapy (limited to 4 in 12 months combined with prophylaxis after completion of active periodontal therapy)
- Localized delivery of antimicrobial agents

Endodontics

- Pulp capping
- Pulpotomy
- Pulpal therapy
- Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp; does not include final restoration)

Restorative dentistry

Does not include inlays, crowns (other than prefabricated stainless steel or resin) and bridges (multiple restorations in 1 surface are considered as a single restoration)

- Amalgam restorations
- Protective restoration
- Resin-based composite restorations (other than for molars)
- Pins
- Pin retention – per tooth, in addition to amalgam or resin restoration
- Crowns (when tooth cannot be restored with a filling material)
  - Prefabricated stainless steel
  - Prefabricated resin crown (excluding temporary crowns)
  - Interim therapeutic restoration – primary teeth
  - Prefabricated porcelain/ceramic crown-primary teeth
- Re-cementation
  - Inlay
  - Crown
  - Fixed partial bridge
  - Prefabricated post and core
  - Implant/abutment supported crown
  - Implant/abutment supported fixed partial denture

Prosthodontics

- Dentures and partials
  - Office reline
  - Laboratory relines
  - Special tissue conditioning, per denture
  - Rebase, per denture
  - Adjustment to denture (more than 6 months after installation)
  - Full and partial denture repairs
  - Broken dentures, no teeth involved

- Repair cast framework
- Replacing missing or broken teeth, each tooth
- Adding teeth to existing partial denture
  - Each tooth
  - Each clasp
- Repairs: bridges; partial bridges

General anesthesia and intravenous sedation

- Only when **medically necessary** and only when provided in conjunction with a covered dental surgical procedure

Major restorative care (type C services)

Periodontics

- Osseous surgery, including flap and closure, 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
- Osseous surgery, including flap and closure, per quadrant (limited to 1 per quadrant every 3 years)
- Pedical soft tissue graft procedures
- Bone replacement graft, first site in quadrant (limited to 1 per quadrant every 3 years)
- Gingivectomy, per quadrant (limited to 1 per quadrant every 3 years)
- Gingivectomy, 1 to 3 teeth per quadrant (limited to 1 per quadrant every 3 years)
- Gingival flap procedure – per quadrant (limited to 1 per quadrant every 3 years)
- Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
- Clinical crown lengthening
- Autogenous connective tissue graft procedures (including donor site surgery)
- Non-autogenous connective soft tissue allograft
- Free soft tissue graft procedures implant, or edentulous tooth position in same graft
- Full mouth debridement (limited to 1 treatment per lifetime)

Endodontics

- Apexification/recalcification
- Apicoectomy
- Root canal therapy including **medically necessary** images:
  - Anterior
  - Bicuspid
  - Molar
- Retreatment of previous root canal therapy:
  - Anterior
  - Bicuspid
  - Molar
- Root amputation
- Hemisection (including any root removal)

Restorative

- Inlays, onlay, labial veneers and crowns are covered only as a treatment for decay or acute traumatic injury and only when the teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge

- Inlays/onlays (limited to 1 per tooth every 5 years)
- Veneers, non-cosmetic (limited to 1 per tooth every 5 years)
- Crowns (limited to 1 per tooth every 5 years)
  - Resin
  - Resin with noble metal
  - Resin with base metal
  - Porcelain/ceramic substrate
  - Porcelain with noble metal
  - Porcelain with base metal
  - Base metal (full cast)
  - Noble metal (full cast)
  - ¾ cast metallic or porcelain/ceramic
  - Titanium
- Post and core
- Core build-up
- Repair
  - Replace all teeth and acrylic on cast metal framework – maxillary/mandibular
  - Crowns, inlays, onlays, veneers

Prosthodontics

- Installation of dentures and bridges is covered only if needed to replace teeth that were not abutments to a denture or bridge less than 5 years old
- Replacement of existing bridges or dentures (limited to 1 every 5 years)
- Bridge abutments (see inlays and crowns) (limited to 1 per tooth every 5 years)
- Pontics (limited to 1 per tooth every 5 years)
  - Base metal (full cast)
  - Noble metal (full cast)
  - Porcelain with noble metal
  - Porcelain with base metal
  - Resin with noble metal
  - Resin with base metal
  - Titanium
- Removable bridge (unilateral) (limited to 1 every 5 years)
- One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics (limited to 1 every 5 years)
- Retainer – cast metal for resin bonded fixed prosthesis (limited to 1 every 5 years)
- Retainer – porcelain/ceramic for resin bonded fixed prosthesis (limited to 1 every 5 years)
- Dentures and partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)
- Complete upper denture (limited to 1 every 5 years)
- Complete lower denture (limited to 1 every 5 years)
- Immediate upper denture (limited to 1 every 5 years)
- Immediate lower denture (limited to 1 every 5 years)
- Partial upper or lower, resin base – including any conventional clasps, rests and teeth (limited to 1 every 5 years)
- Partial upper or lower, cast metal base with resin saddles – including any conventional clasps,

rests and teeth (limited to 1 every 5 years)

- Implants – only if determined as a dental necessity (limited to 1 per tooth every 5 years)
- Implant supported complete denture, partial denture (limited to 1 every 5 years)
- Surgical placement of interium implant body (limited to 1 every 5 years)
- Surgical placement of transosteal implant (limited to 1 every 5 years)
- Implant maintenance procedures (limited to 1 every 5 years)
- Custom abutment (limited to 1 every 5 years)
- Bone graft at time of implant placement (limited to 1 every 5 years)
- Repair implant prosthesis (limited to 1 every 5 years)
- Repair implant abutment (limited to 1 every 5 years)
- Replacement of semi-precision or precision attachment (limited to 1 every 5 years)
- Debridement/osseous contouring of a peri-implant defect (limited to 1 every 5 years)
- Implant removal (limited to 1 every 5 years)
- Implant index (limited to 1 every 5 years
- Connecting bar
- Stress breakers
- Interim partial denture (stayplate), anterior only
- Occlusal guard

Orthodontic services – when medically necessary

- Orthodontic treatment (includes removal of appliances, construction and placement of retainer)
- Limited orthodontic treatment of the primary, transitional and adolescent dentition
- Interceptive orthodontic treatment of the primary, transitional dentition
- Comprehensive orthodontic treatment of the transitional and adolescent dentition
- Periodic orthodontic treatment visit (as part of contract)
- Pre-orthodontic treatment visit
- Replacement of retainer (limited to: 1 per lifetime)

6. Specific conditions

Autism spectrum disorder

Description	In-network coverage
Autism spectrum disorder	Covered based on the type of service and where it is received
Applied behavior analysis	$0 **copay**, no **deductible** applies

Diabetic equipment, supplies and education

Description	In-network coverage
Diabetic equipment	Covered based on the type of service and where it is received
Diabetic supplies	Covered based on the type of service and where it is received
Diabetic education	Covered based on the type of service and where it is received

Family planning services - other

Inpatient services

Description	In-network coverage
Voluntary sterilization for males	$250 **copay** + 10% **coinsurance**, after **deductible**
Abortion (termination of pregnancy)	Not covered

Outpatient services

Description	In-network coverage
Voluntary sterilization for males	Covered based on the type of service and where it is received
Abortion (termination of pregnancy)	Not covered

Jaw joint disorder treatment

Description	In-network coverage
Jaw joint disorder treatment	Covered based on the type of service and where it is received

Maternity and related newborn care

Prenatal care services

Description	In-network coverage
Inpatient and other maternity related services and supplies	$250 **copay** + 10% **coinsurance**, after **deductible**
Other prenatal care services and supplies	Covered based on the type of service and where it is received

Delivery services and postpartum care services

Description	In-network coverage
Inpatient and newborn care services and supplies	$250 **copay** + 10% **coinsurance**, after **deductible**
Performed in a facility or at a **physician** office	10% **coinsurance**, after **deductible**

Important note:
Any cost share that is collected applies to the delivery and postpartum care services provided by an OB, GYN, or OB/GYN only. This cost share does not apply to prenatal care services provided by an OB, GYN, or OB/GYN.

Behavioral health

Mental health treatment

Coverage provided under the same terms, conditions as any other **illness**.

Description	In-network coverage
Inpatient mental health treatment Inpatient **residential treatment facility**	$250 **copay** + 10% **coinsurance**, after **deductible**
Other inpatient mental health treatment services and supplies Other inpatient **residential treatment facility** services and supplies	$250 **copay** + 10% **coinsurance**, after **deductible**
Outpatient mental health treatment visits to a **physician** or **behavioral health provider** (includes **telemedicine**)	10% **coinsurance**, no **deductible** applies
Outpatient mental health **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on the type of service and where it is received
Other outpatient mental health treatment or skilled behavioral health services in the home, **partial hospitalization treatment** and **intensive outpatient program** The cost share doesn't apply to in-network peer counseling support services, after you meet your **deductible**	$0 **copay**, no **deductible** applies

Substance related disorders treatment

Coverage provided under the same terms, conditions as any other **illness**.

Description	In-network coverage
Inpatient **substance abuse detoxification** Inpatient **substance abuse** rehabilitation Inpatient **substance abuse** treatment in **residential treatment facility**	$250 **copay** + 10% **coinsurance**, after **deductible**
Other inpatient **substance abuse detoxification** services and supplies Other inpatient **substance abuse** rehabilitation services and supplies Other inpatient **substance abuse residential treatment facility** services and supplies	$250 **copay** + 10% **coinsurance**, after **deductible**
Outpatient **substance abuse** treatment visits to a **physician** or **behavioral health provider** (includes **telemedicine**)	10% **coinsurance**, no **deductible** applies
Outpatient **substance abuse telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on the type of service and where it is received
Other outpatient **substance abuse** services or **partial hospitalization treatment** and **intensive outpatient program** The cost share doesn't apply to in-network peer counseling support services, after you meet your **deductible**	$0 **copay**, no **deductible** applies

Reconstructive breast surgery

Description	In-network coverage
Reconstructive breast **surgery**	Covered based on the type of service and where it is received

Reconstructive surgery and supplies

Description	In-network coverage
Reconstructive **surgery** and supplies	Covered based on the type of service and where it is received

Transplant services

Description	Network (IOE facility)	Out-of-network (Includes **providers** who are otherwise part of **Aetna's** network but are non-IOE **providers**)
Services and supplies	$250 **copay** + 10% **coinsurance**, after **deductible**	Not covered

Treatment of infertility

Basic infertility

Description	In-network coverage
Basic **infertility**	Covered based on the type of service and where it is received

7. Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

Description	In-network coverage
Performed at a facility	10% **coinsurance**, after **deductible**
Performed at **physician** office	10% **coinsurance**, after **deductible**
Performed at **specialist** office	10% **coinsurance**, after **deductible**

Diagnostic lab work

Description	In-network coverage
Performed at a facility	$15 **copay**, no **deductible** applies
Performed at **physician** office	10% **coinsurance**, after **deductible**
Performed at **specialist** office	10% **coinsurance**, after **deductible**

Diagnostic radiological services (X-ray)

Description	In-network coverage
Performed at a facility	$65 **copay**, no **deductible** applies
Performed at **physician** office	10% **coinsurance**, after **deductible**
Performed at **specialist** office	10% **coinsurance**, after **deductible**

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

Description	In-network coverage (GCIT-designated facility/provider)
Services and supplies	Covered based on the type of service and where it is received

Outpatient therapies

Chemotherapy

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

Outpatient infusion therapy

Description	In-network coverage
Performed in a **physician** office or in a person's home	10% **coinsurance**, after **deductible**
Performed in outpatient facility	10% **coinsurance**, after **deductible**

Radiation therapy

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

Specialty prescription drugs

Description	In-network coverage
Performed in a **physician** office Performed in the outpatient department of a **hospital** Performed in an outpatient facility that is not a **hospital** or in the home	Covered based on the type of service and where it is received

Short-term cardiac and pulmonary rehabilitation services

A visit is equal to no more than 1 hour of therapy.

Description	In-network coverage
Cardiac and pulmonary rehabilitation	$65 **copay**, after **deductible**

Short-term rehabilitation therapy services

A visit is equal to no more than 1 hour of therapy.

Outpatient physical therapy

Description	In-network coverage
Physical therapy	$65 **copay**, after **deductible**
Visit limit per year	None

Outpatient occupational therapy

Description	In-network coverage
Occupational therapy	$65 **copay**, after **deductible**
Visit limit per year	None

Outpatient speech therapy

Description	In-network coverage
Speech therapy	$65 **copay**, after **deductible**
Visit limit per year	None

Spinal manipulation

Description	In-network coverage
Spinal manipulation	25% **coinsurance**, after **deductible**
Visit limit per year	None

Habilitation therapy services

Description	In-network coverage
Physical, occupational, and speech therapies	$0 **copay**, no **deductible** applies

Applied behavior analysis

Description	In-network coverage
Applied behavior analysis	$0 **copay**, no **deductible** applies

8. Other services

Acupuncture

Description	In-network coverage
Acupuncture	10% **coinsurance**, no **deductible** applies
Visit limit per year	10 visits

Ambulance service

Description	In-network coverage
Emergency **ambulance**	10% **coinsurance**, after **deductible**
Non-emergency **ambulance**	10% **coinsurance**, after **deductible**

Clinical trial therapies (experimental or investigational)

Description	In-network coverage
Clinical trial therapies (including routine patient costs)	Covered based on the type of service and where it is received

Durable medical equipment (DME)

Description	In-network coverage
DME	50% **coinsurance**, after **deductible**
Limit per year	None

Hearing aids

Description	In-network coverage
Hearing aids	Not covered

Nutritional support

Description	In-network coverage
Nutritional support	10% **coinsurance**, no **deductible** applies

Obesity (bariatric) surgery

Description	In-network coverage
Obesity (bariatric) **surgery**	Not covered

Orthotic devices

Description	In-network coverage
Orthotic devices	Not covered

Prosthetic devices

Description	In-network coverage
Prosthetic devices	50% **coinsurance**, after **deductible**

Vision care

Pediatric vision care

Coverage is limited to covered persons through the end of the month in which the person turns 19

Routine vision exams (including refraction)

Description	In-network coverage
Performed by an ophthalmologist or optometrist	50% **coinsurance**, after **deductible**
Visit limit per year	Coverage is limited to 1 exam per year age 0-19

Vision care services and supplies

Description	In-network coverage
Office visit for fitting of contact lenses	50% **coinsurance**, after **deductible**
Eyeglass frames, **prescription** lenses or **prescription** contact lenses	50% **coinsurance**, after **deductible**

Limits

Description	Limit
Number of eyeglass frames per year	One set of eyeglass frames
Number of **prescription** lenses per year	One pair of **prescription** lenses
Number of **prescription** contact lenses per year	Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set

Adult vision care

Limited to covered person age 19 and over

Routine vision exams (including refraction)

Description	In-network coverage
Performed by an ophthalmologist or optometrist	50% **coinsurance**, after **deductible**
Visit limit per year	Coverage is limited to 1 exam per year

Vision care services and supplies

Description	In-network coverage
Eyeglass frames, **prescription** lenses or **prescription** contact lenses	Not covered

Important note:
Refer to the *Vision care* section in the certificate for the explanation of these vision care supplies. As to coverage for **prescription** lenses in a year, this benefit will cover either **prescription** lenses for eyeglass frames or **prescription** contact lenses, but not both.

9. Outpatient prescription drugs

Plan features - maximums and limits

Waiver for contraceptives
The **prescription drug** 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 over-the-counter (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** 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 you receive 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**.

Waiver for preventive care drugs and supplements
The **prescription drug** cost share will not apply to preventive care drugs and supplements when obtained at a **network pharmacy**. This means they will be paid at 100%.

Waiver for risk reducing breast cancer prescription drugs
The **prescription drug** cost share will not apply to risk reducing breast cancer **prescription drugs** when obtained at a **network pharmacy**. This means they will be paid at 100%.

Waiver for tobacco cessation prescription and over-the-counter drugs
The **prescription drug** cost share will not apply to the first two 90-day treatment programs for tobacco cessation **prescription** and over-the-counter (OTC) drugs when obtained at a **network pharmacy**. This means they will be paid at 100%. Your **prescription drug** cost share will apply after those two programs have been exhausted.

Per prescription cost share

Tier 1 -- preferred generic prescription drugs

Description	In-network coverage
For each 30 day supply filled at a **retail pharmacy**	$12 **copay**
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a [**retail pharmacy** or] **mail order pharmacy**	$30 **copay**

Tier 2 -- preferred brand-name prescription drugs

Description	In-network coverage
For each 30 day supply filled at a **retail pharmacy**	$55 **copay**
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a [**retail pharmacy** or] **mail order pharmacy**	$137.50 **copay**

Tier 3 -- non-preferred generic and brand-name prescription drugs

Description	In-network coverage
For each 30 day supply filled at a **retail pharmacy**	$95 **copay**

Description	In-network coverage
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a [**retail pharmacy** or] **mail order pharmacy**	$237.50 **copay**

Important note:
[After the initial fill], Tier 1, 2 and 3 **specialty prescription drugs** are not eligible for fill at a **retail pharmacy** or **mail order pharmacy**.

Tier 4 -- preferred specialty prescription drugs

Description	In-network coverage
For each 30 day supply filled at a specialty **network pharmacy**	40% up to $150 per **prescription**

Tier 5 -- non-preferred specialty prescription drugs

Description	In-network coverage
For each 30 day supply filled at a specialty **network pharmacy**	50% up to $150 per **prescription**

Diabetic supplies and insulin

Description	In-network coverage
For each 30 day supply filled at a **retail pharmacy**	Paid according to the tier of drug in the schedule of benefits, above
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a [**retail pharmacy** or] **mail order pharmacy**	Paid according to the tier of drug in the schedule of benefits, above

Important note:
Your cost share will not exceed $30 per 30 day supply of a covered **prescription** insulin drug filled at a **network pharmacy**. Your cost share will not exceed $100 per 30 day supply of covered diabetic supplies filled at a **network pharmacy**. No **deductible** applies for diabetic supplies and insulin.

Orally administered anti-cancer medications

Description	In-network coverage
For each 30 day supply filled at a specialty **network pharmacy**	$0 **copay**, no **deductible** applies

Outpatient prescription contraceptive drugs and devices

Description	In-network coverage
Female contraceptives that are **generic** and OTC drugs and devices . For each 30 day supply, up to a 12 month supply at one time.	$0 per **prescription** or refill no **deductible** applies
Female contraceptives that are **brand-name prescription drugs** and devices . For each 30 day supply, up to a 12 month supply at one time.	Paid according to the tier of drug in the schedule of benefits, above

Important note:
For in-network coverage, **brand-name prescription drugs** and devices covered at 100% to the extent that a generic is not available.

Preventive care drugs and supplements

Description	In-network coverage
For each 30 day supply filled at a **retail pharmacy**	$0 per **prescription** or refill no **deductible** applies

Limitations: 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, see the *How to contact us for help* section.

Risk reducing breast cancer prescription drugs

Description	In-network coverage
For each 30 day supply filled at a **retail pharmacy**	$0 per **prescription** or refill no **deductible** applies

Limitations: 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 risk reducing breast cancer **prescription drugs**, see the *How to contact us for help* section.

Tobacco cessation prescription and over-the-counter drugs

Description	In-network coverage
For each 30 day supply filled at a **retail pharmacy**	$0 per **prescription** or refill no **deductible** applies

Limitations:

- Coverage is limited to two, 90-day treatment programs only. Any additional treatment programs will be paid according to the tier of drug per the schedule of benefits, above.
- Coverage only includes generic drug when there is also a brand-name drug available.
- Coverage is 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, see the *How to contact us for help* section.

Important note:
See the *Outpatient prescription drugs, Other services* section for more information on other **prescription drug** coverage under this plan.

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