Managed Choice Point of Service (POS) Medical Plan

Schedule of Benefits

For Education Association Employees

Prepared exclusively for:

Policyholder:	Morris Hills Regional District
Group policy number:	GP-285512
	Schedule of Benefits 1A
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Plan effective date:	July 1, 2018
Plan issue date:	January 11, 2019

Underwritten by Aetna Life Insurance Company in the state of New Jersey.

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 a **network provider**.
  - "Out-of-network coverage", we mean you can get care from **providers** who are not **network providers** or **network providers** that are seen without a **referral**.
- 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 member **coinsurance** percentage. This is the **coinsurance** amount you pay.
- 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 Navigator® 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**
Deductible		
You have to meet your Calendar Year **deductible** before this plan pays for benefits.		
Individual	$0 per Calendar Year	$100 per Calendar Year
Family	$0 per Calendar Year	$250 per Calendar Year

Maximum out-of-pocket limit		
Maximum out-of-pocket limit per Calendar Year.		
Individual	$2,000 per Calendar Year	$2,100 per Calendar Year
Family	$4,000 per Calendar Year	$5,250 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:

- The covered benefit will be reduced by 30% for each type of eligible health service 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* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
Preventive care and wellness		
Routine physical exams		
Performed at a **physician's**, **PCP** office	0% per visit No **deductible** applies	30% (of the **recognized charge**) 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 Navigator® secure member website at www.aetna.com or calling the number on the back of 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 Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.
Covered persons age 22 and over but less than 65: Maximum visits per Calendar Year	1 visit	1 visit
Covered persons age 65 and over: Maximum visits per Calendar Year	1 visit	1 visit
Health wellness promotion program		
Recommended immunizations for all adults Annual:	No charge	30% (of the **recognized charge**) per visit No **deductible** applies
• blood tests and lifestyle behavior counseling for covered persons age 20 and over	No charge	30% (of the **recognized charge**) per visit No **deductible** applies
• A pap smear for female covered persons age 20 and over	No charge	30% (of the **recognized charge**) per visit No **deductible** applies
• Stool examination for presence of blood for	No charge	30% (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

covered persons age 40 or over • A mammogram for female covered persons age 40 or over Every 5 years: • Glaucoma test for covered persons age 35 and over • A left-sided colon examination of 35 or 60 centimeters for covered persons age 45 and over	No charge No charge No charge No **deductible** applies	30% (of the **recognized charge**) per visit No **deductible** applies 30% (of the **recognized charge**) per visit No **deductible** applies 30% (of the **recognized charge**) per visit No **deductible** applies
Preventive care immunizations		
Performed in a facility or at a **physician's** office	0% per visit No **deductible** applies	30% (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 Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of 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 Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.

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Well woman preventive visits routine gynecological exams (including pap smears)		
Performed at a **physician's**, **PCP**, obstetrician (OB), gynecologist (GYN) or OB/GYN office	0% per visit No **deductible** applies	30% (of the **recognized charge**) per visit No **deductible** applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
Maximum visits per Calendar Year	1 visits	1 visits
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	0% per visit No **deductible** applies	30% (of the **recognized charge**) per visit No **deductible** applies
Obesity and/or healthy diet counseling maximums:		
Maximum visits per Calendar Year (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)
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 Calendar Year	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 Calendar Year	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 Calendar Year	2 visits	2 visits
Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.		
Genetic risk counseling for breast and ovarian cancer maximums:		
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations	Not subject to any age or frequency limitations
Routine cancer screenings (applies whether performed at a physician's, PCP, specialist office or facility)		
Routine cancer screenings	0% per visit No **deductible** applies	30% (of the **recognized charge**) 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 Navigator® secure member website at www.aetna.com or calling the number on the back of 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 Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.
Lung cancer screening maximums	1 screening every Calendar Year	1 screening every Calendar Year
Important note: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.		

Prenatal care **Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)**		
Preventive care services only	0% per visit No **deductible** applies	30% (of the **recognized charge**) 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	0% per visit No **deductible** applies	30% (of the **recognized charge**) per visit No **deductible** applies
Lactation counseling services maximum per Calendar Year either in a group or individual setting	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	0% per item No **deductible** applies	30% (of the **recognized charge**) 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	0% per visit No **deductible** applies	30% (of the **recognized charge**) per visit No **deductible** applies
Contraceptive counseling services maximum visits per Calendar Year either in a group or individual setting	2 visits	2 visits
Important note: Any visits that exceed the contraceptive counseling services maximum are covered under **physician** services office visits.		

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Devices		
Female contraceptive device provided, administered, or removed, by a **physician** during an office visit	0% per item No **deductible** applies	30% (of the **recognized charge**) per visit No **deductible** applies
Female voluntary sterilization		
Inpatient	0% per admission No **deductible** applies	30% (of the **recognized charge**) per admission
Outpatient	0% per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Physicians and other health professionals		
Physicians and **specialists** office visits (non-surgical)		
Physician services		
PCP's office hours visits (non-surgical) non preventive care	$10 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Immunizations when not part of the physical exam		
Immunizations when not part of the physical exam	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.

Telemedicine and/or telehealth consultation with a physician

Your plan covers **telemedicine** and/or **telehealth** only when you and your dependents get your consult through a **provider** who has contracted with **Aetna** to offer these services. You and your dependents can log on to the Aetna Navigator® secure member website at www.aetna.com or call Member Services at the number shown on the ID card for more information.

$10 per consultation **copay.** No **deductible** applies.

Specialist		
Specialist office visits		
Office hours visits (non-surgical)	$10 per visit No **deductible** applies	30% (of the r**ecognized charge**) per visit
Physician surgical services		
Physicians and **specialists** office visits		
Performed at a	$10 per visit	30% (of the **recognized charge**) per visit

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

physician's PCP office	No **deductible** applies	
Performed at a **specialist's** office	$10 per visit No **deductible** applies	30% (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)*	$10 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
	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 Navigator® secure member website at www.aetna.com or calling the number on the back of 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 Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.

Telemedicine and/or telehealth consultation with a specialist

Your plan covers **telemedicine** and/or **telehealth** only when you and your dependents get your consult through a **provider** who has contracted with **Aetna** to offer these services. You and your dependents can log on to the Aetna Navigator® secure member website at www.aetna.com or call Member Services at the number shown on the ID card for more information.

$10 per consultation **copay**. No **deductible** applies.

Eligible health services	**In-network coverage**	**Out-of-network coverage**
Hospital and other facility care		
Hospital care		
Inpatient **hospital**	0% (of the **negotiated charge**) per admission No **deductible** applies	30% (of the **recognized charge**) per admission
Alternatives to hospital stays		
Outpatient surgery and physician surgical services		

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

	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Anesthesia and hospital charges for dental care		
Hospital charges	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.
Home health care		
Outpatient	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Hospice care		
Inpatient facility	0% (of the **negotiated charge**) per admission No **deductible** applies	30% (of the **recognized charge**) per admission
Maximum days per lifetime	Unlimited	Unlimited
Hospice care		
Outpatient	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Outpatient private duty nursing		
Outpatient private duty nursing	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Skilled nursing facility		
Inpatient facility	0% (of the **negotiated charge**) per admission No **deductible** applies	30% (of the **recognized charge**) per admission
Maximum days per Calendar Year	120	60
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Emergency services and urgent care		
Emergency services		
Hospital emergency room	$50 per visit	Paid the same as in-network coverage

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

	No **deductible** applies	
Non-emergency care in a **hospital** emergency room	$50 per visit No **deductible** applies	$50 plus 0%per visit (of the balance of the **recognized charge**) per visit No **deductible** applies

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 **hospita**l 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)	$10 then the plan pays 0% (of the balance of the **negotiated charge** thereafter) No **deductible** applies	$10 then the plan pays 0% (of the balance of the **recognized charge**) per visit thereafter No **deductible** applies

A separate urgent care **deductible** or **copayment/coinsurance** will apply for each visit to an **urgent care provider**.

Eligible health services	In-network coverage	Out-of-network coverage
Specific conditions		
Autism spectrum disorder and other developmental disabilities		
Autism spectrum disorder treatment	$10 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Autism spectrum disorder diagnosis and testing	$10 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Applied behavior analysis	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Physical therapy, occupational and speech therapy	$10 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
If your dependent receives services through the New Jersey Early Intervention System the portion of the family cost share related to such services is a **covered benefit**. Refer to the Schedule of Benefits under Primary Care Physician visit for the family cost share.		
Coverage for diagnosis and treatment, including behavioral therapy, will continue to be provided the same as any other illness under this plan.		
Birthing center		
Inpatient	0% (of the **negotiated charge**) per admission No **deductible** applies	30% (of the **recognized charge**) per admission
Outpatient infertility services		
Performed at an **infertility specialist** office	$10 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Diabetic equipment, supplies and education		
Diabetic equipment, supplies and education	0% per visit No **deductible** applies	30% (of the **recognized charge**) per visit

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

Family planning services - other		
Voluntary sterilization for males		
Outpatient	$10 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Voluntary termination of pregnancy		
Outpatient	$10 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Maternity and related newborn care		
Inpatient	0% (of the **negotiated charge**) per admission No **deductible** applies	30% (of the **recognized charge**) per admission
Delivery services and postpartum care services		
Performed in a facility or at a **physician's** office	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (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.
Mental health treatment - inpatient		
Inpatient **mental disorders** during a **hospital** confinement Inpatient **residential treatment facility** Coverage is provided under the same terms, conditions as any other **illness**.	0% (of the **negotiated charge**) per admission No **deductible** applies	30% (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** and/ or **telehealth**) consultations Coverage is provided under the same terms, conditions as any other **illness**.	$10 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** (includes **telemedicine** and/ or **telehealth**) cognitive behavior therapy consultations Coverage is provided under the same terms, conditions as any other **illness**.	$10 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Other outpatient mental health treatment (includes skilled behavioral health services in the home) **Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) **Intensive outpatient program** (at least 2 hours per day and at least 6 hours per week of clinical treatment)	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit

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

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**.	0% (of the **negotiated charge**) per admission No **deductible** applies	30% (of the **recognized charge**) per admission
Substance use disorders treatment - outpatient: detoxification and rehabilitation		
Outpatient **substance use disorders** office visits to a **physician** or **behavioral health provider** (includes **telemedicine** and/or **telehealth** consultation) Coverage is provided under the same terms, conditions as any other **illness**.	$10 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Outpatient **substance use disorders** office visits to a **physician** or **behavioral health provider** (includes **telemedicine** and/or **telehealth** cognitive behavioral therapy consultations Coverage is provided under the same terms, conditions as any other **illness**.	$10 per visit No **deductible** applies	30% (of the **recognized charge**) per visit

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Other outpatient **substance use disorders** services (includes skilled **behavioral health services** in the home) **Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) **Intensive Outpatient Program** (at least 2 hours per day and at least 6 hours per week of clinical treatment)	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit

Obesity surgery		
Inpatient **hospital** (includes surgical procedure and acute **hospital** services)	0% (of the **negotiated charge**) per admission No **deductible** applies	30% (of the **recognized charge**) per admission

Outpatient obesity surgery		
	0% (of the **negotiated charge**) per admission No **deductible** applies	30% (of the **recognized charge**) per admission

Oral and maxillofacial treatment (mouth, jaws and teeth)		
Oral and maxillofacial treatment (mouth, jaws and teeth)	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit

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

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

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

Eligible health services	Network (IOE facility)	Network (Non-IOE facility)	Out-of-network coverage
Transplant services facility and non-facility			
Inpatient **hospital** transplant services	0% (of the **negotiated charge**) per transplant No **deductible** applies	0% (of the **negotiated charge**) per transplant No **deductible** applies	0% (of the **recognized charge**) per transplant No **deductible** applies
Wilm's tumor	0% (of the **negotiated charge**) per admission No **deductible** applies	0% (of the **negotiated charge**) per admission No **deductible** applies	0% (of the **recognized charge**) per admission No **deductible** applies
Physician services including office visits	$10 per visit No **deductible** applies	30% (of the **negotiated charge**) per visit	30% (of the **recognized charge**) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Specific therapies and tests		
Outpatient diagnostic testing		
Acupuncture and acupuncture therapy		
Acupuncture and acupuncture therapy	$10 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Diagnostic complex imaging services		
	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Diagnostic lab work		
	0% (of the **negotiated** charge) per visit No **deductible** applies	30% (of the **recognized** charge) per visit
Diagnostic radiological services		
	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit

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

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.
Orally-administered anti-cancer prescription drug services		
Orally-administered anti-cancer prescription drug 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.
Outpatient infusion therapy		
	0% (of the **negotiated charge**) per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Outpatient radiation therapy		
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.
Short-term cardiac and pulmonary rehabilitation services		
Cardiac rehabilitation		
Cardiac rehabilitation	$10 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Pulmonary rehabilitation		
Pulmonary rehabilitation	$10 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Short-term rehabilitation services		
Short-term rehabilitation services (outpatient physical, occupational therapies) combined with Habilitation therapy services (outpatient physical, occupational therapies)		
	$10 per visit No **deductible** applies	30% (of the **recognized charge**) per visit
Short-term rehabilitation services (outpatient speech therapies) combined with Habilitation therapy services (outpatient speech therapies)		
	$10 per visit No **deductible** applies	30% (of the **recognized charge**) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Other services		

Ambulance service		
Ambulance	0% (of the **negotiated charge**) per trip No **deductible** applies.	0% (of the **recognized charge**) per trip No **deductible** applies.

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
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

Durable medical equipment (DME)		
DME	0% (of the **negotiated charge**) per item No **deductible** applies.	30% (of the **recognized charge**) per item

Hearing aids and exams		
Hearing aid exams	0% (of the **negotiated charge**) per visit No **deductible** applies.	30% (of the **recognized charge**) per visit
Hearing aids Covered persons through age 15 years and younger	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.

Hearing aids	One per ear every 24 month consecutive period	One per ear every 24 month consecutive period
Maximum per hearing aid	$1,000	$1,000

Home hemophilia treatment		
Home treatment	0% (of the **negotiated charge**) per visit No **deductible** applies.	30% (of the **recognized charge**) per visit

Nutritional supplements		
Nutritional supplements including those used for Inherited Metabolic Disease	0% (of the **negotiated charge**) per item No **deductible** applies	30% (of the **recognized charge**) per item

Infant formulas		
Infant formulas	0% (of the **negotiated charge**) per item No **deductible** applies	30% (of the **recognized charge**) per item

Orthotic or prosthetic devices		
Orthotic or prosthetic devices	0% (of the **negotiated charge**) per item No **deductible** applies	30% (of the **recognized charge**) per item
The **provider's** reimbursement for orthotic and prosthetic appliances shall be either the Federal Medicare reimbursement schedule or the **negotiated charge** whichever is greater.		

Sickle cell anemia		
Medical expenses and prescription drugs for 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.

Vision care		
Routine vision exams (including refraction)		
Performed by a legally qualified ophthalmologist or optometrist	0% per visit No **deductible** applies	30% (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*
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 contraceptives when obtained at a **network pharmacy**. This means that such contraceptives will be paid at 100% for: • 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 drug** 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 obtained at a **network pharmacy** unless you are granted a medical exception.		
Outpatient prescription drug maximum out-of-pocket limit		
Outpatient **prescription drug maximum out-of-pocket limit** per Calendar Year		
Individual	$4,600 per Calendar Year	$4,600 per Calendar Year
Family	$9,200 per Calendar Year	$9,200 per Calendar Year
The amount of the family outpatient prescription drug maximum out-of-pocket limit that an individual must meet in a calendar year will not be greater than the individual out-of-pocket limit permitted by law.		

*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**	$5 **copayment** per supply No Calendar Year **deductible** applies	Coinsurance is 30% (of the **recognized** charge) per supply No Calendar Year **deductible** applies
More than a 30 day supply but less than a 61 day supply filled at a **retail pharmacy**	$10 **copayment** per supply No Calendar Year **deductible** applies	Coinsurance is 30% (of the **recognized** charge) per supply No Calendar Year **deductible** applies
More than a 60 day supply but less than a 91 day supply filled at a **retail pharmacy**	$15 **copayment** per supply No Calendar Year **deductible** applies	Coinsurance is 30% (of the **recognized** charge) per supply No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$15 **copayment** per supply No Calendar Year **deductible** applies	Coinsurance is 30% (of the **recognized** charge) per supply No Calendar Year **deductible** applies
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**	$15 **copayment** per supply No Calendar Year **deductible** applies	Coinsurance is 30% (of the **recognized** charge) per supply No Calendar Year **deductible** applies
More than a 30 day supply but less than a 61 day supply filled at a **retail pharmacy**	$30 **copayment** per supply No Calendar Year **deductible** applies	Coinsurance is 30% (of the **recognized** charge) per supply No Calendar Year **deductible** applies
More than a 60 day supply but less than a 91 day supply filled at a **retail pharmacy**	$45 **copayment** per supply No Calendar Year **deductible** applies	Coinsurance is 30% (of the **recognized** charge) per supply No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$45 **copayment** per supply No Calendar Year **deductible** applies	Coinsurance is 30% (of the **recognized** charge) per supply No Calendar Year **deductible** applies

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

Generic and Preferred Brand-Name diabetic supplies and drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits. No Calendar Year **deductible** applies	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits. No Calendar Year **deductible** applies
More than a 30 day supply but less than a 61 day supply filled at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits. No Calendar Year **deductible** applies	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits. No Calendar Year **deductible** applies
More than a 60 day supply but less than a 91 day supply filled at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits. No Calendar Year **deductible** applies	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits. No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits. No Calendar Year **deductible** applies	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits. No Calendar Year **deductible** applies
Orally administered anti-cancer prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits.	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits.
More than a 30 day supply but less than a 61 day supply filled at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits.	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits.
More than a 60 day supply but less than a 91 day supply filled at a **retail pharmacy**	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits.	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits.

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

More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits.	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits.
Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a **pharmacy**	0% per **prescription** or refill No **deductible** applies	Paid according to the type of drug per the schedule of benefits. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits.
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 Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of 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 Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.
Risk reducing breast cancer prescription drugs		
Risk reducing breast cancer **prescription 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. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits.
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 Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of 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 Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.

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

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. For example, if you have a generic prescription, refer to the generic prescription section of the schedule of benefits.
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 Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of 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 Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.

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

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 not be applied to satisfy the in-network **deductibles**. **Eligible health services** applied to the in-network **deductibles** will not 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 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 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.

Deductible credit

If you paid part or all of your **deductible** under prior coverage for the Calendar Year that this certificate went into effect, the **deductible** of this plan for that Calendar Year will be reduced by the amount you paid under your prior coverage.

Upon request, you must submit a detailed explanation of benefits (EOB) showing the dates and amount of the **deductible** met from the prior coverage in order to receive the credit.

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

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**.

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 applied to the **out-of-network maximum out-of-pocket limit** will not 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 not 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/payment percentage** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit** each of you must meet your **maximum out-of-pocket limit** separately.

Individual

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

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
- Any out of pocket costs for outpatient **prescription drugs**
- 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.

General coverage provisions

This section provides detailed explanations about the:

- Outpatient **prescription drug maximum out-of-pocket limits**

Individual
This is the amount you owe for **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. This Calendar Year outpatient **prescription drug deductible** applies separately to you and each of your covered dependents. After the amount you pay for **eligible health services** reaches the Calendar Year outpatient **prescription drug 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 **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** reaches this family Calendar Year outpatient **prescription drug 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 outpatient **prescription drug deductibles** must reach this family outpatient **prescription drug deductible** limit in a Calendar Year.

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

The outpatient **prescription drug 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 outpatient **prescription drug maximum out-of-pocket limit**. As to the individual outpatient **prescription drug maximum out-of-pocket limit** each of you must meet your outpatient **prescription drug 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 outpatient **prescription drug maximum out-of-pocket limit**, this plan will pay 100% of the **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 outpatient **prescription drug maximum out-of-pocket limit**, this plan will pay 100% of such **covered benefits** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

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

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

- The family outpatient **prescription drug maximum out-of-pocket limit** is a cumulative outpatient **prescription drug 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 outpatient **prescription drug maximum out-of-pocket limit** amount in a Calendar Year.

The outpatient **prescription drug maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the outpatient **prescription drug 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 outpatient **prescription drug maximum out-of-pocket limit** amount.

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

- All costs for non-covered services
- **Copayment**