Health Maintenance Organization (HMO)
Schedule of benefits

Schedule of benefits

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

How to read your schedule of benefits

- You must pay any **deductibles** and **copayments/coinsurance**.
- 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 **calendar year deductible** and **copayment/coinsurance** unless otherwise noted in the schedule of benefits below.

How to contact us for help

We are here to answer any questions.

- Log onto your Aetna Navigator® secure member website at www.aetna.com.
- Call Member Services at the toll-free number on your ID card.

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

Plan features	Cost share/deductible/maximums
	In-network coverage
Deductible	
You have to meet your **calendar year deductible** before this plan pays for benefits.	
Individual	$3,500 per **Calendar Year**
Family	$7,000 per **Calendar Year**
Deductible waiver	
The **calendar year deductible** is waived for all of the following **eligible health services:** • Preventive care and wellness • Family planning services - female contraceptives • Pediatric dental type A services • Pediatric routine vision exam	

Maximum out-of-pocket limit	
Maximum out-of-pocket limit per **calendar year**	
Individual	$7,000 per **Calendar Year**
Family	$14,000 per **Calendar Year**

General coverage provisions

This section explains the:

- **Deductible**
- **Maximum out-of-pocket limits**
- Limitations listed in this schedule of benefits.

Deductible provisions
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 **deductible** You pay for network **eligible health services** each **calendar year** before the plan begins to pay. This individual **calendar year deductible** applies separately to you and each covered dependent. Once you have reached the **calendar year deductible**, this plan will begin to pay for **eligible health services** for the rest of the **calendar year**.
Family **deductible** You pay for network **eligible health services** each **calendar year** before the plan begins to pay. After the amount paid for **eligible health services** reaches your family **calendar year deductible**, this plan will begin to pay for **eligible health services** for the rest of the **calendar year**.
To satisfy this family **deductible** 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** in a **calendar year**. When this happens in a **calendar year**, the individual **calendar year deductibles** for you and your covered dependents is met for the rest of the **calendar year**.

Copayment: 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**.

Per admission **copayment**
A per admission **copayment** is an amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility.

Coinsurance: The specific percentage you have to pay for a **covered benefit** listed in the schedule of benefits.

A separate cost share may apply per facility. This cost share is in addition to any other cost share applicable under this plan. It may apply to each **stay** or on a per day basis up to a per admission maximum amount. If you are in the same type of facility more than once, and your **stays** are separated by less than 48 hours (regardless of cause), only one per admission cost share will apply. Not more than three per admission cost shares will apply for each facility type during a **calendar 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.

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments/coinsurance** and **deductible** for **eligible health services** during the **calendar year**. 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.**

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 **negotiated charge** for **covered benefits** that apply toward the limit for the rest of the **calendar 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 **negotiated charge** for **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** 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 **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 non-emergency use of the emergency room
- Any out of pocket costs incurred for non-urgent use of an **urgent care provider**

Your financial responsibility and determination of benefits provisions

Your financial responsibility for the cost of services is based 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 **calendar year**. Determinations regarding when benefits are covered are subject to the terms and conditions of the policy.

Outpatient prescription drug deductible provisions

The **calendar year** outpatient **prescription drug deductible** may not apply to certain **eligible health services**. You must pay any applicable **copayments/coinsurance** for **eligible health services** to which the outpatient **prescription drug deductible** does not apply.

The **calendar year** outpatient **prescription drug deductible** applies to all outpatient **prescription drug eligible health services** except **generic prescription drugs** and **tier 1A - value drugs** dispensed by a network pharmacy, and diabetic drugs and supplies.

Individual outpatient **prescription drug deductible**

You pay for **eligible health services** each **calendar year** before the plan begins to pay. This **calendar year deductible** applies separately to you and each covered dependent. Once you have reached 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 outpatient **prescription drug deductible**

You and your covered dependents pay for **eligible health services** each **calendar year** before the plan begins to pay. After you reach 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 is met for the rest of the **calendar year**.

Eligible health services	In-network coverage
1. Preventive care and wellness	
Preventive care and wellness	0% per visit

- **Routine physical exams-** Performed at a **physician** or **PCP** 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**, **PCP**, 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**, **PCP**, **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. For details, contact your **physician**.

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 **calendar year** unless stated below.

Obesity and/or healthy diet	Age 0-22, unlimited visits; age 22+, 26 visits every 12 months, of which up to 10 visits may be used for healthy diet counseling
Misuse of alcohol and/or drugs	Limited to 5 visits every 12 months
Use of tobacco products	Limited to 8 visits every 12 months
Sexually transmitted infection	Limited to 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
- Requirements of the State of Nevada for a baseline mammogram between the ages of 35 and 40

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

Comprehensive lactation support and counseling services:

- Lactation counseling services maximum visits every 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
- Limited to 6 visits

Breast feeding durable medical equipment: Review the *Maternity and related newborn care* sections. They will give you more information on coverage levels for maternity care under this plan. See the *Breast feeding durable medical*

equipment section of the certificate for limitations on breast pump and supplies.	
Family planning services: • Contraceptive counseling services maximum visits every 12 months in either a group or individual setting • Limited to 2 visits	
Eligible health services	**In-network coverage**
2. Physicians and other health professionals	
Physician services	
Office hours visits (non-surgical) non preventive care	$15 **copay,** no **deductible** applies
Specialist office visits	
Office hours visit (non-surgical)	$75 **copay,** no **deductible** applies
Telemedicine consultation by a **physician, PCP** or **specialist**	Covered based on type of service and where it is received
Allergy injections	
Without a **physician**, **PCP** or **specialist** office visit	Covered based on type of service and where it is received
Allergy testing and treatment	
Performed at a **physician**, **PCP** or **specialist** office visit	Covered based on type of service and where it is received
Immunizations when not part of the physical exam	
Immunizations when not part of the physical exam	Covered based on the type of service and where it is received

Medical injectables	
Performed at a **physician**, **PCP** or **specialist** office	Covered based on type of service and where it is received
Physician surgical services	
Performed at a **physician**, **PCP** or **specialist** office	Covered based on type of service and where it is received
Alternatives to physician office visits	
Walk-in clinic visits	
Walk-in clinic non-emergency visit	Not covered

Eligible health services	**In-network coverage**
3. Hospital and other facility care	
Hospital care	
Inpatient **hospital**	$500 **copay** per admission after **deductible,** then 30%
Anesthesia for certain dental procedures	
Performed in a **hospital** inpatient facility	Covered based on the type of service and where it is received
Performed in a **hospital** outpatient department	Covered based on the type of service and where it is received
Alternatives to hospital stays	
Outpatient surgery	
Performed in **hospital** outpatient department	$250 **copay** then 30% after **deductible**
Performed in facility other than **hospital** outpatient department	$250 **copay** then 30% after **deductible**
Home health care	
Outpatient	30% after **deductible**
Visit limit per **calendar year**	None
Hospice care	
Inpatient services	30% after **deductible**
Outpatient services	30% after **deductible**
Skilled nursing facility	
Inpatient facility	30% after **deductible**
Day limit per **calendar year**	Coverage is limited to 100 days per **calendar year.**

Eligible health services	In-network coverage
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**.	
Hospital emergency room	30% 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.	
Urgent medical care at a free standing facility that is not a hospital	$75 **copay,** no **deductible** applies
Non-urgent use of **urgent care provider** at a free standing facility that is not a hospital	Not covered

Eligible health services	In-network coverage
5. Pediatric dental care	
Coverage is limited to covered persons through the end of the month in which the person turns 19	
Type A services	0% per visit
Type B services	30% after **deductible**
Type C services	50% after **deductible**
Orthodontic services	50% after **deductible**
Dental emergency maximum benefit: For covered dental care services provided for a dental emergency by an out-of-network **dental provider**, the policy pays a benefit at the in-network level of coverage up to the dental emergency maximum of $75. Any charges above the emergency maximum will not be covered.	
Dental benefits are subject to the medical plan's **deductibles** and **maximum out-of-pocket limits** as explained on the schedule of benefits.	

Diagnostic and preventive care (type A services)

Visits and images

- Office visit during regular office hours, for oral examination, (limited to 2 visits every 12 months)
- Routine comprehensive or recall examination, (limited to 2 visits every 12 months)
- Problem-focused examination, (limited to 2 visits every 12 months)
- Prophylaxis (cleaning), (limited to 2 treatments per year)
- Topical application of fluoride (limited to two courses of treatment per year)
- Sealants, per tooth, (limited to one application every 3 years for permanent molars only)
- Preventive resin restoration, (limited to one application per tooth every 3 years for permanent molars only)
- Bitewing images
- Periapical images
- Complete image series, including bitewings if **medically necessary,** (limited to 1 set every 3 rolling years)
- Vertical bitewing images
- Panoramic film, (limited to 1 set every 3 years)
- Diagnostic cast

Space maintainers

- Space maintainers are covered only when needed to preserve space resulting from premature loss of primary teeth (Includes all adjustments within 6 months after installation)
- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)
- Recementation 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)
- Emergency palliative treatment, per visit

Images and pathology

- Intra-oral, occlusal radiographic image
- Extra-oral radiographic image
- Biopsy and accession of tissue examination of oral tissue

Oral surgery

- Extractions
  - Erupted tooth or exposed root
  - Coronal remnants
  - Surgical removal of erupted tooth/root
- Impacted teeth
  - Removal of tooth (soft tissue)
- Surgical removal of residual tooth roots
- 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
  - Removal of exostosis
  - Removal of torus palatinus
  - Removal of torus mandibularis
  - Mobilization of erupted malpositioned tooth
  - Device to aid eruption of impacted tooth

- Surgical reduction of osseous tuberosity
- Surgical reduction of fibrous tuberosity
- Transplantation of tooth or tooth bud
- Primary closure of sinus perforation
- Crown exposure to aid eruption
- Frenectomy (frenulotomy)
- Frenuloplasty
- Suture of soft tissue Injury
- Excision of pericoromal gingiva
- Biopsy of oral tissue (hard and soft tissue)

Periodontics

- 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 4 separate quadrants every 2 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)
- Anatomical crown exposure, per quadrant
- 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 quadrant every 3 years)
- Periodontal maintenance procedures following active therapy (limited to 4 per year combined with prophylaxis (cleaning))
- Localized delivery of antimicrobial agents

Endodontics

- Pulp capping
- Pulpotomy
- Pulpal therapy
- Apexification/recalcification
- Apicoectomy
- Pulpal regeneration
- Root canal therapy including **medically necessary** images:
  - Anterior
  - Bicuspid
- Retreatment of previous root canal therapy:
  - Anterior
  - Bicuspid
- Root amputation
- Retrograde filling - per root
- Endodontic endosseous implant
- Hemisection (including root removal)

Restorative dentistry

- Multiple restorations in 1 surface will be considered as a single restoration
- Amalgam restorations
- Resin-based composite restorations (other than for molars)
- Protective restorations
- Interim therapeutic restoration - primary
- 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)
- 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)
- 3/4 cast base metal, metallic or porcelain/ceramic
- Full cast predominantly metal
- Titanium

- Post and core
- Core build up
- Repairs:
  - Crowns
- Re-cementation
  - Inlay
  - Crown
  - Bridge
  - Fixed partial denture
  - Implant supported crown
  - Cast or prefabricated post
- Occlusal adjustments (limited or complete)

Major restorative care (type C services)

Oral Surgery

- Surgical removal of impacted teeth
  - Removal of tooth (partially bony)
  - Removal of tooth (completely bony)
- Removal of tooth with surgical complications
- Soft tissue graft procedures
- Clinical crown lengthening

Periodontics

- Osseous surgery (including flap and closure), 1 to 3 teeth per quadrant, (limited to 1 per quadrant, every 3 years)
- Osseous surgery (including flap and closure), per quadrant, (limited to 1 per quadrant, every 3 years)
- Soft tissue allograft procedures
- Pedical soft graft procedure
- Subepithelia connective tissue graft, by tooth
- Full mouth debridement (limited to 1 per lifetime)

Endodontics

- Molar root canal therapy including **medically necessary** images
- Retreatment of previous molar root canal therapy

Restorative

- Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge (limited to 1 per tooth every 5 years)
- Inlays/Onlays (limited to 1 per tooth every 5 years)

Prosthodontics

- Installation of dentures and bridges is covered only if needed to replace teeth which were not abutments to a denture or bridge less than 5 years old, (limited to 1 every 5 years)
- Replacement of existing bridges or dentures (limited to 1 every 5 years)
- Bridge abutments (See Inlays/Onlays and Crowns) (limited to 1 every 5 years)
- Pontics (limited to 1 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

- 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)
- 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)
- Pediatric partial denture
- Stress breakers
- Interim partial denture (stayplate), anterior only
- Occlusal guard (limited to 1 every 3 years)
- Denture and Partials
  - Office reline
  - Laboratory reline
  - 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 and partial dentures
- Fixed partial denture sectioning

General anesthesia and intravenous sedation

- Only when **medically necessary** and only when provided in conjunction with a covered dental surgical procedure
- General anesthesia – each 15 minute increment
- Intravenous sedation – each 15 minute increment

Orthodontic services

- **Medically necessary** comprehensive treatment
- Replacement of retainer (limit one per lifetime)

Eligible health services	In-network coverage
6. Specific conditions	
Autism spectrum disorder	
Autism spectrum disorder	Covered based on the type of service and where it is received
Applied behavior analysis	See the *Habilitation Therapy Services* section below
Diabetic equipment, supplies and education	
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	
Voluntary sterilization for males	$500 **copay** per admission after **deductible,** then 30%
Voluntary termination of pregnancy	Not covered
Outpatient services	
Voluntary sterilization for males	Covered based on type of service and where it is received
Voluntary termination of pregnancy	Not covered
Hormone replacement therapy	
Hormone replacement therapy	Covered based on the type of service and where it is received
Jaw joint disorder treatment	
Jaw joint disorder treatment	Covered based on the type of service and where it is received
Maternity and related newborn care	
Prenatal care services	
Inpatient and other maternity related services and supplies	$500 **copay** per admission after **deductible,** then 30%
Other prenatal care services and supplies	Covered based on the type of service and where it is received
Delivery services and postpartum care services	
Inpatient and newborn care services and supplies	$500 **copay** per admission after **deductible,** then 30%
Performed in a facility or at a **physician** office	30% after **deductible**
Important note: Any **copayment/coinsurance** that is collected applies to the delivery and postpartum care services provided by an OB, GYN, or OB/GYN only. No **copayment/coinsurance** that is collected applies to prenatal care services provided by an OB's, GYN, or OB/GYN.	
Mental health treatment Coverage provided under the same terms, conditions as any other **illness**.	
Inpatient mental health treatment Inpatient **residential treatment facility**	$500 **copay** per admission after **deductible,** then 30%
Other inpatient mental health treatment services and supplies Other inpatient **residential treatment facility** services and supplies	$500 **copay** per admission after **deductible,** then 30%
Outpatient mental health treatment visits to a **physician**, or **behavioral health provider** or skilled behavioral health services in the home, **partial hospitalization treatment** and **intensive outpatient program**	$75 **copay,** no **deductible** applies
Other outpatient mental health treatment	$75 **copay,** no **deductible** applies
Substance related disorders treatment Coverage provided under the same terms, conditions as any other **illness**.	
Inpatient **substance abuse detoxification** Inpatient **substance abuse** rehabilitation Inpatient **substance abuse** treatment in **residential**	$500 **copay** per admission after **deductible,** then 30%

treatment facility	
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	$500 **copay** per admission after **deductible,** then 30%
Outpatient **substance abuse** visits to a **physician** or **behavioral health provider** including **partial hospitalization treatment** and **intensive outpatient program**	$75 **copay,** no **deductible** applies
Other outpatient **substance abuse** services	$75 **copay,** no **deductible** applies
Important note: • **Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**. • **Intensive outpatient program** (at least 2 hours per day and at least 6 hours per week of clinical treatment) provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician.**	
Reconstructive breast surgery	
Reconstructive breast surgery	Covered based on the type of service and where it is received
Reconstructive surgery and supplies	
Reconstructive surgery and supplies	Covered based on the type of service and where it is received

Eligible health services	Network (IOE) facility	Network (non-IOE) facility
Transplant services facility and non-facility		
Inpatient and other inpatient services and supplies	$500 **copay** per admission after **deductible,** then 30%	Coverage is limited to IOE only
Outpatient	Coverage is limited to IOE only	Coverage is limited to IOE only
Physician services	Coverage is limited to IOE only	Coverage is limited to IOE only
Transplant travel and lodging expenses		
Maximum Benefit payable for **IOE** Travel and lodging expenses for any one transplant, including tandem transplant	$10,000	Not Covered
Maximum Benefit payable for lodging expenses per **IOE** patient	$200 per day	Not Covered

Eligible health services	In-network coverage
Treatment of basic infertility	
Basic **infertility**	Covered based on the type of service and where it is received
Comprehensive infertility	
Inpatient services	
Inpatient **hospital**	50% after **deductible**
Other inpatient **hospital** care services and supplies	50% after **deductible**
Outpatient services	
Performed at an **infertility specialist** office	50% after **deductible**
Performed in **hospital** outpatient department	50% after **deductible**
Performed in facility other than **hospital** outpatient department	50% after **deductible**
Maximum number of ovulation induction and intrauterine insemination cycles per lifetime**	6
**As used for this benefit, "lifetime" is defined to include covered benefits paid under this plan or another plan underwritten and/or administered by us or any Aetna affiliate, with the same policyholder	

Eligible health services	In-network coverage
7. Specific therapies and tests	
Outpatient diagnostic testing	
Diagnostic complex imaging services	
Performed at a facility	$250 **copay** then 30% after **deductible**
Performed at **physician**, **PCP** office	Included in OV **Copay**
Performed at **specialist** office	Included in OV **Copay**
Diagnostic lab work	
Performed at a facility	30% after **deductible**
Performed at **physician**, **PCP** office	Included in OV **Copay**
Performed at **specialist** office	Included in OV **Copay**
Diagnostic radiological services	
X-ray	
Performed at a facility	30% after **deductible**
Performed at **physician**, **PCP** office	Included in OV **Copay**
Performed at **specialist** office	Included in OV **Copay**
Outpatient therapies	
Chemotherapy	
Chemotherapy	Covered based on the type of service and where it is received
Outpatient infusion therapy	
Performed in a **physician** office or in a person's home	30% after **deductible**
Performed in outpatient facility	30% after **deductible**
Radiation therapy	
Radiation therapy	Covered based on the type of service and where it is received
Specialty prescription drugs	
Performed in a **physician** office, the outpatient department of a **hospital**, 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.	

Cardiac and pulmonary rehabilitation	30% after **deductible**
Short-term rehabilitation therapy services A visit is equal to no more than 1 hour of therapy.	
Outpatient physical therapy	
Physical therapy	30% after **deductible**
Visit limit per **calendar year**	Coverage is limited to 120 visits per **calendar year** PT/OT/ST combined. PT/OT/ST rehabilitation and habilitation separate.
Outpatient occupational therapy	
Occupational therapy	30% after **deductible**
Visit limit per **calendar year**	Coverage is limited to 120 visits per **calendar year** PT/OT/ST combined. PT/OT/ST rehabilitation and habilitation separate.
Outpatient speech therapy	
Speech therapy	30% after **deductible**
Visit limit per **calendar year**	Coverage is limited to 120 visits per **calendar year** PT/OT/ST combined. PT/OT/ST rehabilitation and habilitation separate.
Spinal manipulation	
Spinal manipulation	30% after **deductible**
Visit limit per **calendar year**	Coverage is limited to 20 visits per **calendar year.**
Habilitation therapy services A visit is equal to no more than 1 hour of therapy.	
Physical, occupational, and speech	30% after **deductible**
Visit limit per **calendar year**	Coverage is limited to 120 visits per **calendar year** PT/OT/ST combined. PT/OT/ST rehabilitation and habilitation separate.
Applied behavior analysis	
Applied behavior analysis	$75 **copay,** no **deductible** applies
Visit limit per **calendar year**	None

Eligible health services	In-network coverage
8. Other services	
Acupuncture	
Acupuncture	Not covered
Ambulance service	
Emergency **ambulance**	30% after **deductible**
Non-emergency **ambulance**	30% after **deductible**
Clinical trial therapies (experimental or investigational)	
Clinical trial therapies (including routine patient costs)	Covered based on the type of service and where it is received
Durable medical equipment (DME)	
DME	50% after **deductible**
Limit per **calendar year**	None
Hearing aids and exams	
Hearing aid exams	Covered based on the type of service and where it is received
Hearing aids	Covered based on the type of service and where it is received
Limit	1 per ear every 3 years
Nutritional supplements	
Nutritional supplements	30% after **deductible**
Obesity (bariatric) surgery	
Obesity (bariatric) surgery	50% after **deductible**
Maximum number of Obesity (bariatric) surgeries per lifetime***	1
***As used for this benefit, "lifetime" is defined to include covered benefits paid under this plan or another plan underwritten and/or administered by us or any Aetna affiliate, with the same policyholder	
Orthotic devices	
Orthotic devices	Not covered
Prosthetic devices	
Prosthetic devices	50% 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)	
Performed by an ophthalmologist or optometrist	$0, no **deductible** applies
Visit limit per **calendar year**	Coverage is limited to 1 exam per **calendar year** age 0-19.
Vision care services and supplies	
Office visit for fitting of contact lenses	Not covered
Preferred or non-preferred eyeglass frames, **prescription** lenses or **prescription** contact lenses	$0, no **deductible** applies
Number of eyeglass frames per **calendar year**	One set of eyeglass frames
Number of **prescription** lenses per **calendar year**	One pair of **prescription** lenses
Number of **prescription** contact lenses per **calendar year** (includes non-conventional **prescription** contact lenses and Aphakic lenses prescribed after cataract surgery)	Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set
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 **calendar year**, this benefit will cover either **prescription** lenses for eyeglass frames or **prescription** contact lenses, but not both.	

Eligible health services	In-network coverage
9. Outpatient prescription drugs	
Plan features	**Deductible/ copayment/coinsurance/ limits**
Outpatient prescription drug deductible A separate **deductible** applies to **prescription drugs**.	
You have to meet your **calendar year deductible** before this plan pays for benefits.	
Individual	$500 Per Member
Family	$0 per **Calendar Year**

Deductible waiver
The **calendar year prescription drug deductible** is waived for all **tier 1A – value** and **generic prescription drugs** filled at a **retail pharmacy** and a **mail order pharmacy**.
Waiver for risk reducing breast cancer prescription drugs
The **calendar year prescription drug** cost share 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%.
Waiver for contraceptives
The **prescription drug** cost share will not apply to female contraceptive methods when obtained at a **network pharmacy**. This means that such contraceptive methods will be paid at 100% for: • The following female contraceptives that are generic prescription drugs**:** – Oral drugs – Injectable drugs – Vaginal rings – Transdermal contraceptive patches • Female contraceptive devices that are generic and brand-name devices • FDA approved female: – Generic emergency contraceptives – Generic over-the-counter (OTC) emergency contraceptives The **prescription drug** cost share will apply to **prescription drugs** that have a generic equivalent, biosimilar or generic alternative available within the same **therapeutic drug class** obtained at a **network pharmacy** unless you receive a medical exception. To the extent **generic prescription drugs** are not available, **brand name prescription drugs** will be covered.
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 regimens for tobacco cessation **prescription drugs** and OTC drugs when obtained at a **retail network pharmacy**. This means that such **prescription drugs** and OTC drugs will be paid at 100%. Your **prescription drug** cost share will apply after those two regimens have been exhausted.

Eligible health services	In-network coverage
Per prescription copayment/coinsurance	
Tier 1A - value prescription drugs	
For each 30 day supply filled at a **retail pharmacy**	$5 **copay,** no **deductible** applies
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **mail order pharmacy**	$12.50 **copay,** no **deductible** applies
Tier 1 -- preferred generic prescription drugs	
For each 30 day supply filled at a **retail pharmacy** (**specialty prescription drugs** are not eligible for a 30 day supply filled at a **retail pharmacy**)	$15 **copay,** no **deductible** applies
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **mail order pharmacy** (**specialty prescription drugs** are not eligible for a 90 day supply filled at a **mail order pharmacy**)	$37.50 **copay,** no **deductible** applies
Tier 2 -- preferred brand-name prescription drugs	
For each fill up to a 30 day supply filled at a **retail pharmacy** (**specialty prescription drugs** are not eligible for a 30 day supply filled at a **retail pharmacy**)	$45 **copay** after **deductible**
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **mail order pharmacy** (**specialty prescription drugs** are not eligible for a 90 day supply filled at a **mail order pharmacy**)	$112.50 **copay** after **deductible**
Tier 3 -- non-preferred generic and brand-name prescription drugs	
For each 30 day supply filled at a **retail pharmacy** (**specialty prescription drugs** are not eligible for a 30 day supply filled at a **retail pharmacy**)	$80 **copay** after **deductible**
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **mail order pharmacy** (**specialty prescription drugs** are not eligible for a 90 day supply filled at a **mail order pharmacy**)	$200 **copay** after **deductible**
Tier 4 -- preferred specialty prescription drugs (including biosimilar prescription drugs)	
For each 30 day supply filled at a specialty **network pharmacy**	40% after **deductible**

Tier 5 -- non-preferred specialty prescription drugs(including biosimilar prescription drugs)	
For each 30 day supply filled at a specialty **network pharmacy**	50% after **deductible**
Diabetic supplies and insulin	
For each 30 day supply filled at a **retail pharmacy**	Paid according to the tier of drug per 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 **mail order pharmacy**	Paid according to the tier of drug per the schedule of benefits, above
Orally administered anti-cancer medications	
For each 30 day supply filled at a specialty network pharmacy	The covered person will not pay more than $100 per prescription for orally administered chemotherapy prescription drugs
Outpatient prescription contraceptive drugs and devices: includes oral and injectable drugs, vaginal rings and transdermal contraceptive patches	
Female contraceptives that are **generic prescription drugs.** For each 30 day supply Brand name vaginal rings covered at 100% to the extent that a generic is not available	$0 per **prescription** or refill
Female contraceptives that are **brand name prescription drugs** For each 30 day supply Brand name vaginal rings covered at 100% to the extent that a generic is not available	Paid according to the tier of drug per the schedule of benefits, above
Female contraceptive **generic** devices and **brand name** devices. For each 30 day supply	Paid according to the tier of drug per the schedule of benefits, above
FDA-approved female **generic** and **brand name** emergency contraceptives. For each 30 day supply	Paid according to the tier of drug per the schedule of benefits, above
FDA-approved female **generic** and **brand name** over-the-counter emergency contraceptives. For each 30 day supply	Paid according to the tier of drug per the schedule of benefits, above
Preventive care drugs and supplements	
For each 30 day supply filled at a **retail pharmacy**	$0 per **prescription** or refill
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	
For each 30 day supply filled at a **retail pharmacy**	$0 per **prescription** or refill
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	
For each 30 day supply filled at a **retail pharmacy**	$0 per **prescription** or refill
Limitations: • Coverage permitted for two, 90-day treatment regimens only. Any additional treatment regimens 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 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, 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 sharing that applies to **brand-name prescription drugs.**	