# OA Managed Choice POS HDHP

## Schedule of benefits

If this is an ERISA plan, you have certain rights under this plan. Please contact your employer for additional information.

**Prepared exclusively for:**

| | |
|---|---|
| **Policyholder**: | President and Board of Trustees of Santa Clara College DBA Santa Clara University |
| **Policyholder** number: | GP-0237642 |
| Schedule of Benefits: | 1B<br>$3,200 Option Benefit Plan |
| **Group policy** effective date: | January 1, 2024 |
| Plan effective date: | January 1, 2024 |
| Plan issue date: | November 16, 2023 |

**Underwritten by Aetna Life Insurance Company in the state of California.**

# Schedule of benefits

This schedule of benefits lists the **deductibles** and **copayments/coinsurance** 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**.
- The **deductibles** and **copayments/coinsurance** listed in the schedule of benefits below reflect the **deductibles** and **copayment/coinsurance** amounts under your plan.
- You are responsible to pay any **deductibles, copayments,** and **coinsurance**.
- **The coinsurance** listed in the schedule of benefits reflects the plan **coinsurance** percentage. This is the **coinsurance** amount the plan pays. You are responsible for paying any remaining **coinsurance.**
- You are responsible for full payment of any health care services you receive that are not a **covered benefit**.
- This plan has maximums for specific **covered benefits**. For example, these could be visit, day or dollar maximums. They are combined maximums between **network providers** and **out-of-network providers** unless we state otherwise.
- At the end of this schedule you will find detailed explanations about your:
  - **Deductible**
  - **Maximum out-of-pocket limits**
  - Maximums

**Important note:**
All **covered benefits** are subject to the Calendar Year **deductible** and **copayment/coinsurance** unless otherwise noted in the schedule of benefits below.

We are here to answer any questions. Contact Member Services by logging onto your Aetna secure member website at www.aetna.com or at the toll-free number on your ID card.

The coverage described in this schedule of benefits will be provided under **Aetna Life Insurance Company's group policy**. This schedule of benefits replaces any schedule of benefits previously in effect under the **group policy**. Keep this schedule of benefits with your booklet-certificate.

| Plan features | Deductible/Maximums | |
|---|---|---|
| | **In-network coverage*** | **Out-of-network coverage*** |
| **Deductible** | | |
| You have to meet your Calendar Year **deductible** before this plan pays for benefits. | | |
| | | |
| Individual | $3,200 per Calendar Year | $4,000 per Calendar Year |
| | | |
| Family | $4,000 per Calendar Year | $8,000 per Calendar Year |
| | | |
| **Deductible waiver** | | |
| The Calendar Year **deductible** is waived for all of the following **eligible health services:**<br>• Preventive care and wellness<br>• Family planning services - female contraceptives | | |
| | | |
| **Deductible waiver provision for preventive prescription drugs** | | |
| **Deductible** waiver provision for preventive **prescription drugs**. No **deductible** will apply to preventive covered **prescription drug** expenses for those **prescription drugs** used to treat:<br><br>The prevention of conditions relating to:<br>• Hypertension<br>• Heart disease<br>• Diabetic complications<br>• Asthmatic episodes<br>• Conditions resulting from osteoporosis<br>• Stroke<br>• Various pediatric conditions, such as vitamins and fluoride deficiency, and maternal and fetal problems during pregnancy. | | |
| | | |
| **Maximum out-of-pocket limit** | | |
| **Maximum out-of-pocket limit** per Calendar Year. | | |
| Individual | $4,000 per Calendar Year | $8,000 per Calendar Year |
| | | |
| Family | $8,000 per Calendar Year | $16,000 per Calendar Year |
| | | |

*See *How to read your schedule of benefit and important note* at the beginning of this schedule of benefits

## Precertification penalty

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 penalty:

- A $400 penalty will be applied separately to each type of **eligible health services** (the penalty will never exceed the cost of the benefit)

**Precertification** and/or **step therapy** for certain **prescription drugs** may be required. In this case, the **prescription drug** will not be covered until you get prior authorization.

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 benefit and important note* at the beginning of this schedule of benefits

| Eligible health services | In-network coverage* | Out-of-network coverage* |
|---|---|---|
| **1. Preventive care and wellness** | | |
| **Routine physical exams** | | |
| Performed at a **physician's**, **PCP** office | 100% per visit<br><br>No **deductible** applies | 70% (of the **recognized charge**) per visit |
| Covered persons through age 21: Maximum age and visit limits per 12 months | 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.<br><br>For details, contact your **physician** or Member Services by logging onto your Aetna 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.<br><br>For details, contact your **physician** or Member Services by logging onto your Aetna 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 12 months | 1 visit | 1 visit |
| Covered persons age 65 and over: Maximum visits per 12 months | 1 visit | 1 visit |
| | | |

*See *How to read your schedule of benefits, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

| | | |
|---|---|---|
| **Preventive care immunizations** | | |
| Performed in a facility or at a **physician's** office | 100% per visit<br><br>No **deductible** applies | 70% (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.<br><br>For details, contact your **physician** or Member Services by logging onto your Aetna 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.<br><br>For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on the back of your ID card. |
| | | |
| **Well woman preventive visits routine gynecological exams (including pap smears)** | | |
| Performed at a **physician's**, **PCP**, obstetrician (OB), gynecologist (GYN) or OB/GYN office | 100% per visit<br><br>No **deductible** applies | 70% (of the **recognized charge**) per visit |
| 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 visit | 1 visit |
| | | |
| **Preventive screening and counseling services** | | |
| Office visits<br>• Obesity and/or healthy diet counseling<br>• Misuse of alcohol and/or drugs<br>• Use of tobacco products<br>• Sexually transmitted infection counseling<br>• Genetic risk counseling for breast and ovarian cancer | 100% per visit<br><br>No **deductible** applies | 70% (of the **recognized charge**) per visit |
| | | |

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| | | |
|---|---|---|
| **Obesity and/or healthy diet counseling maximums:** | | |
| Maximum visits per 12 months<br><br>(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 12 months | 5 visits* | 5 visits* |
| *Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit. | | |
| | | |
| **Use of tobacco products maximums:** | | |
| Maximum visits per 12 months | 8 visits* | 8 visits* |
| *Note: In figuring the maximum visits, each session of up to 60 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 | 100% per visit<br><br>No **deductible** applies | 70% (of the **recognized charge**) per visit |
| | | |
| Maximums | Subject to any age, family history, and frequency guidelines as set forth in the most current:<br>• 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<br>• The comprehensive guidelines supported by the Health Resources and Services Administration.<br><br>For details, contact your **physician** or Member Services by logging onto your Aetna 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:<br>• 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<br>• The comprehensive guidelines supported by the Health Resources and Services Administration.<br><br>For details, contact your **physician** or Member Services by logging onto your Aetna 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 12 months* | 1 screening every 12 months* |
| ***Important note:**<br>Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section. | | |
| | | |
| **Prenatal care**<br>**Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)** | | |
| Preventive care services only (includes participation in the California Prenatal Screening Program | 100% per visit<br><br>No **deductible** applies | 70% (of the **recognized charge**) per visit |
| | | |
| **Important note:**<br>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. | | |
| | | |

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| **Comprehensive lactation support and counseling services** | | |
|---|---|---|
| Lactation counseling services – facility or office visits | 100% per visit<br><br>No **deductible** applies | 70% (of the **recognized charge**) per visit |
| Lactation counseling services maximum visits per 12 months either in a group or individual setting | 6 visits* | 6 visits* |
| ***Important note:**<br>Any visits that exceed the lactation counseling services maximum are covered under **Physician** services office visits. | | |
| | | |
| **Breast feeding durable medical equipment** | | |
| Breast pump supplies and accessories | 100% per item<br><br>No **deductible** applies | 70% (of the **recognized charge**) per item |
| **Important note:**<br>See the *Breast feeding durable medical equipment* section of the booklet-certificate for limitations on breast pump and supplies. | | |
| | | |
| **Family planning services – female contraceptives** | | |
| Female contraceptive education and counseling services office visit | 100% per visit<br><br>No **deductible** applies | 70% (of the **recognized charge**) per visit |
| | | |
| **Devices** | | |
| Female contraceptive device provided, administered, or removed, by a **physician** during an office visit and follow up services | 100% per item<br><br>No **deductible** applies | 70% (of the **recognized charge**) per item |
| | | |
| **Female voluntary sterilization** | | |
| Inpatient | 100% per admission<br><br>No **deductible** applies | 70% (of the **recognized charge**) per admission |
| Outpatient | 100% per visit<br><br>No **deductible** applies | 70% (of the **recognized charge**) per visit |
| | | |

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| Eligible health services | In-network coverage* | Out-of-network coverage* |
|---|---|---|
| **2. Physicians and other health professionals** | | |
| **Physicians** and **specialists** office visits (non-surgical) | | |
| **Physician services** | | |
| Office hours visits (non-surgical) non preventive care | 90% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |
| **Telemedicine** consultation by a **physician**, **PCP** | 90% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |
| **Telemedicine** consultation by a **specialist** | 90% (of the **negotiated charge**) per visit | 70% (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. |
| | | |
| **Specialist** | | |
| **Specialist office visits** | | |
| Office hours visits (non-surgical) | 90% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |
| **Physician surgical services** | | |
| **Physicians** and **specialists** office visits | | |
| Performed at a **physician's**, **PCP** office | 90% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| Performed at a **specialist's** office | 90% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |

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## Walk-in clinic visits

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

| | Network Benefit Level | | Out-of-network benefit level |
|---|---|---|---|
| **Description** | **Designated network coverage** | **Non-designated network coverage** | **Out-of-network coverage** |
| Non-emergency services | 100% (of the **negotiated charge**) per visit after **deductible** | 90% (of the **negotiated charge**) per visit after **deductible** | 70% (of the **recognized charge**) per visit after **deductible** |
| Preventive care immunizations | 100% (of the **negotiated charge**) per visit, no **deductible** applies | 100% (of the **negotiated charge**) per visit, no **deductible** applies | 70% (of the **recognized charge**) per visit after **deductible** |
| Immunization limits | Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention<br><br>For details, contact your **physician** | Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention<br><br>For details, contact your **physician** | Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention<br><br>For details, contact your **physician** |
| Preventive screening and counseling services | 100% (of the **negotiated charge**) per visit, no **deductible** applies | 100% (of the **negotiated charge**) per visit, no **deductible** applies | 70% (of the **recognized charge**) per visit after **deductible** |
| Preventive screening and counseling limits | See the *Preventive care services* section of the SOB | See the *Preventive care services* section of the SOB | See the *Preventive care services* section of the SOB |

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**Important Note:**

Designated network provider
A **network provider** listed in the **directory** under *Best Results for your plan* as a **provider** for your plan.

Non-designated network provider
A **provider** listed in the **directory** under the *All other results* tab as a **provider** for your plan.
See the *Contact us* section if you have questions.

You will pay less cost share when you use a designated network walk-in clinic **provider**. Non-designated network walk-in clinic **providers** are available to you, but the cost share will be at a higher level when these **providers** are used.

| Eligible health services | In-network coverage* | Out-of-network coverage* |
|---|---|---|
| **3. Hospital and other facility care** | | |
| **Hospital care** | | |
| Inpatient **hospital** | 90% (of the **negotiated charge**) per admission | 70% (of the **recognized charge**) per admission |
| | | |
| **Alternatives to hospital stays** | | |
| **Outpatient surgery and physician surgical services** | | |
| | 90% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |
| **Home health care** | | |
| Outpatient | 90% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| Maximum visits per Calendar Year | 120<br><br>Limited to: 3 intermittent visits per day provided by a participating **home health care agency**; 1 visit equals at least a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care<br><br>The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 14 days of discharge | 120<br><br>Limited to: 3 intermittent visits per day provided by a participating **home health care agency**; 1 visit equals at least a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care<br><br>The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 14 days of discharge |
| | | |
| **Hospice care** | | |
| Inpatient facility | 90% (of the **negotiated charge**) per admission | 70% (of the **recognized charge**) per admission |
| Maximum days per lifetime | Unlimited | Unlimited |
| | | |

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

| | | |
|---|---|---|
| **Hospice care** | | |
| Outpatient | 90% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | Part-time or intermittent nursing care by an **R.N.** or **L.P.N.** for up to 8 hours a day<br><br>Part-time or intermittent home health aide services to care for you up to 8 hours a day | Part-time or intermittent nursing care by an **R.N.** or **L.P.N.** for up to 8 hours a day<br><br>Part-time or intermittent home health aide services to care for you up to 8 hours a day |
| | | |
| **Skilled nursing facility** | | |
| Inpatient facility | 90% (of the **negotiated charge**) per admission | 70% (of the **recognized charge**) per admission |
| Maximum days per Calendar Year | 60 | 60 |
| | | |
| **Eligible health services** | **In-network coverage*** | **Out-of-network coverage*** |
| **4. Emergency services and urgent care** | | |
| **Emergency services** | | |
| **Hospital** emergency room | 90% (of the **negotiated charge**) per visit | Paid the same as in-network coverage |
| | | |
| Non-emergency care in a **hospital** emergency room | Not covered | Not covered |
| | | |

**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 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.

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| **Urgent care** | | |
|---|---|---|
| Urgent medical care (at a non-**hospital** free standing facility) | 90% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |
| Non-urgent use of **urgent care provider** (at a non-**hospital** free standing facility) | Not covered | Not covered |
| | | |

*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* |
|---|---|---|
| **5. Specific conditions** | | |

| **Behavioral health**<br>**Mental health treatment - inpatient** | | |
|---|---|---|
| Inpatient mental health treatment<br><br>Inpatient **residential treatment facility** Inpatient mental health treatment | 90% (of the **negotiated charge**) per admission | 70% (of the **recognized charge**) per admission |
| | | |
| **Mental health treatment - outpatient** | | |
| Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** (includes **telemedicine** consultation) | 90% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |
| All other outpatient mental health treatment as described in your booklet-certificate (includes skilled behavioral health services in the home)<br><br>**Partial hospitalization treatment**<br><br>**Intensive outpatient program** | 90% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |

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| Substance related disorders treatment - inpatient | | |
|---|---|---|
| Inpatient **substance abuse detoxification**<br><br>Inpatient **substance abuse** rehabilitation<br><br>Inpatient **residential treatment facility** | 90% (of the **negotiated charge**) per admission | 70% (of the **recognized charge**) per admission |
| | | |
| **Substance related disorders treatment - outpatient** | | |
| Outpatient **substance abuse office** visits to a **physician** or **behavioral health provider** (includes **telemedicine** consultation) | 90% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |
| All other outpatient **substance abuse** services (as described in your booklet-certificate)<br><br>**Partial hospitalization treatment**<br><br>**Intensive outpatient program** | 90% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |
| **Birthing center and physician services** | | |
| Inpatient | 90% (of the **negotiated charge**) per admission | 70% (of the **recognized charge**) per admission |
| | | |
| **Diabetic equipment, supplies and education** | | |
| Diabetic equipment, supplies and education | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| | | |

| | | |
|---|---|---|
| **Family planning services - other** | | |
| **Voluntary sterilization for males** | | |
| Outpatient | 90% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |
| **Termination of pregnancy** | | |
| Inpatient | 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 | 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. |
| | | |
| Physician's office | 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. |
| | | |
| **Jaw joint disorder treatment** | | |
| **Jaw joint disorder** treatment | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| | | |
| **Maternity and related newborn care** | | |
| Inpatient | 90% (of the **negotiated charge**) per admission | 70% (of the **recognized charge**) per admission |
| | | |
| **Delivery services and postpartum care services** | | |
| Performed in a facility or at a **physician's** office | 90% (of the **negotiated charge**) per visit | 70% (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. |
| | | |
| **Pregnancy complications** | | |
| Inpatient | 90% (of the **negotiated charge**) per admission | 70% (of the **recognized charge**) per admission |
| | | |

| Gender reassignment counseling, surgery and injectable hormone replacement therapy | | |
|---|---|---|
| | **In-network coverage** | **Out-of-network coverage** |
| Gender reassignment counseling, surgery and injectable hormone replacement therapy, including office visits and outpatient services | Covered based on type of service and where it is received. | Covered based on type of service and where it is received. |

| Obesity surgery | | |
|---|---|---|
| Inpatient **hospital** (includes surgical procedure and acute **hospital** services) | 90% (of the **negotiated charge**) per admission | Not covered |
| | | |
| **Outpatient obesity surgery** | | |
| | 90% (of the **negotiated charge**) per visit | Not covered |
| | | |
| **Oral and maxillofacial treatment (mouth, jaws and teeth)** | | |
| Oral and maxillofacial treatment (mouth, jaws and teeth) | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| | | |
| **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 |
| | | |

| Eligible health services | Network (IOE facility) | Network (Non-IOE facility) | Out-of-network coverage* |
|---|---|---|---|
| **Transplant services facility and non-facility** | | | |
| Inpatient **hospital** transplant services | 90% (of the **negotiated charge**) per transplant | 70% (of the **negotiated charge**) per transplant | 70% (of the **recognized charge**) per transplant |
| **Physician** services including office visits | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| | | | |

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| Eligible health services | In-network coverage* | Out-of-network coverage* |
|---|---|---|
| **Treatment of infertility** | | |
| **Basic infertility** | | |
| Basic **infertility** | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| | | |
| **Eligible health services** | **In-network coverage*** | **Out-of-network coverage*** |
| **6. Specific therapies and tests** | | |
| **Outpatient diagnostic testing** | | |
| **Diagnostic complex imaging services** | | |
| | 90% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |
| **Diagnostic lab work** | | |
| | 90% (of the **negotiated charge**) per visit. | 70% (of the **recognized charge**) per visit. |
| | | |
| **Diagnostic radiological services** | | |
| | 90% (of the **negotiated charge**) per visit. | 70% (of the **recognized charge**) per visit. |
| | | |
| **Chemotherapy** | | |
| Chemotherapy | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| | | |
| **Outpatient infusion therapy** | | |
| | 90% (of the **negotiated charge**) per visit. | 70% (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. |
| | | |

*See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

| Short-term cardiac and pulmonary rehabilitation services | | |
|---|---|---|
| **Cardiac rehabilitation** | | |
| Cardiac rehabilitation | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| | | |
| **Pulmonary rehabilitation** | | |
| Pulmonary rehabilitation | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| | | |

| Short-term rehabilitation services | | |
|---|---|---|
| **Outpatient Physical and Occupational Therapies** | | |
| | 90% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| **Outpatient Speech Therapy** | | |
| | 90% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |

| **Spinal manipulation** | | |
|---|---|---|
| Spinal manipulation | 90% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |
| Maximum visits per Calendar Year | 20 | 20 |
| | | |

| Habilitation therapy services | | |
|---|---|---|
| **Outpatient physical and occupational 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 |
| | | |
| **Outpatient speech 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 |
| | | |

| Eligible health services | In-network coverage* | Out-of-network coverage* |
|---|---|---|
| **7. Other services** | | |
| **Acupuncture** | | |
| Acupuncture | 90% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |
| Maximum visits per Calendar Year | 20 | 20 |
| | | |
| **Ambulance service** | | |
| Ground, air or water **ambulance** | 90% (of the **negotiated charge**) per trip | 90% (of the **recognized charge**) per trip |
| | | |
| **Clinical trial therapies (experimental or investigational)** | | |
| Clinical trial therapies | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| | | |
| **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** | 90% (of the **negotiated charge**) per item | 70% (of the **recognized charge**) per item |
| | | |
| **Hearing aids and exams** | | |
| Hearing aid exams | 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 | 90% (of the **negotiated charge**) per item | 70% (of the **recognized charge**) per item |
| Hearing aids | One per ear every 24 month consecutive period | One per ear every 24 month consecutive period |
| | | |
| **Nutritional supplements** | | |
| Nutritional supplements | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| | | |

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

| | | |
|---|---|---|
| **Osteoporosis** | | |
| **Physician's** office visits | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| | | |
| **Prosthetic and orthotic devices** | | |
| Prosthetic and orthotic devices | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| | | |
| **Vision care** | | |
| **Routine vision exams (including refraction)** | | |
| Performed by a licensed ophthalmologist or optometrist | 100% (of the **negotiated charge**) per visit<br><br>No **deductible** applies | 70% (of the **recognized charge**) per visit |
| | | |
| Maximum visits per 24 month consecutive period | 1 visit | 1 visit |
| | | |
| **All other outpatient services for which cost sharing is not shown above** | | |
| All other outpatient services | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| | | |

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

| Eligible health services | In-network coverage* | Out-of-network coverage* |
|---|---|---|
| **8. Outpatient prescription drugs** | | |
| **Plan features** | **Deductible/Copayment/Coinsurance/Maximums** | |

## 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 contraceptives

The Calendar Year **deductible** and the per **prescription copayment/coinsurance** will not apply to female contraceptive methods when obtained at a **network pharmacy**. This means that the following will be paid at 100%:

- Certain over-the-counter (OTC) and generic contraceptive **prescription drugs** and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. If a **generic prescription drug** or device is not available for a certain method, you may obtain certain **brand-name prescription drug** for that method paid at 100%. We will cover brand-name emergency contraceptive "Ella" until such time as a generic equivalent is approved by the FDA. At that time, only a generic equivalent will be covered.

The Calendar Year **deductible** and the per **prescription copayment/coinsurance** continue to apply to **prescription drugs** that have a generic equivalent or generic alternative available within the same **therapeutic drug class** obtained at a **network pharmacy** unless you are granted a medical exception.

## Deductible waiver for preventive prescription drugs

No **deductible** will apply to preventive covered **prescription drug** expenses for those **prescription drugs** used for:

The prevention of conditions relating to:

- Hypertension
- Heart disease
- Diabetic complications
- Asthmatic episodes
- Conditions resulting from osteoporosis
- Stroke
- Various pediatric conditions, such as vitamins and fluoride deficiency, and maternal and fetal problems during pregnancy

| **Partial fill dispensing for Schedule II controlled substances, such as opioids** | | |
|---|---|---|
| Partial fill dispensing allows less than the entire prescription to be filled at a **pharmacy**. You will pay a prorated amount of your cost share based on the size of the supply. | | |
| | | |
| **Preferred generic prescription drugs** | | |
| **Per prescription copayment/coinsurance** | | |
| For each fill up to a 30 day supply filled at a **retail pharmacy** | $10 **copayment** per supply<br><br>**Coinsurance** is 100% (of the **negotiated charge**) | Not Covered |
| More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy** | $20 **copayment** per supply<br><br>**Coinsurance** is 100% (of the **negotiated charge**) | Not Covered |
| | | |
| **Non-preferred generic prescription drugs** | | |
| **Per prescription copayment/coinsurance** | | |
| For each fill up to a 30 day supply filled at a **retail pharmacy** | $50 **copayment** per supply<br><br>**Coinsurance** is 100% (of the **negotiated charge**) | Not Covered |
| More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy** | $100 **copayment** per supply<br><br>**Coinsurance** is 100% (of the **negotiated charge**) | Not Covered |
| | | |
| **Preferred brand-name prescription drugs** | | |
| **Per prescription copayment/coinsurance** | | |
| For each fill up to a 30 day supply filled at a **retail pharmacy** | $30 **copayment** per supply<br><br>**Coinsurance** is 100% (of the **negotiated charge**) | Not Covered |
| More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy** | $60 **copayment** per supply<br><br>**Coinsurance** is 100% (of the **negotiated charge**) | Not Covered |
| | | |

| | | |
|---|---|---|
| **Non-preferred brand-name prescription drugs** | | |
| **Per prescription copayment/coinsurance** | | |
| For each fill up to a 30 day supply filled at a **retail pharmacy** | $50 **copayment** per supply<br><br>**Coinsurance** is 100% (of the **negotiated charge**) | Not Covered |
| More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy** | $100 **copayment** per supply<br><br>**Coinsurance** is 100% (of the **negotiated charge**) | Not Covered |
| | | |
| **Orally administered anti-cancer prescription drugs** | | |
| **Per prescription copayment/coinsurance** | | |
| For each fill up to a 30 day supply filled at a **retail pharmacy** | $0 **copayment** per supply<br><br>**Coinsurance** is 100% (of the **negotiated charge**) | Not Covered |
| More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy** | $0 **copayment** per supply<br><br>**Coinsurance** is 100% (of the **negotiated charge**) | Not Covered |
| | | |
| **Specialty drugs** | | |
| **Per prescription copayment/coinsurance** | | |
| For each fill up to a 30 day supply filled at a **retail pharmacy** | **Copayment** is 30% (of the **negotiated charge**) but will be no more than $250 per supply<br><br>**Coinsurance** is 100% (of the **negotiated charge**) | Not Covered |
| | | |

| **Preventive care drugs and supplements** | | |
|---|---|---|
| Preventive care drugs and supplements filled at a **pharmacy** | 100% per **prescription** or refill | Not Covered |
| | | |
| 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 secure member website at www.aetna.com or calling the number on your ID card. | |
| | | |

| | | |
|---|---|---|
| **Risk reducing breast cancer prescription drugs** | | |
| Risk reducing breast cancer **prescription drugs** filled at a **pharmacy** | 100% per **prescription** or refill | Not Covered |
| | | |
| 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 secure member website at www.aetna.com or calling the number on your ID card. | |
| | | |
| **Family planning services - female contraceptives** | | |
| If your **provider** recommends a particular service or FDA-approved item based on a determination of **medical necessity**, that service or item will be covered without cost sharing, regardless of whether it is generic or brand-name. We will defer to the determination made by your **provider**. **Medical necessity** may include considerations such as severity of side effects, differences in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the item or service, as determined by your **provider**. | | |
| Female contraceptives that are **generic prescription drugs:**<br>• Oral drugs<br>• Injectable drugs<br>• Vaginal rings<br>• Transdermal contraceptive patches | $0 per **prescription** or refill<br><br>No **deductible** applies | Not Covered |

| | | |
|---|---|---|
| Female contraceptives that are **brand-name prescription drugs:**<br><br>• Oral drugs<br>• Injectable drugs<br><br>• Vaginal rings<br><br>• Transdermal contraceptive patches | Paid according to the type of drug per the schedule of benefits, above | Not Covered |
| | | |
| **Tobacco cessation prescription and over-the-counter drugs** | | |
| Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** | $0 per **prescription** or refill<br><br>No **deductible** applies | Not Covered |
| | | |
| 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 tobacco cessation **prescription drugs** and OTC drugs, contact Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.<br><br>Coverage for tobacco cessation **prescription drugs** is not subject to any **precertification** requirements. | |
| | | |

If a **prescriber** prescribes a covered **brand-name prescription drug** where **a generic prescription drug** equivalent is available and specifies "Dispense As Written" (DAW), you will pay the cost sharing for the **brand-name prescription drug**. If a **prescriber** does not specify DAW and you request a covered **brand-name prescription drug** where a **generic prescription drug** is available, you will be responsible for the cost difference between **the brand-name prescription drug** and the **generic prescription drug**, plus the cost sharing that applies to the **brand-name prescription drug**.

*See *How to read your schedule of benefit, important note about your cost sharing and important notice* 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** that are subject to the **deductible** include **prescription drug eligible health services** provided under the medical plan **prescription drug** plan.

**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 in-network and out-of-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. This Calendar Year **deductible** applies separately to you and each of your covered dependents. After the amount you pay for **eligible health services** reaches the Calendar Year **deductible**, this plan will begin to pay for **eligible health services** for the rest of the Calendar Year.

**Family**
This is the amount you and your covered dependents owe for in-network and out-of-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. After the amount you and your covered dependents pay for **eligible health services** reach this family Calendar Year **deductible**, this plan will begin to pay for **eligible health services** that you and your covered dependents incur for the rest of the Calendar Year.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

- The combined **eligible health services** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

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

See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefit

## 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**. As it applies to in-network coverage, if **Aetna** compensates **network providers** on the basis of the reasonable amount, your percentage copayment is based on this amount.

## Coinsurance

The specific percentage you and the plan have to pay for a health care service listed in the schedule of benefits.

## Maximum out-of-pocket limits provisions

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

**Eligible health services** applied to the **out-of-network maximum out-of-pocket limit** will 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/coinsurance** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit** each of you must meet your **maximum out-of-pocket limit** separately.

**Individual**

Once the amount of the **copayments/coinsurance** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** or **recognized charge** for **covered benefits** that apply toward the limit for the rest of the Calendar Year for that person.

**Family**

Once the amount of the **copayments/coinsurance** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** or **recognized charge** for such **covered benefits** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefit

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
- All costs for non-emergency use of the emergency room
- All costs incurred for non-urgent use of an **urgent care provider**

## Maximum provisions

**Eligible health services** applied to the **out-of-network** maximum will not be applied to satisfy the network maximum and **eligible health services** applied to the network maximum will not be applied to satisfy the **out-of-network** maximum.

## Calculations; determination of recognized charge; determination of benefits provisions

Your financial responsibility for the costs of services will be calculated on the basis of when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than one Calendar Year. Determinations regarding when benefits are covered are subject to the terms and conditions of the certificate.

## Outpatient prescription drug maximum out-of-pocket limits provisions

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

See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefit