Choice POS II Medical Plan- High option

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:

Employer:	Institute for Advanced Study
Contract number:	MSA- 658955
	Schedule of Benefits 1A
Plan effective date:	January 1, 2020
Plan issue date:	March 13, 2020

These benefits are not insured with Aetna but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Aetna medical benefits plan.

Schedule of benefits

This schedule of benefits lists the **deductibles** and **copayments/payment percentage**, if any, that apply to the services you receive under this plan. You should review this schedule to become familiar with your **deductibles** and **copayments/payment percentage** 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/payment percentage** listed in the schedule of benefits below reflect the **deductibles** and **copayment/payment percentage** amounts under your plan.
- Any **payment percentage** listed in the schedule of benefits reflects the plan **payment percentage**. This is the amount the Plan pays. You are responsible to pay any **deductibles**, **copayments**, and the remaining **payment percentage**.
- 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/payment percentage** 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.

This schedule of benefits replaces any schedule of benefits previously in effect under your plan of benefits. Keep this schedule of benefits with your booklet.

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	$250 per Calendar Year	$500 per Calendar Year
Family	$500 per Calendar Year	$1,000 per Calendar Year
Deductible waiver		
The Calendar Year in-network **deductible** is waived for all of the following **eligible health services:** • Preventive care and wellness • Family planning services - female contraceptives		
Maximum out-of-pocket limit		
Maximum out-of-pocket limit per Calendar Year.		
Individual	$1,000 per Calendar Year	$2,500 per Calendar Year
Family	$2,000 per Calendar Year	$5,000 per Calendar Year
Precertification covered benefit reduction		
This only applies to out-of-network coverage. The booklet contains a complete description of the **precertification** program. You will find details on **precertification** requirements in the *Medical necessity and precertification requirements* section. Failure to **precertify** your **eligible health services** when required will result in the following benefits reduction: • A $400 benefit reduction will be applied separately to each type of **eligible health services** or • The **eligible health services** will not be covered. The additional percentage or dollar amount of the **recognized charge** which you may pay as a penalty for failure to obtain **precertification** is not a **covered benefit**, and will not be applied to the **deductible** amount or the **maximum out-of-pocket limit**, if any.		

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

Eligible health services	In-network coverage*	Out-of-network coverage*
Preventive care and wellness		
Routine physical exams		
Performed at a **physician's**, **PCP** office	100% per visit No **deductible** applies	100% (of the **recognized charge**) per visit No **deductible** applies
Covered persons through age 21:	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on 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
Preventive care immunizations		
Performed in a facility or at a **physician's** office	100% per visit No **deductible** applies	100% (of the **recognized charge**) per visit No **deductible** applies
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.

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Well woman preventive visits routine gynecological exams (including pap smears)		
Performed at a **physician's**, **PCP**, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit No **deductible** applies	100% (of the **recognized charge**) per visit No **deductible** applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
Maximum visits per Calendar Year	1 visit	1 visit
Preventive screening and counseling services		
Office visits • Obesity and/or healthy diet counseling • Misuse of alcohol and/or drugs • Use of tobacco products • Sexually transmitted infection counseling • Genetic risk counseling for breast and ovarian cancer	100% per visit No **deductible** applies	100% (of the **recognized charge**) per visit No **deductible** applies
Obesity and/or healthy diet counseling maximums:		
Maximum visits per 12 months (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.		

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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.		
Sexually transmitted infection counseling maximums:		
Maximum visits per 12 months	2 visits*	2 visits*
*Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.		
Genetic risk counseling for breast and ovarian cancer maximums:		
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations	Not subject to any age or frequency limitations
Routine cancer screenings (applies whether performed at a physician's, PCP, specialist office or facility)		
Routine cancer screenings	100% per visit No **deductible** applies	80% (of the **recognized charge**) per visit
Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.
Lung cancer screening maximums	1 screening every 12 months*	1 screening every 12 months*
***Important note**: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.		

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Prenatal care **Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)**		
Preventive care services only	100% per visit No **deductible** applies	80% (of the **recognized charge**) per visit
Important note: You should review the *Maternity and related newborn care* sections. They will give you more information on coverage levels for maternity care under this plan.		
Comprehensive lactation support and counseling services		
Lactation counseling services – facility or office visits	100% per visit No **deductible** applies	80% (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:** 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 No **deductible** applies	80% (of the **recognized charge**) per item
Important note: See the *Breast feeding durable medical equipment* section of the booklet for limitations on breast pump and supplies.		
Family planning services – female contraceptives		
Counseling services		
Female contraceptive counseling services office visit	100% per visit No **deductible** applies	80% (of the **recognized charge**) per visit
Contraceptive counseling services maximum visits per 12 months either in a group or individual setting	2 visits*	2 visits*
***Important note:** Any visits that exceed the contraceptive counseling services maximum are covered under **Physician** services office visits.		

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Devices		
Female contraceptive device provided, administered, or removed, by a **physician** during an office visit	100% per item No **deductible** applies	80% (of the **recognized charge**) per item
Female voluntary sterilization		
Inpatient	100% per admission No **deductible** applies	80% (of the **recognized charge**) per admission
Outpatient	100% per visit No **deductible** applies	80% (of the **recognized charge**) per visit
Eligible health services	**In-network coverage***	**Out-of-network coverage***
Physicians and other health professionals		
Physicians and **specialists** office visits (non-surgical)		
Physician services		
Office hours visits (non-surgical) non preventive care	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge**) per visit
Allergy injections		
Performed at a **physician's** or **specialist** office when you do not see the **physician**	100% (of the **negotiated charge**) per visit	80% (of the **recognized charge**) per visit
Immunizations that are not considered preventive care		
Immunizations that are not considered preventive care	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)	$20 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge**) per visit

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Physician surgical services		
Physicians and **specialists** office visits		
Performed at a **physician's**, **PCP** office	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge**) per visit
Performed at a **specialist's** office	$20 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge**) per visit
Alternatives to physician office visits		
Walk-in clinic visits		
Walk-in clinic non-emergency visit *(includes coverage for immunizations)*	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge**) per visit
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.

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Eligible health services	In-network coverage*	Out-of-network coverage*
Hospital and other facility care		
Hospital care		
Inpatient **hospital**	100% (of the **negotiated charge**) per admission	80% (of the **recognized charge**) per admission
Alternatives to hospital stays		
Outpatient surgery and physician surgical services		
	100% (of the **negotiated charge**) per visit	80% (of the **recognized charge**) per visit
Home health care		
Outpatient	100% (of the **negotiated charge**) per visit No **deductible** applies	80% (of the **recognized charge**) per visit
Maximum visits per Calendar Year	120 Limited to: 3 intermittent visits per day provided by a participating **home health care agency**; 1 visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge	120 Limited to: 3 intermittent visits per day provided by a participating **home health care agency**; 1 visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge
Hospice care		
Inpatient facility	100% (of the **negotiated charge**) per admission	80% (of the **recognized charge**) per admission
Maximum days per lifetime	Unlimited	Unlimited

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Hospice care		
Outpatient	100% (of the **negotiated charge**) per visit	80% (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 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 Part-time or intermittent home health aide services to care for you up to 8 hours a day
Skilled nursing facility		
Inpatient facility	100% (of the **negotiated charge**) per admission	80% (of the **recognized charge**) per admission
Maximum days per Calendar Year	120	120
Eligible health services	**In-network coverage***	**Out-of-network coverage***
Emergency services and urgent care		
Emergency services		
Hospital emergency room	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **deductible** applies	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 **payment percentage**), 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.
- A separate hospital emergency room **copayment/payment percentage** will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room **copayment/payment percentage** will be waived and your inpatient **copayment/payment percentage** will apply.

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Urgent care		
Urgent medical care (at a non-**hospital** free standing facility)	$25 then the plan pays 100% (of the balance of the **negotiated charge** thereafter) No **deductible** applies	$25 then the plan pays 100% (of the balance of the **recognized charge**) per visit thereafter
Non-urgent use of **urgent care provider** (at a non-**hospital** free standing facility)	Not covered	Not covered
A separate urgent care **deductible** or **copayment/payment percentage** will apply for each visit to an **urgent care provider**.		

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Eligible health services	In-network coverage*	Out-of-network coverage*
Specific conditions		
Autism spectrum disorder		
Autism spectrum 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
Applied behavior analysis	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
All other coverage for diagnosis and treatment, including behavioral therapy, will continue to be provided the same as any other **illness** under this plan.		
Birthing center		
Inpatient	100% (of the **negotiated charge**) per admission	80% (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	100% (of the **negotiated charge**) per visit	80% (of the **recognized charge**) per visit
Abortion		
Outpatient	100% (of the **negotiated charge**) per visit	80% (of the **recognized charge**) per visit
Maternity and related newborn care		
Inpatient	100% (of the **negotiated charge**) per admission	80% (of the **recognized charge**) per admission
Delivery services and postpartum care services		
Performed in a facility or at a **physician's** office	100% (of the **negotiated charge**) per visit	80% (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.

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Mental health treatment - inpatient		
Inpatient mental health treatment Inpatient **residential treatment facility** Coverage is provided under the same terms, conditions as any other **illness**.	100% (of the **negotiated charge**) per admission	80% (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 Coverage is provided under the same terms, conditions as any other **illness**.	$20 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge**) per visit
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** includes **telemedicine** cognitive behavioral therapy consultation	$20 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge**) per visit

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Other outpatient mental health treatment (includes skilled behavioral health services in the home) **Partial hospitalization treatment** **Intensive outpatient program** The cost share doesn't apply to in-network peer counseling support services	100% (of the **negotiated charge**) per visit No **deductible** applies	80% (of the **recognized charge**) per visit
Substance related disorders treatment - inpatient		
Inpatient **substance abuse detoxification** during a **hospital** confinement Inpatient **substance abuse** rehabilitation during a **hospital** confinement Inpatient **residential treatment facility** during a **hospital** confinement Coverage is provided under the same terms, conditions as any other **illness**.	100% (of the **negotiated charge**) per admission	80% (of the **recognized charge**) per admission
Substance related disorders treatment - outpatient: detoxification and rehabilitation		
Outpatient **substance abuse** office visits to a **physician** or **behavioral health provider** (includes **telemedicine** consultation) Coverage is provided under the same terms, conditions as any other **illness**.	$20 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge**) per visit

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Outpatient **substance abuse** office visits to a **physician** or **behavioral health provider** includes **telemedicine** cognitive behavioral therapy consultations Coverage is provided under the same terms, conditions as any other **illness**.	$20 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge**) per visit
Other outpatient **substance abuse** services **Partial hospitalization treatment** **Intensive outpatient program** The cost share doesn't apply to in-network peer counseling support services.	100% (of the **negotiated charge**) per visit No **deductible** applies	80% (of the **recognized charge**) per visit
Obesity surgery		
Inpatient **hospital** (includes surgical procedure and acute **hospital** services)	100% (of the **negotiated charge**) per admission	Not covered
Outpatient obesity surgery		
	100% (of the **negotiated charge**) per visit	Not covered

Oral and maxillofacial treatment (mouth, jaws and teeth)		
Oral and maxillofacial treatment (mouth, jaws and teeth)	100% (of the **negotiated charge**) per visit	80% (of the **recognized charge**) per visit

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Reconstructive breast surgery		
Reconstructive breast **surgery**	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Reconstructive surgery and supplies		
Reconstructive **surgery**	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Eligible health services	**Network (IOE facility)**	**Network (Non-IOE facility)**	**Out-of-network coverage***
Transplant services facility and non-facility			
Inpatient **hospital** transplant services	100% (of the **negotiated charge**) per transplant	80% (of the **negotiated charge**) per transplant	80% (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.

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
Outpatient comprehensive infertility services		
	100% (of the **negotiated charge**) per visit	80% (of the **recognized charge**) per visit
Outpatient ART services		
	100% (of the **negotiated charge**) per visit	80% (of the **recognized charge**) per visit

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Eligible health services	In-network coverage*	Out-of-network coverage*
Specific therapies and tests		
Outpatient diagnostic testing		

Diagnostic complex imaging services		
	100% (of the **negotiated charge**) per visit	80% (of the **recognized charge**) per visit
Diagnostic lab work		
	100% (of the **negotiated charge**) per visit.	80% (of the **recognized charge**) per visit.
Diagnostic radiological services		
	100% (of the **negotiated charge**) per visit.	80% (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		
	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 radiation therapy		
Radiation therapy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Short-term cardiac and pulmonary rehabilitation services		
Cardiac rehabilitation		
Cardiac rehabilitation	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

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Short-term rehabilitation services		
Outpatient Physical, Occupational and Speech Therapies		
	$20 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge**) per visit

Maximum visits per Calendar Year	90	90

Habilitation therapy services		
	$20 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge**) per visit

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Eligible health services	In-network coverage*	Out-of-network coverage*
Other services		
Acupuncture		
Acupuncture	$20 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge**) per visit
Maximum visits per Calendar Year	30	30
Ambulance service		
Ground, air or water **ambulance**	100% (of the **negotiated charge**) per trip	100% (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	100% (of the **negotiated charge**) per item	80% (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 Covered persons through age 15 years and younger	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge**) per visit
Hearing aids	One per ear every 24 month consecutive period	One per ear every 24 month consecutive period
Maximum per 24 month period	$1,000	$1,000

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Non-preventive hearing exams		
For adults and children	100% (of the **negotiated charge**) per visit No **deductible** applies.	80% (of the **recognized charge**) per visit
Maximum	One exam in any 24 consecutive month period.	
Prosthetic devices		
Prosthetic devices	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per item thereafter No **deductible** applies	80% (of the **recognized charge**) per item
Spinal manipulation		
Spinal manipulation	$20 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	80% (of the **recognized charge**) per visit
Maximum visits per Calendar Year	20	20
Vision care		
Routine vision care		
Routine vision exams (including refraction)		
Performed by a legally qualified ophthalmologist or optometrist	100% (of the **negotiated charge**) per visit No **deductible** applies	Not covered
Maximum visits per 24 month consecutive period	1 visit	Not covered

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Eligible health services*	
Outpatient prescription drugs	
Family planning services - female contraceptives	
Female contraceptives that are **generic prescription drugs**: • Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches	100% per **prescription** or refill No **deductible** applies
Female contraceptives that are **brand-name prescription drugs**: • Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches	100% per **prescription** or refill No **deductible** applies
Female contraceptive generic devices and brand-name devices	100% per **prescription** or refill No **deductible** applies
Preventive care drugs and supplements	
Preventive care drugs and supplements filled at a **pharmacy**	100% per **prescription** or refill No **deductible** applies

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Risk reducing breast cancer prescription drugs	
Risk reducing breast cancer **prescription drugs** filled at a **pharmacy**	100% per **prescription** or refill No **deductible** applies
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 secure member website at www.aetna.com or calling the number on your ID card.
Tobacco cessation prescription and over-the-counter drugs	
Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** for each 90 day supply	$0 per **prescription** or refill No **deductible** applies
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below. 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 secure member website at www.aetna.com or calling the number on your ID card.

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

General coverage provisions

This section provides detailed explanations about the:

- **Deductible**
- **Maximum out-of-pocket limits**
- Maximums

that are listed in the first part of this schedule of benefits.

Deductible provisions

Eligible health services applied to the out-of-network **deductibles** will be applied to satisfy the in-network **deductibles**. **Eligible health services** applied to the in-network **deductibles** will 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/payment percentage** 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.

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**.

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

Payment percentage

The specific percentage the plan pays 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 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 be applied to satisfy the out-of-network **maximum out-of-pocket limit**.

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments/payment percentage** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit** each of you must meet your **maximum out-of-pocket limit** separately.

Individual

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

Family

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

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

- The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members. The family **maximum out-of-pocket limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **maximum out-of-pocket limit** amount in a Calendar Year.

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

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/payment percentage** 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**
- As it applies to out-of-network coverage: Charges, expenses or costs in excess of the **recognized charge**

Maximum provisions

Eligible health services applied to the **out-of-network** maximum will be applied to satisfy the network maximum and **eligible health services** applied to the network maximum will be applied to satisfy the **out-of-network** maximum.

Calculations; determination of recognized charge; determination of benefits provisions

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

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