# Schedule of benefits

**Prepared for:**

| | |
|---|---|
| Policyholder: | State of Alaska – Political Subdivision |
| Policyholder number: | GP-0392675 |
| Control number: | 0181162 |
| Group policy effective date: | July 1, 2022 |
| Plan name: | Open Choice - Political Subdivision under the Option II Plan |
| Schedule of Benefits: | 1A |
| Plan effective date: | July 1, 2023 |
| Plan issue date: | May 12, 2026 |
| Plan revision effective date: | July 1, 2026 |

**Underwritten by Aetna Life Insurance Company in the state of Alaska**



# Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles**, **copayments** or **coinsurance**, if any apply to the **covered services** you receive under the plan. You should review this schedule to become aware of these and any limits that apply to these services.

## How your cost share works

- The **deductibles** and **copayments**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
  - For the **covered services** under your medical plan, you will be responsible for the dollar amount
  - For pharmacy benefits where a percentage cost share acts like a **copayment**, you will be responsible for the percentage amount
- **Coinsurance** amounts, if any, listed in the schedule below are what the plan will pay for **covered services**.
- Sometimes your cost share shows a combination of your dollar amount **copayment** that you will be responsible for and the **coinsurance** percentage that your plan will pay.
- You are responsible to pay any **deductibles**, **copayments** and remaining **coinsurance**, if they apply and before the plan will pay for any **covered services**.
- This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits. They may be:
  - Combined limits between in-network and **out-of-network providers**
  - Separate limits for in-network and **out-of-network providers**
  - Based on a rolling, 12-month period starting with the date of your most recent visit under this plan

  See the schedule for more information about limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.

For examples of how cost share and **deductible** work, go to the *Using your Aetna benefits* section under Individuals & Families at https://www.aetna.com/

**Important note:**
**Covered services** are subject to the Calendar Year **deductible**, maximum out-of-pocket, limits, **copayment** or **coinsurance** unless otherwise stated in this schedule. The *Surprise bill* section in the certificate explains your protections from a surprise bill.

Your **out-of-network** cost share is based on the **allowable amount**. Refer to the *Allowable amount* in *What the plan pays and what you pay* in *yo*ur certificate.

## How your deductible works

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **copayment** or **coinsurance** you pay when you get **covered services** from an in-network or **out-of-network provider**.

This schedule shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **covered services**. You will continue to pay **copayments** or **coinsurance**, if any, for **covered services** after you meet your **deductible**.

### How your PCP or physician office visit cost share works

You will pay the **PCP** cost share when you get **covered services** from the **PCP** you select. You will pay a higher cost share when you get **covered services** from a **PCP** that is not your **PCP**. If you did not select a **PCP**, you will pay a higher cost share for **covered services** from any **PCP**, network **physician** or **specialist**.

### How your maximum out-of-pocket works

This schedule shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of that year.

## Contact us

We are here to answer questions. See the *Contact us* section in your certificate.

Aetna Life Insurance Company's group policy provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your certificate.

## Plan features

### Precertification covered services reduction

This only applies to out-of-network **covered services**:
Your certificate contains a complete description of the **precertification** process. You will find details in the *How your plan works - Medical necessity and precertification requirements* section.

If **precertification** for **covered services** isn't completed, when required, it results in the following benefit reduction:

- A $400 benefit reduction applied separately to each type of **covered service**

You may have to pay an additional portion of the **allowable amount** because you didn't get **precertification**. This portion is not a **covered service** and doesn't apply to your **deductible** or **maximum out-of-pocket limit**, if you have one.

### Deductible

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

| Deductible type | In-network | Out-of-network |
|---|---|---|
| Individual | $500 per year | $500 per year |
| Family | $1,500 per year | $1,500 per year |

### Per admission deductible

| Per admission deductible type | In-network | Out-of-network |
|---|---|---|
| Per admission **deductible** | Not applicable | $500 per admission |

### Maximum out-of-pocket limit

Includes the **deductible**.

| Maximum out-of-pocket type | In-network | Out-of-network |
|---|---|---|
| Individual | $1,500 per year | $1,500 per year |
| Family | $4,500 per year | $4,500 per year |

### Prescription drug - outpatient maximum out-of-pocket limit

| Maximum out-of-pocket type | In-network | Out-of-network |
|---|---|---|
| Individual | $1,000 per year | $1,000 per year |
| Family | $3,000 per year | $3,000 per year |

## General coverage provisions

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

### Deductible provisions

**Covered services** apply to the in-network and out-of-network **deductibles.**

The **deductible** may not apply to some **covered services**. You still pay the **copayment** or **coinsurance**, if any, for these **covered services**.

#### Individual deductible

You pay for **covered services** each year before the plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. After the amount paid reaches the individual **deductible**, this plan starts to pay for **covered services** for the rest of the year.

#### Family deductible

You pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this family **deductible**, this plan starts to pay for **covered services** for the rest of the year. To satisfy this family **deductible** for the rest of the year, the combined **covered services** that you and each of your covered dependents incur toward the individual **deductible** must reach this family **deductible** in a year. When this happens in a year, the individual **deductibles** for you and your covered dependents are met for the rest of the year.

### Copayment

This is the dollar amount you pay for **covered services**. In most plans, you pay this after you meet your **deductible** limit. In **prescription** drug plans, it is the amount you pay for covered drugs.

### Coinsurance

This is the percentage of **covered services** you pay after your **deductible**.

### Per admission cost share or deductible

A separate cost share or **deductible** may apply per facility. This is in addition to any other cost share or **deductible** applicable under this plan. It may apply to each **stay** or on a per day basis up to a per admission maximum amount. If you are in the same type of facility more than once, and your **stays** are separated by less than 10 days (regardless of cause), only one per admission cost share or **deductible** will apply. Not more than three per admission cost shares or **deductibles** will apply for a facility type during the year. **Covered services** applied to the per admission **deductible** can't be applied to any other **deductible** required under the plan. **Covered services** applied to the plan's other **deductible** will not apply to the per admission **deductible**.
The per admission **deductible** is equal to a facility's **semi-private room rate** for one day. For the **stay** of a well newborn baby, starting at birth, this amount will not exceed the facility's actual **room and board** charge on the first day of the **stay**.

## Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **coinsurance** and **deductible**, if any, for **covered services**.

**Covered services** apply to the in-network and out-of-network **maximum out-of-pocket limit**.

### Individual maximum out-of-pocket limit

- This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of you must meet your **maximum out-of-pocket limit** separately.
- After you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the year for that person.

### Family maximum out-of-pocket limit

After you or your covered dependents meet the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the remainder of the year for all covered family members. The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members.

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

- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit** amount.

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

- All costs for non-**covered services** which are identified in the certificate and the schedule
- Charges, expenses or costs in excess of the **allowable amount**

## Limit provisions

**Covered services** will apply to the in-network and out-of-network limits.

## Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of **covered services** on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the group policy.

## Prescription drug - outpatient maximum out-of-pocket limit provisions

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **coinsurance** and **deductible**, if any, for **covered services**. This plan may have an individual and family **maximum out-of-pocket limit**.

For purposes of the following **maximum out-of-pocket limit** provisions:

- The individual **maximum out-of-pocket limit** applies to a person enrolled for self-only coverage with no dependent coverage
- The family **maximum out-of-pocket limit** applies to a person enrolled with one or more dependents
- The family **maximum out-of-pocket limit** is met by a combination of family members or by any single individual within the family

### Individual prescription drug maximum out-of-pocket limit

Once the amount of the cost share and **deductible** you have paid during the year for **covered services** meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that apply toward the limit for you for the remainder of the year.

### Family prescription drug maximum out-of-pocket limit

After the amount of the cost share and **deductible** you and your covered dependent pay for **covered services** during the year meets the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charges for **covered services** that apply toward the limit for the rest of the year for all covered family members.

This plan has an individual and family **prescription** drug **maximum out-of-pocket limit**.

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

- The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members. The family **prescription** drug **maximum out-of-pocket limit** is met by a combination of family members with no single person in the family contributing more than the individual **maximum out-of-pocket limit** in a year.

When this happens, the individual **maximum out-of-pocket limit** is also met for the rest of the year.

The **maximum out-of-pocket limit** may not apply to certain **covered services**. If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit**.

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

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

## Covered services

### Abortion

| Description | In-network | Out-of-network |
|---|---|---|
| Abortion | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

### Acupuncture

| Description | In-network | Out-of-network |
|---|---|---|
| Acupuncture | 80% per visit after **deductible** | 80% per visit after **deductible** |
| Visit limit per year | 10 | 10 |

### Ambulance services

| Description | In-network | Out-of-network |
|---|---|---|
| **Emergency services** | 80% per trip after **deductible** | Paid same as in-network |
| Non-**emergency services** ground, air, or water ambulance | Not covered | Not covered |

### Applied behavior analysis

| Description | In-network | Out-of-network |
|---|---|---|
| Applied behavior analysis | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

### Autism spectrum disorder

| Description | In-network | Out-of-network |
|---|---|---|
| Diagnosis and testing | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| Treatment | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Behavioral health

### Mental health treatment

Coverage provided is the same as for any other illness

| Description | In-network | Out-of-network |
|---|---|---|
| Inpatient services - **room and board** including **residential treatment facility** | 80% per admission after **deductible** | $500 then the plan pays 60% per admission after **deductible** |
| Other inpatient services and supplies<br>Other **residential treatment facility** services and supplies | 80% per admission after **deductible** | 60% per admission after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| Outpatient office visit to a **physician** or **behavioral health provider** | 80% per visit after **deductible** | 80% per visit after **deductible** |
| **Physician** or **behavioral health provider telemedicine** consultation | 80% per visit after **deductible** | 80% per visit after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| Other outpatient services including:<br>• Behavioral health services in the home<br>• Partial hospitalization treatment<br>• Intensive outpatient program<br><br>The cost share doesn't apply to in-network peer counseling support services | 80% per visit after **deductible** | 80% per visit after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| **Telemedicine provider mental health disorders** consultation | Covered based on type of service and **provider** from which it is received | Not covered |

**Substance related disorders treatment**

Includes **detoxification**, rehabilitation and **residential treatment facility**

Coverage provided is the same as for any other illness

| Description | In-network | Out-of-network |
|---|---|---|
| Inpatient services-**room and board** during a **hospital stay** | 80% per admission after **deductible** | $500 then the plan pays 60% per admission after **deductible** |
| Other inpatient services and supplies during a **hospital stay** | 80% per admission after **deductible** | 60% per admission after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| Outpatient office visit to a **physician** or **behavioral health provider** | 80% per visit after **deductible** | 80% per visit after **deductible** |
| **Physician** or **behavioral health provider telemedicine** consultation | 80% per visit after **deductible** | 80% per visit after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| Other outpatient services including:<br>• Behavioral health services in the home<br>• Partial hospitalization treatment<br>• Intensive outpatient program<br><br>The cost share doesn't apply to in-network peer counseling support services | 80% per visit after **deductible** | 80% per visit after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| **Telemedicine provider substance related disorders** consultation | Covered based on type of service and **provider** from which it is received | Not covered |

## Clinical trials

| Description | In-network | Out-of-network |
|---|---|---|
| **Experimental or investigational** therapies | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| Routine patient costs | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Diabetic services, supplies, equipment, and self-care programs

| Description | In-network | Out-of-network |
|---|---|---|
| Diabetic services | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| Diabetic supplies | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| Diabetic equipment | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| Diabetic self-care programs | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Durable medical equipment (DME)

| Description | In-network | Out-of-network |
|---|---|---|
| DME | 80% per item after **deductible** | 80% per item after **deductible** |

## Emergency services

| Description | In-network | Out-of-network |
|---|---|---|
| Emergency room | 80% per visit after **deductible** | Paid same as in-network |
| Non-emergency care in a **hospital** emergency room | 50% per visit after **deductible** | 50% per visit after **deductible** |

**Emergency services important note:**
**Out-of-network providers** do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill.

## Habilitation therapy services

### Outpatient physical (PT), occupational (OT) therapies

| Description | In-network | Out-of-network |
|---|---|---|
| PT, OT therapies | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

### Outpatient speech therapy (ST)

| Description | In-network | Out-of-network |
|---|---|---|
| ST therapy | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Hearing aids and exams

| Description | |
|---|---|
| Hearing aids | 80% per item after **deductible** |
| Hearing aids | 80% after **deductible** |

| | |
|---|---|
| Maximum per Plan Year | $1,000 |

## Home health care

A visit is a period of 4 hours or less

| Description | In-network | Out-of-network |
|---|---|---|
| Home health care | 80% per visit after **deductible** | 80% per visit after **deductible** |

**Home health care important note:**
Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits.

## Hospice care

| Description | In-network | Out-of-network |
|---|---|---|
| Inpatient services - **room and board** | 80% per admission after **deductible** | $500 then the plan pays 80% per admission after **deductible** |
| Other inpatient services and supplies | 80% per admission after **deductible** | 80% per admission after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| Outpatient services | 80% per visit after **deductible** | 80% per visit after **deductible** |

**Hospice important note:**
This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8 hours a day.

## Hospital care

| Description | In-network | Out-of-network |
|---|---|---|
| Inpatient services – **room and board** | 80% after **deductible** | $500 then the plan pays 60% per admission after **deductible** |

| | | |
|---|---|---|
| Other inpatient services and supplies | 80% after **deductible** | 60% after **deductible** |

## Infertility services

### Basic infertility

| Description | In-network | Out-of-network |
|---|---|---|
| Treatment of basic infertility | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Jaw joint disorder

Includes TMJ

| Description | In-network | Out-of-network |
|---|---|---|
| **Jaw joint disorder** treatment | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Maternity and related newborn care

Includes complications

| Description | In-network | Out-of-network |
|---|---|---|
| Inpatient services – **room and board** | 80% per admission after **deductible** | $500 then the plan pays 60% per admission after **deductible** |
| Other inpatient services and supplies | 80% per admission after **deductible** | 60% per admission after **deductible** |
| Services performed in **physician** or **specialist** office or a facility | 80% per visit after **deductible** | 80% per visit after **deductible** |
| Other services and supplies | 80% per visit after **deductible** | 80% per visit after **deductible** |

**Maternity and related newborn care important note:**
Any cost share collected applies only to the delivery and postpartum care services provided by an OB, GYN, OB/GYN, midwife, or other **provider**. Review the *Maternity* section of the certificate. It will give you more information about coverage for maternity care under this plan.

## Nutritional support

| Description | In-network | Out-of-network |
|---|---|---|
| Nutritional support | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Oral and maxillofacial treatment (mouth, jaws and teeth)

| Description | In-network | Out-of-network |
|---|---|---|
| Treatment of mouth, jaws and teeth | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Outpatient surgery

| Description | In-network | Out-of-network |
|---|---|---|
| At **hospital** outpatient department | 80% per visit after **deductible** | 60% per visit after **deductible** |
| At facility that is not a **hospital** | 80% per visit after **deductible** | 80% per visit after **deductible** |
| At the **physician** office | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Physician and specialist services

## Physician services-general or family practitioner

Including surgical services

| Description | In-network | Out-of-network |
|---|---|---|
| **Physician** office hours (not-surgical, not preventive) | 80% per visit after **deductible** | 80% per visit after **deductible** |
| **Physician** surgical services | 80% per visit after **deductible** | 80% per visit after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| **Physician** visit during inpatient **stay** | 80% per visit after **deductible** | 80% per visit after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| **Physician telemedicine** consultation | 80% per visit after **deductible** | 80% per visit after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| **Telemedicine provider** consultation<br><br>Basic medical services | Covered based on type of service and **provider** from which it is received | Not covered |

## Specialist

| Description | In-network | Out-of-network |
|---|---|---|
| **Specialist** office hours (not-surgical, not preventive) | 80% per visit after **deductible** | 80% per visit after **deductible** |
| **Specialist** surgical services | 80% per visit after **deductible** | 80% per visit after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| **Specialist telemedicine** consultation | 80% per visit after **deductible** | 80% per visit after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| **Telemedicine provider** consultation<br><br>**Specialist** services | Covered based on type of service and **provider** from which it is received | Not covered |

## All other services not shown above

| Description | In-network | Out-of-network |
|---|---|---|
| All other services | 80% per visit after **deductible** | 80% per visit after **deductible** |

## Prescription drugs - outpatient

### Preferred generic prescription drugs

| Description | In-network | Out-of-network |
|---|---|---|
| 30 day supply at a **retail pharmacy** | $0, no **deductible** applies | 80%, no **deductible** applies |
| 90 day supply at a **retail pharmacy** | $0, no **deductible** applies | 80%, no **deductible** applies |
| 90 day supply at a **mail order pharmacy** | $0, no **deductible** applies | 80%, no **deductible** applies |

### Non-preferred generic prescription drugs

| Description | In-network | Out-of-network |
|---|---|---|
| 30 day supply at a **retail pharmacy** | $30 or 30% whichever is greater but no more than $75, no **deductible** applies | 80%, no **deductible** applies |
| 90 day supply at a **retail pharmacy** | $30 or 30% whichever is greater but no more than $75, no **deductible** applies | 80%, no **deductible** applies |
| 90 day supply at a **mail order pharmacy** | $30 or 30% whichever is greater but no more than $75, no **deductible** applies | 80%, no **deductible** applies |

### Preferred brand-name prescription drugs

| Description | In-network | Out-of-network |
|---|---|---|
| 30 day supply at a **retail pharmacy** | $15 or 20% whichever is greater but no more than $50, no **deductible** applies | 80%, no **deductible** applies |
| 90 day supply at a **retail pharmacy** | $15 or 20% whichever is greater but no more than $50, no **deductible** applies | 80%, no **deductible** applies |
| 90 day supply filled at a **mail order pharmacy** | $15 or 20% whichever is greater but no more than $50, no **deductible** applies | 80%, no **deductible** applies |

### Non-preferred brand-name prescription drugs

| Description | In-network | Out-of-network |
|---|---|---|
| 30 day supply at a **retail pharmacy** | $30 or 30% whichever is greater but no more than $75, no **deductible** applies | 80%, no **deductible** applies |
| 90 day supply at a **retail pharmacy** | $30 or 30% whichever is greater but no more than $75, no **deductible** applies | 80%, no **deductible** applies |
| 90 day supply at a **mail order pharmacy** | $30 or 30% whichever is greater but no more than $75, no **deductible** applies | 80%, no **deductible** applies |

### Anti-cancer drugs taken by mouth

| Description | In-network | Out-of-network |
|---|---|---|
| 30 day supply | $0, no **deductible** applies | 80%, no **deductible** applies |

### Contraceptives (birth control)

**Brand-name prescription drugs** and devices are covered at 100% at a network pharmacy when a generic is not available

| Description | In-network | Out-of-network |
|---|---|---|
| 30 day supply or up to 12 month supply of generic and OTC drugs and devices | $0, no **deductible** applies | Paid based on the tier of drug in the schedule |
| 30 day supply or up to 12 month supply of **brand-name prescription drugs** and devices | Paid based on the tier of drug in the schedule | Paid based on the tier of drug in the schedule |

### Infertility drugs

| Description | In-network | Out-of-network |
|---|---|---|
| Infertility drugs | Paid based on the tier of drug in the schedule | Paid based on the tier of drug in the schedule |

### Diabetic supplies, drugs

| Description | In-network | Out-of-network |
|---|---|---|
| 30 day supply at a **retail pharmacy** | Paid based on the tier of drug in the schedule | Paid based on the tier of drug in the schedule |

### Formulary name insulin

| Description | In-network | Out-of-network |
|---|---|---|
| 30 day supply at a **retail pharmacy** | $25, no **deductible** applies | Paid based on the tier of drug in the schedule |

**Preventive care drugs and supplements**

| Description | In-network | Out-of-network |
|---|---|---|
| Preventive care drugs and supplements | $0, no **deductible** applies | Paid based on the tier of drug in the schedule |
| Limits | Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF).<br><br>For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section | Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF).<br><br>For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section |

**Risk reducing breast cancer prescription drugs**

| Description | In-network | Out-of-network |
|---|---|---|
| Risk reducing breast cancer **prescription** drugs | $0, no **deductible** applies | Paid based on the tier of drug in the schedule |
| Limits | Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF.<br><br>For a current list of risk reducing breast cancer drugs or more information, see the *Contact us* section. | Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF.<br><br>For a current list of risk reducing breast cancer drugs or more information, see the *Contact us* section. |

**Tobacco cessation prescription and OTC drugs (preventive care)**

| Description | In-network | Out-of-network |
|---|---|---|
| Tobacco cessation **prescription** and OTC drugs | $0, no **deductible** applies for the first two 90-day treatment programs.<br><br>Additional treatment programs will be paid based on the tier of drug in the schedule. | Paid based on the tier of drug in the schedule |
| Limits | Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF.<br><br>For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section. | Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF.<br><br>For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section. |

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

## Preventive care

| Description | In-network | Out-of-network |
|---|---|---|
| Preventive care services | 100% per visit, no **deductible** applies | 100% per visit, no **deductible** applies |
| Breast feeding counseling and support | 100% per visit, no **deductible** applies | 100% per visit, no **deductible** applies |
| Breast feeding counseling and support limit | 6 visits in a group or individual setting<br><br>Visits that exceed the limit are covered under the **physician** services office visit | 6 visits in a group or individual setting<br><br>Visits that exceed the limit are covered under the **physician** services office visit |
| Breast pump, accessories and supplies | 100% per visit, no **deductible** applies | 100% per visit, no **deductible** applies |
| Breast pump, accessories and supplies limit | Electric pump: 1 every 1 year<br><br>Manual pump: 1 per pregnancy<br><br>Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump | Electric pump: 1 every 1 year<br><br>Manual pump: 1 per pregnancy<br><br>Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump |
| Breast pump waiting period | Electric pump: 1 year to replace an existing electric pump | Electric pump: 1 year to replace an existing electric pump |
| Counseling for alcohol or drug misuse | 100% per visit, no **deductible** applies | 100% per visit, no **deductible** applies |
| Counseling for alcohol or drug misuse visit limit | 5 visits/12 months | 5 visits/12 months |
| Counseling for obesity, healthy diet | 100% per visit, no **deductible** applies | 100% per visit, no **deductible** applies |
| Counseling for obesity, healthy diet visit limit | Age 0-22: unlimited visits<br><br>Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling. | Age 0-22: unlimited visits<br><br>Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling. |
| Counseling for sexually transmitted infection | 100% per visit, no **deductible** applies | 100% per visit, no **deductible** applies |
| Counseling for sexually transmitted infection visit limit | 2 visits/12 months | 2 visits/12 months |
| Counseling for tobacco cessation | 100% per visit, no **deductible** applies | 100% per visit, no **deductible** applies |
| Counseling for tobacco cessation visit limit | 8 visits/12 months | 8 visits/12 months |
| Family planning services (female contraception counseling) | 100% per visit, no **deductible** applies | 100% per visit, no **deductible** applies |
| Family planning services (female contraception counseling) limit | Contraceptive counseling limited to 2 visits/12 months in a group or individual setting<br><br>Counseling that exceeds this limit covered as a physician services office visit | Contraceptive counseling limited to 2 visits/12 months in a group or individual setting<br><br>Counseling that exceeds this limit covered as a physician services office visit |
| Immunizations | 100%, no **deductible** applies | 100% per visit, no **deductible** applies |

| | | |
|---|---|---|
| Immunizations limit | Subject to any age 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 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** |
| Routine cancer screenings | 100% per visit, no **deductible** applies | 100% per visit, no **deductible** applies |
| Routine cancer screening limits | Subject to any age, family history and frequency guidelines as set forth in the most current:<br><br>Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF<br><br>The comprehensive guidelines supported by the Health Resources and Services Administration<br><br>For more information contact your **physician** or see the *Contact us* section | Subject to any age, family history and frequency guidelines as set forth in the most current:<br><br>Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF<br><br>The comprehensive guidelines supported by the Health Resources and Services Administration<br><br>For more information contact your **physician** or see the *Contact us* section |
| Routine lung cancer screening limit | 1 screening every 12 months<br><br>Screenings that exceed this limit are covered as outpatient diagnostic testing | 1 screening every 12 months<br><br>Screenings that exceed this limit are covered as outpatient diagnostic testing |
| Routine physical exam | 100% per visit, no **deductible** applies | 100% per visit, no **deductible** applies |
| Routine physical exam limits | 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 for children and adolescents<br><br>Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 18; 1 exam every 12 months after age 18<br><br>High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 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 for children and adolescents<br><br>Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 18; 1 exam every 12 months after age 18<br><br>High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months |
| Well woman GYN exam | 100% per visit, no **deductible** applies | 100% per visit, no **deductible** applies |
| Well woman GYN exam limit | Age 18 and over or recommended by a physician | Age 18 and over or recommended by a physician |
| Limit | 1 visit | 1 visit |

### Prosthetic devices

| Description | In-network | Out-of-network |
|---|---|---|
| Prosthetic devices | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

### Reconstructive surgery and supplies

Including breast **surgery**

| Description | In-network | Out-of-network |
|---|---|---|
| **Surgery** and supplies | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

### Short-term rehabilitation services

#### Cardiac rehabilitation

| Description | In-network | Out-of-network |
|---|---|---|
| Cardiac rehabilitation | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

#### Pulmonary rehabilitation

| Description | In-network | Out-of-network |
|---|---|---|
| Pulmonary rehabilitation | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

#### Cognitive rehabilitation

| Description | In-network | Out-of-network |
|---|---|---|
| Cognitive rehabilitation | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

#### Physical and occupational therapies

| Description | In-network | Out-of-network |
|---|---|---|
| | 80% per visit after **deductible** | 80% per visit after **deductible** |

#### Speech therapy (ST)

| Description | In-network | Out-of-network |
|---|---|---|
| | 80% per visit after **deductible** | 80% per visit after **deductible** |

#### Spinal manipulation

| Description | In-network | Out-of-network |
|---|---|---|
| | 80% per visit after **deductible** | 80% per visit after **deductible** |

### Skilled nursing facility

| Description | In-network | Out-of-network |
|---|---|---|
| Inpatient services - **room and board** | 80% per admission after **deductible** | $500 then the plan pays 80% per admission after **deductible** |
| Other inpatient services and supplies | 80% per admission after **deductible** | 80% per admission after **deductible** |

| | | |
|---|---|---|
| Day limit per year | 120 | 120 |

## Tests, images and labs – outpatient

### Diagnostic complex imaging services

| Description | In-network | Out-of-network |
|---|---|---|
| | 80% per visit after **deductible** | 80% per visit after **deductible** |

### Diagnostic lab work

| Description | In-network | Out-of-network |
|---|---|---|
| | 80% per visit after **deductible** | 80% per visit after **deductible** |

### Diagnostic x-ray and other radiological services

| Description | In-network | Out-of-network |
|---|---|---|
| | 80% per visit after **deductible** | 80% per visit after **deductible** |

## Therapies

### Chemotherapy

| Description | In-network | Out-of-network |
|---|---|---|
| Chemotherapy services | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

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

| Description | In-network (GCIT-designated facility/provider) | Out-of-network (Including **providers** who are otherwise part of Aetna's network but are not GCIT-designated facilities/**providers**) |
|---|---|---|
| Services and supplies | Covered based on type of service and where it is received | Not covered |
| Gene therapy products, **prescription** drugs | 80% after **deductible** | Not covered |

### Infusion therapy

Outpatient services

| Description | In-network | Out-of-network |
|---|---|---|
| | 80% per visit after **deductible** | 80% per visit after **deductible** |

### Radiation therapy

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

### Respiratory therapy

| Description | In-network | Out-of-network |
|---|---|---|
| Respiratory therapy | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Transplant services

| Description | In-network (IOE facility) | Out-of-network (Includes **providers** who are otherwise part of Aetna's network but are non-IOE **providers**) |
|---|---|---|
| Inpatient services and supplies | 80% per transplant after **deductible** | $500 then the plan pays 60% per transplant after **deductible** |
| **Physician** services | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Urgent care services

At a freestanding facility or **provider** that is not a **hospital**
A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

| Description | In-network | Out-of- network |
|---|---|---|
| Urgent care facility | 80% per visit after **deductible** | 80% per visit after **deductible** |

## Vision care

Performed by an ophthalmologist or optometrist and includes refraction

| Description | In-network | Out-of-network |
|---|---|---|
| | 100% per visit, no **deductible** applies | 100% per visit, no **deductible** applies |

| | | |
|---|---|---|
| Visit limit | 1 visit every 12 months | 1 visit every 12 months |

## Walk-in clinic

Not all preventive care services are available at a **walk-in clinic**. All services are available from a network **physician**.

| Description | In-network | Out-of-network |
|---|---|---|
| Non-**emergency services** | 80% per visit after **deductible** | 80% per visit after **deductible** |
| Preventive care immunizations | 100% per visit, no **deductible** applies | 100% per visit, no **deductible** applies |
| Preventive care 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** |
| Preventive screening and counseling services | 100% per visit, no **deductible** applies | 100% per visit, no **deductible** applies |
| Preventive screening and counseling limits | See the *Preventive care* section of the schedule | See the *Preventive care* section of the schedule |