# Choice POS II High Deductible Health Plan

## 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**: | Rider University |
| **Contract** number: | ASA-724497 |
| **Control** number: | 884014 |
| | Schedule of Benefits 3B |
| Plan effective date: | January 1, 2019 |
| Plan issue date: | March 26, 2019 |

**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 Navigator® 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 | $2,000 per Calendar Year | $3,000 per Calendar Year |
| | | |
| Family | $4,000 per Calendar Year | $6,000 per Calendar Year |
| | | |
| **Deductible waiver** | | |
| The Calendar Year in-network **deductible** is waived for all of the following **eligible health services:**<br>• Preventive care and wellness<br>• Family planning services - female contraceptives | | |
| | | |
| **Maximum out-of-pocket limit** | | |
| **Maximum out-of-pocket limit** per Calendar Year. | | |
| Individual | $2,000 per Calendar Year | $6,000 per Calendar Year |
| | | |
| Family | $4,000 per Calendar Year | $12,000 per Calendar Year |
| | | |

*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<br><br>No **deductible** applies | 70% (of the **recognized charge**) per visit |
| 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.<br><br>For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on 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 Navigator® 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<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 Navigator® 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.<br><br>For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on 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<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 |
| | | |
| **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. | | |
| | | |

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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<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 Navigator® 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:<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 Navigator® 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**:<br>Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section. | | |
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*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

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| **Prenatal care**<br>**Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)** | | |
| Preventive care services only | 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. | | |
| | | |
| **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 for limitations on breast pump and supplies. | | |
| | | |
| **Family planning services – female contraceptives** | | |
| **Counseling services** | | |
| Female contraceptive counseling services office visit | 100% per visit<br><br>No **deductible** applies | 70% (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:**<br>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<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 |
| | | |
| **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 | 100% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |
| **Telemedicine** consultation by a **physician**, **PCP** | 100% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |
| Maximum visits per day | 1 | 1 |
| | | |
| **Telemedicine** consultation by a **specialist** | 100% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |
| Maximum visits per day | 1 | 1 |
| | | |
| **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) | 100% (of the **negotiated charge**) per visit | 70% (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 | 100% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| Performed at a **specialist's** office | 100% (of the **negotiated charge**) per visit | 70% (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)* | 100% (of the **negotiated charge**) per visit | 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 Navigator® 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.<br><br>For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on 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 | 70% (of the **recognized charge**) per admission |
| | | |
| **Alternatives to hospital stays** | | |
| **Outpatient surgery and physician surgical services** | | |
| | 100% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |
| **Home health care** | | |
| Outpatient | 100% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| Maximum visits per Calendar Year | 200<br><br>Limited to: 1 intermittent visit 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<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 10 days of discharge | 200<br><br>Limited to: 1 intermittent visit 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<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 10 days of discharge |
| | | |
| **Hospice care** | | |
| Inpatient facility | 100% (of the **negotiated charge**) per admission | 70% (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 | 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 | 100% (of the **negotiated charge**) per admission | 70% (of the **recognized charge**) per admission |
| Maximum days per Calendar Year | 90 | 90 |
| | | |
| **Eligible health services** | **In-network coverage*** | **Out-of-network coverage*** |
| **Emergency services and urgent care** | | |
| **Emergency services** | | |
| **Hospital** emergency room | 100% (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:**<br>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. | | |
| | | |
| **Urgent care** | | |
| Urgent medical care (at a non-**hospital** free standing facility) | 100% (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* |
|---|---|---|
| **Specific conditions** | | |
| **Birthing center** | | |
| Inpatient | 100% (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 | 100% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |
| **Abortion** | | |
| Outpatient | 100% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |
| **Maternity and related newborn care** | | |
| Inpatient | 100% (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 | 100% (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. |
| | | |
| **Mental health treatment - inpatient** | | |
| Inpatient mental health treatment<br><br>Inpatient **residential treatment facility**<br><br>Coverage is provided under the same terms, conditions as any other **illness**. | 100% (of the **negotiated charge**) per admission | 70% (of the **recognized charge**) per admission |
| | | |

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

| Mental health treatment - outpatient | | |
|---|---|---|
| Outpatient mental health treatment<br><br>Coverage is provided under the same terms, conditions as any other **illness**. | 100% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |
| **Substance related disorders treatment - inpatient** | | |
| Inpatient **substance abuse detoxification** during a **hospital** confinement<br><br>Inpatient **substance abuse** rehabilitation during a **hospital** confinement<br><br>Inpatient **residential treatment facility** during a **hospital** confinement<br><br>Coverage is provided under the same terms, conditions as any other **illness**. | 100% (of the **negotiated charge**) per admission | 70% (of the **recognized charge**) per admission |
| | | |
| **Substance related disorders treatment - outpatient: detoxification and rehabilitation** | | |
| Outpatient **substance abuse** treatment<br><br>Coverage is provided under the same terms, conditions as any other **illness**. | 100% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |
| **Obesity surgery** | | |
| Inpatient **hospital** (includes surgical procedure and acute **hospital** services) | 100% (of the **negotiated charge**) per admission | 70% (of the **recognized charge**) per admission |
| | | |

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

| Outpatient obesity surgery | | |
|---|---|---|
| | 100% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |

| Oral and maxillofacial treatment (mouth, jaws and teeth) | | |
|---|---|---|
| Oral and maxillofacial treatment (mouth, jaws and teeth) | 100% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |
| **Reconstructive breast surgery** | | |
| Reconstructive breast **surgery** | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| | | |
| **Reconstructive surgery and supplies** | | |
| Reconstructive **surgery** | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| | | |

| 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 | 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. |
| | | | |

| 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 |
| | | |

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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 | 70% (of the **recognized** charge) per visit |
| | | |
| **Diagnostic lab work** | | |
| | 100% (of the **negotiated charge**) per visit | 70% (of the **recognized** charge) per visit |
| | | |
| **Diagnostic radiological services** | | |
| | 100% (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** | | |
| | 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. |
| | | |

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|---|---|---|
| **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, Occupational and Speech Therapies** | | |
| | 100% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |

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

| **Acupuncture** | | |
|---|---|---|
| Acupuncture | 100% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |
| **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 | 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 | 100% (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 |
| | | |
| Maximum per 24 months | $1,000 | $1,000 |
| | | |

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| **Non-preventive hearing exams** | | |
|---|---|---|
| For adults and children | 100% (of the **negotiated charge**) per visit<br><br>No **deductible** applies. | 70% (of the **recognized charge**) per visit |
| | | |

| | |
|---|---|
| Maximum | One exam in any 24 consecutive month 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 |
| | | |
| **Prosthetic devices** | | |
| Prosthetic 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 |
| | | |
| **Spinal manipulation** | | |
| Spinal manipulation | 100% (of the **negotiated charge**) per visit | 70% (of the **recognized charge**) per visit |
| | | |
| **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<br><br>No **deductible** applies | Not covered |
| | | |
| Maximum visits per 24 month consecutive period | 1 visit | 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* |
|---|---|---|
| **Outpatient prescription drugs** | | |
| **Plan features** | **Deductible/Copayment/Payment Percentage/Maximums** | |
| **Deductible and copayment/payment percentage waiver for risk reducing breast cancer prescription drugs** | | |
| The Calendar Year **deductible** and the per **prescription copayment/payment percentage** 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/payment percentage waiver for tobacco cessation prescription and over-the-counter drugs** | | |
| The Calendar Year **deductible** and the per **prescription copayment/payment percentage** will not apply to two 90-day treatment regimens for tobacco cessation **prescription drugs** and OTC drugs when obtained at a **network pharmacy**. This means that such **prescription drugs** and OTC drugs will be paid at 100%. | | |
| | | |
| **Deductible and copayment/payment percentage waiver for contraceptives** | | |
| The Calendar Year **deductible** and the per **prescription copayment/payment percentage** will not apply to female contraceptive methods when obtained at a **network pharmacy**. This means that the following will be paid at 100%:<br><br>• 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 drugs** for that method paid at 100%.<br><br>The Calendar Year **deductible** and the per **prescription copayment/payment percentage** 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. | | |
| | | |
| **Important note**:<br>Review the *How to access out-of-network pharmacies* section of the booklet for more information on how these **pharmacies** are subject to higher out-of-pocket costs. | | |
| | | |

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

| Generic prescription drugs (including specialty drugs) | | |
|---|---|---|
| **Per prescription copayment/payment percentage** | | |
| For each fill up to a 30 day supply filled at a **retail pharmacy** | **Copayment** is 0% (of the **negotiated charge**)<br><br>**Payment percentage** is 100% (of the **negotiated charge**) | **Deductible** is 0% (of the **recognized charge**)<br><br>**Payment percentage** is 70% (of the **recognized charge**) |
| More than a 30 day supply but less than a 61 day supply filled at a **retail pharmacy** | **Copayment** is 0% (of the **negotiated charge**)<br><br>**Payment percentage** is 100% (of the **negotiated charge**) | **Deductible** is 0% (of the **recognized charge**)<br><br>**Payment percentage** is 70% (of the **recognized charge**) |
| More than a 60 day supply but less than a 91 day supply filled at a **retail pharmacy** | **Copayment** is 0% (of the **negotiated charge**)<br><br>**Payment percentage** is 100% (of the **negotiated charge**) | **Deductible** is 0% (of the **recognized charge**)<br><br>**Payment percentage** is 70% (of the **recognized charge**) |
| More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy** | **Copayment** is 0% (of the **negotiated charge**)<br><br>**Payment percentage** is 100% (of the **negotiated charge**) | Not covered |

| Brand-name prescription drugs (including specialty drugs) | | |
|---|---|---|
| **Per prescription copayment/payment percentage** | | |
| For each fill up to a 30 day supply filled at a **retail pharmacy** | **Copayment** is 0% (of the **negotiated charge**)<br><br>**Payment percentage** is 100% (of the **negotiated charge**) | **Deductible** is 0% (of the **recognized charge**)<br><br>**Payment percentage** is 70% (of the **recognized charge**) |
| More than a 30 day supply but less than a 61 day supply filled at a **retail pharmacy** | **Copayment** is 0% (of the **negotiated charge**)<br><br>**Payment percentage** is 100% (of the **negotiated charge**) | **Deductible** is 0% (of the **recognized charge**)<br><br>**Payment percentage** is 70% (of the **recognized charge**) |
| More than a 60 day supply but less than a 91 day supply filled at a **retail pharmacy** | **Copayment** is 0% (of the **negotiated charge**)<br><br>**Payment percentage** is 100% (of the **negotiated charge**) | **Deductible** is 0% (of the **recognized charge**)<br><br>**Payment percentage** is 70% (of the **recognized charge**) |
| More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy** | **Copayment** is 0% (of the **negotiated charge**)<br><br>**Payment percentage** is 100% (of the **negotiated charge**) | Not covered |

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| **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 Navigator® secure member website at www.aetna.com or calling the number on your ID card. | |
| | | |

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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 | 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 Navigator® 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** | $0 per **prescription** or refill<br><br>No **deductible** applies | Not covered |
| | | |
| Maximums: | Coverage is permitted for two 90-day treatment regimens only.<br><br>Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card. | |
| | | |

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## 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/payment percentage** for **eligible health services** to which the **deductible** does not apply.

For purposes of the Calendar Year **deductible** provision below, an individual means an employee enrolled for self only coverage with no dependent coverage and a family means an employee enrolled with one or more dependents. The family **deductible** can be met by one family member, or a combination of family members. For purposes of the Calendar Year **deductible** provision below:

- The individual **deductible** applies to a person who is enrolled for self only coverage with no dependent coverage
- The family **deductible** applies to a person who is enrolled with one or more dependents. The family **deductible** can be met by one family member, or a combination of family members.

**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**. After the amount you pay for **eligible health services** reaches this individual 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.

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## 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**.

## 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 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 **payment percentage** and **deductibles** for **eligible health services** during the Calendar Year. This plan has 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 dependents 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** can be met by a combination of family members or by any single individual within the family.

**Individual**
Once the amount of the **payment percentage** and **deductibles** you have paid during the Calendar Year for **eligible health services** meet the Individual **maximum out-of-pocket limit** this plan will pay 100% of **covered benefits** that apply toward the limit for you for the remainder of the Calendar Year.

**Family**
Once the amount of the **payment percentage** and **deductibles** paid during the Calendar Year for **eligible health services** meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the family's **covered benefits** that apply toward the limit for the rest of the 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**/**payment percentage** for that covered benefit will not count toward satisfying the **maximum out-of-pocket limit** amount.

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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.

## 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 benefits* at the beginning of this schedule of benefits