Choice POS II Medical Plan

New Jersey Educator Health Plan

Schedule of Benefits

Prepared exclusively for:

Employer:	Newark Board of Education
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Control number:	0176696
Schedule of Benefits	3A
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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	$0 per Calendar Year	$350 per Calendar Year
Family	$0 per Calendar Year	$700 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	$500 per Calendar Year	$2,000 per Calendar Year
Family	$1,000 per Calendar Year	$5,000 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 No **deductible** applies	Not covered
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 member website at www.aetna.com or calling the number on your ID card.	Not applicable
Covered persons age 22 and over but less than 65: Maximum visits per Calendar Year	1 visit	Not applicable
Covered persons age 65 and over: Maximum visits per Calendar Year months	1 visit	Not applicable
Preventive care immunizations		
Performed in a facility or at a **physician's** office	100% per visit No **deductible** applies	Not covered except covered persons through age 12 months: 70% (of the **recognized charge**) after the deductible
	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	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 • 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	Not covered
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)*	Not applicable
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Maximum visits per 12 months	5 visits*	Not applicable
*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*	Not applicable
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Maximum visits per 12 months	2 visits*	Not applicable
*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	Not subject to any age or frequency limitations	Not applicable
Routine cancer screenings (applies whether performed at a physician's, PCP, specialist office or facility)		
Routine cancer screenings	100% per visit No **deductible** applies	Not covered
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.	Not applicable
Lung cancer screening maximums	1 screening every 12 months*	Not applicable
***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	70% (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.		
Lactation counseling services – facility or office visits	100% per visit 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:** Any visits that exceed the lactation counseling services maximum are covered under **Physician** services office visits.		
Breast pump supplies and accessories	100% per item No **deductible** applies	70% (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.		
Counseling services		
Female contraceptive counseling services office visit	100% per visit 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:** 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	70% (of the **recognized charge**) per item
Female voluntary sterilization		
Inpatient	100% per admission No **deductible** applies	70% (of the **recognized charge**) per admission
Outpatient	100% per visit 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	$10 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	70% (of the **recognized charge**) per visit
***Telemedicine Consultations**		
**The plan may utilize one or more telemedicine vendors. To obtain information regarding potential cost share when utilizing a telemedicine vendor, contact member services at the number on your ID card.*		
Performed at a **physician's** or **specialist** office when you do not see the **physician**	100% (of the **negotiated charge**) per visit No **deductible** applies	70% (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.	Not covered

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Specialist		
Specialist office visits		
Office hours visits (non-surgical)	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	70% (of the **recognized charge**) per visit
Physician surgical services		
Physicians and **specialists** office visits		
Performed at a **physician's**, **PCP** office	$10 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	70% (of the **recognized charge**) per visit
Performed at a **specialist's** office	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	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)*	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter 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. 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 No **deductible** applies	70% (of the **recognized charge**) per admission
Alternatives to hospital stays		
Outpatient surgery and physician surgical services		
	100% (of the **negotiated charge**) per visit No **deductible** applies	70% (of the **recognized charge**) per visit
Home health care		
Outpatient	100% (of the **negotiated charge**) per visit No **deductible** applies	70% (of the **recognized charge**) per visit
	Limited to: 3 intermittent visits per day provided by a participating **home health care agency**; 1 visit equals a period of 4 hours. Intermittent visits are considered periodic and recurring visits that skilled nurses or home health aides 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	Limited to: 3 intermittent visits per day provided by a participating **home health care agency**; 1 visit equals a period of 4 hours. Intermittent visits are considered periodic and recurring visits that skilled nurses or home health aides 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 No **deductible** applies	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 No **deductible** applies	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 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

Outpatient private duty nursing		
Outpatient private duty nursing	90% (of the **negotiated charge**) per visit No **deductible** applies	70% (of the **recognized charge**) per visit

Skilled nursing facility		
Inpatient facility	100% (of the **negotiated charge**) per admission No **deductible** applies	70% (of the **recognized charge**) per admission
Maximum days per Calendar Year	120	60

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Eligible health services	In-network coverage*	Out-of-network coverage*
Emergency services and urgent care		
Emergency services		
Hospital emergency room No copayment if admitted	$125 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.		
Urgent medical care (at a non-**hospital** free standing facility)	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	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
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 No **deductible** applies	70% (of the **recognized charge**) per admission
Diabetic equipment, supplies and education		
Diabetic equipment, supplies and education	90% (of the **negotiated charge**) per item/visit No **deductible** applies	70% (of the **recognized charge**) per item/visit
Family planning services - other		
Voluntary sterilization for males		
Outpatient	100% (of the **negotiated charge**) per visit No **deductible** applies	70% (of the **recognized charge**) per visit
Abortion		
Outpatient	100% (of the **negotiated charge**) per visit No **deductible** applies	70% (of the **recognized charge**) per visit
Jaw joint disorder treatment		
Jaw joint disorder treatment	100% (of the **negotiated charge**) per visit	70% (of the **recognized charge**) per visit

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	No **deductible** applies	
Maternity and related newborn care		
Inpatient	100% (of the **negotiated charge**) per admission No **deductible** applies	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 No **deductible** applies	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 Inpatient **residential treatment facility** Coverage is provided under the same terms, conditions as any other **illness**.	100% (of the **negotiated charge**) per admission No **deductible** applies	70% (of the **recognized charge**) per admission
Mental health treatment - outpatient		
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** includes **telemedicine** consultation Coverage is provided under the same terms, conditions as any other **illness**.	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	70% (of the **recognized charge**) per visit
Outpatient mental health treatment office visits to a **physician** or **behavioral health**	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter	70% (of the **recognized charge**) per visit

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provider includes **telemedicine** cognitive behavioral therapy consultation	No **deductible** applies	
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	70% (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 No **deductible** applies	70% (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**	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	70% (of the **recognized charge**) per visit

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consultation) Coverage is provided under the same terms, conditions as any other **illness**.		
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**.	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	70% (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	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 No **deductible** applies	70% (of the **recognized charge**) per admission
Outpatient obesity surgery		
	100% (of the **negotiated charge**) per visit No **deductible** applies	70% (of the **recognized charge**) per visit

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Oral and maxillofacial treatment (mouth, jaws and teeth)		
Oral and maxillofacial treatment (mouth, jaws and teeth)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Reconstructive 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**	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 No **deductible** applies	70% (of the **negotiated charge**) per transplant	70% (of the **recognized charge**) per transplant
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

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Eligible health services	In-network coverage*	Out-of-network coverage*
Treatment of infertility		
Basic infertility		
Basic **infertility**	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Outpatient comprehensive infertility services		
	100% (of the **negotiated charge**) per visit No **deductible** applies	70% (of the **recognized charge**) per visit
Outpatient ART services		
	100% (of the **negotiated charge**) per visit No **deductible** applies	70% (of the **recognized charge**) per visit
Maximum per lifetime**	4 completed egg retrievals per lifetime	4 completed egg retrievals per lifetime
As used for this benefit, "lifetime" is defined to include covered benefits paid under this plan or another plan underwritten and/or administered by **Aetna or any **Aetna** affiliate, with the same policyholder		

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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 No **deductible** applies	70% (of the **recognized charge**) per visit
Diagnostic lab work		
	100% (of the **negotiated charge**) per visit. No **deductible** applies	70% (of the **recognized charge**) per visit.
Diagnostic radiological services		
	100% (of the **negotiated charge**) per visit. No **deductible** applies	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

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

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Outpatient infusion therapy		
Performed in a **physician's** office	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies.	70% (of the **recognized charge**) per visit
Performed in a person's home	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies.	70% (of the **recognized charge**) per visit
Performed in the outpatient department of a **hospital**	100% (of the **negotiated charge**) per visit No **deductible** applies.	70% (of the **recognized charge**) per visit
Performed at an outpatient facility other than the outpatient department of a **hospital**	100% (of the **negotiated charge**) per visit No **deductible** applies.	70% (of the **recognized charge**) per visit
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.
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	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 Speech and Occupational Therapies		
	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	70% (of the **recognized charge**) per visit
Outpatient Physical Therapy		
	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	Lesser of $52 **copayment** per visit or 75% of the **negotiated charge**

Habilitation therapy services		
	100% (of the **negotiated charge**) per visit No **deductible** applies	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	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	Lesser of $60 **copayment** per visit or 75% (of the **negotiated charge**)
Ambulance service		
Ground, air or water **ambulance**	90% (of the **negotiated charge**) per trip No **deductible** applies.	70% (of the **recognized charge**) per trip
Clinical trial therapies (experimental or investigational)		
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Clinical trials (routine patient costs)		
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Durable medical equipment (DME)		
DME	90% (of the **negotiated charge**) per item No **deductible** applies.	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 for dependents to age 16 only	$10 then the plan pays 100% (of the balance of the **negotiated charge**) per item No **deductible** applies	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

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Maximum per 24 months	$1,000	$1,000

Non-preventive hearing exams		
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.	70% (of the **recognized charge**) per visit

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	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per item thereafter No **deductible** applies	70% (of the **recognized charge**) per item
Spinal manipulation		
Spinal manipulation	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	Lesser of $35 **copayment** per visit or 75% of the **negotiated charge**
Maximum visits per Calendar Year	30	30

Routine vision care		
Routine vision exams (including refraction)		
Performed by a legally qualified ophthalmologist or optometrist	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per item thereafter No **deductible** applies	Not covered
Maximum visits per 12 month consecutive period	1 visit	Not covered

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Eligible health services*	
Outpatient prescription drugs	
Prescription drugs	70% (of the **recognized charge**) **prescription** or refill No **deductible** applies
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
FDA-approved female generic and brand-name emergency contraceptives	100% per **prescription** or refill No **deductible** applies
FDA-approved female generic and brand-name over-the-counter (OTC) emergency contraceptives	100% per **prescription** or refill No **deductible** applies

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

Preventive care drugs and supplements	
Preventive care drugs and supplements filled at a **pharmacy**	100% per **prescription** or refill No **deductible** applies
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 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.
Individual This is the amount you owe for 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 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.
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**.
The specific percentage the plan pays for a health care service listed in the schedule of benefits.

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

Maximum out-of-pocket limits provisions

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

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments/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.

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**
- Any out of pocket costs for outpatient **prescription drugs**
- 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

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

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