OA Elect Choice EPO

Schedule of benefits

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

Prepared exclusively for:

Policyholder:	Aspen HR PEO, LLC
Policyholder number:	GP-0175126
Control number**:**	CN-0175126
	CN-0175127
	CN-0175128
	CN-0175129
Schedule of Benefits:	3A
	Open Access Elect Choice $0 100% Plan
Group policy effective date:	September 1, 2021
Plan effective date:	September 1, 2021
Plan issue date:	September 1, 2022
Plan revision effective date:	September 1, 2022

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

Schedule of benefits

This schedule of benefits lists the **copayments**/**coinsurance** that apply to the services you receive under this plan. You should review this schedule to become familiar with your **copayments/coinsurance** and any limits that apply to the services.

How to read your schedule of benefits

- When we say:
  - "In-network coverage", we mean you get care from a **network provider**.
- "The **copayments**/**coinsurance** listed in the schedule of benefits below reflects the **copayment/coinsurance** amounts under your plan.
- You are responsible to pay any **copayments** and **coinsurance**.
- The **coinsurance** listed in the schedule of benefits reflects the plan **coinsurance** percentage. This is the **coinsurance** amount the plan pays. You are responsible for paying any remaining **coinsurance**.
- You are responsible for full payment of any health care services you receive that are not a **covered benefit**.
- This plan has maximums for specific **covered benefits**. For example, these could be visit, day or dollar maximums.
- At the end of this schedule you will find detailed explanations about your:
  - **Maximum out-of-pocket limits**
  - Maximums

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

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

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

Per admission copayment	
Per admission **copayment**	$300 per day up to 5 days per admission
Maximum out-of-pocket limit	
Maximum out-of-pocket limit per Calendar Year.	
Individual	$4,000 per Calendar Year
Family	$8,000 per Calendar Year

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

Eligible health services	In-network coverage*
1. Preventive care and wellness	
Routine physical exams	
Performed at a **physician's**, **PCP** office	100% per visit No **deductible** applies
Covered persons through age 21: Maximum age and visit limits per 12 months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your **physician** or Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.
Covered persons age 22 and over but less than 65: Maximum visits per 12 months	1 visit
Covered persons age 65 and over: Maximum visits per 12 months	1 visit
Preventive care immunizations	
Performed in a facility or at a **physician's** office	100% per visit No **deductible** applies
	Subject to any age and visit 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.

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

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
Maximums	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

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

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)*
*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*
*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*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	
Genetic risk counseling for breast and ovarian cancer maximums:	
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations
Routine cancer screenings (applies whether performed at a physician's, PCP, specialist office or facility)	
Routine cancer screenings	100% per visit No **deductible** applies
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 member website at www.aetna.com or calling the number on your ID card.
Lung cancer screening maximums	1 screening every 12 months*
Important note: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.	
Prenatal care **Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)**	
Preventive care services only (includes participation in the California Prenatal Screening Program	100% per visit No **deductible** applies
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.	

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

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Eligible health services	In-network coverage*
2. Physicians and other health professionals	
Physicians and **specialists** office visits (non-surgical)	
Physician services	
Office hours visits (non-surgical) non preventive care	$25 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Telemedicine consultation by a **physician, PCP**	$25 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Telemedicine consultation by a **specialist**	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies

Allergy injections	
Performed at a **physician's**, **PCP** or **specialist** office when you do not see the **physician**	100% (of the **negotiated charge**) per visit No **deductible** applies
Immunizations when not part of the physical exam	
Immunizations when not part of the physical exam	Covered according to the type of benefit and the place where the service is received.
Specialist	
Specialist office visits	
Office hours visits (non-surgical)	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies

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Physician surgical services

Physicians and **specialists** office visits

Performed at a **physician's**, **PCP** office	$25 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Performed at a **specialist's** office	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies

Walk-in clinic visits

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

	Network Benefit Level	
Description	**Designated network coverage**	**Non-designated network coverage**
Non-emergency services	100% (of the **negotiated charge**) per visit, no **deductible** applies	$25 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter, no **deductible** applies
Preventive care immunizations	100% (of the **negotiated charge**) per visit, no **deductible** applies	100% (of the **negotiated charge**) per visit, no **deductible** applies
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 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 For details, contact your **physician**
Preventive screening and counseling services	100% (of the **negotiated charge**) per visit, no **deductible** applies	100% (of the **negotiated charge**) per visit, no **deductible** applies
Preventive screening and counseling limits	See the *Preventive care services* section of the SOB	See the *Preventive care services* section of the SOB

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

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

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

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Eligible health services	In-network coverage*
3. Hospital and other facility care	
Hospital care	
Inpatient **hospital**	100% (of the **negotiated charge**) per admission, after the per admission **copayment** No **deductible** applies
Alternatives to hospital stays	
Outpatient surgery and physician surgical services	
	$300 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Home health care	
Outpatient	100% (of the **negotiated charge**) per visit No **deductible** applies
Maximum visits per Calendar Year	120 Limited to: 3 intermittent visits per day provided by a participating home health care agency; 1 visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 14 days of discharge
Hospice care	
Inpatient facility	100% (of the **negotiated charge**) per admission, after the per admission **copayment** No **deductible** applies
Maximum days per lifetime	Unlimited

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Hospice care	
Outpatient	100% (of the **negotiated charge**) per visit No **deductible** applies
	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	100% (of the **negotiated charge**) per visit No **deductible** applies
Maximum visits/shifts per Calendar Year	70 shifts Up to eight hours equal one shift.
Skilled nursing facility	
Inpatient facility	100% (of the **negotiated charge**) per admission, after the per admission **copayment** No **deductible** applies
Maximum days per Calendar Year	60

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Eligible health services	In-network coverage*
4. Emergency services and urgent care	
Emergency services	
Hospital emergency room	$350 then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **deductible** applies
Non-emergency care in a **hospital** emergency room	Not covered
Important Note: • As **out-of-network providers** do not have a contract with us the **provider** may not accept payment of your cost share (**deductible, copayment,** and **coinsurance**) as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by this plan. If the **provider** bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, and we will resolve any payment dispute with the **provider** over that amount. Make sure the member's ID number is on the bill. • A separate hospital emergency room **copayment/coinsurance** will apply for each visit to an emergency room. If you are admitted to a **hospita**l as an inpatient right after a visit to an emergency room, your emergency room **copayment/coinsurance** will be waived and your inpatient **copayment/coinsurance** will apply.	
Urgent Care	
Urgent medical care (at a non-**hospital** free standing facility)	$85 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Non-urgent use of **urgent care provider** (at a non-**hospital** free standing facility)	Not covered

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Eligible health services	In-network coverage*
5. Specific conditions	

Behavioral health **Mental health treatment - inpatient**	
Inpatient mental health treatment Coverage is provided under the same terms, conditions as any other **illness**.	100% (of the **negotiated charge**) per admission, after the per admission copayment No **deductible** applies
Mental health treatment - outpatient	
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** (includes **telemedicine** consultation)	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
All other outpatient mental health treatment as described in your [booklet-certificate] (includes skilled behavioral health services in the home) **Partial hospitalization treatment** **Intensive outpatient program**	100% (of the **negotiated charge**) per visit No **deductible** applies

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Substance related disorders treatment - inpatient	
Inpatient **substance abuse detoxification** Inpatient **substance abuse** rehabilitation Inpatient residential treatment facility	100% (of the **negotiated charge**) per admission, after the per admission copayment No **deductible** applies
Substance related disorders treatment - outpatient: detoxification and rehabilitation	
Outpatient **substance abuse office** visits to a **physician** or **behavioral health provider** (includes **telemedicine** consultation)	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
All other outpatient **substance abuse** services (as described in your booklet-certificate) **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
Birthing Center	
Inpatient	100% (of the **negotiated charge**) per admission, after the per admission copayment No **deductible** applies
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.

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Family planning services - other	
Voluntary sterilization for males	
Outpatient	100% (of the **negotiated charge**) per visit No **deductible** applies
Termination of pregnancy	
Inpatient	Covered according to the type of benefit and the place where the service is received.
Outpatient	Covered according to the type of benefit and the place where the service is received.
Physician's office	Covered according to the type of benefit and the place where the service is received.
Jaw joint disorder treatment	
Jaw joint disorder treatment	Covered according to the type of benefit and the place where the service is received
Maternity and related newborn care	
Inpatient	100% (of the **negotiated charge**) per admission, after the per admission copayment No **deductible** applies
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
Other prenatal care services	Covered according to the type of benefit and the place where the service is received.
Pregnancy complications	
Inpatient	100% (of the **negotiated charge**) per admission, after the per admission copayment No **deductible** applies

Gender reassignment counseling, surgery and injectable hormone replacement therapy	
Gender reassignment counseling	Covered according to the type of benefit and the place where the service is received.
Gender reassignment surgery	$300 plus 100% (of the balance of the **negotiated charge**) per admission No **deductible** applies
Gender reassignment injectable hormone therapy	Covered according to the type of benefit and the place where the service is received.
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
Reconstructive surgery and supplies	
Reconstructive **surgery**	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)
Transplant services facility and non-facility		
Inpatient **hospital** transplant services	100% (of the **negotiated charge**) per transplant, after the per admission copayment No **deductible** applies	Not covered
Physician services including office visits	Covered according to the type of benefit and the place where the service is received	Not covered

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Eligible health services	In-network coverage*
Treatment of infertility	
Basic infertility	
Basic **infertility**	Covered according to the type of benefit and the place where the service is received

Eligible health services	In-network coverage*
6. Specific therapies and tests	
Outpatient diagnostic testing	
Diagnostic complex imaging services	
	$250 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Diagnostic lab work	
	100% (of the **negotiated** charge) per visit. No **deductible** applies.

Diagnostic radiological services	
	100% (of the **negotiated charge**) per visit. No **deductible** applies.
Chemotherapy	
Chemotherapy	Covered according to the type of benefit and the place where the service is received

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Outpatient infusion therapy	
Performed in a **physician's** office	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Performed in a person's home	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Performed in the outpatient department of a **hospital**	100% (of the **negotiated charge**) per visit No **deductible** applies
Performed at an outpatient facility other than the outpatient department of a **hospital**	100% (of the **negotiated charge**) per visit No **deductible** applies

Outpatient radiation therapy	
	Covered according to the type of benefit and the place where the service is received.

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

Short-term rehabilitation services	
Outpatient Physical and Occupational Therapies	
	100% (of the **negotiated charge**) per visit No **deductible** applies
Outpatient Speech Therapy	
	100% (of the **negotiated charge**) per visit No **deductible** applies

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Spinal manipulation	
Spinal manipulation	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Habilitation therapy services	
Outpatient physical and occupational therapies	
	Covered according to the type of benefit and the place where the service is received
Outpatient speech therapy	
	Covered according to the type of benefit and the place where the service is received

Eligible health services	In-network coverage*
7. Other services	
Acupuncture	
Acupuncture	$25 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Maximum visits per Calendar Year	10

Ambulance service	
Ground, air or water **ambulance**	100% (of the **negotiated charge**) per trip No **deductible** applies.

Clinical trial therapies (experimental or investigational)	
Clinical trial therapies	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

Durable medical equipment (DME)	
DME	50% (of the **negotiated charge**) per item No **deductible** applies.

Non-preventive hearing exams	
For adults and children	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies.

Nutritional supplements	
Nutritional supplements	Covered according to the type of benefit and the place where the service is received

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Osteoporosis	
Physician's office visits	Covered according to the type of benefit and the place where the service is received

Prosthetic and orthotic devices	
Prosthetic and orthotic devices	Covered according to the type of benefit and the place where the service is received

Vision care	
Routine vision exams (including refraction)	
Performed by a legally qualified ophthalmologist or optometrist	100% (of the **negotiated charge**) per visit No **deductible** applies

Maximum visits per 12 consecutive month period	1 visit

All other outpatient services for which cost sharing is not shown above	
All other outpatient services	Covered according to the type of benefit and the place where the service is received

Eligible health services	In-network coverage*
8. Outpatient prescription drugs	
Plan features	**Deductible/Copayment/Coinsurance/Maximums**
Deductible waiver	
The Calendar Year **deductible** is waived for all **prescription drugs**.	
Deductible and copayment/coinsurance waiver for risk reducing breast cancer prescription drugs	
The Calendar Year **deductible** and the per **prescription copayment/coinsurance** will not apply to risk reducing breast cancer **prescription drugs** when obtained at a **network pharmacy**. This means that such risk reducing breast cancer **prescription drugs** will be paid at 100%.	
Deductible and copayment/coinsurance waiver for contraceptives	
The Calendar Year **deductible** and the per **prescription copayment/coinsurance** will not apply to female contraceptive methods when obtained at a **network pharmacy**. This means that the following will be paid at 100%: • Certain over-the-counter (OTC) and generic contraceptive **prescription drugs** and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. If a **generic prescription drug** or device is not available for a certain method, you may obtain certain **brand-name prescription drug** for that method paid at 100%. We will cover brand-name emergency contraceptive "Ella" until such time as a generic equivalent is approved by the FDA. At that time, only a generic equivalent will be covered. The Calendar Year **deductible** and the per **prescription copayment/coinsurance** continue to apply to **prescription drugs** that have a generic equivalent or generic alternative available within the same **therapeutic drug class** obtained at a **network pharmacy** unless you are granted a medical exception.	
Preferred generic prescription drugs	
Per prescription copayment/coinsurance	
For each fill up to a 30 day supply filled at a **retail pharmacy**	$10 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year deductible applies
More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$20 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year deductible applies

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Value prescription drugs	
Per prescription copayment/coinsurance	
For each fill up to a 30 day supply filled at a **retail pharmacy**	$3 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year deductible applies
More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$6 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year deductible applies
Preferred brand-name prescription drugs	
Per prescription copayment/coinsurance	
For each fill up to a 30 day supply filled at a **retail pharmacy**	$45 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year deductible applies
More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$90 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year deductible applies
Non-preferred generic prescription drugs	
Per prescription copayment/coinsurance	
For each fill up to a 30 day supply filled at a **retail pharmacy**	$70 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year deductible applies
More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$140 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year deductible applies

Non-preferred brand-name prescription drugs	
Per prescription copayment/coinsurance	
For each fill up to a 30 day supply filled at a **retail pharmacy**	$70 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year deductible applies
More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$140 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year deductible applies
Specialty prescription drugs	
Per prescription copayment/coinsurance	
For each fill up to a 30 day supply filled at a **retail pharmacy**	**Copayment** is 30% (of the **negotiated charge**) but will be no more than $250 per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies
Orally administered anti-cancer prescription drugs	
Per prescription copayment/coinsurance	
For each fill up to a 30 day supply filled at a **retail pharmacy**	$0 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies
More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$0 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies

Preventive care drugs and supplements	
Preventive care drugs and supplements filled at a **pharmacy**	100% per **prescription** or refill
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.
Risk reducing breast cancer prescription drugs	
Risk reducing breast cancer **prescription drugs** filled at a **pharmacy**	100% per **prescription** or refill
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.
Family planning services - female contraceptives	
If your **provider** recommends a particular service or FDA-approved item based on a determination of **medical necessity**, that service or item will be covered without cost sharing, regardless of whether it is generic or brand-name. We will defer to the determination made by your **provider**. **Medical necessity** may include considerations such as severity of side effects, differences in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the item or service, as determined by your **provider**.	
Female contraceptives that are **generic prescription drugs:** • Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches	$0 per **prescription** or refill No **deductible** applies

Female contraceptives that are **brand-name prescription drugs:** • Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches	Paid according to the type of drug per the schedule of benefits, above

Tobacco cessation prescription and over-the-counter drugs	
Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy**	$0 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 tobacco cessation **prescription drugs** and OTC drugs, contact Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card. Coverage for tobacco cessation **prescription drugs** is not subject to any **precertification** requirements.

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

General coverage provisions

This section provides detailed explanations about the **Maximum out-of-pocket limits** that are listed in the first part of this schedule of benefits.

Copayments

Copayment
As it applies to in-network coverage, this is a specified dollar amount or percentage that must be paid by you at the time you receive **eligible health services** from a **network provider**. As it applies to in-network coverage, if **Aetna** compensates **network providers** on the basis of the reasonable amount, your percentage copayment is based on this amount.

Per Admission Copayment

A per admission **copayment** is an amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility.

Separate **copayments** may apply per facility. These **copayments** are in addition to any other **copayments** applicable under this plan. They may apply to each **stay** or they may apply on a per day basis up to a per admission maximum amount.

The per admission **copayment** amount is equal to a facility's **semi-private room rate** for one day. However, for the **stay** of a well newborn baby (starting at birth), the per admission **copayment** amount will not exceed the **hospital**'s actual **room and board** charge on the first day of the **stay**.

Coinsurance

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

Maximum out-of-pocket limits provisions

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

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **coinsurance** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual and family **maximum out-of-pocket limit**.

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

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

Family
Once the amount of the **coinsurance** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the **recognized charge** for such **covered benefits** that apply toward the limit for the remainder of the Calendar Year for all covered family members. In a family plan, an individual is responsible for satisfying only their **maximum out-of-pocket limit** before this plan pays 100% of the **negotiated charge** for such covered benefits for the rest of the Calendar Year. Once two family members have individually satisfied their individual **maximum out-of-pocket limit** in a Calendar Year, the individual **maximum out-of-pocket limit** is considered met for the remaining family members for the rest of the Calendar Year.

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**
- Certain other **eligible health services** in the schedule of benefits that are not essential health benefits

Calculations; determination of benefits provisions

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

Outpatient prescription drug maximum out-of-pocket limits provisions

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

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