



OA Managed Choice POS

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

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CN-0175129

Schedule of Benefits: 1B

Open Access Managed Choice \$0 100%

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

Schedule of benefits

This schedule of benefits lists the **deductibles** and **copayments/coinsurance** that apply to the services you receive under this plan. You should review this schedule to become familiar with your **deductibles** and **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**.
 - “Out-of-network coverage”, we mean you can get care from **providers** who are not **network providers**.
- The **deductibles** and **copayments/coinsurance** listed in the schedule of benefits below reflect the **deductibles** and **copayment/coinsurance** amounts under your plan.
- You are responsible to pay any **deductibles, 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. 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/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.

| 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 | \$300 per Calendar Year |
| Family | \$0 per Calendar Year | \$900 per Calendar Year |
| Deductible waiver | | |
| The Calendar Year deductible is waived for all of the following eligible health services : | | |
| <ul style="list-style-type: none"> • Preventive care and wellness • Family planning services - female contraceptives | | |
| Per admission copayment | | |
| Per admission copayment | \$250 per admission | Not applicable |
| Maximum out-of-pocket limit | | |
| Maximum out-of-pocket limit per Calendar Year. | | |
| Individual | \$3,000 per Calendar Year | \$6,000 per Calendar Year |
| Family | \$6,000 per Calendar Year | \$18,000 per Calendar Year |
| Precertification penalty | | |
| This only applies to out-of-network coverage. The booklet-certificate contains a complete description of the precertification program. You will find details on precertification requirements in the <i>Medical necessity and precertification requirements</i> section. | | |
| Failure to precertify your eligible health services when required will result in the following penalty: | | |
| <ul style="list-style-type: none"> • A \$400 penalty will be applied separately to each type of eligible health services (the penalty will never exceed the cost of the benefit) | | |
| Precertification and/or step therapy for certain prescription drugs may be required. In this case, the prescription drug will not be covered until you get prior authorization. | | |
| The additional percentage or dollar amount of the recognized charge which you may pay as a penalty for failure to obtain precertification is not a covered benefit , and will not be applied to the deductible amount or the maximum out-of-pocket limit , if any. | | |

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

| Eligible health services | In-network coverage* | Out-of-network coverage* |
|--|--|--|
| 1. Preventive care and wellness | | |
| Routine physical exams | | |
| Performed at a physician's, PCP office | 100% per visit No deductible applies | 50% (of the recognized charge) per visit |
| 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 the back of your ID card. | Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on the back of your ID card. |
| Covered persons age 22 and over but less than 65: Maximum visits per 12 months | 1 visit | 1 visit |
| Covered persons age 65 and over: Maximum visits per 12 months | 1 visit | 1 visit |
| Preventive care immunizations | | |
| Performed in a facility or at a physician's office | 100% per visit No deductible applies | 50% (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 member website at www.aetna.com or calling the number on the back of 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 member website at www.aetna.com or calling the number on the back of your ID card. |

*See *How to read your schedule of benefits* 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 | 50% (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 <ul style="list-style-type: none"> • 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 | 50% (of the recognized charge) per visit |
| Obesity and/or healthy diet counseling maximums: | | |
| Maximum visits per 12 months (This maximum applies only to covered persons age 22 and older.) | 26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)* | 26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)* |
| *Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit. | | |
| Misuse of alcohol and/or drugs maximums: | | |
| Maximum visits per 12 months | 5 visits* | 5 visits* |
| *Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit. | | |

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

| | | |
|---|---|---|
| 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. | | |
| Genetic risk counseling for breast and ovarian cancer maximums: | | |
| Genetic risk counseling for breast and ovarian cancer | Not subject to any age or frequency limitations | Not subject to any age or frequency limitations |
| Routine cancer screenings (applies whether performed at a physician's, PCP, specialist office or facility) | | |
| Routine cancer screenings | 100% per visit No deductible applies | 50% (of the recognized charge) per visit |
| Maximums | <p>Subject to any age, family history, and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> 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. <p>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 the back of your ID card.</p> | <p>Subject to any age, family history, and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> 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. <p>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 the back of your ID card.</p> |
| Lung cancer screening maximums | 1 screening every 12 months* | 1 screening every 12 months* |
| <p>*Important note: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the <i>Outpatient diagnostic testing</i> section.</p> | | |

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

| | | |
|--|---|--|
| 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 | 50% (of the recognized charge) per visit |
| Important note: You should review the <i>Maternity and related newborn care</i> sections. They will give you more information on coverage levels for maternity care under this plan. | | |
| Comprehensive lactation support and counseling services | | |
| Lactation counseling services – facility or office visits | 100% per visit No deductible applies | 50% (of the recognized charge) per visit |
| Lactation counseling services maximum visits per 12 months either in a group or individual setting | 6 visits* | 6 visits* |
| *Important note: Any visits that exceed the lactation counseling services maximum are covered under Physician services office visits. | | |
| Breast feeding durable medical equipment | | |
| Breast pump supplies and accessories | 100% per item No deductible applies | 50% (of the recognized charge) per item |
| Important note: See the <i>Breast feeding durable medical equipment</i> section of the booklet-certificate for limitations on breast pump and supplies. | | |

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

| Family planning services – female contraceptives | | |
|---|---|--|
| Female contraceptive education and counseling services office visit | 100% per visit No deductible applies | 50% (of the recognized charge) per visit |
| 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 | 50% (of the recognized charge) per item |
| Female voluntary sterilization | | |
| Inpatient | 100% per admission No deductible applies | 50% (of the recognized charge) per admission |
| Outpatient | 100% per visit No deductible applies | 50% (of the recognized charge) per visit |

*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* |
|--|---|--|
| 2. Physicians and other health professionals | | |
| Physicians and specialists office visits (non-surgical) | | |
| Physician services | | |
| Office hours visits (non-surgical) non preventive care | \$20 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies | 50% (of the recognized charge) per visit |
| Telemedicine consultation by a physician, PCP | \$20 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies | 50% (of the recognized charge) per visit |
| Telemedicine consultation by a specialist | \$40 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies | 50% (of the recognized charge) per visit |

| | | |
|--|---|---|
| Allergy injections | | |
| Performed at a physician's or specialist office when you do not see the physician | 100% (of the negotiated charge) per visit No deductible applies | 50% (of the recognized charge) per visit |
| 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. | Covered according to the type of benefit and the place where the service is received. |

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

| | | |
|---|---|--|
| Specialist | | |
| Specialist office visits | | |
| Office hours visits (non-surgical) | \$40 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies | 50% (of the recognized charge) per visit |
| Physician surgical services | | |
| Physicians and specialists office visits | | |
| Performed at a physician's, PCP office | \$20 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies | 50% (of the recognized charge) per visit |
| Performed at a specialist's office | \$40 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies | 50% (of the recognized charge) per visit |

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

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**.

| Description | Network Benefit Level | | Out-of-network benefit level |
|--|--|--|--|
| | Designated network coverage | Non-designated network coverage | Out-of-network coverage |
| Non-emergency services | 100% (of the negotiated charge) per visit, no deductible applies | \$20 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter, no deductible applies | 50% (of the recognized charge) per visit after deductible |
| Preventive care immunizations | 100% (of the negotiated charge) per visit, no deductible applies | 100% (of the negotiated charge) per visit, no deductible applies | 50% (of the recognized charge) per visit after deductible |
| 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 | 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 | 50% (of the recognized charge) per visit after deductible |
| Preventive screening and counseling limits | See the <i>Preventive care services</i> section of the SOB | See the <i>Preventive care services</i> section of the SOB | See the <i>Preventive care services</i> 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.

*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* |
|---|--|--|
| 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 | 50% (of the recognized charge) per admission |
| | | |
| Alternatives to hospital stays | | |
| Outpatient surgery and physician surgical services | | |
| | \$100 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies | 50% (of the recognized charge) per visit |
| | | |
| Home health care | | |
| Outpatient | 100% (of the negotiated charge) per visit No deductible applies | 50% (of the recognized charge) per visit |
| Maximum visits per Calendar Year | 120 Limited to: 3 intermittent visits per day provided by a participating home health care agency ; 1 visit equals at least 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 | 120 Limited to: 3 intermittent visits per day provided by a participating home health care agency ; 1 visit equals at least 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 |
| | | |

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

| Hospice care | | |
|---|--|--|
| Inpatient facility | 100% (of the negotiated charge) per admission thereafter, after the per admission copayment No deductible applies | 50% (of the recognized charge) per admission |
| Maximum days per lifetime | Unlimited | Unlimited |
| Hospice care | | |
| Outpatient | 100% (of the negotiated charge) per visit No deductible applies | 50% (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 | 100% (of the negotiated charge) per visit No deductible applies | 50% (of the recognized charge) per visit |
| Maximum visits/shifts per Calendar Year | 70 shifts Up to eight hours equal one shift. | 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 | 50% (of the recognized charge) per admission |
| Maximum days per Calendar Year | 60 | 60 |

*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* |
|--|---|--|
| 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 | Paid the same as in-network coverage |
| Non-emergency care in a hospital emergency room | Not covered | Not covered |
| <p>Important Note:</p> <ul style="list-style-type: none"> 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 hospital 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 | 50% (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/coinsurance will apply for each visit to an urgent care provider . | | |
| | | |

*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* |
|---|---|--|
| 5. Specific conditions | | |
| Behavioral health | | |
| Mental health treatment - inpatient | | |
| Inpatient mental health treatment Inpatient residential treatment facility Inpatient mental health treatment | 100% (of the negotiated charge) per admission, after the per admission copayment No deductible applies | 50% (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) | \$40 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies | 50% (of the recognized charge) per visit |
| 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 The cost share doesn't apply to in-network peer counseling support services | 100% (of the negotiated charge) per visit No deductible applies | 50% (of the recognized charge) per visit |

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

| Substance related disorders treatment - inpatient | | |
|---|--|--|
| Inpatient substance abuse detoxification | 100% (of the negotiated charge) per admission, after the per admission copayment | 50% (of the recognized charge) per admission |
| Inpatient substance abuse rehabilitation | No deductible applies | |
| Inpatient residential treatment facility | | |
| Substance related disorders treatment - outpatient | | |
| Outpatient substance abuse office visits to a physician or behavioral health provider (includes telemedicine consultation) | \$40 then the plan pays 100% (of the negotiated charge) per visit thereafter No deductible applies | 50% (of the recognized charge) per visit |
| 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 | 50% (of the recognized charge) per visit |

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

| Birthing center and physician services | | |
|---|--|---|
| Inpatient | 100% (of the negotiated charge) per admission, after the per admission copayment No deductible applies | 50% (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 No deductible applies | 50% (of the recognized charge) per visit |
| Termination of pregnancy | | |
| Inpatient | 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 | 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. |
| Physician's office | 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. |
| Jaw joint disorder treatment | | |
| Jaw joint 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 |
| Maternity and related newborn care | | |
| Inpatient | 100% (of the negotiated charge) per admission, after the per admission copayment No deductible applies | 50% (of the recognized charge) per admission |

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

| 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 | 50% (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. |
| Pregnancy complications | | |
| Inpatient | 100% (of the negotiated charge) per admission, after the per admission copayment No deductible applies | 50% (of the recognized charge) per admission |
| 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. | Covered according to the type of benefit and the place where the service is received. |
| Gender reassignment surgery | 100% (of the negotiated charge) per admission, after the per admission copayment No deductible applies | 50% (of the recognized charge) per admission |
| Gender reassignment injectable hormone 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. |
| 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 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 |

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

| 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, after the per admission copayment No deductible applies | 50% (of the negotiated charge) per transplant | 50% (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 | |
| | | | |

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

| Eligible health services | In-network coverage* | Out-of-network coverage* |
|--|--|--|
| 6. Specific therapies and tests | | |
| Outpatient diagnostic testing | | |
| Diagnostic complex imaging services | | |
| | 100% (of the negotiated charge) per visit No deductible applies | 50% (of the recognized charge) per visit |
| Diagnostic lab work | | |
| | 100% (of the negotiated charge) per visit. No deductible applies | 50% (of the recognized charge) per visit. |
| Diagnostic radiological services | | |
| | 100% (of the negotiated charge) per visit. No deductible applies | 50% (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 |

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

| Outpatient infusion therapy | | |
|---|--|--|
| Performed in a physician's office | \$40 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies. | 50% (of the recognized charge) per visit |
| Performed in a person's home | \$40 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies. | 50% (of the recognized charge) per visit |
| Performed in the outpatient department of a hospital | 100% (of the negotiated charge) per visit No deductible applies. | 50% (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. | 50% (of the recognized charge) per visit |
| | | |

| Outpatient radiation therapy | | |
|---|---|---|
| Radiation therapy | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| | | |
| Short-term cardiac and pulmonary rehabilitation services | | |
| Cardiac rehabilitation | | |
| Cardiac rehabilitation | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| | | |
| Pulmonary rehabilitation | | |
| Pulmonary rehabilitation | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| | | |

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

| | | |
|---|---|--|
| Short-term rehabilitation services | | |
| Outpatient Physical and Occupational Therapies | | |
| | 100% (of the negotiated charge) per visit No deductible applies | 50% (of the recognized charge) per visit |
| Outpatient Speech Therapy | | |
| | 100% (of the negotiated charge) per visit No deductible applies | 50% (of the recognized charge) per visit |
| Spinal manipulation | | |
| Spinal manipulation | \$40 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies | 50% (of the recognized charge) per visit |
| Habilitation therapy services | | |
| Outpatient physical and occupational 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 |
| Outpatient speech 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 |

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

| Eligible health services | In-network coverage* | Out-of-network coverage* |
|---|--|---|
| 7. Other services | | |
| Acupuncture | | |
| Acupuncture | \$20 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies | 50% (of the recognized charge) per visit |
| Maximum visits per Calendar Year | 10 | 10 |
| Ambulance service | | |
| Ground, air or water ambulance | 100% (of the negotiated charge) per trip No deductible applies. | 100% (of the recognized 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 | 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 | 50% (of the negotiated charge) per item No deductible applies. | 50% (of the recognized charge) per item |
| Non-preventive hearing exams | | |
| For adults and children | \$40 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies. | 50% (of the recognized charge) per visit |

*See *How to read your schedule of benefit* at the beginning of this schedule of benefits
AL HSOB 03 as amended by
AL COCAmend-2021 01

| 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 |
| | | |
| Osteoporosis | | |
| Physician's 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 |
| | | |
| Prosthetic and orthotic devices | | |
| Prosthetic and orthotic 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 |
| | | |
| Vision care | | |
| Routine vision exams (including refraction) | | |
| Performed by a licensed ophthalmologist or optometrist | 100% (of the negotiated charge) per visit No deductible applies | 50% (of the recognized charge) per visit |
| | | |
| Maximum visits per 12 consecutive month period | 1 visit | 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 | Covered according to the type of benefit and the place where the service is received |
| | | |

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AL HSOB 03 as amended by
AL COCAmend-2021 01

| Eligible health services | In-network coverage* | Out-of-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%: | | |
| <ul style="list-style-type: none"> • 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. | | |
| | | |
| Partial fill dispensing for Schedule II controlled substances, such as opioids | | |
| Partial fill dispensing allows less than the entire prescription to be filled at a pharmacy . You will pay a prorated amount of your cost share based on the size of the supply. | | |
| | | |
| Important note: | | |
| <ul style="list-style-type: none"> • Review the How to access out-of-network pharmacies section of the booklet-certificate for more information on how these pharmacies are subject to higher out-of-pocket costs. | | |
| | | |

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

| Preferred generic prescription drugs | | |
|--|--|--|
| Per prescription copayment/coinsurance | | |
| For each fill up to a 30 day supply filled at a retail pharmacy | <p>\$10 copayment per supply</p> <p>Coinsurance is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p> | <p>Coinsurance is 50% (of the recognized charge) but will be no more than \$250 per supply</p> <p>No Calendar Year deductible applies</p> |
| More than a 31 day supply but less than a 91 day supply filled at a mail order pharmacy | <p>\$20 copayment per supply</p> <p>Coinsurance is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p> | Not Covered |
| Value prescription drugs | | |
| Per prescription copayment/coinsurance | | |
| For each fill up to a 30 day supply filled at a retail pharmacy | <p>\$3 copayment per supply</p> <p>Coinsurance is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p> | <p>Coinsurance is 50% (of the recognized charge) but will be no more than \$250 per supply</p> <p>No Calendar Year deductible applies</p> |
| More than a 31 day supply but less than a 91 day supply filled at a mail order pharmacy | <p>\$6 copayment per supply</p> <p>Coinsurance is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p> | Not Covered |
| Non-preferred generic prescription drugs | | |
| Per prescription copayment/coinsurance | | |
| For each fill up to a 30 day supply filled at a retail pharmacy | <p>\$70 copayment per supply</p> <p>Coinsurance is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p> | <p>Coinsurance is 50% (of the recognized charge) but will be no more than \$250 per supply</p> <p>No Calendar Year deductible applies</p> |
| More than a 31 day supply but less than a 91 day supply filled at a mail order pharmacy | <p>\$140 copayment per supply</p> <p>Coinsurance is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p> | Not Covered |

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| Preferred brand-name prescription drugs | | |
|--|--|--|
| Per prescription copayment/coinsurance | | |
| For each fill up to a 30 day supply filled at a retail pharmacy | <p>\$45 copayment per supply</p> <p>Coinsurance is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p> | <p>Coinsurance is 50% (of the recognized charge) but will be no more than \$250 per supply</p> <p>No Calendar Year deductible applies</p> |
| More than a 31 day supply but less than a 91 day supply filled at a mail order pharmacy | <p>\$90 copayment per supply</p> <p>Coinsurance is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p> | Not Covered |
| Non-preferred brand-name prescription drugs | | |
| Per prescription copayment/coinsurance | | |
| For each fill up to a 30 day supply filled at a retail pharmacy | <p>\$70 copayment per supply</p> <p>Coinsurance is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p> | <p>Coinsurance is 50% (of the recognized charge) but will be no more than \$250 per supply</p> <p>No Calendar Year deductible applies</p> |
| More than a 31 day supply but less than a 91 day supply filled at a mail order pharmacy | <p>\$140 copayment per supply</p> <p>Coinsurance is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p> | Not Covered |
| Orally administered anti-cancer prescription drugs | | |
| Per prescription copayment/coinsurance | | |
| For each fill up to a 30 day supply filled at a retail pharmacy | <p>\$0 copayment per supply</p> <p>Coinsurance is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p> | <p>Coinsurance is 50% (of the recognized charge) but will be no more than \$250 per supply</p> <p>No Calendar Year deductible applies</p> |
| More than a 31 day supply but less than a 91 day supply filled at a mail order pharmacy | <p>\$0 copayment per supply</p> <p>Coinsurance is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p> | Not Covered |

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| Specialty drugs | | |
|---|--|--|
| Per prescription copayment/coinsurance | | |
| For each fill up to a 30 day supply filled at a retail pharmacy | <p>Copayment is 30% (of the negotiated charge) but will be no more than \$250 per supply</p> <p>Coinsurance is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p> | Not Covered |
| Preventive care drugs and supplements | | |
| Preventive care drugs and supplements filled at a pharmacy | 100% per prescription or refill | Paid according to the type of drug per the schedule of benefits, above |
| 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. | 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 | Paid according to the type of drug per the schedule of benefits, above |
| 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. | 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. |

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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**.

| | | |
|--|--|---|
| <p>Female contraceptives that are generic prescription drugs:</p> <ul style="list-style-type: none"> • Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches | <p>\$0 per prescription or refill</p> <p>No deductible applies</p> | <p>Paid according to the type of drug per the schedule of benefits, above</p> |
| <p>Female contraceptives that are brand-name prescription drugs:</p> <ul style="list-style-type: none"> • Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches | <p>Paid according to the type of drug per the schedule of benefits, above</p> | <p>Paid according to the type of drug per the schedule of benefits, above</p> |
| | | |

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| 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 | Paid according to the type of drug per the schedule of benefits, above |
| 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. | 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 . | | |

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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 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/coinsurance 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: <ul style="list-style-type: none">• 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. |

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

| |
|--|
| <p>Deductible credit</p> <p>If you paid part or all of your deductible under prior coverage for the Calendar Year that this certificate went into effect, the deductible of this plan for that Calendar Year will be reduced by the amount you paid under your prior coverage.</p> <p>Upon request, you must submit a detailed explanation of benefits (EOB) showing the dates and amount of the deductible met from the prior coverage in order to receive the credit.</p> |
| <p>Copayments</p> <p>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.</p> |
| <p>Per Admission Copayment</p> <p>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.</p> <p>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.</p> <p>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.</p> |
| <p>Coinsurance</p> <p>The specific percentage you and the plan have to pay for a health care service listed in the schedule of benefits.</p> |

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

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 **copayments/coinsurance** 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/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** 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/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 **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/coinsurance** 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**

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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 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