Preferred Provider Organization (PPO) Medical Plan

Schedule of Benefits

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

Prepared exclusively for:

Policyholder:	Pace University
Policyholder number:	GP-0181579
	Schedule of Benefits 2A
Group policy effective date:	January 1, 2022
Plan effective date:	January 1, 2022
Plan issue date:	February 28, 2022

Underwritten by Aetna Life Insurance Company in the state of New York.

Schedule of Benefits

This Schedule of Benefits lists the Deductibles and Copayments/Coinsurance, if any, that apply to the services You receive under this plan. You should review this schedule to become familiar with Your Deductibles and Copayments/Coinsurance and any limits that apply to the services.

How to read your schedule of benefits

- When We say:
  - "Participating Provider coverage", We mean You get care from a Network Provider.
  - "Non-Participating Provider 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 member Coinsurance percentage. This is the Coinsurance amount you must pay
- 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 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	
	Participating Provider Coverage*	**Non-Participating Provider Coverage***
Deductible		
You have to meet your Calendar Year Deductible before this plan pays for benefits.		
Individual	$750 per Calendar Year	$2,000 per Calendar Year
Family	$1,500 per Calendar Year	$4,000 per Calendar Year
Deductible waiver		
The Calendar Year Deductible is waived for all of the following Eligible Health Services: • Preventive care and wellness • Family planning services - female contraceptives		
Maximum out-of-pocket limit		
Maximum Out-of-Pocket Limit per Calendar Year.		
Individual	$2,000 per Calendar Year	$5,000 per Calendar Year
Family	$4,000 per Calendar Year	$10,000 per Calendar Year
Preauthorization covered benefit reduction		
This only applies to out-of-network coverage. The booklet-certificate contains a complete description of the Preauthorization program. You will find details on Preauthorization requirements in the *Medical necessity and preauthorization requirements* section. Failure to Preauthorize your Eligible Health Services when required will result in the following benefits reduction: • Covered benefits will be reduced by the lesser of 50% of the benefit that would otherwise have been payable and $500 The additional percentage or dollar amount of the Recognized Charge which you may pay as a penalty for failure to obtain Preauthorization 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 benefits* at the beginning of this schedule of benefits

Eligible health services	Participating Provider coverage**	Non-Participating Provider coverage*
Preventive care and wellness		
Routine physical exams		
Performed at a Physician's, PCP office	0% per visit No Deductible applies	30% (of the Recognized Charge) per visit
Covered persons through age 21:	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. 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.	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your Physician or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.
Covered persons age 22 and over but less than 65: Maximum visits per Calendar Year	1 visit	1 visit
Covered persons age 65 and over: Maximum visits per Calendar Year	1 visit	1 visit
Preventive care immunizations		
Performed in a facility or at a Physician's office	0% per visit No Deductible applies	30% (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 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 your ID card.

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Well woman preventive visits routine gynecological exams (including pap smears)		
Performed at a Physician's, PCP, obstetrician (OB), gynecologist (GYN) or OB/GYN office	0% per visit No Deductible applies	30% (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	2 visits	2 visits
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	0% per visit No Deductible applies	30% (of the Recognized Charge) per visit
Obesity and/or healthy diet counseling maximums:		
Maximum visits per Calendar Year (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 Calendar Year	5 visits*	5 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		

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Use of tobacco products maximums:		
Maximum visits per Calendar Year	8 visits*	8 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		

Sexually transmitted infection counseling maximums:		
Maximum visits per Calendar Year	2 visits*	2 visits*
*Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.		

Genetic risk counseling for breast and ovarian cancer maximums:		
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations	Not subject to any age or frequency limitations

Routine cancer screenings (applies whether performed at a physician's, PCP, specialist office or facility)		
Routine cancer screenings	0% per visit No Deductible applies	30% (of the Recognized Charge) per visit
Prostate cancer screening	0% per screening No Deductible applies	30% (of the Recognized Charge) per screening
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.	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*	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.		

*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	0% per visit No Deductible applies	30% (of the Recognized Charge) per visit
Important note: You should review the *Maternity and related newborn care* sections. They will give you more information on coverage levels for maternity care under this plan.		
Comprehensive lactation support and counseling services		
Lactation counseling services – facility or office visits	0% per visit No Deductible applies	30% (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	0% per item No Deductible applies	30% (of the Recognized Charge) per item
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		
Counseling services		
Female contraceptive counseling services office visit	0% per visit No Deductible applies	30% (of the Recognized Charge) per visit
Contraceptive counseling services maximum visits per 12 months either in a group or individual setting	2 visits*	2 visits*
*Important note: Any visits that exceed the contraceptive counseling services maximum are covered under Physician services office visits.		

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Devices		
Female contraceptive device provided, administered, or removed, by a Physician during an office visit	0% per item No deductible applies	30% (of the Recognized Charge) per item
Female voluntary sterilization		
Inpatient	0% per admission No Deductible applies	30% (of the Recognized Charge) per admission
Outpatient	0% per visit No Deductible applies	30% (of the Recognized Charge) per visit
Eligible health services	**Participating Provider coverage***	**Non-Participating Provider coverage***
Physicians and other health professionals		
Physicians and Specialists office visits (non-surgical)		
Physician services		
Office hours visits (non-surgical) non preventive care	$30 plus 0% (of the balance of the Negotiated Charge) per visit thereafter No Deductible applies	30% (of the Recognized Charge) per visit
Telemedicine consultation by a Physician, PCP	$30 plus 0% (of the balance of the Negotiated Charge) per visit thereafter No Deductible applies	30% (of the Recognized Charge) per visit
Telemedicine consultation by a Specialist	$50 plus 0% (of the balance of the Negotiated Charge) per visit thereafter No Deductible applies	30% (of the Recognized Charge) per visit
Allergy injections		
Performed at a Physician's, PCP or Specialist office when you do not see the Physician	15% (of the Negotiated Charge) per visit	35% (of the Recognized Charge) per visit

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Immunizations that are not considered preventive care		
Immunizations that are not considered preventive care	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Specialist		
Specialist office visits		
Office hours visits (non-surgical)	$50 plus 0% (of the balance of the Negotiated Charge) per visit thereafter No Deductible applies	30% (of the Recognized Charge) per visit
Physician surgical services		
Physicians and specialists office visits		
Performed at a Physician's, PCP office	$30 plus 0% (of the balance of the Negotiated Charge) per visit thereafter No Deductible applies	30% (of the Recognized Charge) per visit
Performed at a Specialist's office	$50 plus 0% (of the balance of the Negotiated Charge) per visit thereafter No Deductible applies	30% (of the Recognized Charge) per visit
Alternatives to physician office visits		
Walk-in clinic visits		
Preventive Care Services		
Immunizations	0% per visit No Deductible applies	30% (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.
All non preventive care services for which cost sharing is not shown above		
All other services	$30 plus 0% (of the balance of the Negotiated Charge) per visit thereafter No Deductible applies	30% (of the Recognized Charge) per visit

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Eligible health services	Participating Provider coverage*	Non-Participating Provider coverage*
Hospital and other facility care		
Hospital care		
Inpatient Hospital	15% (of the Negotiated Charge) per admission	35% (of the Recognized Charge) per admission
Alternatives to hospital stays		
Outpatient surgery and physician surgical services		
	15% (of the Negotiated Charge) per visit	35% (of the Recognized Charge) per visit
Home health care		
Outpatient	15% (of the Negotiated Charge) per visit No Deductible applies	25% (of the Recognized Charge) per visit No Deductible applies
	Limited to: 3 intermittent visits per day provided by a participating home health care agency; 1 visit equals a period of 4 hours. Intermittent visits are considered periodic and recurring visits that skilled nurses or home health aides make to ensure your proper care The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge	Limited to: 3 intermittent visits per day provided by a participating home health care agency; 1 visit equals a period of 4 hours. Intermittent visits are considered periodic and recurring visits that skilled nurses or home health aides make to ensure your proper care The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge
Hospice care		
Inpatient facility	15% (of the Negotiated Charge) per admission	35% (of the Recognized Charge) per admission
Maximum days per lifetime	Unlimited	Unlimited

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Hospice care		
Outpatient	15% (of the Negotiated Charge) per visit	35% (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
	5 visits for family bereavement counseling	5 visits for family bereavement counseling
Skilled nursing facility		
Inpatient facility	15% (of the Negotiated Charge) per admission	35% (of the Recognized Charge) per admission
Maximum days per Calendar Year	60	60

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Eligible health services	Participating coverage*	Non-Participating coverage*
Emergency services and urgent care		
Emergency services		
Hospital emergency room	$85 plus 0% (of the balance of the Negotiated Charge) per visit No Deductible applies	Paid the same as Participating Provider coverage
Non-emergency care in a Hospital emergency room	Not covered	Not covered
Important Note: • As Non-Participating 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 Deductible or 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)	$30 plus 0% (of the balance of the Negotiated Charge) per visit thereafter No Deductible applies	$30 plus 0% (of the balance of the Recognized Charge) per visit thereafter No Deductible applies
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.		

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Eligible health services	Participating Provider coverage*	Non-Participating coverage*
Specific conditions		
Autism spectrum disorder		
Autism spectrum disorder treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Autism spectrum disorder diagnosis and testing	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	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
Birthing center		
Inpatient	15% (of the Negotiated charge) per admission	35% (of the Recognized charge) per admission
Diabetic services, equipment, supplies and education		
Diabetic 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
Diabetic Supplies at a pharmacy	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
Diabetic Supplies and Equipment at a Non-Pharmacy	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
Diabetic 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	15% (of the Negotiated charge) per visit	35% (of the Recognized charge) per visit

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Interruption of Pregnancy – Medically Necessary Abortions		
Inpatient	Covered in full No Deductible applies	30% (of the Recognized charge) per admission
Outpatient	Covered in full No Deductible applies	30% (of the Recognized charge) per visit
Physician's office	Covered in full No Deductible applies	30% (of the Recognized charge) per visit
Interruption of Pregnancy – Elective Abortions		
Inpatient	0% of the Negotiated Charge per admission No Deductible applies	30% (of the Recognized charge) per admission
Outpatient	0% of the Negotiated Charge No Deductible applies	30% (of the Recognized charge) per visit
Physician's office	0% of the Negotiated Charge No Deductible applies	30% (of the Recognized charge) per visit
Maternity and related newborn care		
Inpatient	15% (of the Negotiated charge) per admission	35% (of the Recognized charge) per admission
Delivery services and postpartum care services		
Performed in a facility or at a physician's office	15% (of the Negotiated charge) per visit	35% (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.

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Mental health treatment - inpatient		
Inpatient mental health treatment Inpatient Residential Treatment Facility Coverage is provided under the same terms, conditions as any other illness	15% (of the **negotiated charge**) per admission	35% (of the **recognized charge**) per admission
Mental health treatment - outpatient		
Outpatient mental health treatment office visits to a physician or behavioral health provider (includes Telemedicine consultation) Coverage is provided under the same terms, conditions as any other illness	$30 plus 0% (of the balance of the Negotiated charge) per visit thereafter No deductible applies	30% (of the Recognized charge) per visit
Outpatient mental health treatment office visits to a Physician or Behavioral Health Provider (includes Telemedicine cognitive behavioral therapy consultations)	$30 plus 0% (of the balance of the Negotiated charge) per visit thereafter No deductible applies	30% (of the Recognized charge) per visit
Other outpatient mental health treatment Partial hospitalization treatment Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services	0% (of the Negotiated charge) per visit No deductible applies	30% (of the Recognized charge) per visit

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Substance related disorders treatment- inpatient		
Detoxification - inpatient		
Inpatient Substance Abuse detoxification during a Hospital confinement Inpatient Substance Abuse rehabilitation during a Hospital confinement Inpatient Residential Treatment Facility during a Hospital confinement Coverage is provided under the same terms, conditions as any other illness	15% (of the Negotiated Charge) per admission	35% (of the Recognized Charge) per admission
Substance related disorders treatment - outpatient: detoxification and rehabilitation		
Outpatient Substance Abuse visits to a physician or Behavioral Health Provider (includes Telemedicine consultation) Coverage is provided under the same terms, conditions as any other illness	$30 plus 0% (of the balance of the Negotiated Charge) per visit thereafter No Deductible applies	30% (of the Recognized Charge) per visit
Outpatient Substance Abuse office visits to a Physician or Behavioral Health Provider (includes Telemedicine cognitive behavioral therapy consultations) Coverage is provided under the same terms, conditions as any other illness	$30 plus 0% (of the balance of the Negotiated Charge) per visit thereafter No Deductible applies	30% (of the Recognized Charge) per visit

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Other outpatient Substance Abuse services Partial hospitalization Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services	0% (of the Negotiated Charge) per visit No Deductible applies	30% (of the Recognized Charge) per visit
Obesity surgery		
Inpatient hospital (includes surgical procedure and acute hospital services)	15% (of the Negotiated charge) per admission	35% (of the Recognized charge) per admission
Outpatient obesity surgery		
	15% (of the Negotiated charge) per visit	35% (of the Recognized charge) per visit
Oral and maxillofacial treatment (mouth, jaws and teeth)		
Oral and maxillofacial treatment (mouth, jaws and teeth)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Reconstructive breast surgery		
Reconstructive breast surgery	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Reconstructive surgery 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

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Eligible health services	Participating Provider coverage* Network (IOE facility)	Participating Provider coverage* Network (Non-IOE facility)	Non-Participating Provider *
Transplant services facility and non-facility			
Inpatient hospital transplant services	15% (of the Negotiated Charge) per transplant	35% (of the Negotiated Charge) per transplant	35% (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	Participating Provider coverage*	Non-Participating Provider coverage*
Treatment of infertility		
Basic infertility		
Basic infertility	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Outpatient comprehensive infertility services		
	15% (of the Negotiated charge) per visit	35% (of the Recognized charge) per visit
Outpatient ART services		
	15% (of the Negotiated charge) per visit	35% (of the Recognized charge) per visit

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Eligible health services	Participating Provider coverage*	Non-Participating Provider coverage*
Specific therapies and tests		
Outpatient diagnostic testing		
Diagnostic complex imaging services		
	0% (of the Negotiated charge) per visit No Deductible applies	30% (of the Recognized charge) per visit

Diagnostic lab work		
	0% (of the Negotiated charge) per visit. No Deductible applies.	30% (of the Recognized charge) per visit.

Diagnostic radiological services		
	0% (of the Negotiated charge) per visit. No Deductible applies.	30% (of the Recognized charge) per visit.
Chemotherapy		
Chemotherapy	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Outpatient infusion therapy		
Performed in a physician's office	$50 plus 0% (of the balance of the Negotiated charge) per visit thereafter No Deductible applies.	30% (of the Recognized charge) per visit
Performed in a person's home	$50 plus 0% (of the balance of the Negotiated charge) per visit thereafter No Deductible applies.	30% (of the Recognized charge) per visit
Performed in the outpatient department of a hospital	15% (of the Negotiated charge) per visit	35% (of the Recognized charge) per visit
Performed at an outpatient facility other than the outpatient department of a hospital	15% (of the Negotiated charge) per visit	35% (of the Recognized charge) per visit

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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
Short-term rehabilitation services		
Outpatient physical ,speech and occupational therapies		
	$50 plus 0% (of the balance of the Negotiated charge) per visit thereafter No Deductible applies	30% (of the Recognized charge) per visit
Maximum visits per Calendar Year	90 visits	90 visits
Habilitation therapy services		
	0% (of the Negotiated charge) per visit No Deductible applies	30% (of the Recognized charge) per visit

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Eligible health services	Participating Provider coverage*	Non-Participating Provider coverage*
Other services		
Acupuncture		
Acupuncture	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
Emergency Ambulance service		
Ground, air or water Ambulance	15% (of the Negotiated Charge) per trip	15% (of the Recognized Charge) per trip
Non-emergency Ambulance service		
Ground, air or water Ambulance	15% (of the Negotiated Charge) per trip	15% (of the Recognized Charge) per trip
Chiropractic Care		
Chiropractic Care	$50 plus 0% (of the balance of the Negotiated Charge) per visit thereafter No **Deductible** applies	30% (of the **Recognized Charge**) per visit

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	15% (of the Negotiated Charge) per item	35% (of the Recognized Charge) per item
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

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Prosthetic devices		
Prosthetic devices	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Vision care		
Routine vision exams (including refraction)		
Performed by a legally qualified ophthalmologist or optometrist	0% (of the Negotiated Charge) per visit No Deductible applies	30% (of the Recognized Charge) per visit
Maximum visits per 24 month consecutive period	1 visit	1 visit
All other 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

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

Eligible health services	Participating Provider coverage*	Non-Participating Provider coverage*
Outpatient Prescription Drugs		
Plan features	**Deductible/Copayment/Coinsurance/Maximums**	
Outpatient Prescription Drug Deductible **A separate Deductible applies to Prescription Drugs.**		
You have to meet your Deductible before this plan pays for benefits.		
Individual	$125 per Calendar Year	$125 per Calendar Year
Family	$375 per Calendar Year	$375 per Calendar Year

Deductible and Copayment/Coinsurance waiver for risk reducing breast cancer Prescription Drugs
The Prescription Drug 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 tobacco cessation Prescription and over-the-counter drugs
The Prescription Drug Deductible and the per Prescription Copayment/Coinsurance will not apply to two 90-day treatment regimens for tobacco cessation Prescription Drugs and OTC drugs when obtained at a Network Pharmacy. This means that such Prescription Drugs and OTC drugs will be paid at 100%.
Deductible and Copayment/Coinsurance waiver for contraceptives
The Prescription Drug 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%. The Prescription Drug 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.

*See *How to read your Schedule of Benefits* at the beginning of this Schedule of Benefits

Outpatient Prescription Drug Maximum Out-of-Pocket Limit		
Outpatient Prescription Drug Maximum Out-of-Pocket Limit per calendar year		
Individual	$4,000 per calendar year	$4,000 per calendar year
Family	$8,000 per calendar year	$8,000 per calendar year
Important note: 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.		
Tier 1 Prescription Drugs		
Per Prescription Copayment/Coinsurance		
For each fill up to a 30 day supply filled at a Retail or Specialty Pharmacy	$20 Copayment per supply Coinsurance is 0% (of the Negotiated Charge) No Calendar Year Deductible applies	$20 Deductible per supply Coinsurance is 30% (of the Recognized Charge) No Calendar Year Deductible applies
More than a 30 day supply but less than a 91 day supply filled at a Mail Order Pharmacy	$20 Copayment per supply Coinsurance is 0% (of the Negotiated Charge) No Calendar Year Deductible applies	Not covered
Per Prescription Copayment/Coinsurance		
For each fill up to a 30 day supply filled at a Retail or Specialty Pharmacy	$70 Copayment per supply Coinsurance is 0% (of the Negotiated Charge) No Calendar Year Deductible applies	$70 Deductible per supply Coinsurance is 30% (of the Recognized Charge) No Calendar Year Deductible applies
More than a 30 day supply but less than a 91 day supply filled at a Mail Order Pharmacy	$70 Copayment per supply Coinsurance is 0% (of the Negotiated Charge) No Calendar Year Deductible applies	Not covered

*See *How to read your Schedule of Benefits* at the beginning of this Schedule of Benefits

Tier 2 Prescription Drugs		
Per Prescription Copayment/Coinsurance		
For each fill up to a 30 day supply filled at a Retail or Specialty Pharmacy	$45 Copayment per supply Coinsurance is 0% (of the Negotiated Charge)	$45 Deductible per supply Coinsurance is 30% (of the Recognized Charge)
More than a 30 day supply but less than a 91 day supply filled at a Mail Order Pharmacy	$45 Copayment per supply Coinsurance is 0% (of the Negotiated Charge)	Not covered
Tier 3 Prescription Drugs		
Per Prescription Copayment/Coinsurance		
For each fill up to a 30 day supply filled at a Retail or Specialty Pharmacy	$70 Copayment per supply Coinsurance is 0% (of the Negotiated Charge)	$70 Deductible per supply Coinsurance is 30% (of the Recognized Charge)
More than a 30 day supply but less than a 91 day supply filled at a Mail Order Pharmacy	$70 Copayment per supply Coinsurance is 0% (of the Negotiated Charge)	Not covered

*See *How to read your Schedule of Benefits* at the beginning of this Schedule of Benefits

Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a Pharmacy	No charge	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 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 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	No charge	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 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 member website at www.aetna.com or calling the number on your ID card.

*See *How to read your Schedule of Benefits* at the beginning of this Schedule of Benefits

Tobacco cessation Prescription and over-the-counter drugs		
Tobacco cessation Prescription Drugs and OTC drugs filled at a Pharmacy	No charge	Paid according to the type of drug per the Schedule of Benefits, above
Maximums:	Coverage is permitted for two 90-day treatment regimens only. 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 member website at www.aetna.com or calling the number on your ID card.	Coverage is permitted for two 90-day treatment regimens only. 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 member website at www.aetna.com or calling the number on your ID card.

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 equivalent is available, You will be responsible for the cost difference between the Brand-Name Prescription Drug and the Generic Prescription Drug equivalent, plus the cost sharing that applies to the Brand-Name Prescription Drug.

*See *How to read your Schedule of Benefits* at the beginning of this Schedule of Benefits

General coverage provisions

This section provides detailed explanations about the:

- Deductible
- Maximum Out-of-Pocket Limits
- Maximums

that are listed in the first part of this schedule of benefits.

Deductible provisions

Eligible Health Services applied to the out-of-network Deductibles will not be applied to satisfy the in-network Deductibles. Eligible Health Services applied to the Participating Deductibles will not be applied to satisfy the Non-Participating 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 in-network and 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 in-network and out-of-network Eligible Health Services each Calendar Year before the plan begins to pay for Eligible Health Services. After the amount You and Your covered dependents pay for Eligible Health Services reach this family Calendar Year Deductible, this plan will begin to pay for Eligible Health Services that You and Your covered dependents incur for the rest of the Calendar Year.

To satisfy this family Deductible limit for the rest of the Calendar Year, the following must happen:

- The combined Eligible Health Services that You and each of Your covered dependents incur towards the individual Calendar Year Deductibles must reach this family Deductible limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year Deductibles for You and Your covered dependents will be considered to be met for the rest of the Calendar Year.

Copayments

Copayment
As it applies to network coverage, this is a specified dollar amount or percentage that must be paid by You at the time You receive an Eligible Health Services from a Participating Provider.

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

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 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
- Any out of pocket costs for outpatient Prescription Drugs
- As it applies to out-of-network coverage: Charges, expenses or costs in excess of the Recognized Charge

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

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 benefits* at the beginning of this schedule of benefits.