Aetna Life Insurance Company

(a stock company)
151 Farmington Avenue
Hartford, Connecticut 06156

Student Health Insurance

Preferred Provider Organization (PPO)
Medical and Outpatient Prescription Drug Plan

Schedule of Benefits

Prepared exclusively for:

Policyholder:	Augustana College
Policyholder number:	175375
Student policy effective date:	08/01/2022
Plan effective date:	08/01/2022
Plan issue date:	12/20/2022
Actuarial value and metallic level:	87.17% - Platinum

Coverage provided by Aetna Life Insurance Company in the State of Illinois.

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.

Schedule of benefits

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

How to read your schedule of benefits

- When we say:
  - "In-network coverage", we mean you get care from our **in-network providers**.
  - "Out-of-network coverage", we mean you can get care from **out-of-network providers.**
- The **policy year deductibles, copayments** and **coinsurance** listed in the schedule of benefits below reflect the **policy year deductibles** and **copayment** and **coinsurance** amounts under your plan.
- The **coinsurance** listed in the schedule of benefits reflects the plan **coinsurance** percentage. This is the **coinsurance** amount that the plan pays. You are responsible for paying any remaining **coinsurance**.
- You are responsible for paying any **policy year deductibles**, **copayments**, and your **coinsurance**.
- You are responsible for full payment of any health care services you receive that are not **covered benefits**.
- This plan has maximums for specific **covered benefits**. For example, these could be visit, day or dollar maximums. They are combined maximums for **in-network providers** and **out-of-network providers** unless we state otherwise.
- At the end of this schedule of benefits you will find detailed explanations about your:
  - **Policy year deductibles**
  - **Copayments**
  - Maximums
  - **Coinsurance**
  - **Maximum out-of-pocket limits**

Important note:

All **covered benefits** are subject to the **policy year deductible**, **copayment** and **coinsurance** unless otherwise noted in the schedule of benefits below.

How to contact us for help

We are here to answer your questions.

- Log in to your Aetna website at www.aetnastudenthealth.com.
- Call Member Services at the toll-free number on your ID card 1-877-480-4161.

The coverage described in this schedule of benefits will be provided under **Aetna's student policy.** This schedule of benefits replaces any schedule of benefits previously in effect under the **student policy** for medical and pharmacy coverage. Keep this schedule of benefits with your certificate of coverage.

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.

Important note about your cost sharing:

The way the cost sharing works under this plan, you pay the **policy year deductible** first. Then you pay your **copayment** and then you pay your **coinsurance**. Your **copayment** does not apply towards any **policy year deductible**.

You are required to pay the **policy year deductible** before **eligible health services** are **covered benefits** under the plan, and then you pay your **copayment** and **coinsurance**.

Here's an example of how cost sharing works:

You pay your policy year deductible	**Your physician charges**	**Your physician collects the copayment from you**	**The plan pays 80% coinsurance**	**You pay 20% coinsurance**
$1,000	$120	$20	$80	$20

Plan features	**In-network coverage***	**Out-of-network coverage***
Policy year deductibles		
You have to meet your **policy year deductible** before this plan pays for benefits.		
Student	$250 per **policy year**	$500 per **policy year**
Policy year deductible waiver		
The **policy year deductible** is waived for all of the following **eligible health services:** • **In-network** care for *Preventive care and wellness, Pediatric Dental Type A services, Pediatric Vision Care, and Outpatient Prescription drugs* • **In-network** care and **out-of-network** care for *Physician, specialist including Consultants Office visits, Walk-in clinic visits, Hospital Emergency Room, Urgent Care, Outpatient mental health and substance abuse treatment office visits, Spinal manipulation services, and Well newborn nursery care.*		

Policy year maximum out-of-pocket limits		
Maximum out-of-pocket limit per **policy year**		
	In-network coverage*	**Out-of-network coverage***
Student	$5,000 per **policy year**	Unlimited

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Coinsurance listed in the schedule of benefits

The **coinsurance** listed in the schedule of benefits below reflects the plan **coinsurance** percentage. This is the **coinsurance** amount that the plan pays. You are responsible for paying any remaining **coinsurance**.

Eligible health services	In-network coverage*	Out-of-network coverage*
1. Preventive care and wellness		
Routine physical exams		
Performed at a **physician's** office	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Covered persons through age 21: Maximum age and visit limits per **policy year**	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 in to your Aetna website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Preventive care immunizations		
Performed in a facility or at a **physician's** office	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Maximums	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 in to your Aetna website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	

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Well woman preventive visits **Routine gynecological exams (including Pap smears)**		
Performed at a **physician's,** obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (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 Women's Preventive Services Guidelines.	
Preventive screening and counseling services		
Obesity and/or healthy diet counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Misuse of alcohol and/or drugs counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	70% (of the **recognized charge**) per visit
Use of tobacco products counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Depression screening counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Sexually transmitted infection counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit

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Genetic risk counseling for breast and ovarian cancer office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Skin cancer behavioral counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Falls prevention counseling office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Routine cancer screenings **Performed at a physician's office, specialist's office or facility.**		
Routine cancer screenings	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
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 into your Aetna website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	

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Prenatal care **Prenatal care services (provided by a physician, an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)**		
Preventive care services only	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Important note: You should review the *Maternity care* and *Well newborn nursery care* sections. They will give you more information on coverage levels for maternity care under this plan.		
Comprehensive lactation support and counseling services		
Lactation counseling services - facility or office visits	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit
Breast feeding durable medical equipment		
Breast pump supplies and accessories	100% (of the **negotiated charge**) per item No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per item
Important note: See the *Breast feeding durable medical equipment* section of the certificate of coverage for limitations on breast pump and supplies.		
Family planning services – female contraceptives		
Counseling services		
Female contraceptive counseling services office visit	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit

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Contraceptives (prescription drugs and devices)		
Female contraceptive **prescription drugs** and devices provided, administered, or removed, by a **provider** during an office visit	100% (of the **negotiated charge**) per item No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per item
Female voluntary sterilization		
Inpatient **provider** services	100% (of the **negotiated charge**) No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**)
Outpatient **provider** services	100% (of the **negotiated charge**) per visit No **copayment** or **policy year deductible** applies	60% (of the **recognized charge**) per visit

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Eligible health services	In-network coverage*	Out-of-network coverage*
2. Physicians and other health professionals		
Physician and specialist services (non-surgical and non-preventive)		
Office hours visits (non-surgical and non-preventive care by a **physician** and **specialist,** includes **telemedicine** consultations)	$20 **copayment** per visit then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	60% (of the **recognized charge**) per visit No **policy year deductible** applies
Allergy testing and treatment		
Allergy testing performed at a **physician's** or **specialist's** office	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Allergy injections treatment performed at a **physician's** or **specialist's** office	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Physician and specialist – inpatient surgical services		
Inpatient **surgery** performed during your **stay** in a **hospital** or **birthing center** by a surgeon (includes **anesthetist** and surgical assistant expenses)	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission
Physician and specialist –outpatient surgical services		
Outpatient surgery performed at a **physician**'s or **specialist**'s office or outpatient department of a **hospital** or **surgery center** by a surgeon (includes **anesthetist** and surgical assistant expenses)	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
In-hospital non-surgical physician services		
In-**hospital** non-surgical **physician** services	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission

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Consultant services (non-surgical and non-preventive)		
Consultant office visits		
Office hours visits (non-surgical and non-preventive care, includes **telemedicine** consultations)	$20 **copayment** per visit then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	60% (of the **recognized charge**) per visit No **policy year deductible** applies
Second surgical opinion		
Second surgical opinion	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)		
Walk-in clinic (non-emergency **charge)**	$20 **copayment** per visit then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	60% (of the **recognized charge**) per visit No **policy year deducible** applies
Important note: Some **walk-in clinics** can provide preventive care and wellness services. The types of services offered will vary by the **provider** and location of the clinic. *If you get preventive care and wellness benefits at a **walk-in clinic,** they are paid at the cost-sharing shown in the Preventive care and wellness section.*		

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Eligible health services	In-network coverage*	Out-of-network coverage*
3. Hospital and other facility care		
Hospital care (facility charges)		
Inpatient **hospital** (**room and board**) and other miscellaneous services and supplies Subject to **semi-private room rate** unless **intensive care unit** required **Room and board** intensive care For **physician** charges, refer to the *Physician and specialist-inpatient surgical services* benefit	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission
Preadmission testing		
Preadmission 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.
Anesthesia and related facility charges for a dental procedure ***Coverage is subject to certain conditions. See the benefit description in the certificate of coverage for details*.**		
Anesthesia and related facility charges for a dental procedure	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.
Alternatives to hospital stays		
Outpatient surgery (facility charges)		
Facility charges for **surgery** performed in the outpatient department of a **hospital** or **surgery center** For **physician** charges, refer to the *Physician and specialist - outpatient surgical services* benefit	80% (of the **negotiated charge**)	60% (of the **recognized charge**)

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Home health care		
Outpatient	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Hospice care		
Inpatient facility (**room and board** and other miscellaneous services and supplies)	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission
Outpatient	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Outpatient private duty nursing		
Outpatient private duty nursing	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Skilled nursing facility		
Inpatient facility (**room and board**) and miscellaneous inpatient care services and supplies Subject to **semi-private room rate** unless **intensive care unit** is required **Room and board** includes intensive care	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission

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Eligible health services	In-network coverage*	Out-of-network coverage*
4. Emergency services and urgent care		
Emergency services		
Hospital emergency room	$100 **copayment** per visit then the plan pays 80% (of the balance of the **negotiated charge**) No **policy year deductible** applies	Paid the same as in-network coverage
Emergency services resulting from a criminal sexual assault or abuse	100% (of the **negotiated charge**) per visit	Paid the same as in-network coverage

Important note:

- As **out-of-network providers** do not have a contract with us the **provider** may not accept payment of your cost share, (**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 ID card number is on the bill.
- A separate **hospital** emergency room **copayment** 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** will be waived and your inpatient **copayment** will apply.
- **Covered benefits** that are applied to the **hospital** emergency room **copayment** cannot be applied to any other **copayment** under the plan. Likewise, a **copayment** that applies to other **covered benefits** under the plan cannot be applied to the **hospital** emergency room **copayment.**
- Separate **copayment** amounts may apply for certain services given to you in the **hospital** emergency room that are not part of the **hospital** emergency room benefit. These **copayment** amounts may be different from the **hospital** emergency room **copayment**. They are based on the specific service given to you.
- Services given to you in the **hospital** emergency room that are not part of the **hospital** emergency room benefit may be subject to **copayment** amounts that are different from the **hospital** emergency room **copayment** amounts.

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Urgent care		
Urgent medical care provided by an **urgent care provider**	$50 **copayment** per visit then the plan pays 80% (of the balance of the **negotiated charge**) No **policy year deductible** applies	$50 **copayment** per visit then the plan pays 80% (of the balance of the **recognized charge**) No **policy year deductible** applies

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Eligible health services	In-network coverage*	Out-of-network coverage*
5. Pediatric dental care		
Limited to covered persons through the end of the month in which the person turns age 19		
Type A services	100% (of the **negotiated charge**) per visit No **copayment** or **deductible** applies	60% (of the **recognized charge**) per visit
Type B services	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Type C services	50% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Orthodontic services	50% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Dental emergency 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.
Dental benefits are subject to the medical plan's **policy year deductibles** and **maximum out-of-pocket limit**s as explained on the schedule of benefits.		

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Pediatric dental care schedule

Diagnostic and preventive care (type A services)
Dental service or supply
Visits and images
• Periodic oral examination (office or school setting), limited to 2 visits every 12 months
• Routine comprehensive or recall examination, limited to 2 visits every 12 months
• Problem-focused examination
• Oral examination performed in school setting, limited to 2 visits every 12 months
• Prophylaxis (cleaning) (office or school setting), limited to 2 treatments per year
• Topical application of fluoride (office or school setting), limited to 2 applications of treatment per year
• Topical application of fluoride varnish, limited to 3 treatments per year
• Sealants, per tooth, limited to one application every 3 years for permanent molars and premolars only
• Bitewing images, limited to 2 sets per year
• Complete image series, including bitewings if **medically necessary** or panoramic image, limited to 1 set every 36 months
• Vertical bitewing images, limited to 1 set every 36 months
• Panoramic Periapical images
• Intra-oral, occlusal view, maxillary or mandibular
• Emergency palliative treatment per visit
***Note: Any number of bitewings submitted for the same date of service is considered a set**
Space maintainers
• Space maintainers are covered only when needed to preserve space resulting from premature loss of posterior primary teeth (Includes all adjustments within 6 months after installation)
• Space maintainers - fixed, unilateral, per quadrant
• Space maintainers - fixed, bilateral upper and lower
• Space maintainers - removable unilateral
• Space maintainers – removable, bilateral upper and lower
• Re-cementation of space maintainer
• Removal of fixed space maintainer
Basic restorative care (type B services)
Dental service or supply
Visits and images
• Consultation (by other than the treating **provider)**
• Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)

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Oral surgery
• Extraction, coronal remnants
• Extraction, erupted tooth or exposed root
• Surgical removal of erupted tooth/root tip
• Impacted teeth, removal of tooth (soft tissue)
• Odontogenic cysts and neoplasms, incision and drainage of abscess
• Odontogenic cysts and neoplasms, removal of odontogenic cyst or tumor
• Closure of oral fistula of maxillary sinus
• Tooth reimplantation
• Alveoplasty, in conjunction with extractions, per quadrant
• Alveoplasty, in conjunction with extractions, per quadrant
• Alveoplasty, not in conjunction with extraction, per quadrant
• Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces, per quadrant
• Removal of exostosis
• Transplantation of tooth or tooth bud
• Crown exposure to aid eruption
• Frenectomy
• Excision of hyperplastic tissue
Periodontics
• Occlusal adjustment (other than with an appliance or by restoration)
• Periodontal scaling and root planing, per quadrant, limited to 4 separate quadrants every 2 years
• Periodontal scaling and root planing – 1 to 3 teeth per quadrant; limited to 4 separate quadrants every 2 years
• Gingivectomy, per quadrant, limited to 1 per quadrant every 24 months
• Gingivectomy, 1 to 3 teeth per quadrant, limited to 1 per site every 24 months
• Gingival flap procedure – per quadrant, limited to 1 per quadrant every 24 months
• Gingival flap procedure – 1 to 3 teeth per quadrant, limited to 1 per site every 24 months
• Periodontal scaling and root planing, per quadrant, limited to 4 separate quadrants every 2 years
• Periodontal scaling and root planing – 1 to 3 teeth per quadrant; limited to 4 separate quadrants every 2 years
Endodontics
• Pulp capping
• Pulpotomy
• Pulpal therapy
• Pulpal regeneration
• Apexification/recalcification
• Apicectomy

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• Root canal therapy including **medically necessary** images:
Anterior tooth
Premolar tooth
Restorative dentistry (Multiple restorations in 1 surface will be considered as a single restoration)
• Amalgam restorations
• Resin-based composite restorations (other than for molars)
Pins:
• Pin retention – per tooth, in addition to amalgam or resin restoration
Crowns (when tooth cannot be restored with a filling material):
• Prefabricated stainless steel
• Prefabricated resin crown (excluding temporary crowns)
Re-cementation:
• Inlay
• Crown
• Bridge
Major restorative care (type C services)
Dental service or supply
Oral surgery
• Surgical removal of impacted teeth:
Removal of tooth (partially bony)
Removal of tooth (completely bony)
Periodontics
• Clinical crown lengthening
• Osseous surgery (including flap and closure), limited to 1 per quadrant 24 months
• Osseous surgery (including flap and closure), 1 to 3 teeth per quadrant, limited to 1 per site every 24 months
• Soft tissue graft procedures
• Full mouth debridement, limited to 2 per year
Endodontics
Root canal therapy including medically necessary images:
• Molar tooth
Retreatment of previous root canal therapy including medically necessary images:
• Molar tooth
Restorative (Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic **injury** and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge.)
• Inlays/Onlays - limited to 1 per tooth every 5 years

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Crowns (limited to 1 per tooth every 5 years):
• Resin, limited to 1 per tooth every 5 years
• Resin with noble metal, limited to 1 per tooth every 5 years
• Resin with base metal, limited to 1 per tooth every 5 years
• Porcelain/ceramic substrate, limited to 1 per tooth every 5 years
• Porcelain with noble metal, limited to 1 per tooth every 5 years
• Porcelain with base metal, limited to 1 per tooth every 5 years
• ¾ cast metallic or porcelain/ceramic, limited to 1 per tooth every 5 years
• Full cast base metal, limited to 1 per tooth every 5 years
• Full cast noble metal, limited to 1 per tooth every 5 years
• Titanium, limited to 1 per tooth every 5 years
• Core build-up
• Post and core
Prosthodontics
• Replacement of existing bridges or dentures, limited to 1 every 5 years
• Installation of dentures and bridges is covered only if needed to replace teeth which were not abutments to a denture or bridge less than 5 years old
• Bridge abutments (see inlays and crowns),), limited to 1 every 5 years
Dentures and partial dentures (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)
• Complete upper denture, limited to 1 every 5 years
• Complete lower denture, limited to 1 every 5 years
• Immediate upper denture/immediate upper partial denture, limited to 1 every 5 years
• Immediate lower denture/immediate upper partial denture, limited to 1 every 5 years
• Immediate upper denture/Immediate upper partial denture, limited to 1 every 5 years
• Immediate lower denture/Immediate lower partial denture, limited to 1 every 5 years
• Partial upper or lower, resin base (including any conventional clasps, rests and teeth), limited to 1 every 5 years
• Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth), limited to 1 every 5 years
• Stress breakers
• Interim partial denture (stayplate), anterior only
• Office reline
• Laboratory relines
• Special tissue conditioning, per denture
• Rebase, per denture
• Adjustment to denture (more than 6 months after installation)

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• Full and partial denture repairs:
Broken dentures, no teeth involved
Repair cast framework
• Replacing missing or broken teeth, each tooth:
Adding teeth to existing partial denture
Each tooth
Each clasp
• Repairs: crowns and bridges
• Occlusal guard (for bruxism only)
• Occlusal guard adjustment (not eligible within first 6 months after placement of appliance)
Pontics:
• Full cast base metal, limited to 1 every 5 years
• Full cast noble metal, limited to 1 every 5 years
• Titanium, limited to 1 every 5 years
• Porcelain with base metal, limited to 1 every 5 years
• Porcelain with noble metal, limited to 1 every 5 years
• Resin with noble metal, limited to 1 every 5 years
• Resin with base metal, limited to 1 every 5 years
• Removable bridge (unilateral), limited to 1 every 5 years
• One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics, limited to 1 every 5 years
General Anesthesia and Intravenous Sedation
• General anesthesia and IV sedation only when **medically necessary** and only when provided in conjunction with a covered dental surgical procedure
• Nitrous oxide/analgesia
• Therapeutic drug injection, limited to medical necessity
• Non-intravenous conscious sedation
• Other drugs or medicaments, by report
Orthodontic services **Medically necessary** comprehensive treatment. **Medically necessary** orthodontic treatment (includes removal of appliances and construction and placement of retainers.)
All comprehensive orthodontic services require **precertification** to ensure treatment is **medically necessary**. To qualify for coverage, your severe, dysfunctional, handicapping malocclusion may be evaluated using the Modified Salzmann Index where coverage would need to score 42 points or greater.
• Orthodontic waiting period, none

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Eligible health services	In-network coverage*	Out-of-network coverage*
6. Specific conditions		
Birthing center (facility charges)		
Inpatient (**room and board** and other miscellaneous services and supplies)	Paid at the same cost-sharing as hospital care.	Paid at the same cost-sharing as hospital care.
Diabetic services and supplies (including equipment and training)		
Diabetic services and supplies (including equipment and training)	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		
Inpatient **physician** or **specialist surgical** services	100% (of the **negotiated charge**) No **policy year deductible** applies	60% (of the **recognized charge**)
Outpatient **physician** or **specialist surgical** services	100% (of the **negotiated charge**) No **policy year deductible** applies	60% (of the **recognized charge**)
Abortion		
Inpatient **physician** or **specialist surgical** services	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission
Outpatient **physician** or **specialist surgical** services	80% (of the **negotiated charge**)	60% (of the **recognized charge**)
Travel and lodging expenses		
Travel and lodging reimbursement	100% No **policy year deductible** applies	
Limit per **policy year**	$3000	

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.

Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment		
TMJ and **CMJ** 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.
Impacted wisdom teeth		
Impacted wisdom teeth	80% (of the **negotiated charge**)	60% (of the **recognized charge**)
Accidental injury to sound natural teeth		
Accidental **injury** to **sound natural teeth**	80% (of the **negotiated charge**)	60% (of the **recognized charge**)
Dermatological treatment		
Dermatological 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 care		
Maternity care (includes delivery and postpartum care services in a **hospital** or **birthing center**)	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.
Well newborn nursery care		
Well newborn nursery care in a **hospital** or **birthing center**	80% (of the **negotiated charge**) No **policy year deductible** applies	60% (of the **recognized charge**) No **policy year deductible** applies
Note: *If applicable, the per admission* ***copayment*** *and/or* ***policy year deductible*** *amounts for newborns will be waived for nursery charges for the duration of the newborn's initial routine facility* ***stay****. The nursery charges waiver will not apply for non-routine facility* ***stays****.*		
Gender affirming treatment		
Surgical, hormone replacement therapy, and counseling 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.

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.

Autism spectrum disorder		
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.
Autism spectrum disorder treatment (includes **physician** and **specialist** 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.
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.
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.
Behavioral health		
Mental health treatment – inpatient		
Inpatient **hospital mental health disorders** treatment (**room and board** and other miscellaneous **hospital** services and supplies) Inpatient **residential treatment facility mental health disorders** treatment (**room and board** and other **miscellaneous residential treatment facility** services and supplies) Subject to **semi-private room rate** unless intensive care unit is required **Mental health disorder room and board** intensive care	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.

Mental health treatment – outpatient		
Outpatient **mental health disorder** treatment office visits to a **physician** or **behavioral health provider** (includes **telemedicine** consultations)	$20 **copayment** per visit then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	60% (of the **recognized charge**) per visit No **policy year deductible** applies
Other outpatient **mental health disorders** treatment (includes skilled behavioral health services in the home) **Partial hospitalization treatment** **Intensive outpatient program**	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Substance use related disorders treatment-inpatient		
Detoxification – inpatient		
Inpatient **hospital substance use** detoxification (**room and board** and other miscellaneous hospital services and supplies) Inpatient **hospital substance use disorder** rehabilitation (**room and board** and other miscellaneous **hospital** services and supplies) Inpatient **residential treatment facility substance use** disorder (**room and board** and other **miscellaneous residential treatment facility** services and supplies) Subject to **semi-private room rate** unless **intensive care unit** is required **Substance use disorder** r**oom and board** intensive care	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.

Substance use related disorder treatment-outpatient: detoxification and rehabilitation		
Outpatient **substance use disorder** office visits to a **physician** or **behavioral health provider** (includes **telemedicine** consultations)	$20 **copayment** per visit then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	60% (of the **recognized charge**) per visit No **policy year deductible** applies
Other outpatient **substance use** disorder services **Partial hospitalization treatment** **Intensive Outpatient Program**	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Obesity (bariatric) surgery		
Obesity **surgery**-- inpatient and outpatient facility and **physician** 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.
Reconstructive surgery and supplies		
Reconstructive surgery and supplies (includes 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.

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.

Eligible health services	**In-network coverage** (IOE facility)*	**Out-of-network coverage*** (Includes providers who are otherwise part of Aetna's network but are non-IOE providers)
Transplant services		
Inpatient and outpatient transplant facility 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.
Inpatient and outpatient transplant **physician** and **specialist** 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.
Transplant services-travel and lodging		
Transplant services-travel and lodging	Covered	
Maximum Benefit payable for Travel and Lodging Expenses for any one transplant, including tandem transplants	$10,000	
Maximum Benefit payable for Lodging Expenses per **IOE** patient	$50 per night	
Maximum Benefit payable for Lodging Expenses per companion	$50 per night	

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.

Eligible health services	In-network coverage*	Out-of-network coverage*
Treatment of infertility		
Basic infertility services		
Inpatient and outpatient care - 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.
Comprehensive infertility services		
Inpatient and outpatient care - comprehensive infertility 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.
Advanced reproductive technology (ART) service		
Inpatient and outpatient care – ART 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.
For treatment that includes an oocyte retrieval, maximum number of oocyte retrievals	4, however if a live birth follows a completed oocyte retrieval, 2 additional oocyte retrievals will be covered.	

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.

Eligible health services	In-network coverage*	Out-of-network coverage*
7. Specific therapies and tests		
Outpatient diagnostic testing		
Diagnostic complex imaging services		
Diagnostic complex imaging services performed in the outpatient department of a **hospital** or other facility No additional expense, such as a **copayment** or **deductible** amount, will be imposed for mammograms	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Diagnostic lab work and radiological services		
Diagnostic lab work and radiological services performed in the outpatient department of a **hospital** or other facility No additional expense, such as a **copayment** or **deductible** amount, will be imposed for mammograms	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Chemotherapy		
Chemotherapy	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Eligible health services	**In-network coverage (GCIT-designated facility/provider)***	**Out-of-network coverage*** (Including **providers** who are otherwise part of **Aetna's** network but are not GCIT designated facilities/**providers**)
Gene-based, cellular and other innovative therapies (GCIT)		
Services and supplies	Covered according to the type of benefit and the place where the service is received.	Not covered

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.

Eligible health services	In-network coverage*	Out-of-network coverage*
Outpatient infusion therapy		
Outpatient infusion therapy performed in a **covered person's** home, **physician's** office, outpatient department of a **hospital** or other facility	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
Outpatient radiation therapy		
Outpatient radiation therapy	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Specialty prescription drugs **(Purchased and injected or infused by your provider in an outpatient setting)**		
Specialty prescription drugs purchased and injected or infused by your **provide**r in an outpatient setting	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
Outpatient respiratory therapy		
Respiratory therapy	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Transfusion or kidney dialysis of blood		
Transfusion or kidney dialysis of blood	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	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Pulmonary rehabilitation		
Pulmonary rehabilitation	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.

Short-term rehabilitation and habilitation therapy services		
Outpatient physical, occupational, speech, and cognitive therapies Combined for short-term rehabilitation services and habilitation therapy services	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Maximum visits per **policy year**	Unlimited	
Chiropractic services		
Chiropractic services	$30 **copayment** then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **policy year deductible** applies	60% (of the **recognized charge**) No **policy year deductible** applies
Diagnostic testing for learning disabilities		
Diagnostic testing for learning disabilities	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 the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.

Eligible health services	In-network coverage*	Out-of-network coverage*
8. Other services and supplies		
Ambulance service		
Emergency ground, air or water **ambulance**	80% (of the **negotiated charge**) per trip	Paid the same as in-network coverage
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)		
Durable medical equipment	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item
Nutritional support		
Nutritional Support	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 (non-preventive care)		
Physician's or **specialist'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.
Orthotic devices		
	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.

Prosthetic and customized devices		
Prosthetic and customized orthotic devices	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item
Cranial prosthetics *(Medical wigs)*	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item
Prosthetic devices	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item
Hearing aids		
Hearing aids **Covered persons** under age 18	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item
Hearing aid maximum	One hearing aid per ear every 36 months	
Hearing aids		
Hearing aids	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item
Hearing aid maximum per ear	One hearing aid per ear every 36 months	
Hearing exams		
Hearing exams Covered persons over age 18	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit
Podiatric (foot care) treatment		
Physician and **Specialist** non-routine foot care 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.

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.

Vision care		
Pediatric vision care **Limited to covered persons through the end of the month in which the person turns age 19**		
Pediatric routine vision exams (including refraction)		
Performed by a legally qualified ophthalmologist or optometrist	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	60% (of the **recognized charge**) per visit
Pediatric comprehensive low vision evaluations		
Performed by a legally qualified ophthalmologist or optometrist	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.
Maximum	One comprehensive low vision evaluation every policy year	
Pediatric vision care services and supplies		
Office visit for fitting of contact lenses	100% (of the **negotiated charge**) per visit No **policy year deductible** applies	60% (of the **recognized charge**) per visit
Pediatric vision care services and supplies		
Eyeglass frames, **prescription** lenses or **prescription** contact lenses	100% (of the **negotiated charge**) per item No **policy year deductible** applies	60% (of the **recognized charge**) per item
Maximum number of eyeglass frames per **policy year**	One set of eyeglass frames	
Maximum number of **prescription** lenses per **policy year**	One pair of **prescription** lenses	
Maximum number of **prescription** contact lenses per **policy year** (includes nonconventional **prescription** contact lenses and aphakic lenses prescribed after cataract surgery)	Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set	

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.

Optical 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.
Maximum number of optical devices per **policy year**	One optical device	
***Important note:** Refer to the *Vision care* section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for **prescription** lenses in a **policy year**, this benefit will cover either **prescription** lenses for eyeglass frames or **prescription** contact lenses, but not both.		

Eligible health services	In-network coverage*	Out-of-network coverage*
9. Outpatient prescription drugs		
Plan features		
Outpatient **prescription drug** benefits are subject to the medical plan's **policy year deductibles** and **maximum out-of-pocket limit**s as explained earlier in this schedule of benefits.		
Policy year deductible waiver		
The **policy year deductible** is waived for all **non-preferred preferred brand-name value preferred generic, generic prescription drugs** filled at an in-network, and out-of-network **retail pharmacy** or **mail order pharmacy.**		
Policy year deductible and copayment waiver for risk reducing breast cancer		
The **policy year deductible** will not apply to risk reducing breast cancer **prescription drugs** when obtained at a **retail** or **mail order** in-network **pharmacy**. This means that such risk reducing breast cancer **prescription drugs** are paid at 100%.		
Policy year deductible and copayment waiver for tobacco cessation prescription and over-the-counter drugs		
The **policy year deductible** and the **prescription** drug **copayment** will not apply to the first two 90 day treatment regimens per **policy year** for tobacco cessation **prescription drugs** and OTC drugs when obtained at a **retail** or **mail order in-network pharmacy**. This means that such **prescription drugs** and OTC drugs are paid at 100%. Your **policy year deductible** and any **prescription drug copayment** will apply after those two regimens per **policy year** have been exhausted.		

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.

Policy year deductible and copayment waiver for contraceptives

The **policy year deductible** and the **prescription drug copayment** will not apply to female contraceptive methods when obtained at an **in-network pharmacy**.

This means that such contraceptive methods are paid at 100% for:

- 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** or device for that method paid at 100%.

The **policy year deductible** and the **prescription drug copayment** continue to apply to **prescription drugs** that have a generic equivalent, biosimilar or generic alternative available within the same **therapeutic drug class** obtained at an **in-network pharmacy** unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.

Preferred generic prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a **retail pharmacy**	$20 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	Not covered
More than a 30 day supply but less than a 90 day supply filled at a **mail order pharmacy**	$60 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	Not covered
Non-preferred generic prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a **retail pharmacy**	$60 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	Not covered

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.

More than a 30 day supply but less than a 90 day supply filled at a **mail order pharmacy**	$180 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	Not covered
Preferred brand-name prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a **retail pharmacy**	$40 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	Not covered
More than a 30 day supply but less than a 90 day supply filled at a **mail order pharmacy**	$120 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	Not covered
Non-preferred brand-name prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a **retail pharmacy**	$60 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	Not covered
More than a 30 day supply but less than a 90 day supply filled at a **mail order pharmacy**	$180 **copayment** per supply then the plan pays 100% (of the balance of the **negotiated charge**) No **policy year deductible** applies	Not covered

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.

Diabetic Insulin		
30 day supply at **retail pharmacy**	Paid according to the type of drug per the schedule of benefits above	Not covered
90 day supply at **mail order pharmacy**	Paid according to the type of drug per the schedule of benefits above	Not covered
Important note: Your cost share will not exceed $100 per 30 day supply of a covered **prescription** insulin drug filled at a **network pharmacy**. No **deductible** applies for insulin.		
Contraceptives (birth control)		
For each fill up to a 12 month supply of generic and OTC drugs and devices filled at a **retail** or **mail order pharmacy**	100% (of the **negotiated charge**) No **policy year deductible** applies	Not covered
For each fill up to a 12 month supply of brand name prescription drugs and devices filled at a **retail** or **mail order pharmacy**	Paid according to the type of drug per the schedule of benefits above	Not covered
Orally administered anti-cancer prescription drugs		
For each fill up to a 30 day supply filled at a **retail pharmacy**	100% (of the **negotiated charge**) per **prescription** or refill No **policy year deductible** applies	Not covered

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.

Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a **retail pharmacy** For each 30 day supply	100% (of the **negotiated charge**) per **prescription** or refill No **copayment** or **policy year deductible** applies	Not covered
Maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging in to your Aetna website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Risk reducing breast cancer prescription drugs		
Risk reducing breast cancer **prescription drugs** filled at a **pharmacy** For each 30 day supply	100% (of the **negotiated charge**) per **prescription** or refill No **copayment** or **policy year deductible** applies	Not covered
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered risk reducing breast cancer **prescription drugs**, contact Member Services by logging in to your Aetna website at www.aetnastudenthealth.com or calling the toll-free number on your ID card 1-877-480-4161.	

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.

Tobacco cessation prescription and over-the-counter drugs		
Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** For each 30 day supply	100% (of the **negotiated charge**) per **prescription** or refill No **copayment** or **policy year deductible** applies	Not covered
Maximums	Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits above. 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**, contact **Member Services** by calling the toll-free number on your ID card.	

Generic prescription drug substitution

If you or your **prescriber** requests a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost difference between the **generic prescription drug** and the **brand-name prescription drug**, plus the cost sharing that applies to the **brand-name prescription drug**.

The cost difference is not applied towards your **maximum out-of-pocket limit**.

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.

General coverage provisions

This section provides detailed explanations about the:

- **Policy year deductibles**
- **Copayments**
- Maximums
- **Coinsurance**
- **Maximum out-of-pocket limits**

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

Policy year deductible provisions

Eligible health services that are subject to the **policy year deductible** include **covered benefits** provided under the medical plan and outpatient **prescription drug** benefits provided under the **prescription drug** benefit.

Eligible health services applied to the out-of-network **policy year deductibles** will not be applied to satisfy the in-network **policy year deductibles**. **Eligible health services** applied to the in-network **policy year deductibles** will not be applied to satisfy the out-of-network **policy year deductibles**.

The in-network and out-of-network **policy year deductible** may not apply to certain **eligible health services**. You must pay any applicable **copayments** for **eligible health services** to which the **policy year deductible** does not apply.

Individual
This is the amount you owe for in-network and out-of-network **eligible health services** each **policy year** before the plan begins to pay for **eligible health services**. See the *Policy year deductibles* provision at the beginning of this schedule for any exceptions to this general rule. This **policy year deductible** applies separately to you. After the amount you pay for **eligible health services** reaches the **policy year deductible**, this plan will begin to pay for **eligible health services** for the rest of the **policy year**.

Copayments

In-network coverage
This is a specified dollar amount or percentage that must be paid by you when you receive **eligible health services** from an **in-network provider**. If **Aetna** compensates **in-network providers** on the basis of the **negotiated charge** amount, your percentage **copayment** is based on this amount.

Out-of-network coverage
This is a specified dollar amount or percentage that must be paid by you when you receive **eligible health services** from an **out-of-network provider**. If **Aetna** compensates **out-of-network providers** on the basis of the **recognized charge** amount, your percentage **copayment** is based on this amount.

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.

Coinsurance

Coinsurance is both the percentage of **eligible health services** that the plan pays and what you pay. The specific percentage that we have to pay for **eligible health services** is listed earlier in the schedule of benefits. **Coinsurance** is not a **copaymen**t.

Maximum out-of-pocket limits provisions

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

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 **policy year deductibles** for **eligible health services** during the **policy year**. This plan has an individual **maximum-out-of-pocket limit**.

Individual
Once the amount of the **copayments**, **coinsurance** and **policy year deductibles** you have paid for **eligible health services** during the **policy year** meets the individual **maximum out-of-pocket limits**, this plan will pay:

- 100% of the **negotiated charge** for in-network **covered benefits**
- 100% of the **recognized charge** for out-of-network **covered benefits**

that apply towards the limits for the rest of the **policy year** for that person.

Medical and Outpatient Prescription Drugs

In-network care
Costs that you incur that do not apply to your in-network **maximum out-of-pocket limits**.
Certain costs that you incur do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services

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 **policy year**. Determinations regarding when benefits are covered are subject to the terms and conditions of the certificate of coverage.

*See the *How to read your schedule of benefits, Important note about your cost sharing* and *Important notices* sections of this schedule of benefits.