



**Open Choice®  
Preferred Provider Organization (PPO)  
Medical and Outpatient Prescription Drug Plan**

**Schedule of Benefits**

**Prepared exclusively for:**

<b>Policyholder:</b>	Eastern Washington University
<b>Policyholder number:</b>	686215
<b>Student policy effective date:</b>	September 17, 2024
<b>Plan effective date:</b>	September 17, 2024
<b>Plan issue date:</b>	August 20, 2024
<b>Actuarial value and metallic level:</b>	88.64% - Platinum

**Underwritten by Aetna Life Insurance Company  
in the state of Washington**

## Schedule of benefits

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This schedule of benefits lists the **policy year deductibles, copayments** and **coinsurance**, if any, that apply to the **eligible health services** you receive under this plan. You should review this schedule of benefits to become familiar with these 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 reflects the **policy year deductibles, copayment** and **coinsurance** amounts under your plan.
- Any **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**.
- Sometimes we don’t show a specific cost share for a benefit. Instead we say, “Covered based on the type of service and where it is received.” That means your cost share will depend on the exact care you get and who provides it. For example, if you receive services for diabetes from a **health professional** in their office, you will pay the cost share listed in *Health professional services*. If you receive services for diabetes during a **hospital stay**, you will pay the cost share listed in *Hospital care*.
- 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 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 for **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 any:
  - **Policy year deductibles**
  - **Copayments**
  - **Coinsurance**
  - **Maximum out-of-pocket limits**

**Important note:** All **covered benefits** are subject to any **policy year deductible, copayment** and **coinsurance** unless otherwise noted in the schedule of benefits below. *Your Rights and Protections Against Surprise Medical Bills and Balance Billing* explains your protections from a surprise bill. See your certificate for this consumer notice.

## How to contact us for help

We are here to answer your questions.

- Log onto your Aetna® website at <https://www.aetnastudenthealth.com>
- Call Member Services at the toll-free number 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.

### Important note about your medical cost sharing:

The way your medical cost sharing works under this plan, you pay the **policy year deductible** first. Then you pay any applicable copayment and **coinsurance**. Your emergency room **copayment** does not apply towards any **policy year deductible**. Any cost share for diabetic insulin applies towards your **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 any applicable **copayment** and **coinsurance**.

Here’s an example of how your medical cost sharing works:

You pay your policy year deductible	Your physician charges	Your physician collects from you	The plan pays 80% coinsurance	You pay 20% coinsurance
\$250	\$120	\$0	\$96	\$24

## General coverage provisions

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This section provides detailed explanations about:

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

### Policy year deductibles

**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 deductibles** may not apply to certain **eligible health services**. You must pay any applicable **copayments** for **eligible health services** to which the **policy year deductibles** do not apply. **Copayments** do not apply towards your **policy year deductible** except for any cost share for diabetic insulin.

### 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* section of this schedule for any exceptions to this general rule. This **policy year deductible** applies separately to you and each of your **covered dependents**. 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 a **network provider**.

### 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 in the schedule of benefits below. **Coinsurance** is not a **copayment**.

### Maximum out-of-pocket limits

**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 outpatient **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**.

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

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 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 **policy year deductibles** you and your **covered dependents** 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.

### **Family**

Once the amount of the **copayments, coinsurance** and **policy year deductibles** you and your **covered dependents** have paid for **eligible health services** during the **policy year** meets this family **maximum out-of-pocket limit**, 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 all covered family members.

To satisfy this family **maximum out-of-pocket limit** for the rest of the **policy 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 **policy year**.

Certain costs that you incur do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services
- Any out of pocket costs incurred for non-emergency use of the emergency room
- Any out of pocket costs incurred for non-urgent use of an **urgent care provider**

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

Plan features	In-network coverage	Out-of-network coverage
<b>Policy year deductibles</b>		
You have to meet your <b>policy year deductible</b> before this plan pays for benefits.		
Student	\$250 per <b>policy year</b>	\$500 per <b>policy year</b>
Spouse	\$250 per <b>policy year</b>	\$500 per <b>policy year</b>
Each child	\$250 per <b>policy year</b>	\$500 per <b>policy year</b>
<b>Policy year deductible waiver</b>		
<p>The <b>policy year deductible</b> is waived for all of the following <b>eligible health services</b>:</p> <ul style="list-style-type: none"> <li>• In-network care for: <ul style="list-style-type: none"> <li>– <i>Preventive care and wellness services</i></li> <li>– <i>Pediatric dental care - Type A services</i></li> <li>– <i>Pediatric vision care services</i></li> <li>– <i>Abortion</i></li> <li>– <i>Ambulance</i></li> </ul> </li> <li>• In-network and out-of-network care for: <ul style="list-style-type: none"> <li>– <i>Hospital emergency room services</i></li> <li>– <i>Outpatient prescription drugs</i></li> </ul> </li> </ul>		
<b>Maximum out-of-pocket limits</b>		
<b>Maximum out-of-pocket limit per policy year.</b>		
Student	\$ 4,500 per <b>policy year</b>	\$9,000 per <b>policy year</b>
Spouse	\$4,500 per <b>policy year</b>	\$9,000 per <b>policy year</b>
Each child	\$4,500 per <b>policy year</b>	\$9,000 per <b>policy year</b>
Family	\$9,000 per <b>policy year</b>	\$18,000 per <b>policy year</b>
<b>Coinsurance listed in the schedule of benefits</b>		
<p>The <b>coinsurance</b> listed in the schedule of benefits below reflects the plan <b>coinsurance</b> percentage. This is the <b>coinsurance</b> amount that the plan pays. You are responsible for paying any remaining <b>coinsurance</b>.</p>		
<b>School health services benefits</b>		
<p>The <b>policy year deductible</b> is waived and benefits will be paid at 100% for <b>eligible health services</b> received as <b>school health services</b>. This includes lab work performed at LabCorp when referred by <b>school health services</b>.</p>		

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

Eligible health services	In-network coverage	Out-of-network coverage
<b>1. Preventive care and wellness</b>		
<b>Routine physical exams</b>		
Performed at a <b>health professional's</b> office	100% (of the <b>negotiated charge</b> ) per visit  No <b>copayment</b> or <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> ) per visit
<b>Covered persons</b> through age 21: Maximum age and visit limits per <b>policy year</b>	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 <b>health professional</b> or <b>Aetna</b> by logging onto your Aetna website at <a href="https://www.aetnastudenthealth.com">https://www.aetnastudenthealth.com</a> or calling the toll-free number in the <i>How to contact us for help</i> section.	
<b>Covered persons</b> age 22 and over: Maximum visits per <b>policy year</b>	1 visit	
<b>Preventive care immunizations</b>		
Performed in a facility or at a <b>health professional's</b> office	100% (of the <b>negotiated charge</b> ) per visit  No <b>copayment</b> or <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> ) 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 <b>health professional</b> or <b>Aetna</b> by logging onto your Aetna website at <a href="https://www.aetnastudenthealth.com">https://www.aetnastudenthealth.com</a> or calling the toll-free number in the <i>How to contact us for help</i> section.	

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

<b>Well woman preventive visits, routine gynecological exams (including Pap smears)</b>		
Performed at a <b>health professional's</b> office, such as an obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the <b>negotiated charge</b> ) per visit  No <b>copayment</b> or <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> ) per visit
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	
Maximum visits per <b>policy year</b>	1 visit	
<b>Preventive screening and counseling services</b>		
Obesity and/or healthy diet counseling office visits	100% (of the <b>negotiated charge</b> ) per visit  No <b>copayment</b> or <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> ) per visit
Misuse of alcohol and/or drugs counseling office visits	100% (of the <b>negotiated charge</b> ) per visit  No <b>copayment</b> or <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> ) per visit
Use of tobacco products counseling office visits	100% (of the <b>negotiated charge</b> ) per visit  No <b>copayment</b> or <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> ) per visit
Depression screening counseling office visits	100% (of the <b>negotiated charge</b> ) per visit  No <b>copayment</b> or <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> ) per visit
Sexually transmitted infection counseling office visits	100% (of the <b>negotiated charge</b> ) per visit  No <b>copayment</b> or <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> ) per visit

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



Genetic risk counseling for breast and ovarian cancer office visits	100% (of the <b>negotiated charge</b> ) per visit  No <b>copayment</b> or <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> ) per visit
Age and frequency limitations	Not subject to any age or frequency limitations	
<b>Routine cancer screenings (applies whether performed at a health professional’s office or a facility)</b>		
Routine cancer screenings, including diagnostic and supplemental breast exams	100% (of the <b>negotiated charge</b> ) per visit  No <b>copayment</b> or <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> ) per visit
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> <li>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, including colorectal cancer screenings for adults starting either at age 45, or earlier if at increased risk due to health factors or family history</li> <li>The comprehensive guidelines supported by the Health Resources and Services Administration</li> </ul> For details, contact your <b>health professional</b> or <b>Aetna</b> by logging onto your Aetna website at <a href="https://www.aetnastudenthealth.com">https://www.aetnastudenthealth.com</a> or calling the toll-free number in the <i>How to contact us for help</i> section.	
Lung cancer screening maximums	1 screening every 12 months	
<b>Important note:</b> Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the <i>Outpatient diagnostic testing</i> section.		
<b>Prenatal care services (provided by a health professional, an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)</b>		
Preventive care services only	100% (of the <b>negotiated charge</b> ) per visit  No <b>copayment</b> or <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> ) per visit
<b>Important note:</b> You should review the <i>Maternity care</i> section. They will give you more information on coverage levels for maternity care under this plan.		

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

<b>Comprehensive lactation support and counseling services</b>		
Lactation counseling services - facility or office visits	100% (of the <b>negotiated charge</b> ) per visit  No <b>copayment</b> or <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> ) per visit
<b>Breast feeding durable medical equipment</b>		
Breast pump supplies and accessories	100% (of the <b>negotiated charge</b> ) per item  No <b>copayment</b> or <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> ) per item
<b>Important note:</b> See the <i>Breast feeding durable medical equipment</i> section of the certificate of coverage for limitations on breast pump and supplies.		
<b>Family planning services</b>		
<b>Counseling services</b>		
Contraceptive counseling services office visit	100% (of the <b>negotiated charge</b> ) per visit  No <b>copayment</b> or <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> ) per visit
<b>Contraceptives (prescription drugs and devices)</b>		
Contraceptive <b>prescription drugs</b> and devices provided, administered, or removed, by a <b>provider</b> or other <b>health professional</b> during an office visit	100% (of the <b>negotiated charge</b> ) per item  No <b>copayment</b> or <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> ) per item
<b>Voluntary sterilization</b>		
Inpatient	100% (of the <b>negotiated charge</b> ) per visit  No <b>copayment</b> or <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> ) per visit
Outpatient	100% (of the <b>negotiated charge</b> ) per visit  No <b>copayment</b> or <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> ) per visit

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

Eligible health services	In-network coverage	Out-of-network coverage
<b>2. Physicians and other health professionals</b>		
<b>Health professional services</b>		
Office hours visits (non-surgical and non-preventive care) by a <b>health professional</b>  Includes <b>telemedicine</b> consultation or use of <b>store and forward technology</b>	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
<b>Allergy testing and treatment</b>		
Allergy testing performed at a <b>health professional's office</b>	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
Allergy sera and extracts administered via injection at a <b>health professional's office</b>	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
<b>Physician and specialist - inpatient surgical services</b>		
Inpatient <b>surgery</b> performed during your <b>stay</b> in a <b>hospital</b> or <b>birthing center</b> by a surgeon (includes anesthetist and <b>surgical</b> assistant expenses)	80% (of the <b>negotiated charge</b> )	60% (of the <b>recognized charge</b> )
<b>Physician and specialist - outpatient surgical services</b>		
Outpatient <b>surgery</b> performed at a <b>physician's</b> or <b>specialist's</b> office or outpatient department of a <b>hospital</b> or <b>surgery center</b> by a surgeon (includes anesthetist and <b>surgical</b> assistant expenses)	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
<b>In-hospital non-surgical health professional services</b>		
In-hospital non-surgical <b>health professional</b> services	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit

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

<b>Consultant services (non-surgical and non-preventive)</b>		
<b>Consultant office visits</b>		
Office hours visits (non-surgical and non-preventive care)  Includes <b>telemedicine</b> consultation or use of <b>store and forward technology</b>	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
<b>Alternatives to physician or other health professional office visits</b>		
<b>Walk-in clinic visits</b>		
<b>Walk-in clinic</b> (non-emergency visit)	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
<b>Important note:</b> Some <b>walk-in clinics</b> can provide preventive care and wellness services. The types of services offered will vary by the <b>provider</b> and location of the clinic. If you get preventive care and wellness benefits at a <b>walk-in clinic</b> , they are paid at the cost-sharing shown in the <i>Preventive care and wellness</i> section.		

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

Eligible health services	In-network coverage	Out-of-network coverage
<b>3. Hospital and other facility care</b>		
<b>Hospital care (facility charges)</b>		
<p>Inpatient <b>hospital (room and board)</b> and other services and supplies</p> <p>Subject to <b>semi-private room rate</b> unless intensive care unit required</p> <p><b>Room and board</b> includes intensive care</p> <p>For <b>physician</b> charges, refer to the <i>Physician and specialist – inpatient surgical services</i> benefit</p>	<p>80% (of the <b>negotiated charge</b>) per admission</p>	<p>60% (of the <b>recognized charge</b>) per admission</p>
<b>Preadmission testing</b>		
<p>Preadmission testing</p>	<p>Covered according to the type of benefit and the place where the service is received</p>	<p>Covered according to the type of benefit and the place where the service is received</p>
<b>Alternatives to hospital stays</b>		
<b>Outpatient surgery (facility charges)</b>		
<p>Facility charges for <b>surgery</b> performed in the outpatient department of a <b>hospital</b> or <b>surgery center</b></p> <p>For <b>physician</b> charges, refer to the <i>Physician and specialist - outpatient surgical services</i> benefit</p>	<p>80% (of the <b>negotiated charge</b>) per visit</p>	<p>60% (of the <b>recognized charge</b>) per visit</p>
<b>Home health care</b>		
<p>Outpatient</p>	<p>80% (of the <b>negotiated charge</b>) per visit</p>	<p>60% (of the <b>recognized charge</b>) per visit</p>
<p>Maximum visits per <b>policy year</b></p>	<p>130</p>	

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

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

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

Eligible health services	In-network coverage	Out-of-network coverage
<b>4. Emergency services and urgent care</b>		
<b>Emergency services</b>		
Hospital emergency room	\$100 <b>copayment</b> then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit  No <b>policy year deductible</b> applies	Paid the same as in-network coverage
<b>Important note:</b> <ul style="list-style-type: none"> <li>• If you get <b>emergency services</b> from an <b>out-of-network provider</b> or <b>hospital</b>, the most the <b>provider</b> or <b>hospital</b> may bill you is your plan’s in-network cost-sharing amount. You can’t be balance billed for these <b>emergency services</b>. See <i>Your Rights and Protections Against Surprise Medical Bills and Balance Billing in Washington State</i> in the certificate of coverage for more information. A separate <b>hospital</b> emergency room <b>copayment</b> will apply for each visit to an emergency room. If you are admitted to a <b>hospital</b> as an inpatient right after a visit to an emergency room, your emergency room <b>copayment</b> will be waived and your inpatient <b>copayment</b> will apply.</li> <li>• <b>Covered benefits</b> that are applied to the <b>hospital</b> emergency room <b>copayment</b> cannot be applied to any other <b>copayment</b> under the plan. Likewise, a <b>copayment</b> that applies to other <b>covered benefits</b> under the plan cannot be applied to the <b>hospital</b> emergency room <b>copayment</b>.</li> <li>• Separate <b>copayment</b> amounts may apply for certain services given to you in the <b>hospital</b> emergency room that are not part of the <b>hospital</b> emergency room benefit. These <b>copayment</b> amounts may be different from the <b>hospital</b> emergency room <b>copayment</b>. They are based on the specific service given to you.</li> <li>• Services given to you in the <b>hospital</b> emergency room that are not part of the <b>hospital</b> emergency room benefit may be subject to <b>copayment</b> or <b>coinsurance</b> amounts.</li> </ul>		
Non-emergency care in a <b>hospital</b> emergency room	Not covered	Not covered
<b>Urgent care</b>		
Urgent medical care provided by an <b>urgent care provider</b>	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
Non-urgent use of <b>urgent care provider</b>	Not covered	Not covered

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

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

**Diagnostic and preventive care (type A services)**

**Visits and images**

- Periodic oral evaluation (limited to: 2 visits per year)
- Comprehensive oral evaluation, beginning before age 1 (limited to: 2 visits per year)
  - Complete dental and medical history
  - General health assessment
  - Evaluation of extra-oral and intra-oral hard and soft tissue
  - Evaluation and recording of:
    - Dental caries
    - Missing teeth
    - Unerupted teeth
    - Restorations
    - Occlusal relationships
    - Periodontal conditions
    - Periodontal charting
    - Hard and soft tissue anomalies
  - Oral cancer screening
- Routine comprehensive or recall examination, new or established patient (limited to 2 visits per year)
- Limited oral evaluations to evaluate the member for a specific dental problem or oral health complaint, dental emergency or referral for other treatment (limited to 2 per year)

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- Screening or assessment to determine need for sealants, fluoride treatment or triage services (limited to 2 per year)
- Oral hygiene instructions (limited to 2 per year for children age 8 and under)
  - Individualized oral hygiene instructions
  - Tooth brushing techniques
  - Flossing
  - Use of oral hygiene aids
- Emergency palliative treatment, per visit
- Problem-focused examination
- Prophylaxis (cleaning) (limited to: 2 treatments per year)
- Topical application of fluoride (limited to: 3 applications per year, additional topical fluoride treatments by report)
- Topical application of fluoride varnish (limited to: 3 applications per year)
- Sealants, per tooth (limited to: 1 application per tooth every 3 years for permanent bicuspid and molars only)
- Sealant repair
- Bitewing images (limited to: 2 sets per year)
- Complete image series, including bitewings if **medically necessary** (limited to: 1 set every 3 years)
- Vertical bitewing images (limited to 1 set every 3 years)
- Periapical images
- Intra-oral, occlusal view
- Cephalometric film (limited to: 1 in a 2 year period)
- Panoramic film radiographic image (limited to 1 set every 3 years)
- Photographic images, when **medically necessary**
- Diagnostic casts

#### **Space maintainers**

- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)
- Recementation of space maintainer
- Removal of space maintainer
- Replacement space maintainers when dentally appropriate

#### **Basic restorative care (type B services)**

##### **Visits and images**

- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- House or extended care facility visits
- Treatment of post-surgical complications
- Consultation provided by dentist other than the treating dentist

##### **Images and pathology**

- Extra-oral posterior dental radiographic image
- Accession of tissue examination of oral tissue

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## Oral surgery

- Extractions
  - Erupted tooth or exposed root
  - Coronal remnants (baby teeth)
  - Surgical removal of erupted tooth or root tip
  - Removal of tooth (soft tissue)
  - Incision and drainage of abscess
- Impacted teeth
  - Surgical removal of impacted teeth
  - Removal of tooth (partially bony)
  - Removal of tooth (fully bony)
  - Removal of tooth (complication)
  - Surgical removal of residual tooth roots
- Other surgical procedures
  - Alveoplasty, in conjunction with extractions, per quadrant
  - Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces 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
  - Vestibuloplasty
  - Excision of hyperplastic tissue
  - Removal of exostosis
  - Removal of torus palatinus
  - Removal of torus mandibularis
  - Crown exposure to aid eruption
  - Removal of foreign body from soft tissue
  - Frenulectomy/frenuloplasty

## Periodontics

- Periodontal scaling and root planing, 4 or more teeth per quadrant (limited to once per quadrant every 2 years)
- Periodontal scaling and root planing, 1 to 3 teeth per quadrant (limited to once per quadrant every 2 years)
- Periodontal maintenance procedures (limited to 2 per year)
- Gingivectomy or gingivoplasty, 4 or more teeth per quadrant (limited to 1 per quadrant every 3 years)
- Gingivectomy or gingivoplasty, 1 to 3 teeth per quadrant (limited to 1 per quadrant every 3 years)
- Gingival flap procedure, per quadrant 4 or more teeth (limited to 1 per quadrant every 3 years)
- Gingival flap procedure, 1 to 3 teeth per quadrant (limited to 1 per quadrant every 3 years)
- Full mouth debridement (limited to 1 every 3 years)
- Osseous surgery, including flap and closure, 1 to 3 teeth per quadrant (limited to 1 per quadrant every 3 years)
- Osseous surgery, including flap and closure, 4 or more teeth per quadrant (limited to 1 per quadrant, every 3 years)
- Localized delivery of antimicrobial agents
- Occlusal adjustment (other than with an appliance or by restoration)

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## Endodontics

- Pulp capping (direct and indirect)
- Pulpotomy (therapeutic)
- Pulpal debridement
- Pulpal therapy, resorbable filling
- Pulpal regeneration
- Pulp vitality test
- Apexification/recalcification
- Apicoectomy
- Retrograde filling, per root
- Root amputation, per root
- Hemisection
- Root canal therapy, including **medically necessary** images, for:
  - Anterior tooth
  - Premolar tooth
  - Molar (excluding teeth 1, 16, 17 and 32)
- Retreatment of previous root canal therapy for:
  - Anterior tooth
  - Premolar tooth
  - Molar tooth

## Restorative dentistry

- Fillings consisting of amalgam and resin based composite restorations, limited to the following:
  - Maximum of 5 surfaces per tooth for permanent posterior teeth (except for upper molars)
  - Maximum of 6 surfaces per tooth for teeth 1, 2, 3, 14, 15 and 16
  - Maximum of 6 surfaces per tooth for permanent anterior teeth
  - Restorations on the same tooth are limited to:
    - 1 every 2 years
    - 2 occlusal restorations for the upper molars on teeth 1, 2, 3, 14, 15 and 16
- 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/onlays
  - Crowns
  - Fixed partial dentures (bridge)

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**General anesthesia, intravenous sedation, oral or parenteral conscious sedation with any covered dental procedure when medically necessary (15 minute increments)**

- In connection with extractions of partially or completely bony impacted teeth
- To safeguard your health
- For a covered procedure performed in a dental office if **medically necessary** because a child is under 8 years of age, or is physically or developmentally disabled

Eligible health services include:

- Evaluation – deep anesthesia or general anesthesia
- General anesthesia
- IV sedation
- Other drugs/medicines
- Drugs or medicaments when used with parenteral conscious sedation, deep sedation or general anesthesia
- Local anesthesia
- Regional block anesthesia including office-based oral or parenteral conscious sedation or general anesthesia
- Nitrous oxide and analgesia (limited to 1 administration per day)

**Major restorative care (type C services)**

**Oral surgery**

- Coronectomy

**Periodontics**

- Clinical crown lengthening
- Pedical soft tissue graft procedures

**Restorative**

- Inlays/onlays (limited to 1 per tooth every 5 years)
- Crowns (limited to 1 per tooth every 5 years)
  - Resin
  - Resin with noble metal
  - Resin with base metal
  - Porcelain/ceramic substrate
  - Porcelain with noble metal
  - Porcelain with base metal
  - Base metal (full cast)
  - Noble metal (full cast)
  - $\frac{3}{4}$  cast metallic or porcelain/ceramic
- Cast post and core or prefabricated post and core
- Core build-up, including pins

**Prosthodontics**

- Replacement of complete existing fixed bridges or dentures (limited to 1 every 5 years)
- Removable partial dentures, immediate partial dentures, resin based, cast metal framework with resin denture bases, flexible base and one piece cast metal – unilateral, including any conventional clasps, rests and teeth (limited to 1 every 3 years)
- Bridge/partial abutments (see inlays and crowns) (limited to 1 per tooth every 5 years)

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- Pontics (limited to 1 per tooth every 5 years)
  - Base metal (full cast)
  - Noble metal (full cast)
  - Porcelain with noble metal
  - Porcelain with base metal
  - Resin with noble metal
  - Resin with base metal
- One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics (limited to 1 per tooth every 5 years)
  - Fees for dentures and partial dentures include relines and rebases within 6 months from the seat date
  - Fees for adjustments to dentures and partial dentures include adjustments within 6 months from the seat date
- Complete dentures (limited to 1 every 5 years)
  - Fees for dentures include relines and rebases within 6 months after installation
  - Fees for adjustments to dentures include adjustments within 6 months after installation
  - Specialized techniques and characterizations are not eligible
- Resin partial dentures (limited to 1 every 3 years)
  - Fees for dentures and partial dentures include relines and rebases within 6 months after installation
  - Fees for adjustments to dentures and partial dentures include adjustments within 6 months after installation
  - Specialized techniques and characterizations are not eligible
- Immediate partial upper or lower, resin base (including any conventional clasps, rests and teeth)) (limited to 1 every 5 years)
  - Fees for adjustments to dentures and partial dentures include adjustments within 6 months after installation
  - Specialized techniques and characterizations are not eligible
- Immediate upper/lower partial denture – flexible base (including any clasps, rests and teeth) (limited to 1 every 5 years)
  - Fees for adjustments to dentures and partial dentures include adjustments within 6 months after installation
  - Specialized techniques and characterizations are not eligible
- Immediate partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth) (limited to 1 every 5 years)
  - Fees for adjustments to dentures and partial dentures include adjustments within 6 months after installation
  - Specialized techniques and characterizations are not eligible
- Office reline (limited to within 6 months after installation)
- Laboratory relines (limited to within 6 months after installation)
- Special tissue conditioning, per denture (limited to within 6 months after installation)
- Rebase, per denture (limited to within 6 months after installation)
- Adjustment to complete and partial denture (more than 6 months after installation)
- Full and partial denture repairs:
  - Broken dentures, no teeth involved
  - Repair cast framework
  - Replacing missing or broken teeth, each tooth

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- Adding teeth to existing partial denture:
    - Each tooth
    - Each clasp
- Complete upper denture (limited to 1 every 5 years)
- Complete lower denture (limited to 1 every 5 years)
- Immediate upper denture (limited to 1 every 5 years)
- Immediate lower denture (limited to 1 every 5 years)
- Stress breakers
- Overdenture, complete or partial upper and lower (limited to 1 every 5 years)
- Cleaning and inspection of complete and partial dentures
- Dental implant crown and abutment related procedures, one per member per tooth (limited to 1 every 5 years)
- Interim partial denture (stayplate), anterior only
- Occlusal guard
- Repairs
  - Crowns and bridges
  - Implant supported prosthesis or abutment
  - Repair of occlusal guards
- Removable appliance therapy
- Fixed appliance therapy

#### **Behavioral management**

- Behavioral management when **medically necessary** for children age 8 and under

#### **Orthodontic services**

- **Medically necessary** orthodontic treatment for a severe, dysfunctional or disabling condition including cleft lip and palate, cleft palate and cleft lip with alveolar process involvement; and craniofacial anomalies for hemifacial microsomia, craniosynostosis syndromes, cleidocranial dental dysplasia, arthrogryposis or Marfan syndrome
  - Removal of appliance
  - Construction of retainer
  - Placement of retainer

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Eligible health services	In-network coverage	Out-of-network coverage
<b>6. Specific conditions</b>		
<b>Birthing center</b>		
Inpatient (room and board and other services and supplies)	Paid at the same cost-sharing as <b>hospital care</b>	Paid at the same cost-sharing as <b>hospital care</b>
<b>Diabetic equipment, supplies and education</b>		
Diabetic equipment, supplies and education	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
<b>Temporomandibular joint dysfunction (TMJ)</b>		
TMJ 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
<b>Impacted wisdom teeth</b>		
Impacted wisdom teeth	80% (of the <b>negotiated charge</b> )	60% (of the <b>recognized charge</b> )
<b>Accidental injury to sound natural teeth</b>		
Accidental injury to <b>sound natural teeth</b>	80% (of the <b>negotiated charge</b> )	80% (of the <b>recognized charge</b> )
<b>Dermatological treatment</b>		
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
<b>Maternity care</b>		
Maternity care (includes delivery and postpartum care services in a <b>hospital</b> or <b>birthing center</b> )	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
<b>Gender affirming treatment</b>		
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

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<b>Autism spectrum disorder</b>		
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	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
<b>Behavioral health</b>		
<b>Mental health treatment - inpatient</b>		
Inpatient ( <b>room and board</b> ) facility and other inpatient services and supplies, including <b>residential treatment facilities</b>	80% (of the <b>negotiated charge</b> ) per admission	60% (of the <b>recognized charge</b> ) per admission
<b>Mental health treatment - outpatient</b>		
Outpatient mental health office visits to a <b>health professional</b>  Includes <b>telemedicine</b> consultation or use of <b>store and forward technology</b>	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
Other outpatient <b>mental health disorders</b> treatment (includes skilled behavioral health services in the home, <b>partial hospitalization treatment</b> and <b>intensive outpatient program</b> )	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit

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<b>Substance related disorders treatment - inpatient</b>		
Inpatient ( <b>room and board</b> ) facility and other inpatient services and supplies, including <b>residential treatment facilities</b>	80% (of the <b>negotiated charge</b> ) per admission	60% (of the <b>recognized charge</b> ) per admission
<b>Substance related disorders treatment - outpatient</b>		
Outpatient <b>substance related disorders</b> office visits to a <b>health professional</b>  Includes <b>telemedicine</b> consultation or use of <b>store and forward technology</b>	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
Other outpatient <b>substance related disorders</b> services, <b>partial hospitalization treatment</b> and <b>intensive outpatient program</b>	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
<b>Reconstructive surgery and supplies</b>		
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

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<b>Eligible health services</b>	<b>In-network coverage (IOE facility)</b>	<b>Out-of-network coverage</b> (Includes <b>providers</b> who are otherwise part of <b>Aetna's</b> network but are non-IOE <b>providers</b> )
<b>Transplant services</b>		
Inpatient	80% per transplant	60% per transplant
Outpatient	80% per transplant	60% per transplant
<b>Physician and specialist services</b>	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
<b>Transplant services - travel and lodging</b>		
Transplant services - travel and lodging	Covered	
Maximum payable for travel and lodging expenses for any one transplant, including tandem transplant	\$10,000	
Maximum payable for lodging expenses per patient	\$50 per night	
Maximum payable for lodging per companion	\$50 per night	
<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>Treatment of infertility</b>		
<b>Basic infertility services</b>		
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

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Eligible health services	In-network coverage	Out-of-network coverage
<b>7. Specific therapies and tests</b>		
<b>Outpatient diagnostic testing</b>		
<b>Diagnostic complex imaging services</b>		
Performed in the outpatient department of a <b>hospital</b> or other facility	80% (of the <b>negotiated charge</b> )	60% (of the <b>recognized charge</b> )
<b>Diagnostic lab work and radiological services</b>		
Diagnostic lab work and radiological services performed in a <b>health professional's</b> office, the outpatient department of a <b>hospital</b> or other facility	80% (of the <b>negotiated charge</b> )	60% (of the <b>recognized charge</b> )
<b>Genetic and prenatal testing</b>		
Genetic and prenatal 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
<b>Outpatient therapies</b>		
<b>Chemotherapy</b>		
Chemotherapy	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
<b>Eligible health services</b>	<b>In-network coverage (GCIT-designated facility/provider)</b>	<b>Out-of-network coverage</b> (Including <b>providers</b> who are otherwise part of <b>Aetna's</b> network but are not GCIT-designated facilities/ <b>providers</b> )
<b>Gene-based, cellular and other innovative therapies (GCIT)</b>		
Services and supplies	Covered according to the type of benefit and the place where the service is received.	Not covered

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<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>Outpatient infusion therapy</b>		
Performed in a <b>covered person's home, health professional's office, outpatient department of a hospital or other facility</b>	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
<b>Outpatient radiation therapy</b>		
Outpatient radiation therapy	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
<b>Specialty prescription drugs</b>		
<b>Specialty prescription drugs</b> purchased and injected or infused by your <b>provider</b> 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
<b>Outpatient respiratory therapy</b>		
Respiratory therapy	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
<b>Transfusion or kidney dialysis of blood</b>		
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
<b>Cardiac and pulmonary rehabilitation services</b>		
<b>Cardiac rehabilitation</b>		
Cardiac rehabilitation	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
<b>Pulmonary rehabilitation</b>		
Pulmonary rehabilitation	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit

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<b>Rehabilitation and habilitation therapy services</b>		
<b>Rehabilitation therapy services</b>		
Outpatient cognitive rehabilitation, physical, occupational and speech therapies  Combined for rehabilitation services and habilitation therapy services	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
Maximum visits per <b>policy year</b>	Unlimited	
<b>Habilitation therapy services</b>		
Outpatient aural, physical, occupation and speech therapies	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
Cochlear implants	80% (of the <b>negotiated charge</b> )	60% (of the <b>recognized charge</b> )
Maximum visits per <b>policy year</b>	Unlimited	
<b>Neurodevelopmental therapy services</b>		
Neurodevelopmental therapy	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
Maximum visits per <b>policy year</b>	Unlimited	
<b>Chiropractic services</b>		
Chiropractic services	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
Maximum visits per <b>policy year</b>	35*	
*Note: A visit is equal to no more than 1 hour of therapy.		
<b>Diagnostic testing for learning disabilities</b>		
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

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<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>8. Other services and supplies</b>		
<b>Abortion</b>		
Inpatient	100% (of the <b>negotiated charge</b> ) per admission  No <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> ) per admission
Outpatient	100% (of the <b>negotiated charge</b> )  No applies	60% (of the <b>recognized charge</b> )
<b>Acupuncture</b>		
Acupuncture	80% (of the <b>negotiated charge</b> )	60% (of the <b>recognized charge</b> )
<b>Ambulance service</b>		
Emergency use of <b>ambulance</b> (air, ground and water)	\$100 <b>copayment</b> then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per trip  No <b>policy year deductible</b> applies	Paid the same as in-network coverage
Non-emergency <b>ambulance</b>	\$100 <b>copayment</b> then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per trip  No <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> ) per trip
<b>Clinical trials (routine patient costs)</b>		
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
<b>Durable medical equipment (DME)</b>		
Durable medical equipment	80% (of the <b>negotiated charge</b> ) per item	60% (of the <b>recognized charge</b> ) per item
<b>Nutritional support</b>		
Nutritional support	80% (of the <b>negotiated charge</b> ) per item	60% (of the <b>recognized charge</b> ) per item

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<b>Experimental or investigational therapies</b>		
Experimental or investigational 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
<b>Prosthetic devices</b>		
Prosthetic devices	80% (of the <b>negotiated charge</b> ) per item	60% (of the <b>recognized charge</b> ) per item
<b>Hearing aids</b>		
Hearing aids	80% (of the <b>negotiated charge</b> ) per item	60% (of the <b>recognized charge</b> ) per item
Hearing aids maximum per ear	One hearing aid per ear every 3 years	
<b>Hearing exams</b>		
Hearing exams	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
Hearing exam maximum	One hearing exam every <b>policy year</b>	
<b>Podiatric (foot care) treatment</b>		
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
<b>Travel and lodging expenses</b>		
Travel and lodging reimbursement	100%, No <b>policy year deductible</b> applies	
Limit per <b>policy year</b>	\$3,000	

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<b>Vision care</b>		
<b>Pediatric vision care (limited to covered persons through the end of the month in which the person turns age 19)</b>		
<b>Pediatric routine vision exams</b>		
Performed by a legally qualified ophthalmologist or optometrist	100% (of the <b>negotiated charge</b> ) per visit  No <b>copayment</b> or <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> ) per visit
Maximum visits per <b>policy year</b>	1 visit	
<b>Pediatric comprehensive vision exams (including refraction)</b>		
Performed by a legally qualified ophthalmologist or optometrist	100% (of the <b>negotiated charge</b> ) per visit  No <b>copayment</b> or <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> ) per visit
Maximum visits per <b>policy year</b>	1 visit	
<b>Pediatric comprehensive low vision evaluations and services</b>		
Performed by a legally qualified ophthalmologist or optometrist, including optical devices, services, training and instructions	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 visits per <b>policy year</b>	1 visit every 5 <b>policy years</b>	
<b>Pediatric vision care services and supplies</b>		
Eyeglass frames or <b>prescription</b> contact lenses	100% (of the <b>negotiated charge</b> ) per item  No <b>copayment</b> or <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> ) per item
Maximum number of eyeglass frames per <b>policy year</b>	One set of eyeglass frames	

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Prescription eyeglass lenses	100% (of the <b>negotiated charge</b> )  No <b>copayment</b> or <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> )
Maximum number of <b>prescription</b> eyeglass lenses per <b>policy year</b>	One pair of <b>prescription</b> eyeglass lenses	
Office visit for fitting of contact lenses	100% (of the <b>negotiated charge</b> ) per visit  No <b>copayment</b> or <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> ) per visit
Prescription contact lenses	100% (of the <b>negotiated charge</b> )  No <b>copayment</b> or <b>policy year deductible</b> applies	60% (of the <b>recognized charge</b> )
Maximum number of <b>prescription</b> contact lenses per <b>policy year</b>	One year supply	One year supply
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
<b>Important note:</b> Refer to the <i>Vision care</i> section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for <b>prescription</b> lenses in a <b>policy year</b> , this benefit will cover either <b>prescription</b> lenses for eyeglass frames or <b>prescription</b> contact lenses, but not both.		

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

Eligible health services	In-network coverage	Out-of-network coverage
<b>9. Outpatient prescription drugs</b>		
<b>Plan features</b>		
<b>Important note:</b> Any outpatient <b>prescription drug</b> cost sharing amounts paid by another person on your behalf will be applied toward your applicable cost sharing or <b>maximum out-of-pocket limits</b> .		
<b>Maximum for diabetic insulin</b>		
The <b>prescription drug</b> cost share for diabetic insulin will not exceed \$35 for a 30 day supply and any cost share will apply towards your <b>deductible</b> .		
<b>Policy year deductible and copayment waiver for risk reducing breast cancer drugs</b>		
The <b>prescription drug</b> cost share will not apply to risk reducing breast cancer <b>prescription drugs</b> when obtained at a <b>network pharmacy</b> . This means they will be paid at 100%.		
<b>Policy year deductible and copayment waiver for tobacco cessation prescription and over-the-counter drugs</b>		
The <b>prescription drug</b> cost share will not apply to the first two 90-day treatment programs for tobacco cessation <b>prescription</b> and OTC drugs when obtained at a <b>retail network pharmacy</b> . This means they will be paid at 100%. Your <b>prescription drug</b> cost share will apply after those two programs have been exhausted.		

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## Policy year deductible and copayment waiver for contraceptives

The **prescription drug** cost share will not apply to contraceptive methods when obtained at a **network pharmacy**. This means they will be paid at 100% for:

- The following contraceptives that are **generic prescription drugs**:
  - Oral drugs
  - Injectable drugs
  - Vaginal rings
  - Transdermal contraceptive patches
- The following generic and brand-name contraceptive devices:
  - IUDs
  - Implantable rods
  - Diaphragms and cervical caps
  - Sponges
  - Spermicides
  - Condoms
- FDA approved:
  - Generic emergency contraceptives
  - Generic over-the-counter (OTC) emergency contraceptives

The **prescription drug** cost share will apply to **prescription drugs** that have a generic equivalent or biosimilar or generic alternative available within the same therapeutic drug class obtained at a **network pharmacy** unless you receive a medical exception. To the extent **generic prescription drugs** are not available, **brand-name prescription drugs** are covered. A therapeutic drug class is a group of drugs or medications that have a similar or identical mode of action or are used for the treatment of the same or similar disease or **injury**.

### Tier 1 - Preferred generic prescription drugs (includes specialty prescription drugs)

For each fill up to a 30 day supply filled at a <b>retail pharmacy</b> or <b>specialty pharmacy</b>	\$15 <b>copayment</b> per supply then the plan pays 100% (of the balance of the <b>negotiated charge</b> )  No <b>policy year deductible</b> applies	\$15 <b>copayment</b> per supply then the plan pays 50% (of the balance of the <b>recognized charge</b> )  No <b>policy year deductible</b> applies
For each fill up to a 90 day supply filled at a <b>mail order pharmacy</b>	\$37.50 <b>copayment</b> per supply then the plan pays 100% (of the balance of the <b>negotiated charge</b> )  No <b>policy year deductible</b> applies	Not Covered

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<b>Tier 2 - Preferred brand-name prescription drugs (includes specialty prescription drugs)</b>		
For each fill up to a 30 day supply filled at a <b>retail pharmacy</b> or <b>specialty pharmacy</b>	\$35 <b>copayment</b> per supply then the plan pays 100% (of the balance of the <b>negotiated charge</b> )  No <b>policy year deductible</b> applies	\$35 <b>copayment</b> per supply then the plan pays 50% (of the balance of the <b>recognized charge</b> )  No <b>policy year deductible</b> applies
For each fill up to a 90 day supply filled at a <b>mail order pharmacy</b>	\$87.50 <b>copayment</b> per supply then the plan pays 100% (of the balance of the <b>negotiated charge</b> )  No <b>policy year deductible</b> applies	Not Covered
<b>Tier 3 - Non-preferred generic and brand-name prescription drugs (includes specialty prescription drugs)</b>		
For each fill up to a 30 day supply filled at a <b>retail pharmacy</b> or <b>specialty pharmacy</b>	\$70 <b>copayment</b> per supply then the plan pays 100% (of the balance of the <b>negotiated charge</b> )  No <b>policy year deductible</b> applies	\$70 <b>copayment</b> per supply then the plan pays 50% (of the balance of the <b>recognized charge</b> )  No <b>policy year deductible</b> applies
For each fill up to a 90 day supply filled at a <b>mail order pharmacy</b>	\$175 <b>copayment</b> per supply then the plan pays 100% (of the balance of the <b>negotiated charge</b> )  No <b>policy year deductible</b> applies	Not Covered
<b>Important note: Specialty prescription drugs are not eligible for fill at a mail order pharmacy.</b>		
<b>Diabetic prescription drugs, supplies and insulin</b>		
For each fill up to a 30 day supply filled at a <b>retail pharmacy</b>	Paid according to the type of drug per the <i>schedule of benefits</i> above	Paid according to the type of drug per the <i>schedule of benefits</i> above
For each fill up to a 90 day supply filled at a <b>mail order pharmacy</b>	Paid according to the tier of drug per the <i>schedule of benefits</i> above	Paid according to the type of drug per the <i>schedule of benefits</i> above

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<b>Orally administered anti-cancer prescription drugs</b>		
For each 30 day supply filled at a specialty <b>pharmacy</b>	\$0 per <b>prescription</b> or refill	\$0 per <b>prescription</b> or refill
<b>Outpatient prescription contraceptive drugs and devices</b>		
Includes oral and injectable drugs, vaginal rings and transdermal contraceptive patches		
For each 30 day supply of: <ul style="list-style-type: none"> <li>• Generic and brand-name <b>prescription drugs</b></li> <li>• Generic and brand-name devices</li> <li>• FDA-approved generic and brand-name emergency contraceptives (including those available over-the-counter)</li> </ul>	\$0 per <b>prescription</b> or refill	Paid according to the type of drug per the <i>schedule of benefits</i> above
<b>Important note:</b> Covered contraceptives can be filled for a 12 month supply, unless you request a smaller supply or your <b>provider</b> decides you need a smaller supply.		
<b>Preventive care drugs and supplements</b>		
For each 30 day supply filled at a <b>retail pharmacy</b>	\$0 per <b>prescription</b> or refill	Paid according to the type of drug per the <i>schedule of benefits</i> 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, see the <i>How to contact us for help</i> section.	
<b>Risk reducing breast cancer prescription drugs</b>		
For each 30 day supply filled at a <b>retail pharmacy</b>	\$0 per <b>prescription</b> or refill	Paid according to the type of drug per the <i>schedule of benefits</i> 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 risk reducing breast cancer <b>prescription drugs</b> , see the <i>How to contact us for help</i> section.	

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<b>Tobacco cessation prescription and over-the-counter drugs (preventive care)</b>		
For each 30 day supply filled at a <b>retail pharmacy</b>	\$0 per <b>prescription</b> or refill	Paid according to the type of drug per the <i>schedule of benefits</i> above
Limitations:	<p>Coverage is limited to two, 90-day treatment programs only. Any additional treatment programs will be paid according to the tier of drug per the schedule of benefits, above.</p> <p>Coverage only includes <b>generic drug</b> when there is also a brand-name drug available.</p> <p>Coverage is 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 <b>prescription drugs</b> and OTC drugs, see the <i>How to contact us for help</i> section.</p>	
<b>Dispense As Written (DAW)</b>		
<p>If a <b>provider</b> prescribes a covered <b>brand-name prescription drug</b> when a <b>generic prescription drug</b> equivalent is available and specifies “Dispense As Written” (DAW), you will pay the cost share for the brand-name drug. If a <b>provider</b> does not specify DAW and you request a covered <b>brand-name prescription drug</b>, you will be responsible for the cost share that applies to the brand-name drug plus the cost difference between the generic drug and the brand-name drug.</p>		

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