The PPO Plan
Pre-65 Retiree PPO Plan
Schedule of Benefits

Prepared exclusively for:

Employer:	The Pennsylvania State University
Contract number:	285717
Control number:	285717
	Schedule of Benefits 1E
Contract effective date:	January 1, 2018
Plan effective date:	January 1, 2018
Plan issue date:	December 21, 2017

These benefits are not insured with Aetna but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Aetna medical benefits plan.

Plan features	Deductible/Maximums	
	In-network coverage*	**Out-of-network coverage***
Deductible		
You have to meet your Calendar Year **deductible** before this plan pays for benefits.		
Individual	$375 per Calendar Year	$750 per Calendar Year
Family	$750 per Calendar Year	$1,500 per Calendar Year
Deductible waiver		
The Calendar Year in-network **deductible** is waived for all of the following **eligible health services:** • Preventive care and wellness • Family planning services - female contraceptives		
Maximum out-of-pocket limits		
Maximum Coinsurance out-of-pocket limit per Calendar Year.		
Individual	$1,250 per Calendar Year	$2,500 per Calendar Year
Family	$2,500 per Calendar Year	$5,000 per Calendar Year
Overall Maximum out-of-pocket limit per Calendar Year (including deductibles, copayments and coinsurance).		
Individual	$7,150 per Calendar Year	Not Applicable
Family	$14,300 per Calendar Year	Not Applicable

Schedule of benefits

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

How to read your schedule of benefits

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

Important note:
All **covered benefits** are subject to the Calendar Year **deductible** and **copayment/payment percentage** unless otherwise noted in the schedule of benefits below.

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

This schedule of benefits replaces any schedule of benefits previously in effect under your plan of benefits. Keep this schedule of benefits with your booklet.

Eligible health services	In-network coverage*	Out-of-network coverage*
Preventive care and wellness		
Routine physical exams		
Performed at a **physician's**, **PCP** office	100% per visit No **deductible** applies	70% (of the **recognized charge**) per visit
Covered persons through age 21:	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.
Covered persons age 22 and over but less than 65: Maximum visits per Calendar Year	1 visit	1 visit
Covered persons age 65 and over: Maximum visits per Calendar Year	1 visit	1 visit
Preventive care immunizations		
Performed in a facility or at a **physician's** office	100% per visit No **deductible** applies	70% (of the **recognized charge**) per visit
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.

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

Eligible health services	In-network coverage*	Out-of-network coverage*
Well woman preventive visits routine gynecological exams (including pap smears)		
Performed at a **physician's**, **PCP**, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit No **deductible** applies	70% (of the **recognized charge**) per visit No **deductible** applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
Maximum visits per Calendar Year	1 visit	1 visit
Preventive screening and counseling services		
Office visits • Obesity and/or healthy diet counseling • Misuse of alcohol and/or drugs • Use of tobacco products • Sexually transmitted infection counseling • Genetic risk counseling for breast and ovarian cancer	100% per visit No **deductible** applies	70% (of the **recognized charge**) per visit
Obesity and/or healthy diet counseling maximums:		
Maximum visits per 12 months (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these, only *10* visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*	26 visits (however, of these, only *10* visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Misuse of alcohol and/or drugs maximums:		
Maximum visits per 12 months	5 visits*	5 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		

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

Eligible health services	In-network coverage*	Out-of-network coverage*
Use of tobacco products maximums:		
Maximum visits per 12 months	8 visits*	8 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Sexually transmitted infection counseling maximums:		
Maximum visits per 12 months	2 visits*	2 visits*
*Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.		
Genetic risk counseling for breast and ovarian cancer maximums:		
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations	Not subject to any age or frequency limitations
Routine cancer screenings (applies whether performed at a physician's, PCP, specialist office or facility)		
Routine cancer screenings	100% per visit No **deductible** applies	70% (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 onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.
Lung cancer screening maximums	1 screening every 12 months*	1 screening every 12 months*
***Important note**: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.		

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

Eligible health services	In-network coverage*	Out-of-network coverage*

Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)		
Preventive care services only	100% per visit No **deductible** applies	70% (of the **recognized charge**) per visit No **deductible** applies
Important note: You should review the *Maternity and related newborn care* sections. They will give you more information on coverage levels for maternity care under this plan.		
Comprehensive lactation support and counseling services		
Lactation counseling services – facility or office visits	100% per visit No **deductible** applies	70% (of the **recognized charge**) per visit
Lactation counseling services maximum visits per 12 months either in a group or individual setting	6 visits*	6 visits*
***Important note:** Any visits that exceed the lactation counseling services maximum are covered under **physician** services office visits.		
Breast feeding durable medical equipment		
Breast pump supplies and accessories	100% per item No **deductible** applies	70% (of the **recognized charge**) per item
Important note: See the *Breast feeding durable medical equipment* section of the booklet for limitations on breast pump and supplies.		
Family planning services – female contraceptives		
Counseling services		
Female contraceptive counseling services office visit	100% per visit No **deductible** applies	70% (of the **recognized charge**) per visit
Contraceptive counseling services maximum visits per 12 months either in a group or individual setting	2 visits*	2 visits*
***Important note:**		

*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*
Any visits that exceed the contraceptive counseling services maximum are covered under **physician** services office visits.		
Devices		
Female contraceptive device provided, administered, or removed, by a **physician** during an office visit	100% per item No **deductible** applies	70% (of the **recognized charge**) per item
Female voluntary sterilization		
Inpatient	100% per admission No **deductible** applies	70% (of the **recognized charge**) per admission
Outpatient	100% per visit No **deductible** applies	70% (of the **recognized charge**) per visit
Physicians and other health professionals		
Physicians and **specialists** office visits (non-surgical)		
Physician services		
Office visits (non-surgical) non preventive care	$20 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	70% (of the **recognized charge**) per visit
Complex imaging services, lab work and radiological services performed during a **physician's** office visit	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Allergy injections		
Performed at a **physician's** or **specialist** office when you do not see the **physician**	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible

*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*
Allergy testing, treatment and injections		
Performed at a **physician's**, **PCP** or **specialist** office	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Immunizations that are not considered Preventive Care		
Immunizations that are not considered Preventive Care	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Specialist office visits		
Office visits (non-surgical)	$30 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	70% (of the **recognized charge**) per visit
Complex imaging services, lab work and radiological services performed during a **specialist** office visit	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Physician surgical services		
Physicians and **specialists** office visits		
Performed at a **physician's**, **PCP** office	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Performed at a **specialist's** office	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible

*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*
Alternatives to physician office visits		
Walk-in clinic visits		
Preventive Care Services		
Immunizations	100% per visit No **deductible** applies	70% (of the **recognized charge**) per visit
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.
All non-preventive care services for which cost sharing is not shown above		
All other services	$30 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	70% (of the **recognized charge**) per visit
Hospital and other facility care		
Hospital care		
Inpatient **hospital**	90% (of the **negotiated charge**) per admission after deductible	70% (of the **recognized charge**) per admission after deductible
Alternatives to hospital stays		
Outpatient surgery and physician surgical services		
	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Home health care		
Outpatient	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Maximum visits per Calendar Year	120	120

*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*
Hospice care		
Inpatient facility	90% (of the **negotiated charge**) per admission after deductible	70% (of the **recognized charge**) per admission after deductible
Maximum days per lifetime	Unlimited	Unlimited
Hospice care		
Outpatient	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Outpatient private duty nursing		
Outpatient private duty nursing	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Maximum visits/shifts per Calendar Year	70 shifts Up to eight hours equal one shift	70 shifts Up to eight hours equal one shift
Skilled nursing facility		
Inpatient facility	90% (of the **negotiated charge**) per admission after deductible	70% (of the **recognized charge**) per admission after deductible
Maximum days per Calendar Year	100	100
Emergency services		
Hospital emergency room	$100 then the plan pays 100% (of the balance of the **negotiated charge**) per visit –Waive if admitted No **deductible** applies	Paid the same as in-network coverage
Non-emergency care in a **hospital** emergency room	Not covered	Not covered

Important Note:

- As **out-of-network providers** do not have a contract with us the **provider** may not accept payment of your cost share, (**deductible, copayment** and **payment percentage**), 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 the back of your ID card, and we will resolve any payment dispute with the **provider** over that amount. Make sure the member's ID number is on the bill.

*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*
▪ A separate hospital emergency room **copayment/payment percentage** 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/payment percentage** will be waived and your inpatient **copayment/payment percentage** will apply.		
Urgent care		
Urgent medical care (at a non-**hospital** free standing facility)	$30 then the plan pays 100% (of the balance of the **negotiated charge** thereafter) No **deductible** applies	70% (of the **recognized charge**) per visit
Non-urgent use of **urgent care provider** (at a non-**hospital** free standing facility)	Not covered	Not covered
A separate urgent care **copayment/payment percentage** will apply for each visit to an **urgent care provider**.		
Autism spectrum disorder		
Autism spectrum disorder treatment	Covered according to the type of benefit.	Covered according to the type of benefit.
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.
All other coverage for diagnosis and treatment, including behavioral therapy, will continue to be provided the same as any other **illness** under this plan.		
Birthing center		
Inpatient	90% (of the **negotiated charge**) per admission after deductible	70% (of the **recognized charge**) per admission after deductible
Diabetic equipment, supplies and education		
Diabetic equipment, supplies and education	Covered according to the type of benefit and the place where the service is received. See Diabetic Supply Guidelines for full coverage details.	Covered according to the type of benefit and the place where the service is received. See Diabetic Supply Guidelines for full coverage details.

*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*
Family planning services - other		
Voluntary sterilization for males		
Outpatient	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Maternity and related newborn care		
Inpatient	90% (of the **negotiated charge**) per admission after deductible	70% (of the **recognized charge**) per admission after deductible
Delivery services and postpartum care services		
Performed in a facility or at a **physician's** office	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Other prenatal care services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Mental health treatment - inpatient		
Inpatient mental health treatment Inpatient **residential treatment facility** Coverage is provided under the same terms, conditions as any other **illness**.	90% (of the **negotiated charge**) per admission after deductible	70% (of the **recognized charge**) per admission after deductible
Mental health treatment - outpatient		
Outpatient mental health treatment visits to a **physician** or **behavioral health provider** (includes skilled behavioral health services in the home) **Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment)	$20 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	70% (of the **recognized charge**) per visit after deductible

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Eligible health services	In-network coverage*	Out-of-network coverage*
Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment) Coverage is provided under the same terms, conditions as any other **illness**.		
Other outpatient mental health treatment	$20 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	70% (of the **recognized charge**) per visit after deductible
Substance related disorders treatment - inpatient		
Inpatient **substance abuse** detoxification during a **hospital** confinement Inpatient **substance abuse** rehabilitation during a **hospital** confinement Inpatient **residential treatment facility** during a **hospital** confinement Coverage is provided under the same terms, conditions as any other **illness**.	90% (of the **negotiated charge**) per admission after deductible	70% (of the **recognized charge**) per admission after deductible
Substance related disorders treatment - outpatient: detoxification and rehabilitation		
Outpatient **substance abuse** visits to a **physician** or **behavioral health provider**	$20 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	70% (of the **recognized charge**) per visit after deductible

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Eligible health services	In-network coverage*	Out-of-network coverage*
Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical treatment) **Intensive Outpatient Program** (at least 2 hours per day and at least 6 hours per week of clinical treatment) Coverage is provided under the same terms, conditions as any other **illness**.		
Other outpatient substance abuse services	$20 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	70% (of the **recognized charge**) per visit after deductible
Obesity surgery		
Inpatient **hospital** (includes surgical procedure and acute **hospital** services)	90% (of the **negotiated charge**) per admission after deductible	Not covered
Outpatient obesity surgery		
	90% (of the **negotiated charge**) per visit after deductible	Not covered
Oral and maxillofacial treatment (mouth, jaws and teeth)		
Oral and maxillofacial treatment (mouth, jaws and teeth)	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit
Reconstructive breast surgery		
Reconstructive breast surgery	Covered according to the type of benefit and the place where the service is received. Deductible & Coinsurance may apply	Covered according to the type of benefit and the place where the service is received.

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

Eligible health services	In-network coverage*	Out-of-network coverage*

Reconstructive surgery and supplies		
Reconstructive surgery	Covered according to the type of benefit and the place where the service is received. Deductible & Coinsurance may apply	Covered according to the type of benefit and the place where the service is received.

Eligible health services	Network (IOE facility)	Network (Non-IOE facility)	Out-of-network coverage*
Transplant services facility and non-facility			
Inpatient **hospital** transplant services	90% (of the **negotiated charge**) per transplant after deductible	90% (of the **negotiated charge**) per transplant after deductible	Not Covered
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Not Covered
Treatment of infertility			
Basic infertility			
Basic **infertility**	Covered according to the type of benefit and the place where the service is received. Deductible & Coinsurance apply		Covered according to the type of benefit and the place where the service is received. Deductible & Coinsurance apply
Outpatient comprehensive infertility services			
	90% (of the **negotiated charge**) per visit after deductible		70% (of the **recognized charge**) per visit after deductible
Specific therapies and tests			
Outpatient diagnostic testing			

Diagnostic complex imaging services		
	90% (of the **negotiated** charge) per visit after deductible	70% (of the **recognized** charge) per visit after deductible
Diagnostic lab work		
	90% (of the **negotiated** charge) per visit after deductible.	70% (of the **recognized** charge) per visit. after deductible

*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*
Diagnostic radiological services		
	90% of the **negotiated charge** per visit after deductible.	70% (of the **recognized charge)** per visit after deductible.
Chemotherapy		
	90% (of the **negotiated charge**) after deductible	70% (of the **recognized charge**) per visit after deductible
Outpatient infusion therapy		
	90% (of the **negotiated charge**) per visit after deductible.	70% (of the **recognized charge**) per visit after deductible.
Outpatient radiation therapy		
	90% (of the **negotiated charge**) per visit after deductible.	70% (of the **recognized charge**) per visit after deductible.
Short-term rehabilitation services		
Short-term rehabilitation services (outpatient physical, occupational therapies) combined with Habilitation therapy services (outpatient physical, occupational therapies)		
	$30 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter 24 visits No **deductible** applies	70% (of the **recognized charge**) per visit after deductible
Short-term rehabilitation services (outpatient speech therapies) combined with Habilitation therapy services (outpatient speech therapies)		
	$30 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter 24 visits No **deductible** applies	70% (of the **recognized charge**) per visit after deductible
Outpatient Physical and Occupational Therapies Maximum		
Maximum visits per Calendar Year	24 visits; medical necessity reviewed for beyond 24 visits	24 visits; medical necessity reviewed for beyond 24 visits

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Eligible health services	In-network coverage*	Out-of-network coverage*

Outpatient Speech Therapy Maximum		
Maximum visits per Calendar Year	24 visits; medical necessity reviewed for beyond 24 visits	24 visits; medical necessity reviewed for beyond 24 visits

Other services		
Ambulance service		
Ground, air or water **ambulance**	90% (of the **negotiated charge**) per trip after deductible	90% (of the **recognized charge**) per trip after deductible
Durable medical equipment (DME)		
DME	90% (of the **negotiated charge**) per item after deductible	70% (of the **recognized charge**) per item after deductible

Hearing exams		
Hearing exams	90% (of the **negotiated charge**) per visit after deductible	90% (of the **recognized charge**) per visit after deductible
	One exam in any 36 consecutive month period.	

Hearing aids		
Hearing aids	90% (of the **negotiated charge**) per item after deductible	90% (of the **recognized charge**) per item. *Note: In-network deductible applies.*
Maximum one device per ear, per 36 months	$700	$700

Prosthetic devices		
Prosthetic devices	90% (of the **negotiated charge**) per item after deductible	70% (of the **recognized charge**) per item after deductible
Spinal manipulation		
Spinal manipulation	$30 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	70% (of the **recognized charge**) per visit after deductible
Maximum visits per **Calendar Year**	24 visits; medical necessity reviewed for beyond 24 visits	24 visits; medical necessity reviewed for beyond 24 visits

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Family planning services - female contraceptives	
• Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches	100% per **prescription** or refill No **deductible** applies ***Prescriptions filled at CVS Caremark participating pharmacies and University Health Services pharmacy will run through the CVS Caremark prescription drug plan. All other female contraceptives will run through the Aetna medical plan.***
Female contraceptive devices	100% per **prescription** or refill No **deductible** applies
Preventive care drugs and supplements	
Preventive care drugs and supplements filled at a **pharmacy**	100% per **prescription** or refill No **deductible** applies ***Prescriptions filled at CVS Caremark participating pharmacies and University Health Services pharmacy will run through the CVS Caremark prescription drug plan. All other female contraceptives will run through the Aetna medical plan.***
Risk reducing breast cancer prescription drugs	
Risk reducing breast cancer **prescription drugs** filled at a **pharmacy**	100% per **prescription** or refill No **deductible** applies ***Prescriptions filled at CVS Caremark participating pharmacies and University Health Services pharmacy will run through the CVS Caremark prescription drug plan. All other female contraceptives will run through the Aetna medical plan.*** Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.

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

Tobacco cessation prescription and over-the-counter drugs	
Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** for each 90 day supply	$0 per **prescription** or refill No **deductible** applies ***Prescriptions filled at CVS Caremark participating pharmacies and University Health Services pharmacy will run through the CVS Caremark prescription drug plan. All other female contraceptives will run through the Aetna medical plan.*** 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 below. 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.

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

General coverage provisions

This section provides detailed explanations about the:

- **Deductible**
- **Maximum coinsurance out-of-pocket limits**
- Overall maximum out-of-pocket limits

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

Deductible provisions

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

The **deductible** may not apply to certain **eligible health services**. You must pay any applicable **copayments/payment percentage** for **eligible health services** to which the **deductible** does not apply.

For purposes of the Calendar Year **deductible** provision below, an individual means an employee enrolled for self only coverage with no dependent coverage and a family means an employee enrolled with one or more dependents. The family **deductible** can be met by one family member, or a combination of family members. For purposes of the Calendar Year **deductible** provision below:

- The individual **deductible** applies to a person who is enrolled for self only coverage with no dependent coverage
- The family **deductible** applies to a person who is enrolled with one or more dependents. The family **deductible** can be met by one family member, or a combination of family members.

Individual

This is the amount you owe for in-network and out-of-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. After the amount you pay for **eligible health services** reaches this individual Calendar Year **deductible**, this plan will begin to pay for **eligible health services** for the rest of the Calendar Year.

Family

This is the amount you and your covered dependents owe for in-network and out-of-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. After the amount you and your covered dependents pay for **eligible health services** reach this family Calendar Year **deductible**, this plan will begin to pay for **eligible health services** that you and your covered dependents incur for the rest of the Calendar Year.

Copayments

Copayment

As it applies to in-network coverage, this is a specified dollar amount or percentage that must be paid by you at the time you receive **eligible health services** from a **network provider**.

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

Payment percentage

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

Maximum out-of-pocket limits provisions

Eligible health services applied to the **out-of-network maximum out-of-pocket limit** will not be applied to satisfy the in-network **maximum out-of-pocket limit** and **eligible health services** applied to the in-network **maximum out-of-pocket limit** will not be applied to satisfy the out-of-network **maximum out-of-pocket limit**.

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

For purposes of the following **maximum out-of-pocket limit** provisions:

- The individual **maximum out-of-pocket limit** applies to a person enrolled for self only coverage with no dependents coverage
- The family **maximum out-of-pocket limit** applies to a person enrolled with one or more dependents. The family **maximum out-of-pocket limit** can be met by a combination of family members or by any single individual within the family.

Individual

Once the amount of the **payment percentage** you have paid during the Calendar Year for **eligible health services** meet the Individual **maximum out-of-pocket limit** this plan will pay 100% of **covered benefits** that apply toward the limit for you for the remainder of the Calendar Year.

Family

Once the amount of the **payment percentage** paid during the Calendar Year for **eligible health services** meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the family's **covered benefits** that apply toward the limit for the rest of the Calendar Year.

The **maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the **maximum out-of-pocket limit** does not apply to a covered benefit, your **copayment**/**payment percentage** for that covered benefit will not count toward satisfying the **maximum out-of-pocket limit** amount.

Costs that you incur that do not apply to your **overall maximum out-of-pocket limit**

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

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

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

Maximum provisions

Eligible health services applied to the **out-of-network** maximum will be applied to satisfy the network maximum and **eligible health services** applied to the network maximum will be applied to satisfy the **out-of-network** maximum.

Calculations; determination of recognized charge; determination of benefits provisions

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

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

Prescription drug coverage is included as part of both medical plans and administered through CVS Caremark.

CVS CAREMARK 844-462-0203 PPO PLAN FACULTY/STAFF PRESCRIPTION DRUG BENEFITS	
Prescription Drug Deductible	None
Total Prescription Drug Out-of-Pocket Maximum Individual Family	 $2,000 $8,000
Retail (30-day supply) Prescriptions filled at CVS Caremark participating pharmacies or University Health Services pharmacy Generic Drugs Preferred Brand Drugs Non-Preferred Brand Drugs	 50% coinsurance 50% coinsurance 70% coinsurance
Mail Order (90-day supply) Prescriptions filled at CVS Caremark Mail Order or University Health Services pharmacy Generic Drugs Preferred Brand Drugs Non-Preferred Brand Drugs	 20% coinsurance 20% coinsurance 70% coinsurance
Specialty (30-day supply) Prescriptions filled at CVS Caremark Specialty Pharmacy. Select few specialty medications also available at University Health Service pharmacy; contact them for details. Preferred Brand Drugs Non-Preferred Brand Drugs	 50% coinsurance; $50 maximum 70% coinsurance; $100 maximum

Note: Total Maximum Out-of-Pocket Maximum (TMOOP) is mandated by the federal government effective with plan years beginning on or after January 1, 2014. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense. With plan years beginning on or after January 1, 2018, TMOOP cannot be more than $7,150 for an individual and $14,300 for plans with two or more persons. Your plan satisfies this requirement.

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

CVS CAREMARK 844-462-0203 TECHNICAL SERVICE PRESCRIPTION DRUG BENEFITS	
Prescription Drug Deductible	None
Total Prescription Drug Out-of-Pocket Maximum Individual Family	 $1,000 $6,000
Retail (30-day supply) Prescriptions filled at CVS Caremark participating pharmacies or University Health Services pharmacy Generic Drugs Preferred Brand Drugs Non-Preferred Brand Drugs	 50% coinsurance 50% coinsurance 70% coinsurance
Mail Order (90-day supply) Prescriptions filled at CVS Caremark Mail Order or University Health Services pharmacy Generic Drugs Preferred Brand Drugs Non-Preferred Brand Drugs	 20% coinsurance 20% coinsurance 70% coinsurance
Specialty (30-day supply) Prescriptions filled at CVS Caremark Specialty Pharmacy. Select few specialty medications also available at University Health Service pharmacy; contact them for details. Preferred Brand Drugs Non-Preferred Brand Drugs	 50% coinsurance; $50 maximum 70% coinsurance; $100 maximum

Note: Total Maximum Out-of-Pocket Maximum (TMOOP) is mandated by the federal government effective with plan years beginning on or after January 1, 2014. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense. With plan years beginning on or after January 1, 2018, TMOOP cannot be more than $7,150 for an individual and $14,300 for plans with two or more persons. Your plan satisfies this requirement.

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