



## OA Managed Choice POS

### Schedule of benefits

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

**Prepared exclusively for:**

**Policyholder:** Lloyd A. Wise Motors Inc.  
**Policyholder number:** GP-0186813  
**Schedule of Benefits:** 8A  
OA Managed Choice POS \$6,500 Deductible Plan  
**Group policy effective date:** January 1, 2023  
**Plan effective date:** January 1, 2023  
**Plan issue date:** April 5, 2024  
**Plan revision effective date:** January 1, 2024

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

## Schedule of benefits

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

### How to read your schedule of benefits

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

#### Important note:

All **covered benefits** are subject to the Calendar Year **deductible** and **copayment/coinsurance** unless otherwise noted in the schedule of benefits below.

We are here to answer any questions. Contact Member Services by logging onto your Aetna secure member website at [www.aetna.com](http://www.aetna.com) or at the toll-free number on your ID card.

The coverage described in this schedule of benefits will be provided under **Aetna Life Insurance Company’s group policy**. This schedule of benefits replaces any schedule of benefits previously in effect under the **group policy**. Keep this schedule of benefits with your booklet-certificate.

Plan features	Deductible/Maximums	
	In-network coverage*	Out-of-network coverage*
<b>Deductible</b>		
You have to meet your Calendar Year <b>deductible</b> before this plan pays for benefits.		
Individual	\$6,500 per Calendar Year	\$7,500 per Calendar Year
Family	\$13,000 per Calendar Year	\$15,000 per Calendar Year
<b>Deductible waiver</b>		
The Calendar Year <b>deductible</b> is waived for all of the following <b>eligible health services</b> :		
<ul style="list-style-type: none"> <li>• Preventive care and wellness</li> <li>• Family planning services - female contraceptives</li> </ul>		
<b>Maximum out-of-pocket limit</b>		
<b>Maximum out-of-pocket limit</b> per Calendar Year.		
Individual	\$8,300 per Calendar Year	\$10,000 per Calendar Year
Family	\$16,600 per Calendar Year	\$20,000 per Calendar Year
<b>Precertification penalty</b>		
This only applies to out-of-network coverage. The booklet-certificate contains a complete description of the <b>precertification</b> program. You will find details on <b>precertification</b> requirements in the <i>Medical necessity and precertification requirements</i> section.		
Failure to <b>precertify</b> your <b>eligible health services</b> when required will result in the following penalty:		
<ul style="list-style-type: none"> <li>• A \$400 penalty will be applied separately to each type of <b>eligible health services</b> (the penalty will never exceed the cost of the benefit)</li> </ul>		
<b>Precertification</b> and/or <b>step therapy</b> for certain <b>prescription drugs</b> may be required. In this case, the <b>prescription drug</b> will not be covered until you get prior authorization.		
The additional percentage or dollar amount of the <b>recognized charge</b> which you may pay as a penalty for failure to obtain <b>precertification</b> is not a <b>covered benefit</b> , and will not be applied to the <b>deductible</b> amount or the <b>maximum out-of-pocket limit</b> , if any.		

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

Eligible health services	In-network coverage*	Out-of-network coverage*
<b>1. Preventive care and wellness</b>		
<b>Routine physical exams</b>		
Performed at a <b>physician's, PCP</b> office	100% per visit  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
Covered persons through age 21: Maximum age and visit limits per 12 months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.  For details, contact your <b>physician</b> or Member Services by logging onto your Aetna secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on the back of your ID card.	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.  For details, contact your <b>physician</b> or Member Services by logging onto your Aetna secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on the back of your ID card.
Covered persons age 22 and over but less than 65: Maximum visits per 12 months	1 visit	1 visit
Covered persons age 65 and over: Maximum visits per 12 months	1 visit	1 visit
<b>Preventive care immunizations</b>		
Performed in a facility or at a <b>physician's</b> office	100% per visit  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) 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 <b>physician</b> or Member Services by logging onto your Aetna member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on the back of your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.  For details, contact your <b>physician</b> or Member Services by logging onto your Aetna member website at <a href="http://www.aetna.com">www.aetna.com</a> 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

<b>Well woman preventive visits routine gynecological exams (including pap smears)</b>		
Performed at a <b>physician's, PCP,</b> obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit  No <b>deductible</b> applies	50% (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.	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
<b>Preventive screening and counseling services</b>		
Office visits <ul style="list-style-type: none"> <li>• Obesity and/or healthy diet counseling</li> <li>• Misuse of alcohol and/or drugs</li> <li>• Use of tobacco products</li> <li>• Sexually transmitted infection counseling</li> <li>• Genetic risk counseling for breast and ovarian cancer</li> </ul>	100% per visit  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
<b>Obesity and/or healthy diet counseling maximums:</b>		
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.		
<b>Misuse of alcohol and/or drugs maximums:</b>		
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.		

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<b>Use of tobacco products maximums:</b>		
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.		
<b>Genetic risk counseling for breast and ovarian cancer maximums:</b>		
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations	Not subject to any age or frequency limitations
<b>Obesity surgery</b>		
Inpatient <b>hospital</b> (includes surgical procedure and acute <b>hospital</b> services)	70% (of the <b>negotiated charge</b> ) per admission	Not covered

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

<b>Routine cancer screenings</b> <b>(applies whether performed at a physician's, PCP, specialist office or facility)</b>		
Routine cancer screenings	100% per visit  No <b>deductible</b> applies	50% (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; and</li> <li>The comprehensive guidelines supported by the Health Resources and Services Administration.</li> </ul> For details, contact your <b>physician</b> or Member Services by logging onto your Aetna secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on the back of your ID card.	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; and</li> <li>The comprehensive guidelines supported by the Health Resources and Services Administration.</li> </ul> For details, contact your <b>physician</b> or Member Services by logging onto your Aetna secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on the back of your ID card.
Lung cancer screening maximums	1 screening every 12 months*	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.		

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

<b>Prenatal care</b>		
<b>Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)</b>		
Preventive care services only (includes participation in the California Prenatal Screening Program)	100% per visit  No deductible applies	50% (of the <b>recognized charge</b> ) per visit
<b>Important note:</b> You should review the <i>Maternity and related newborn care</i> sections. They will give you more information on coverage levels for maternity care under this plan.		
<b>Comprehensive lactation support and counseling services</b>		
Lactation counseling services – facility or office visits	100% per visit  No deductible applies	50% (of the <b>recognized charge</b> ) per visit
Lactation counseling services maximum visits per 12 months either in a group or individual setting	6 visits*	6 visits*
<b>*Important note:</b> Any visits that exceed the lactation counseling services maximum are covered under <b>Physician</b> services office visits.		
<b>Breast feeding durable medical equipment</b>		
Breast pump supplies and accessories	100% per item  No deductible applies	50% (of the <b>recognized charge</b> ) per item
<b>Important note:</b> See the <i>Breast feeding durable medical equipment</i> section of the booklet-certificate for limitations on breast pump and supplies.		
<b>Family planning services – female contraceptives</b>		
Female contraceptive education and counseling services office visit	100% per visit  No deductible applies	50% (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>Devices</b>		
Female contraceptive device provided, administered, or removed, by a <b>physician</b> during an office visit and follow up services	100% per item  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per item
<b>Female voluntary sterilization</b>		
Inpatient	100% per admission  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per admission
Outpatient	100% per visit  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
<b>Eligible health services</b>	<b>In-network coverage*</b>	<b>Out-of-network coverage*</b>
<b>2. Physicians and other health professionals</b>		
<b>Physicians and specialists office visits (non-surgical)</b>		
<b>Physician services</b>		
Office hours visits (non-surgical) non preventive care	\$55 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
<b>Telemedicine</b> consultation by a <b>physician, PCP</b>	\$55 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
<b>Telemedicine</b> consultation by a <b>specialist</b>	\$80 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit

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<b>Allergy injections</b>		
Performed at a <b>physician's</b> or <b>specialist</b> office when you do not see the <b>physician</b>	70% (of the <b>negotiated charge</b> ) per visit	50% (of the <b>recognized charge</b> ) per visit
<b>Immunizations when not part of the physical exam</b>		
Immunizations when not part of the physical exam	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<b>Specialist</b>		
<b>Specialist office visits</b>		
Office hours visits (non-surgical)	\$80 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
<b>Physician surgical services</b>		
<b>Physicians and specialists</b> office visits		
Performed at a <b>physician's, PCP</b> office	\$55 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
Performed at a <b>specialist's</b> office	\$80 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit

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## Walk-in clinic visits

Not all preventive care services are available at all **walk-in clinics**. The types of services offered will vary by the **provider** and location of the clinic. These services may also be obtained from a network **physician**.

Description	Network Benefit Level		Out-of-network benefit level
	Designated network coverage	Non-designated network coverage	Out-of-network coverage
Non-emergency services	100% (of the <b>negotiated charge</b> ) per visit, no <b>deductible</b> applies	\$55 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter, no <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit after <b>deductible</b>
Preventive care immunizations	100% (of the <b>negotiated charge</b> ) per visit, no <b>deductible</b> applies	100% (of the <b>negotiated charge</b> ) per visit, no <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit after <b>deductible</b>
Immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention  For details, contact your <b>physician</b>	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention  For details, contact your <b>physician</b>	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention  For details, contact your <b>physician</b>
Preventive screening and counseling services	100% (of the <b>negotiated charge</b> ) per visit, no <b>deductible</b> applies	100% (of the <b>negotiated charge</b> ) per visit, no <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit after <b>deductible</b>
Preventive screening and counseling limits	See the <i>Preventive care services</i> section of the SOB	See the <i>Preventive care services</i> section of the SOB	See the <i>Preventive care services</i> section of the SOB

### Important Note:

Designated network provider

A **network provider** listed in the **directory** under *Best Results for your plan* as a **provider** for your plan.

Non-designated network provider

A **provider** listed in the **directory** under the *All other results* tab as a **provider** for your plan.

See the *Contact us* section if you have questions.

You will pay less cost share when you use a designated network walk-in clinic **provider**. Non-designated network walk-in clinic **providers** are available to you, but the cost share will be at a higher level when these **providers** are used.

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

Eligible health services	In-network coverage*	Out-of-network coverage*
<b>3. Hospital and other facility care</b>		
<b>Hospital care</b>		
Inpatient hospital	70% (of the <b>negotiated charge</b> ) per admission	50% (of the <b>recognized charge</b> ) per admission
<b>Alternatives to hospital stays</b>		
<b>Outpatient surgery and physician surgical services</b>		
	70% (of the <b>negotiated charge</b> ) per visit	50% (of the <b>recognized charge</b> ) per visit
<b>Home health care</b>		
Outpatient	70% (of the <b>negotiated charge</b> ) per visit	50% (of the <b>recognized charge</b> ) per visit
Maximum visits per Calendar Year	120  Limited to: 3 intermittent visits per day provided by a participating <b>home health care agency</b> ; 1 visit equals at least a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care  The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 14 days of discharge	120  Limited to: 3 intermittent visits per day provided by a participating <b>home health care agency</b> ; 1 visit equals at least a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care  The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 14 days of discharge

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<b>Hospice care</b>		
Inpatient facility	70% (of the <b>negotiated charge</b> ) per admission	50% (of the <b>recognized charge</b> ) per admission
Maximum days per lifetime	Unlimited	Unlimited
<b>Hospice care</b>		
Outpatient	70% (of the <b>negotiated charge</b> ) per visit	50% (of the <b>recognized charge</b> ) per visit
	Part-time or intermittent nursing care by an <b>R.N.</b> or <b>L.P.N.</b> for up to 8 hours a day  Part-time or intermittent home health aide services to care for you up to 8 hours a day	Part-time or intermittent nursing care by an <b>R.N.</b> or <b>L.P.N.</b> for up to 8 hours a day  Part-time or intermittent home health aide services to care for you up to 8 hours a day
<b>Skilled nursing facility</b>		
Inpatient facility	70% (of the <b>negotiated charge</b> ) per admission	50% (of the <b>recognized charge</b> ) per admission
Maximum days per Calendar Year	60	60
<b>Eligible health services</b>	<b>In-network coverage*</b>	<b>Out-of-network coverage*</b>
<b>4. Emergency services and urgent care</b>		
<b>Emergency services</b>		
<b>Hospital</b> emergency room	\$250 then the plan pays 70% (of the balance of the <b>negotiated charge</b> ) per visit  No <b>deductible</b> applies	Paid the same as in-network coverage
Non-emergency care in a <b>hospital</b> emergency room	Not covered	Not covered

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

**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 coinsurance**) as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by this plan. If the **provider** bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, and we will resolve any payment dispute with the **provider** over that amount. Make sure the member's ID number is on the bill.
- A separate hospital emergency room **copayment/coinsurance** will apply for each visit to an emergency room. If you are admitted to a **hospital** as an inpatient right after a visit to an emergency room, your emergency room **copayment/coinsurance** will be waived and your inpatient **copayment/coinsurance** will apply.

**Urgent care**

Urgent medical care (at a non- <b>hospital</b> free standing facility)	\$50 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
Non-urgent use of <b>urgent care provider</b> (at a non- <b>hospital</b> free standing facility)	Not covered	Not covered
A separate urgent care <b>deductible</b> or <b>copayment/coinsurance</b> will apply for each visit to an <b>urgent care provider</b> .		

\*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. Specific conditions</b>		

<b>Behavioral health Mental health treatment - inpatient</b>		
Inpatient mental health treatment	70% (of the <b>negotiated charge</b> ) per admission	50% (of the <b>recognized charge</b> ) per admission
Inpatient <b>residential treatment facility</b> Inpatient mental health treatment		
<b>Mental health treatment - outpatient</b>		
Outpatient mental health treatment office visits to a <b>physician</b> or <b>behavioral health provider</b> (includes <b>telemedicine</b> consultation)	\$80 then the plan pays 100% (of the <b>balance of the negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
All other outpatient mental health treatment as described in your booklet-certificate (includes skilled behavioral health services in the home)  <b>Partial hospitalization treatment</b>  <b>Intensive outpatient program</b>  The cost share doesn't apply to in-network peer counseling support services	70% (of the <b>negotiated charge</b> ) per visit	50% (of the <b>recognized charge</b> ) per visit

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

<b>Substance related disorders treatment - inpatient</b>		
Inpatient <b>substance abuse detoxification</b>	70% (of the <b>negotiated charge</b> ) per admission	50% (of the <b>recognized charge</b> ) per admission
Inpatient <b>substance abuse</b> rehabilitation		
Inpatient <b>residential treatment facility</b>		
<b>Substance related disorders treatment - outpatient</b>		
Outpatient <b>substance abuse office</b> visits to a <b>physician or behavioral health provider</b> (includes <b>telemedicine</b> consultation)	\$80 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
All other outpatient <b>substance abuse</b> services (as described in your booklet-certificate)  <b>Partial hospitalization treatment</b>  <b>Intensive outpatient program</b>  The cost share doesn't apply to in-network peer counseling support services	70% (of the <b>negotiated charge</b> ) per visit	50% (of the <b>recognized charge</b> ) per visit
<b>Birthing center and physician services</b>		
Inpatient	70% (of the <b>negotiated charge</b> ) per admission	50% (of the <b>recognized charge</b> ) per admission
<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

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<b>Family planning services - other</b>		
<b>Voluntary sterilization for males</b>		
Outpatient	100% (of the <b>negotiated charge</b> ) per visit  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
<b>Termination of pregnancy</b>		
Inpatient	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Physician's office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<b>Jaw joint disorder treatment</b>		
<b>Jaw joint disorder 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
<b>Maternity and related newborn care</b>		
Inpatient	70% (of the <b>negotiated charge</b> ) per admission	50% (of the <b>recognized charge</b> ) per admission
<b>Delivery services and postpartum care services</b>		
Performed in a facility or at a <b>physician's office</b>	70% (of the <b>negotiated charge</b> ) per visit	50% (of the <b>recognized charge</b> ) per visit
Other prenatal care services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<b>Pregnancy complications</b>		
Inpatient	70% (of the <b>negotiated charge</b> ) per admission	50% (of the <b>recognized charge</b> ) per admission

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<b>Gender reassignment counseling, surgery and injectable hormone replacement therapy</b>		
	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
Gender reassignment counseling, surgery and injectable hormone replacement therapy, including office visits and outpatient services	Covered based on type of service and where it is received.	Covered based on type of service and where it is received.

<b>Oral and maxillofacial treatment (mouth, jaws and teeth)</b>		
Oral and maxillofacial treatment (mouth, jaws and teeth)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

<b>Reconstructive surgery and supplies</b>		
Reconstructive surgery	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

<b>Eligible health services</b>	<b>Network (IOE facility)</b>	<b>Network (Non-IOE facility)</b>	<b>Out-of-network coverage*</b>
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<b>Transplant services facility and non-facility</b>			
Inpatient hospital transplant services	70% (of the <b>negotiated charge</b> ) per transplant	50% (of the <b>negotiated charge</b> ) per transplant	50% (of the <b>recognized charge</b> ) per transplant
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

<b>Eligible health services</b>	<b>In-network coverage*</b>	<b>Out-of-network coverage*</b>
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**Treatment of infertility**

<b>Basic infertility</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

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

Eligible health services	In-network coverage*	Out-of-network coverage*
<b>6. Specific therapies and tests</b>		
<b>Outpatient diagnostic testing</b>		
<b>Diagnostic complex imaging services</b>		
	70% (of the <b>negotiated charge</b> ) per visit	50% (of the <b>recognized charge</b> ) per visit
<b>Diagnostic lab work</b>		
	70% (of the <b>negotiated charge</b> ) per visit.	50% (of the <b>recognized charge</b> ) per visit.
<b>Diagnostic radiological services</b>		
	70% (of the <b>negotiated charge</b> ) per visit.	50% (of the <b>recognized charge</b> ) per visit.
<b>Chemotherapy</b>		
Chemotherapy	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
<b>Outpatient infusion therapy</b>		
Performed in a <b>physician's office</b>	\$80 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies.	50% (of the <b>recognized charge</b> ) per visit
Performed in a person's home	\$80 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies.	50% (of the <b>recognized charge</b> ) per visit
Performed in the outpatient department of a <b>hospital</b>	70% (of the <b>negotiated charge</b> ) per visit.	50% (of the <b>recognized charge</b> ) per visit
Performed at an outpatient facility other than the outpatient department of a <b>hospital</b>	70% (of the <b>negotiated charge</b> ) per visit.	50% (of the <b>recognized charge</b> ) per visit

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<b>Outpatient radiation therapy</b>		
Radiation therapy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<b>Short-term cardiac and pulmonary rehabilitation services</b>		
<b>Cardiac rehabilitation</b>		
Cardiac rehabilitation	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
<b>Pulmonary rehabilitation</b>		
Pulmonary rehabilitation	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
<b>Short-term rehabilitation services</b>		
<b>Outpatient Physical and Occupational Therapies</b>		
	\$80 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
<b>Outpatient Speech Therapy</b>		
	\$80 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
<b>Spinal manipulation</b>		
Spinal manipulation	\$80 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
Maximum visits per Calendar Year	20	20

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<b>Habilitation therapy services</b>		
<b>Outpatient physical and occupational therapies</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 speech therapy</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

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

Eligible health services	In-network coverage*	Out-of-network coverage*
<b>7. Other services</b>		
<b>Acupuncture</b>		
Acupuncture	\$55 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit

Maximum visits per Calendar Year	20	20
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<b>Ambulance service</b>		
Ground, air or water ambulance	70% (of the <b>negotiated charge</b> ) per trip  No <b>deductible</b> applies.	70% (of the <b>recognized charge</b> ) per trip  No <b>deductible</b> applies.

<b>Clinical trial therapies (experimental or investigational)</b>		
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

<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>		
DME	70% (of the <b>negotiated charge</b> ) per item	50% (of the <b>recognized charge</b> ) per item

<b>Nutritional supplements</b>		
Nutritional supplements	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

<b>Osteoporosis</b>		
Physician's office visits	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

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

AL HSOB 03 as amended by

AL COCAmend-2021 01

<b>Prosthetic and orthotic devices</b>		
Prosthetic and orthotic devices	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
<b>Vision care</b>		
<b>Routine vision exams (including refraction)</b>		
Performed by a licensed ophthalmologist or optometrist	100% (of the <b>negotiated charge</b> ) per visit  No <b>deductible</b> applies	50% (of the <b>recognized charge</b> ) per visit
Maximum visits per 24 month consecutive period	1 visit	1 visit
<b>All other outpatient services for which cost sharing is not shown above</b>		
All other outpatient services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

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

Eligible health services	In-network coverage*	Out-of-network coverage*
<b>8. Outpatient prescription drugs</b>		
<b>Plan features</b>	<b>Deductible/Copayment/Coinsurance/Maximums</b>	
<b>Deductible waiver</b>		
The Calendar Year <b>deductible</b> is waived for all <b>prescription drugs</b> .		
<b>Deductible and copayment/coinsurance waiver for risk reducing breast cancer prescription drugs</b>		
The Calendar Year <b>deductible</b> and the per <b>prescription copayment/coinsurance</b> will not apply to risk reducing breast cancer <b>prescription drugs</b> when obtained at a <b>network pharmacy</b> . This means that such risk reducing breast cancer <b>prescription drugs</b> will be paid at 100%.		
<b>Deductible and copayment/coinsurance waiver for contraceptives</b>		
The Calendar Year <b>deductible</b> and the per <b>prescription copayment/coinsurance</b> will not apply to female contraceptive methods when obtained at a <b>network pharmacy</b> . This means that the following will be paid at 100%:		
<ul style="list-style-type: none"> <li>• Certain over-the-counter (OTC) and generic contraceptive <b>prescription drugs</b> and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. If a <b>generic prescription drug</b> or device is not available for a certain method, you may obtain certain <b>brand-name prescription drug</b> for that method paid at 100%. We will cover brand-name emergency contraceptive “Ella” until such time as a generic equivalent is approved by the FDA. At that time, only a generic equivalent will be covered.</li> </ul>		
The Calendar Year <b>deductible</b> and the per <b>prescription copayment/coinsurance</b> continue to apply to <b>prescription drugs</b> that have a generic equivalent or generic alternative available within the same <b>therapeutic drug class</b> obtained at a <b>network pharmacy</b> unless you are granted a medical exception.		

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**Partial fill dispensing for Schedule II controlled substances, such as opioids**

Partial fill dispensing allows less than the entire prescription to be filled at a **pharmacy**. You will pay a prorated amount of your cost share based on the size of the supply.

**Preferred generic prescription drugs****Per prescription copayment/coinsurance**

For each fill up to a 30 day supply filled at a <b>retail pharmacy</b>	<p>\$10 <b>copayment</b> per supply</p> <p><b>Coinsurance</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not Covered
More than a 31 day supply but less than a 91 day supply filled at a <b>mail order pharmacy</b>	<p>\$20 <b>copayment</b> per supply</p> <p><b>Coinsurance</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not Covered

**Non-preferred generic prescription drugs****Per prescription copayment/coinsurance**

For each fill up to a 30 day supply filled at a <b>retail pharmacy</b>	<p>\$50 <b>copayment</b> per supply</p> <p><b>Coinsurance</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not Covered
More than a 31 day supply but less than a 91 day supply filled at a <b>mail order pharmacy</b>	<p>\$100 <b>copayment</b> per supply</p> <p><b>Coinsurance</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not Covered

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<b>Preferred brand-name prescription drugs</b>		
<b>Per prescription copayment/coinsurance</b>		
For each fill up to a 30 day supply filled at a <b>retail pharmacy</b>	<p>\$30 <b>copayment</b> per supply</p> <p><b>Coinsurance</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not Covered
More than a 31 day supply but less than a 91 day supply filled at a <b>mail order pharmacy</b>	<p>\$60 <b>copayment</b> per supply</p> <p><b>Coinsurance</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not Covered
<b>Non-preferred brand-name prescription drugs</b>		
<b>Per prescription copayment/coinsurance</b>		
For each fill up to a 30 day supply filled at a <b>retail pharmacy</b>	<p>\$50 <b>copayment</b> per supply</p> <p><b>Coinsurance</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not Covered
More than a 31 day supply but less than a 91 day supply filled at a <b>mail order pharmacy</b>	<p>\$100 <b>copayment</b> per supply</p> <p><b>Coinsurance</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not Covered
<b>Orally administered anti-cancer prescription drugs</b>		
<b>Per prescription copayment/coinsurance</b>		
For each fill up to a 30 day supply filled at a <b>retail pharmacy</b>	<p>\$0 <b>copayment</b> per supply</p> <p><b>Coinsurance</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not Covered
More than a 31 day supply but less than a 91 day supply filled at a <b>mail order pharmacy</b>	<p>\$0 <b>copayment</b> per supply</p> <p><b>Coinsurance</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not Covered

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<b>Specialty drugs</b>		
<b>Per prescription copayment/coinsurance</b>		
For each fill up to a 30 day supply filled at a <b>retail pharmacy</b>	<p><b>Copayment</b> is 30% (of the <b>negotiated charge</b>) but will be no more than \$250 per supply</p> <p><b>Coinsurance</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not Covered
<b>Preventive care drugs and supplements</b>		
Preventive care drugs and supplements filled at a <b>pharmacy</b>	100% per <b>prescription</b> or refill	Not Covered
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.	

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<b>Risk reducing breast cancer prescription drugs</b>		
Risk reducing breast cancer <b>prescription drugs</b> filled at a <b>pharmacy</b>	100% per <b>prescription</b> or refill	Not Covered
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.	
<b>Family planning services - female contraceptives</b>		
If your <b>provider</b> recommends a particular service or FDA-approved item based on a determination of <b>medical necessity</b> , that service or item will be covered without cost sharing, regardless of whether it is generic or brand-name. We will defer to the determination made by your <b>provider</b> . <b>Medical necessity</b> may include considerations such as severity of side effects, differences in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the item or service, as determined by your <b>provider</b> .		
Female contraceptives that are <b>generic prescription drugs</b> : <ul style="list-style-type: none"> <li>• Oral drugs</li> <li>• Injectable drugs</li> <li>• Vaginal rings</li> <li>• Transdermal contraceptive patches</li> </ul>	\$0 per <b>prescription</b> or refill  No <b>deductible</b> applies	Not Covered
Female contraceptives that are <b>brand-name prescription drugs</b> : <ul style="list-style-type: none"> <li>• Oral drugs</li> <li>• Injectable drugs</li> <li>• Vaginal rings</li> <li>• Transdermal contraceptive patches</li> </ul>	Paid according to the type of drug per the schedule of benefits, above	Not Covered

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<b>Tobacco cessation prescription and over-the-counter drugs</b>		
Tobacco cessation <b>prescription drugs</b> and OTC drugs filled at a <b>pharmacy</b>	\$0 per <b>prescription</b> or refill  No <b>deductible</b> applies	Not Covered
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation <b>prescription drugs</b> and OTC drugs, contact Member Services by logging onto your Aetna secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.  Coverage for tobacco cessation <b>prescription drugs</b> is not subject to any <b>precertification</b> requirements.	

If a **prescriber** prescribes a covered **brand-name prescription drug** where a **generic prescription drug** equivalent is available and specifies “Dispense As Written” (DAW), you will pay the cost sharing for the **brand-name prescription drug**. If a **prescriber** does not specify DAW and you request a covered **brand-name prescription drug** where a **generic prescription drug** is available, you will be responsible for the cost difference between **the brand-name prescription drug** and the **generic prescription drug**, plus the cost sharing that applies to the **brand-name prescription drug**.

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## General coverage provisions

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This section provides detailed explanations about the:

- **Deductible**
- **Maximum out-of-pocket limits**
- **Maximums**

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

<b>Deductible provisions</b>
<b>Eligible health services</b> applied to the out-of-network <b>deductibles</b> will not be applied to satisfy the in-network <b>deductibles</b> . <b>Eligible health services</b> applied to the in-network <b>deductibles</b> will not be applied to satisfy the out-of-network <b>deductibles</b> .
The <b>deductible</b> may not apply to certain <b>eligible health services</b> . You must pay any applicable <b>copayments/coinsurance</b> for <b>eligible health services</b> to which the <b>deductible</b> does not apply.
<b>Individual</b> This is the amount you owe for in-network and out-of-network <b>eligible health services</b> each Calendar Year before the plan begins to pay for <b>eligible health services</b> . This Calendar Year <b>deductible</b> applies separately to you and each of your covered dependents. After the amount you pay for <b>eligible health services</b> reaches the Calendar Year <b>deductible</b> , this plan will begin to pay for <b>eligible health services</b> for the rest of the Calendar Year.
<b>Family</b> This is the amount you and your covered dependents owe for in-network and out-of-network <b>eligible health services</b> each Calendar Year before the plan begins to pay for <b>eligible health services</b> . After the amount you and your covered dependents pay for <b>eligible health services</b> reach this family Calendar Year <b>deductible</b> , this plan will begin to pay for <b>eligible health services</b> that you and your covered dependents incur for the rest of the Calendar Year.
To satisfy this family <b>deductible</b> limit for the rest of the Calendar Year, the following must happen: <ul style="list-style-type: none"><li>▪ The combined <b>eligible health services</b> that you and each of your covered dependents incur towards the individual Calendar Year <b>deductibles</b> must reach this family <b>deductible</b> limit in a Calendar Year.</li></ul>
When this occurs in a Calendar Year, the individual Calendar Year <b>deductibles</b> for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

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

## 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**. As it applies to in-network coverage, if **Aetna** compensates **network providers** on the basis of the reasonable amount, your percentage copayment is based on this amount.

## Coinsurance

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

## Maximum out-of-pocket limits provisions

**Eligible health services** that are subject to the **maximum out-of-pocket limit** include **prescription drug eligible health services** provided under the medical plan outpatient **prescription drug** plan.

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

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments/coinsurance** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit** each of you must meet your **maximum out-of-pocket limit** separately.

### Individual

Once the amount of the **copayments/coinsurance** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** or **recognized charge** for **covered benefits** that apply toward the limit for the rest of the Calendar Year for that person.

### Family

Once the amount of the **copayments/coinsurance** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** or **recognized charge** for such **covered benefits** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

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

To satisfy this family **maximum out-of-pocket limit** for the rest of the Calendar Year, the following must happen:

- The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members. The family **maximum out-of-pocket limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **maximum out-of-pocket limit** amount in a Calendar Year.

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

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

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

### **Maximum provisions**

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

### **Calculations; determination of recognized charge; determination of benefits provisions**

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

### **Outpatient prescription drug maximum out-of-pocket limits provisions**

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

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