Aetna 2-50
HealthNetworkOptionOpenAccess | ID 01/01/2018

Member benefits

Plan name	ID Gold HNOption 500 80/60		ID Silver HNOption 5000 80/50	
	In Network	Out of Network	In Network	Out of Network
Deductible (Individual/Family)	$500/$1,000	$5,000/$10,000	$5,000/$10,000	$15,000/$30,000
Out-of-pocket limit (Individual/Family)	$4,000/$8,000	$10,000/$20,000	$7,000/$14,000	$21,000/$42,000
Deductible/out-of-pocket limit accumulation	Embedded [1]		Embedded [1]	
Primary care physician office visit	$30 DW	40% AD	$30 DW	50% AD
Specialist office visit	$50 DW	40% AD	$75 DW	50% AD
Walk-in clinics	$30 DW	40% AD	$30 DW	50% AD
Diagnostic testing: Lab	20% AD	40% AD	20% AD	50% AD
Diagnostic testing: X-ray	20% AD	40% AD	20% AD	50% AD
Imaging CT/PET scans MRIs	20% AD	40% AD	20% AD	50% AD
Inpatient hospital facility	20% AD	40% AD	20% AD	50% AD
Outpatient surgery	20% AD	40% AD	20% AD	50% AD
Emergency room	$300 plus 20% AD	Paid as In-Network	20% AD	Paid as In-Network
Urgent care	$50 DW	40% AD	$60 DW	50% AD
Habilitation/Rehabilitation services (PT/OT/ST)[2]	$50 DW	40% AD	20% AD	50% AD
Chiropractic [3]	$50 DW	40% AD	20% AD	50% AD
Pediatric Dental and Vision [4]	In Network	Out of Network	In Network	Out of Network
Dental Check-Up (aka preventive/diagnostic)	Covered in full AD	Covered in full AD	Covered in full AD	Covered in full AD
Dental Basic	30% AD	30% AD	30% AD	30% AD
Dental Major	50% AD	50% AD	50% AD	50% AD
Dental Ortho	50% AD	50% AD	50% AD	50% AD
Vision exam (1 exam per 12 months)	Covered in full DW	40% AD	50% AD	50% AD
Pediatric Vision Hardware	Covered in full DW	40% AD	50% AD	50% AD
Pharmacy [5]	In Network	Out of Network	In Network	Out of Network
Pharmacy Deductible	$250 per Member	$250 per Member	None	None
Preferred generic drugs	$15 DW	$15 DW	$12	$12
Preferred brand drugs	$40 AD	$40 AD	$55	$55
Non-preferred drugs	$75 AD	$75 AD	$95	$95
Specialty drugs	Preferred Specialty: 30% AD Non-Preferred Specialty: 50% AD	Preferred Specialty: 30% AD Non-Preferred Specialty: 50% AD	Preferred Specialty: 40% up to $500 Non-Preferred Specialty: 50% up to $750	Preferred Specialty: 40% up to $500 Non-Preferred Specialty: 50% up to $750

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health of Utah Inc. (Aetna). **This is a Managed Care Plan**.

50.02.098.1-ID(11/17)

Aetna 2-50
HealthNetworkOptionOpenAccess | ID 01/01/2018

Member benefits

Plan name	ID Gold Peak Pref HNOpt 500 80/50/40			ID Silver HNOption Pk Pref 5000 80/65/50		
	In Network	Non-Designated	Out of Network	In Network	Non-Designated	Out of Network
Deductible (Individual/Family)	$500/$1,000	$500/$1,000	$5,000/$10,000	$5,000/$10,000	$5,000/$10,000	$15,000/$30,000
Out-of-pocket limit (Individual/Family)	$5,000/$10,000	$5,000/$10,000	$10,000/$20,000	$6,000/$12,000	$7,000/$14,000	$18,000/$36,000
Deductible/out-of-pocket limit accumulation	Embedded [1]			Embedded [1]		
Primary care physician office visit	$30 DW	$50 DW	60% AD	$30 DW	$40 DW	50% AD
Specialist office visit	$50 DW	$70 AD	60% AD	$70 DW	$95 DW	50% AD
Walk-in clinics	$30 DW	Paid at the designated level	60% AD	$30 DW	Paid at the designated level	50% AD
Diagnostic testing: Lab	20% AD	50% AD	60% AD	20% AD	35% AD	50% AD
Diagnostic testing: X-ray	20% AD	50% AD	60% AD	20% AD	35% AD	50% AD
Imaging CT/PET scans MRIs	20% AD	50% AD	60% AD	20% AD	35% AD	50% AD
Inpatient hospital facility	20% AD	50% AD	60% AD	20% AD	35% AD	50% AD
Outpatient surgery	20% AD	50% AD	60% AD	20% AD	35% AD	50% AD
Emergency room	$300 plus 20% AD	Paid at the designated level	Paid at the designated level	20% AD	Paid at the designated level	Paid at the designated level
Urgent care	$50 DW	$70 AD	60% AD	$60 DW	Paid at the designated level	50% AD
Habilitation/Rehabilitation services (PT/OT/ST)[2]	$50 DW	$70 AD	60% AD	20% AD	35% AD	50% AD
Chiropractic [3]	$50 DW	$70 AD	60% AD	20% AD	35% AD	50% AD
Pediatric Dental and Vision [4]	In Network	Non-Designated	Out of Network	In Network	Non-Designated	Out of Network
Dental Check-Up (aka preventive/diagnostic)	Covered in full AD	Paid at the designated level	Covered in full AD	Covered in full AD	Paid at the designated level	Covered in full AD
Dental Basic	30% AD	Paid at the designated level	30% AD	30% AD	Paid at the designated level	30% AD
Dental Major	50% AD	Paid at the designated level	50% AD	50% AD	Paid at the designated level	50% AD
Dental Ortho	50% AD	Paid at the designated level	50% AD	50% AD	Paid at the designated level	50% AD
Vision exam (1 exam per 12 months)	Covered in full DW	Covered in full DW	60% AD	50% AD	Paid at the designated level	50% AD
Pediatric Vision Hardware	Covered in full DW	Covered in full DW	60% AD	50% AD	Paid at the designated level	50% AD
Pharmacy [5]	In Network		Out of Network	In Network		Out of Network
Pharmacy Deductible	None		None	None		None
Preferred generic drugs	$15		$15	$12		$12
Preferred brand drugs	$40		$40	$55		$55
Non-preferred drugs	$75		$75	$95		$95
Specialty drugs	Preferred Specialty: 30% Non-Preferred Specialty: 50%		Preferred Specialty: 30% Non-Preferred Specialty: 50%	Preferred Specialty: 40% up to $500 Non-Preferred Specialty: 50% up to $750		Preferred Specialty: 40% up to $500 Non-Preferred Specialty: 50% up to $750

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health of Utah Inc. (Aetna). **This is a Managed Care Plan**.

50.02.098.1-ID(11/17)

Exceptions and exclusions

Acupuncture, **acupressure and acupuncture therapy**, except where described in the Eligible health services under your plan section.
Ambulance services
· Ambulance services, for routine transportation to receive outpatient or inpatient services
Artificial organs
· Any device that would perform the function of a body organ
Blood, blood plasma, synthetic blood, blood derivatives or substitutes
Examples of these are:
· The provision of blood to the hospital, other than blood derived clotting factors
· Any related services including processing, storage or replacement expenses
· The services of blood donors, apheresis or plasmapheresis
For autologous blood donations, only administration and processing expenses are covered.
Clinical trial therapies (experimental or investigational)
· Your plan does not cover clinical trial therapies (experimental or investigational), except where described in the Eligible health services under your plan - Clinical trial therapies (experimental or investigational) section.
Clinical trial therapies (routine patient costs)
• Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
• Services and supplies provided by the trial sponsor without charge to you
• The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna's claim policies)
Cosmetic services and plastic surgery
· Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons, except where described in the Eligible health services under your plan - Reconstructive surgery and supplies section
Counseling
· Marriage, religious, family, career, social adjustment, pastoral, or financial counseling
Court-ordered services and supplies
· Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding
Custodial care
Examples are:
· Routine patient care such as changing dressings, periodic turning and positioning in bed.
· Administering oral medications.
· Care of a stable tracheostomy (including intermittent suctioning).
· Care of a stable colostomy/ileostomy.
· Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings.
· Care of a bladder catheter (including emptying/changing containers and clamping tubing).
· Watching or protecting you.
· Respite care, adult (or child) day care, or convalescent care.
· Institutional care. This includes room and board for rest cures, adult day care and convalescent care.
· Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating or preparing foods.
· Any other services that a person without medical or paramedical training could be trained to perform.
· Any service performed by a person without any medical or paramedical training.
Dialysis
· Any supplies or equipment for comfort, convenience or luxury
· Any non-medical items (such as generators) to make home dialysis equipment portable for travel
Durable medical equipment (DME)
Examples of these items are:
· Whirlpools
· Portable whirlpool pumps
· Massage table
· Sauna baths
· Message devices (personal voice recorder)
· Over bed tables
· Elevators
· Communication aids
· Vision aids
· Telephone alert systems
Early intensive behavioral interventions
Examples of those services are:
· Early intensive behavioral interventions (Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions
Educational services
Examples of those services are:
· Any service or supply for education, training or retraining services or testing. This includes special education, remedial education, wilderness treatment program, job training and job hardening programs.
· Services provided by a school district.
Elective abortions
Services and supplies provided for an elective abortion, which means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed

Non-Emergency services and non-urgent care
· Non-emergency care in a hospital emergency room facility
· Non-urgent care in an urgent care facility or at a non-hospital freestanding facility
Examinations
Any health or dental examinations needed:
· Because a third party requires the exam. Examples include examinations to get or keep a job, or examinations required under a labor agreement or other contract.
· Because a court order requires it.
· To buy insurance or to get or keep a license.
· To travel.
· To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.
Experimental or investigational
· Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (experimental or investigational) or covered under clinical trials (routine patient costs)
Facility charges
For care, services or supplies provided in:
· Rest homes
· Assisted living facilities
· Similar institutions serving as a person's main residence or providing mainly custodial or rest care
· Health resorts
· Spas or sanitariums
· Infirmaries at schools, colleges, or camps
Family planning services – female contraceptives counseling, devices and voluntary sterilization
· Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
· Contraception services during a stay in a hospital or other facility for medical care
· Male contraceptive methods, sterilization procedures or devices
Family planning services - other
· Reversal of voluntary sterilization procedures including related follow-up care
· Services and supplies provided for an elective abortion, which means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed
Foot care
· Services and supplies for:
o The treatment of calluses, bunions, toenails, hammertoes, fallen arches
o The treatment of weak feet, chronic foot pain or conditions caused by routine
o activities, such as walking, running, working or wearing shoes
o Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
Growth/Height care
Except as covered under the Eligible health services under your plan – Growth hormone therapy section:
· A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
· Surgical procedures, devices and growth hormones to stimulate growth
Hearing aids
Home health care
· Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
· Transportation
· Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present
Hospice care
· Funeral arrangements.
· Pastoral counseling.
· Financial or legal counseling. This includes estate planning and the drafting of a will.
· Homemaker or caretaker services. These are services which are not solely related to your care and may include:
o Sitter or companion services for either you or other family members.
o Transportation.
o Maintenance of the house.
Jaw joint disorder
· Jaw joint disorder treatment performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutic services related to jaw joint disorder
Maintenance care
· Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function except for habilitation therapy services
Medical supplies – outpatient disposable
· Any outpatient disposable supply or device. Examples of these include:
Sheaths
Bags
Elastic
garments
Support
hose
Bandages
Bedpans
Syringes
Blood

or urine testing supplies
Other
home test kits
Splints
Neck
braces
Compresses
Other devices not intended for reuse by another patient

Mental health treatment

· Mental health services for the following categories (or equivalent terms as listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)):
Stay in a facility for treatment for dementias or amnesia without a behavioral disturbance that necessitates mental health treatment.
Sexual deviations and disorders except for gender identity disorders
Sexual deviations and disorders except for gender identity disorders
Tobacco use disorders
Pathological gambling, kleptomania, pyromania
School and/or education service, including special educational, remedial education, wilderness treatment programs or any such related or similar programs
· Services provided in conjunction with school, vocation, work or recreational activities
· Transportation

Nutritional support

· Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in the Eligible health services under your plan – Other services section

Obesity (bariatric) surgery and weight management

· Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, except as described in the Eligible health services under your plan – Preventive care and wellness section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions.
Examples of these are:
o Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery
o Surgical procedures, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of, obesity, including morbid obesity
o Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
o Hypnosis or other forms of therapy
o Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Other primary payer

· Payment that Medicare or another party is responsible for as the primary payer

Outpatient infusion therapy

· Enteral nutrition
· Blood transfusions and blood products

Outpatient prescription drugs

· Abortion drugs
· Allergy serum and extracts administered by injection
· Any services related to the dispensing, injection or application of a drug
· Biological liquids and fluids
· Cosmetic drugs - Medications or preparations used for cosmetic purposes
· Compound prescriptions containing bulk chemicals that have not been approved by the U.S. Food and Drug Administration (FDA), including compounded bioidentical hormones
· Devices, products and appliances, except those that are specifically covered
· Dietary supplements including medical foods
· Drugs or medications:
o Administered or entirely consumed at the time and place it is prescribed or dispensed
o Which do not, by federal or state law, require a prescription order (i.e. over-the counter (OTC) drugs), even if a prescription is written, except where stated in the Eligible health services under your plan – Outpatient prescription drugs section
o That includes the same active ingredient or a modified version of an active ingredient
o That is therapeutically equivalent or a therapeutic alternative to a covered prescription drug unless a medical exception is approved
o That is therapeutically equivalent or a therapeutic alternative to an over-the counter (OTC) product unless a medical exception is approved
o Provided under your medical benefits while an inpatient of a healthcare facility
o Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by Aetna's Pharmacy and Therapeutics Committee
o That includes vitamins and minerals unless recommended by the United States
o Preventive Services Task Force (USPSTF)
o For which the cost is covered by a federal, state or government agency (for example: Medicaid or Veterans Administration)
o Not approved by the FDA or not proven to be safe and effective
o That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our precertification and clinical policies
· Duplicative drug therapy (e.g. two antihistamine drugs)
· Genetic care - Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up or the expression of the body's genes except for the correction of congenital birth defects
· Immunizations related to travel or work
· Immunization or immunological agents
· Implantable drugs and associated devices except where stated in the Eligible health services under your plan – Preventive care and wellness and Outpatient prescription drugs section

· **Infertility**
Prescription drugs used primarily for the treatment of infertility
· Injectables:
Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by us.
Needles and syringes, except those used for self-administration of an injectable drug.
For any drug, which due to its characteristics, as determined by us, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting.This exception does not apply to Depo Provera and other injectable drugs used for contraception.
• Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps. See the Eligible health services under your plan – Diabetic equipment, supplies and education section.
• **Prescription drugs**:
o For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a prescription is written.
o Filled prior to the effective date or after the end date of coverage under this plan.
o Dispensed by a mail order pharmacy that includes prescription drugs that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.
o That include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and are not clinically superior to that drug as determined by the plan.
o That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or prescription drugs for the treatment of a dental condition unless dental benefits are provided under the plan.
o That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the drug guide.
o That are non-preferred drugs, unless non-preferred drugs are specifically covered as described in your schedule of benefits. However, a non-preferred drug will be covered if in the judgment of the prescriber there is no equivalent prescription drug on the drug guide or the product on the drug guide is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.
o That are not covered or related to a non-covered service.
o That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not medically necessary or otherwise improper and drugs obtained for use by anyone other than the member identified on the ID card.
· Refills
Refills dispensed more than one year from the date the latest prescription order was written
· Replacement of lost or stolen prescriptions
· Tobacco use
Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). See the Eligible health services under the plan – Outpatient prescription drugs section.
• Test agents except diabetic test agents

Outpatient surgery
· The services of any other physician who helps the operating physician.
· A stay in a hospital. (A hospital stay is an inpatient hospital benefit. See the Eligible health services under your plan – Hospital and other facility care section.)
· A separate facility charge for surgery performed in a physician's office.
· Services of another physician for the administration of a local anesthetic.

Pediatric dental care
In addition to the exclusions that apply to health coverage:
· Any instruction for diet, plaque control and oral hygiene
· Cosmetic services and supplies including:
- Plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
- Augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the Eligible health services under your plan section
- Facings on molar crowns and pontics will always be considered cosmetic
· Crown, inlays, onlays, and veneers unless:
It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material
The tooth is an abutment to a covered partial denture or fixed bridge
· Dental implants and braces (that are determined not to be medically necessary), mouth guards and other devices to protect, replace or reposition teeth
· Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
For splinting
To alter vertical dimension
To restore occlusion
For correcting attrition, abrasion, abfraction or erosion

· Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment

· General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another eligible health service
· Orthodontic treatment except as covered in the Eligible health services under your plan – Pediatric dental care section
· Pontics, crowns, cast or processed restorations made with high noble metals (gold)
· Prescribed drugs, pre-medication or analgesia (nitrous oxide)
· Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
· Replacement of teeth beyond the normal complement of 32
· Routine dental exams and other preventive services and supplies, except as specifically described in the Eligible health services under your plan – Pediatric dental care section
· Services and supplies:
- Done where there is no evidence of pathology, dysfunction or disease other than covered preventive services
- Provided for your personal comfort or convenience or the convenience of another person, including a provider
- Provided in connection with treatment or care that is not covered under your policy
· Surgical removal of impacted wisdom teeth only for orthodontic reasons
· Treatment by other than a dental provider

Dental care for adults
· Dental services for adults, including services related to:
- The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
- Dental services related to the gums
- Apicoectomy (dental root resection)
- Orthodontics
- Root canal treatment
- Removal of soft tissue impactions
- Removal of bony impacted teeth
- Alveolectomy
- Augmentation and vestibuloplasty treatment of periodontal disease
- False teeth
- Dental implants
This exclusion does not include bone fractures, removal of tumors, and odontogenic cysts.
Personal care, comfort or convenience items
· Any service or supply primarily for your convenience and personal comfort or that of a third party
Physician surgical services
· The services of any other physician who helps the operating physician.
· A stay in a hospital. (See the Eligible health services under your plan – Hospital and other facility care section.)
· A separate facility charge for surgery performed in a physician's office.
· Services of another physician for the administration of a local anesthetic.
Private duty nursing
Prosthetic devices
· Services covered under any other benefit
· Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace
· Trusses, corsets, and other support items
· Repair and replacement due to loss, misuse, abuse or theft
Services provided by a family member
· Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member
Services, supplies and drugs received outside of the United States
· Non-emergency medical services, outpatient prescription drugs or supplies received outside of the United States. They are not covered even if they are covered in the United States under this certificate.
Sexual dysfunction and enhancement
· Any treatment, prescription drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
- Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ
- Sex therapy, sex counseling, marriage counseling or other counseling or advisory services
Strength and performance
• Services, devices and supplies such as drugs or preparations designed primarily to enhance your strength, physical condition, endurance or physical performance
Telemedicine
• Services given when you are not present at the same time as the provider
• Services including:
- Telephone calls
- Telemedicine kiosks
- Electronic vital signs monitoring or exchanges (e.g. Tele-ICU, Tele-stroke)
Therapies and tests
· Full body CT scans
· Hair analysis
· Hypnosis and hypnotherapy
· Massage therapy, except when used as a physical therapy modality
· Sensory or auditory integration therapy
Tobacco cessation
- Hypnosis and other therapies
- Medications, except where stated in the Eligible health services under your plan – Outpatient prescription drugs section
- Nicotine patches
- Gum
Transplant services
· Services and supplies furnished to a donor when the recipient is not a covered person
· Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
· Outpatient drugs including bio-medicals and immunosuppressant not expressly related to an outpatient transplant occurrence
· Harvesting and/or storage of bone marrow or hematopoietic stem cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness
Treatment in a federal, state, or governmental entity
Except where required by law:
• Charges you have no legal obligation to pay
• Charges that would not be made if you did not have coverage under the plan

Treatment of infertility
All charges associated with the treatment of infertility, except as described under the Eligible health services under your plan – Treatment of infertility – Basic infertility section. This includes:
· All charges associated with:
- Cryopreservation (freezing) of eggs, embryos or sperm.
- Storage of eggs, embryos or sperm.
- Thawing of cryopreserved (frozen) eggs, embryos or sperm.
- The care of the donor in a donor egg cycle. This includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests and any charges associated with care of the donor required for donor egg retrievals or transfers.
- The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which she is not genetically related.
• Home ovulation prediction kits or home pregnancy tests.
• Injectable infertility medication, including but not limited to menotropins, hCG and GnRH agonists.
• The purchase of donor embryos, donor oocytes or donor sperm.
• Reversal of voluntary sterilizations, including follow-up care.
• Any charges associated with obtaining sperm from a person not covered under this plan for ART services.
· Ovulation induction with menotropins, intrauterine insemination and any related services, products or procedures.
· In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery).

Vision care

Adult vision care
· Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing
· Vision care services and supplies

Pediatric vision care services and supplies
Your plan does not cover vision care services and supplies, except as described in the Eligible health services under your plan – Other services section.
· Special supplies such as non-prescription sunglasses
· Non-prescription eyeglass frames, non-prescription lenses and non-prescription contact lenses
· Special vision procedures, such as orthoptics or vision therapy
· Eye exams during your stay in a hospital or other facility for health care
· Eye exams for contact lenses or their fitting
· Acuity tests
· Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures
· Services to treat errors of refraction

Wilderness treatment programs
· Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
· Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting

Work related illness or injuries
· Coverage available to you under workers' compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.
· A source of coverage or reimbursement is considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law.
· If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered "non-occupational" regardless of cause.

50.02.098.1-ID(11/17)

Footnotes

"AD" indicates after deductible and "DW" indicates Deductible waived

All services are subject to the deductible unless noted otherwise. Some benefits are subject to age and frequency schedules, limitations or visit maximums. Members or Providers may be required to precertify or obtain approval for certain services.

Note: Please refer to Aetna's Producer World® web site at **www.aetna.com** for specific Summary of Benefits and Coverage documents. Or for more information, please contact your licensed agent or Aetna Sales Representative.

Deductibles, copays and coinsurance apply to the out-of-pocket maximum (OOP). After the out of pocket maximum is met, members continue to be responsible for any applicable premiums, penalties for failure to precertify (where applicable) and services not covered by Aetna.

[1] **Embedded** – No one family member may contribute more than the individual deductible/out-of-pocket limit amount to the family deductible/out-of-pocket limit. Once the family deductible/out-of-pocket limit is met, all family members will be considered as having met their deductible/out-of-pocket limit for the remainder of the calendar year.

[2] **Habilitation/Rehabilitation services -** Coverage is limited to **20** visits for PT/OT/ST per calendar year. Benefit limits are not shared between rehabilitation and habilitation services.

[3] **Chiropractic/subluxation** services have a combined limit of **18** visits per calendar year.

[4] **Vision and Dental services -** These plans do not cover all dental and vision expenses and have exclusions and limitations. Members should refer to their plan documents to determine which services are covered and to what extent.
– Important Notes: This plan will cover **1** set of frames and **1** set of contact lenses or eyeglass lenses per calendar year.

[5] **Pharmacy**
Choose Generics applies - If the physician prescribes or the member requests a covered brand name prescription drug when a generic prescription drug equivalent is available, the member will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent plus the applicable cost-sharing. The cost difference between the generic and brand does not count toward the Out of Pocket Limit. Not all drugs are covered. It is important to look at the Drug List (SG ACA Open) to understand which drugs are covered.

Network
How your out-of-network care is reimbursed: We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care. You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital. When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount.

Professional Services/Facility Services: 90% of Medicare
Your doctor sets his or her own rate to charge you. It may be higher – sometimes much higher – than what your Aetna plan "recognizes." Your doctor may bill you for the dollar amount that your plan doesn't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit Aetna.com. Type "how Aetna pays" in the search box. You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to **www.aetna.com** and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site.

This applies when you choose to get care out of network. When you have no choice (usually, for emergency services), some of our plans pay the bill as if you got care in network. For those plans, you pay cost sharing and deductibles based on your in-network level of benefits. You do not have to pay anything else. Other plans pay the bill differently. And, under those plans, you may be responsible for more than your in-network cost sharing. The additional amounts could be very large. Look at your plan or contact us to find out more about how your plan pays for emergency services.

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits may vary by location. Health/dental benefits and health/dental insurance plans contain exclusions and limitations. Plan features and availability may vary by location and group size. Investment services are independently offered through PayFlex. Providers are independent contractors and not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Not all health and dental services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **www.aetna.com**.

Policy forms issued in Idaho by Aetna Health of Utah Inc. include : HC SG HCOC-2018 02, HC SG HCOC-NM 2018 02, HI SG HGrpAg 03
50.02.098.1-ID(11/17)