Aetna 51-100
PPOMedical | ID 01/01/2018

Member benefits

Plan name	ID PPO 1000 80/60		ID PPO 1500 80/60		ID PPO 2500 70/50		ID PPO 5000 70/50	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible (Individual/Family)	$1,000/$2,000	$2,000/$4,000	$1,500/$3,000	$3,000/$6,000	$2,500/$5,000	$5,000/$10,000	$5,000/$10,000	$10,000/$20,000
Out-of-pocket limit (Individual/Family)	$4,000/$8,000	$8,000/$16,000	$4,000/$8,000	$8,000/$16,000	$6,850/$13,700	$13,700/$27,400	$6,850/$13,700	$13,700/$27,400
Deductible/out-of-pocket limit accumulation	Embedded [1]		Embedded [1]		Embedded [1]		Embedded [1]	
Primary care physician office visit	$25 DW	40% AD	$25 DW	40% AD	$30 DW	50% AD	$50 DW	50% AD
Specialist office visit	$50 DW	40% AD	$50 DW	40% AD	$65 DW	50% AD	$75 DW	50% AD
Walk-in clinics	$25 DW	40% AD	$25 DW	40% AD	$30 DW	50% AD	$50 DW	50% AD
Diagnostic testing: Lab	20% AD	40% AD	20% AD	40% AD	30% AD	50% AD	30% AD	50% AD
Diagnostic testing: X-ray	20% AD	40% AD	20% AD	40% AD	30% AD	50% AD	30% AD	50% AD
Imaging CT/PET scans MRIs	20% AD	40% AD	20% AD	40% AD	30% AD	50% AD	30% AD	50% AD
Inpatient hospital facility	20% AD	40% AD	20% AD	40% AD	30% AD	50% AD	30% AD	50% AD
Outpatient surgery	20% AD	40% AD	20% AD	40% AD	30% AD	50% AD	30% AD	50% AD
Emergency room	$250 AD	Paid as In-Network	$250 AD	Paid as In-Network	$300 AD	Paid as In-Network	$300 plus 30% AD	Paid as In-Network
Urgent care	$50 DW	40% AD	$50 DW	40% AD	$65 DW	50% AD	$75 DW	50% AD
Habilitation/Rehabilitation services (PT/OT/ST) [3]	$50 DW	40% AD	$50 DW	40% AD	$65 DW	50% AD	$75 DW	50% AD
Chiropractic [4]	$50 DW	40% AD	$50 DW	40% AD	$65 DW	50% AD	$75 DW	50% AD
Pediatric Dental and Vision	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Dental Check-Up (aka preventive/diagnostic)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Dental Basic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Dental Major	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Dental Ortho	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Vision exam (1 exam per 12 months)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Vision Hardware	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Pharmacy [5]	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Pharmacy Deductible	None	None	None	None	Integrated with Medical Deductible	Integrated with Medical Deductible	$500 per Member	$500 per Member
Preferred generic drugs	$15	$15	$15	$15	$15 DW	$15 DW	$15 DW	$15 DW
Preferred brand drugs	$30	$30	$30	$30	$30 AD	$30 AD	$50 AD	$50 AD
Non-preferred drugs	$75	$75	$75	$75	$100 AD	$100 AD	$150 AD	$150 AD
Specialty drugs	Preferred Specialty: 30% Non-Preferred Specialty: 40%	Preferred Specialty: 30% Non-Preferred Specialty: 40%	Preferred Specialty: 30% Non-Preferred Specialty: 40%	Preferred Specialty: 30% Non-Preferred Specialty: 40%	Preferred Specialty: 30% AD Non-Preferred Specialty: 40% AD	Preferred Specialty: 30% AD Non-Preferred Specialty: 40% AD	Preferred Specialty: 30% AD Non-Preferred Specialty: 40% AD	Preferred Specialty: 30% AD Non-Preferred Specialty: 40% AD

14.02.286.1A-ID_(11/17)

Aetna 51-100
PPOMedical | ID 01/01/2018

Member benefits

Plan name	ID PPO 5750 70/50 HSA EMB		ID PPO 1500 80/60 HSA TIF	
	In Network	Out of Network	In Network	Out of Network
Deductible (Individual/Family)	$5,750/$11,500	$11,500/$23,000	$1,500/$3,000	$3,000/$6,000
Out-of-pocket limit (Individual/Family)	$6,450/$12,900	$12,900/$25,800	$6,450/$6,450	$12,900/$25,800
Deductible/out-of-pocket limit accumulation	Embedded [1]		TIF [2]	
Primary care physician office visit	30% AD	50% AD	20% AD	40% AD
Specialist office visit	30% AD	50% AD	20% AD	40% AD
Walk-in clinics	30% AD	50% AD	20% AD	40% AD
Diagnostic testing: Lab	30% AD	50% AD	20% AD	40% AD
Diagnostic testing: X-ray	30% AD	50% AD	20% AD	40% AD
Imaging CT/PET scans MRIs	30% AD	50% AD	20% AD	40% AD
Inpatient hospital facility	30% AD	50% AD	20% AD	40% AD
Outpatient surgery	30% AD	50% AD	20% AD	40% AD
Emergency room	30% AD	Paid as In-Network	20% AD	Paid as In-Network
Urgent care	30% AD	50% AD	20% AD	40% AD
Habilitation/Rehabilitation services (PT/OT/ST) [3]	30% AD	50% AD	20% AD	40% AD
Chiropractic [4]	30% AD	50% AD	20% AD	40% AD
Pediatric Dental and Vision	In Network	Out of Network	In Network	Out of Network
Dental Check-Up (aka preventive/diagnostic)	Not Covered	Not Covered	Not Covered	Not Covered
Dental Basic	Not Covered	Not Covered	Not Covered	Not Covered
Dental Major	Not Covered	Not Covered	Not Covered	Not Covered
Dental Ortho	Not Covered	Not Covered	Not Covered	Not Covered
Vision exam (1 exam per 12 months)	Not Covered	Not Covered	Not Covered	Not Covered
Vision Hardware	Not covered	Not covered	Not covered	Not covered
Pharmacy [5]	In Network	Out of Network	In Network	Out of Network
Pharmacy Deductible	Integrated with Medical Deductible	Integrated with Medical Deductible	Integrated with Medical Deductible	Integrated with Medical Deductible
Preferred generic drugs	$15 AD	$15 AD	$15 AD	$15 AD
Preferred brand drugs	$30 AD	$30 AD	$30 AD	$30 AD
Non-preferred drugs	$125 AD	$125 AD	$100 AD	$100 AD
Specialty drugs	Preferred Specialty: 30% AD Non-Preferred Specialty: 40% AD	Preferred Specialty: 30% AD Non-Preferred Specialty: 40% AD	Preferred Specialty: 30% AD Non-Preferred Specialty: 40% AD	Preferred Specialty: 30% AD Non-Preferred Specialty: 40% AD

Health insurance plans are offered and/or underwritten by Aetna Life Insurance Company (Aetna).

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General exceptions

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.

Contraception services and supplies
Examples of these are:
- Over-the-counter (OTC) contraceptive supplies, such as male and female condoms, spermicides and sponges
- OTC emergency contraceptives
- Any drug, or supply to prevent or terminate pregnancy, including birth control pills, patches and implantable prescription drug contraceptives
- Contraceptive devices such as inter-uterine devices (IUDs) and diaphragms, including initial fitting and insertion even if for a medical condition other than birth control
- Tubal ligation, vasectomy and other forms of voluntary sterilization, along with related services and supplies, follow-up care and treatment of complications of such procedures
- Services related to prescribing, monitoring and/or administration of the prescription drug contraceptive devices
- Female contraceptives that are brand-name prescription drugs and biosimilar prescription drugs
- FDA-approved female brand-name and biosimilar emergency contraceptives
- Family planning services during a stay in a hospital or other facility for medical care

Cornea or cartilage transplants
- Cornea (corneal graft with amniotic membrane)
- Cartilage (autologous chondrocyte implant or osteochondral allograft or autograft) transplants

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. This cosmetic services exclusion does not apply to surgery after an accidental injury when performed as soon as medically feasible, or for surgery to correct a congenital anomaly . Injuries that occur during medical treatments are not considered accidental injuries, even if unplanned or unexpected.

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 as a result 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, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training

Dental care for adults except as covered in the *Eligible health services under your plan* Oral and maxillofacial treatment section.
Dental 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
· Soft tissue impactions
· Bony impacted teeth
· Alveolectomy
· Augmentation and vestibuloplasty treatment of periodontal disease
· False teeth
· Prosthetic restoration of dental implants
· Dental implants

This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts.

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.

Examinations

Any health or dental examinations needed:

· Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract.
· Because a law 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)* . See the *Eligible health services under your plan – Other services* section.

Facility charges

For care, services or supplies provided in:

· Rest homes
· Assisted living facilities
· Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
· Health resorts
· Spas or sanitariums
· Infirmaries at schools, colleges, or camps

Foot care

· Services and supplies for:
- The treatment of calluses, bunions, toenails, hammertoes, or fallen arches
- The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
- Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
- Routine pedicure services, such as routine cutting of nails, when there is no illness or injury in the nails

Growth/height care

· 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 and exams

Jaw joint disorder
- Non-surgical treatment of jaw joint disorder (TMJ)
- Jaw joint disorder treatment (TMJ) performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to TMJ

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. See the *Eligible health services under your plan – Habilitation therapy service*s section.

Medical supplies – outpatient disposable
- Any outpatient disposable supply or device. Examples of these are:
- 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

Other primary payer
- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer

Outpatient prescription or non-prescription drugs and medicines
- Outpatient prescription or non-prescription drugs and medicines provided by the policyholder or through a third party vendor contract with the policyholder
- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan

Personal care, comfort or convenience items
- Any service or supply primarily for your convenience and personal comfort or that of a third party

Pregnancy charges
- Charges in connection with pregnancy care other than for complications of pregnancy and other covered expenses as specifically described in the *Eligible health services under your plan* section

Routine exams
- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Eligible health services under your plan* section

Services provided by a family member
- Services provided by a spouse, domestic partner, parent, child, stepchild, 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 booklet-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

Spinal manipulation
- Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body
- Other physical treatment of any condition caused by or related to neuromusculoskeletal disorders of the spine, including manipulation of the spine

Strength and performance
- Services, devices and supplies such as drugs or preparations designed primarily for enhancing your:
- Strength
- Physical condition

- Endurance
- 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
· 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). This also includes:
- Counseling, except as specifically provided in the *Eligible health services under your plan – Preventive care and wellness* section
- Hypnosis and other therapies
- Medications, except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section
- Nicotine patches
- Gum

Treatment in a federal, state, or governmental entity
· Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

Vision care
· Vision care services and supplies, including:
- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) and
- Laser in-situ keratomileusis (LASIK), including related procedures designed to surgically correct refractive errors

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 will be 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.

Additional exceptions for specific types of care
1. Preventive care and wellness

· Services for diagnosis or treatment of a suspected or identified illness or injury
· Exams given during your stay for medical care
· Services not given by or under a physician's direction
· Psychiatric, psychological, personality or emotional testing or exams

Family planning services
· 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
· Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care
· Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
· Male contraceptive methods, sterilization procedures or devices
· The reversal of voluntary sterilization procedures, including any related follow-up care

· Voluntary sterilization procedures that were not billed separately by the provider or were not the primary purpose of a confinement

2. Physicians and other health professionals

There are no additional exceptions specific to physicians and other health professionals.

3. Hospital and other facility care

Alternatives to facility stays

Outpatient surgery and physician surgical services
· The services of any other physician who helps the operating physician
· A stay in a hospital (hospital stays are covered in 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

Home health care
· Services for infusion therapy
· 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:
- Sitter or companion services for either you or other family members
- Transportation
- Maintenance of the house

Outpatient private duty nursing
(See home health care in the *Eligible health services under your plan* and *Outpatient and inpatient skilled nursing care* sections regarding coverage of nursing services).

4. Non-Emergency services and non-urgent care

· Non-emergency care in a hospital emergency room facility
· Non-urgent care in an urgent care facility(at a non-hospital freestanding facility)

5. Pediatric dental care
· Any instruction for diet, plaque control and oral hygiene
· Crown, inlays, onlays, and veneers unless:
- It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material, or
- The tooth is an abutment to a covered partial denture or fixed bridge
· Dental implants and removal of implants, braces, 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, or
- 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, orthogenetic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services under your plan – Specific conditions* section
· General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another eligible health service
· Orthodontic treatment for:
- Replacement of broken appliances
- Re-treatment of orthodontic cases
- Changes in treatment necessitated by an accident

- Maxillofacial surgery
- Myofunctional therapy
- Lingually placed direct bonded appliances and arch wires (e.g. “invisible braces”)
- Removable acrylic aligners e.g. “invisible aligners”)

· Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium)
· 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 provided in the *Eligible health services under your plan – Other services* section
· Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth
· Surgical removal of impacted wisdom teeth only for orthodontic reasons
· Treatment by other than a dentist

6. Specific conditions

Artificial organs

· Any device that would perform the function of a body organ

Family planning services – other

· Voluntary sterilization for males
· Reversal of voluntary sterilization procedures, including related follow-up care
· Family planning services received while confined as an inpatient in a hospital or other facility

Maternity and related newborn care

· Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries
· Routine pregnancy including prenatal visits, delivery and postnatal visits

Mental health treatment

· Mental health services for the following categories (or equivalent terms as listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association):

- Stay in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
- Sexual deviations and disorders except for gender identity disorders
- Tobacco use disorders, except as described in the *Eligible health services under your plan – Preventive care and wellness* section
- Pathological gambling, kleptomania, pyromania
- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation

Obesity (bariatric) surgery

· 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:

- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery
- Surgical procedures, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity
- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
- Hypnosis or other forms of therapy
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Oral and maxillofacial treatment (mouth, jaws and teeth)

· Dental implants

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
· 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
· Travel and lodging expenses for transplants that are not obtained at an IOE facility.

Treatment of infertility

· Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.
· All charges associated with:

- Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father.
- 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.
- Obtaining sperm from a person not covered under this plan for ART services**.**

· Home ovulation prediction kits or home pregnancy tests.
· The purchase of donor embryos, donor oocytes, or donor sperm.
· Reversal of voluntary sterilizations, including follow-up care.
· 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).
· ART services are not provided for out-of-network care.

7. Specific therapies and tests
Acupuncture

Outpatient infusion therapy
· Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan
· Enteral nutrition
· Blood transfusions and blood products
· Dialysis

Specialty prescription drugs
· Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan

8. Other services

Clinical trial therapies (experimental or investigational)
· Your plan does not cover clinical trial therapies (experimental or investigational), except as 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)

Durable medical equipment (DME)
Examples of these items are:
· Whirlpools
· Portable whirlpool pumps
· Sauna baths
· Massage devices
· Over bed tables
· Elevators
· Communication aids
· Vision aids
· Telephone alert systems

Hearing aids and exams
The following services or supplies:
· A replacement of:
- A hearing aid that is lost, stolen or broken
- A hearing aid installed within the prior 12-36 month period
· Replacement parts or repairs for a hearing aid
· Batteries or cords
· A hearing aid that does not meet the specifications prescribed for correction of hearing loss
· Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist

· Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay
· Any tests, appliances and devices to:
- Improve your hearing. This includes hearing aid batteries and auxiliary equipment.
- Enhance other forms of communication to make up for hearing loss or devices that simulate speech.

Nutritional supplements
· 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

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

Vision Care
Pediatric vision care
· Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
· Eyeglass frames, prescription lenses and prescription contact lenses that are not identified as preferred by a vision provider
· Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

Adult vision care
· Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
· Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

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
· 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
· Eyeglasses or duplicate or spare eyeglasses or lenses or frames
· Replacement of lenses or frames that are lost or stolen or broken
· Acuity tests
· Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures
· Services to treat errors of refraction

9. **Outpatient prescription drugs**

Abortion drugs

Allergy sera and extracts administered via injection

Any services related to the dispensing, injection or application of a drug

Biological sera

Cosmetic drugs
· Medications or preparations used for cosmetic purposes

Compounded 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 specially covered

Dietary supplements including medical foods

Drugs or medications

- Administered or entirely consumed at the time and place it is prescribed or dispensed
- 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 as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section
- That includes the same active ingredient or a modified version of an active ingredient as a covered prescription drug (unless a medical exception is approved)
- That is therapeutically equivalent or therapeutically alternative to a covered prescription drug including biosimilars (unless a medical exception is approved)
- That is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product (unless a medical exception is approved)
- Not approved by the FDA or not proven safe and effective
- Provided under your medical plan while an inpatient of a healthcare facility
- 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
- That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
- For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration)
- That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
- That are used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications.
- 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 anomalies.

Immunizations related to travel or work

Immunization or immunological agents except as specifically provided in the Eligible health services under your plan – Outpatient prescription drugs section.

Implantable drugs and associated devices except as specifically provided in the *Eligible health services under your plan –Outpatient prescription drugs* sections.

Infertility

Injectable 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 for those used for self-administration of an injectable drug.
- Any drug, which due to its characteristics, 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, except as specifically provided in the *Eligible health services under your plan – Diabetic equipment, supplies and education* section.

Prescription drugs:

- For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a prescription is written.
- Packaged in unit dose form.
- Filled prior to the effective date or after the termination date of coverage under this plan.
- Dispensed by a mail order pharmacy that include 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.
- That include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and are not clinically superior to that drug.
- 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.
- That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the preferred drug guide.
- 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 preferred drug guide or the product on the preferred drug guide is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.
- 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

Smoking cessation

- Smoking cessation products unless recommended by the United States Preventive Services Task Force (USPSTF)

Test agents except diabetic test agents

We reserve the right to exclude:
- A manufacturer's product when a same or similar drug (that is, a drug with the same active ingredient or same therapeutic effect), supply or equipment is on the preferred drug guide.
- Any dosage or form of a drug when the same drug (that is, a drug with the same active ingredient or same therapeutic effect) is available in a different dosage or form on our preferred drug guide.

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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] **TIF (Non-Embedded) -** The individual deductible/out-of-pocket limit can only be met when a member is enrolled for self only coverage with no dependent coverage. The family deductible/out-of-pocket limit can be met by a combination of family members or by any single individual within the family. 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.

[3] **Habilitation/Rehabilitation services -** Coverage is limited to **20** visits per calendar year physical therapy/occupational therapy/speech therapy combined. Benefit limits are shared between rehabilitation and habilitation services.

[4] **Chiropractic/subluxation** services are limited of **18** visits 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 (Aetna Value Plus Formulary) 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: **90% of Medicare**
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 and 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 Life Insurance Company include: GR-9/GR-9N, GR-29/GR-29N, GR-23, AL HGrpPol 04.

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