Preferred Provider Organization (PPO) Medical Plan

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:	BorgWarner Inc.
Group policy number:	468847
Schedule of Benefits	1A
Group policy effective date:	January 1, 2018
Plan effective date:	January 1, 2018
Plan issue date:	March 11, 2020
Plan revision effective date:	January 1, 2020

Underwritten by Aetna Life Insurance Company in the state of Delaware.

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

Schedule of benefits

This schedule of benefits lists the **deductibles** and **copayments/coinsurance**, if any, that apply to the services you receive under this plan. You should review this schedule to become familiar with your **deductibles** and **copayments/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 **network providers**.
  - "Out-of-network coverage", we mean you can get care from **out-of-network providers**.
- "Other Health Care (out-of-area): When care is provided in the U.S. in a geographic area where **Aetna** has not contracted with a **provider**, charges are payable at 80% after any applicable **deductible** (does not apply to those expenses paid at a reduced payment percentage). The benefit levels for the following in-network provisions would apply: **deductible**, family **deductible**, inpatient **hospital deductible**, **maximum out-of-pocket limits.** 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 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.

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

Plan features	Deductible/Maximums		
	In-network coverage* **In the U.S**	**Out-of-network coverage*** **In the U.S**	**Outside the U.S.**
Deductible			
You have to meet your **Calendar Year deductible** before this plan pays for benefits.			
Individual	$1,500 per **Calendar Year**	$3,000 per **Calendar Year**	$1,500 per **Calendar Year**
Family	$3,000 per **Calendar Year**	$6,000 per **Calendar Year**	$3,000 per **Calendar Year**
Maximum out-of-pocket limit			
Maximum out-of-pocket limit per Calendar Year.			
Individual	$3,750 per Calendar Year	$6,750 per Calendar Year	$3,750 per Calendar Year
Family	$7,500 per Calendar Year	$13,500 per Calendar Year	$7,500 per Calendar Year
Precertification covered benefit reduction			
This only applies to out-of-network coverage. The booklet-certificate contains a complete description of the **precertification** program. You will find details on **precertification** requirements in the *Medical necessity and precertification requirements* section. Failure to **precertify** your **eligible health services** when required will result in the following benefits reduction: • A $400 benefit reduction will be applied separately to each type of **eligible health services** or • The **eligible health services** will not be covered. The additional percentage or dollar amount of the **recognized charge** which you may pay as a penalty for failure to obtain **precertification** is not a **covered benefit**, and will not be applied to the **deductible** amount or the **maximum out-of-pocket limit**, if any.			
Annual HealthFund amount			
Individual	$750 per Calendar Year		
Family	$1,500 per 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 benefits

Eligible health services	In-network coverage* In the U.S.	Out-of-network coverage* In the U.S.	Outside the U.S.*
Preventive care and wellness			
Routine physical exams			
Performed at a **physician's** office	100% per visit No **deductible** applies	60% per visit No **deductible** applies	100% per visit No **deductible** applies
Covered persons through age 21:	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your **physician** or Member Services by logging onto your Aetna secure member website at www.aetnainternational.com or calling the number on your ID card.	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your **physician** or Member Services by logging onto your Aetna secure member website at www.aetnainternational.com or calling the number on your ID card.	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your **physician** or Member Services by logging onto your Aetna secure member website at www.aetnainternational.com or calling the number on your ID card.
Covered persons age 22 and over but less than 65: Maximum visits per 12 months	1 visit	1 visit	1 visit
Covered persons age 65 and over: Maximum visits per 12 months	1 visit	1 visit	1 visit
Adult maximum per 12 months for all preventive care and wellness services listed above	Not applicable	Not applicable	$1,000

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

Preventive care immunizations			
Performed in a facility or at a **physician's** office	100% per visit No **deductible** applies	60% per visit No **deductible** applies	100% per visit No **deductible** applies
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna secure member website at www.aetnainternational.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna secure member website at www.aetnainternational.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna secure member website at www.aetnainternational.com or calling the number on your ID card.

Well woman preventive visits **routine gynecological exams (including pap smears)**			
Performed at a **physician's**, **PCP**, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit No **deductible** applies	60% per visit No **deductible** applies	100% per visit No **deductible** applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.
Maximum visits per Calendar Year	1 visit	1 visit	1 visit

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

Preventive screening and counseling services			
Office visits • Obesity and/or healthy diet counseling • Misuse of alcohol and/or drugs • Use of tobacco products • Sexually transmitted infection counseling • Genetic risk counseling for breast and ovarian cancer	100% per visit No **deductible** applies	60% per visit No **deductible** applies	100% per visit No **deductible** applies
Obesity and/or healthy diet counseling maximums:			
Maximum visits per 12 months (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*	26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*	26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.			
Misuse of alcohol and/or drugs maximums:			
Maximum visits per 12 months	5 visits*	5 visits*	5 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.			
Use of tobacco products maximums:			
Maximum visits per 12 months	8 visits*	8 visits*	8 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.			
Sexually transmitted infection counseling maximums:			
Maximum visits per 12 months	2 visits*	2 visits*	2 visits*
*Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.			
Genetic risk counseling for breast and ovarian cancer maximums:			
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations	Not subject to any age or frequency limitations	Not subject to any age or frequency limitations

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

Routine cancer screenings (applies whether performed at a physician's, PCP, specialist office or facility)			
Routine cancer screenings	100% per visit No **deductible** applies	60% per visit No **deductible** applies	100% per visit No **deductible** applies
Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna secure member website at www.aetnainternational.com or calling the number on your ID card.	Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna secure member website at www.aetnainternational.com or calling the number on your ID card.	Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna secure member website at www.aetnainternational.com or calling the number on your ID card.
Lung cancer screening maximums	1 screening every 12 months*	1 screening every 12 months*	1 screening every 12 months*
***Important note**: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.			
Prenatal care Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)			
Preventive care services only	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit	100% per visit No **deductible** applies
Important note: You should review the *Maternity and related newborn care* sections. They will give you more information on coverage levels for maternity care under this plan.			

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

Comprehensive lactation support and counseling services			
Lactation counseling services – facility or office visits	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit	100% per visit No **deductible** applies
Lactation counseling services maximum visits per 12 months either in a group or individual setting	6 visits*	6 visits*	6 visits*
***Important note:** Any visits that exceed the lactation counseling services maximum are covered under **Physician** services office visits.			
Breast feeding durable medical equipment			
Breast pump supplies and accessories	100% per item No **deductible** applies	60% (of the **recognized charge**) per item	100% per item No **deductible** applies
Important note: See the *Breast feeding durable medical equipment* section of the booklet-certificate for limitations on breast pump and supplies.			
Family planning services – female contraceptives			
Counseling services			
Female contraceptive counseling services office visit	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit	100% per visit No **deductible** applies
Contraceptive counseling services maximum visits per 12 months either in a group or individual setting	2 visits*	2 visits*	2 visits*
***Important note:** Any visits that exceed the contraceptive counseling services maximum are covered under **Physician** services office visits.			
Devices			
Female contraceptive device provided, administered, or removed, by a **physician** during an office visit	100% per item No **deductible** applies	60% (of the **recognized charge**) per item	100% per item No **deductible** applies

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Female voluntary sterilization			
Inpatient	100% per admission No **deductible** applies	60% (of the **recognized charge**) per admission	100% per admission No **deductible** applies
Outpatient	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit	100% per visit No **deductible** applies
Eligible health services	**In-network coverage*** **In the U.S.**	**Out-of-network coverage*** **In the U.S.**	**Outside the U.S.**
Physicians and other health professionals			
Physicians and **specialists** office visits (non-surgical)			
Physician services			
Office hours visits (non-surgical) non preventive care	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Telemedicine consultation by a **physician**	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit	Not Covered
Maximum visits per day	1	1	Not Covered
Telemedicine consultation by a **specialist**	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit	Not Covered
Maximum visits per day	1	1	Not Covered
Screening for lead poisoning for children			
Performed at a **physician's** office	100% (of the **negotiated charge**) per visit	100% (of the **recognized charge**) per visit	100% (of the **recognized charge**) per visit
Screening for infants and toddlers for developmental delays			
Performed at a **physician's** office	100% (of the **negotiated charge**) per visit	100% (of the **recognized charge**) per visit	100% (of the **recognized charge**) per visit

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Immunizations that are not considered preventive care			
Immunizations that are not considered preventive care	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Specialist			
Specialist office visits			
Office hours visits (non-surgical)	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Physician surgical services			
Physicians and **specialists** office visits			
Performed at a **physician's** office	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Performed at a **specialist's** office	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Alternatives to physician office visits			
Walk-in clinic visits			
Walk-in clinic non-emergency visit *(includes coverage for immunizations)*	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetnainternational.com or calling the number on your ID card.	Subject to any age limit+ 6s provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetnainternational.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetnainternational.com or calling the number on your ID card.

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Eligible health services	**In-network coverage*** **In the U.S.**	**Out-of-network coverage*** **In the U.S.**	**Outside the U.S.***
Hospital and other facility care			
Hospital care			
Inpatient **hospital**	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission	80% (of the **recognized charge**) per admission
Alternatives to hospital stays			
Outpatient surgery and physician surgical services			
	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Home health care			
Outpatient	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Maximum visits per Calendar Year	120 Limited to: 3 intermittent visits per day provided by a participating **home health care agency**; 1 visit equals 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 10 days of discharge	120 Limited to: 3 intermittent visits per day provided by a participating **home health care agency**; 1 visit equals 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 10 days of discharge	120 Limited to: 3 intermittent visits per day provided by a participating **home health care agency**; 1 visit equals 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 10 days of discharge

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Hospice care			
Inpatient facility	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission	80% (of the **recognized charge**) per admission
Maximum days per **Calendar Year**	30	30	30
Hospice care			
Outpatient	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
	Part-time or intermittent nursing care by an **R.N.** or **L.P.N.** 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 **R.N.** or **L.P.N.** 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 **R.N.** or **L.P.N.** 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
Outpatient private duty nursing			
Outpatient private duty nursing	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Maximum visits/shifts per ***Calendar Year***	70 shifts Up to eight hours equal one shift.	70 shifts Up to eight hours equal one shift.	70 shifts Up to eight hours equal one shift.
Skilled nursing facility			
Inpatient facility	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission	80% (of the **recognized charge**) per admission
Maximum days per Calendar Year	120	120	120

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

Eligible health services	In-network coverage* In the U.S.	Out-of-network coverage* In the U.S.	Outside the U.S.
Emergency services and urgent care			
Emergency services			
Hospital emergency room	80% (of the **negotiated charge**) per visit	Paid the same as in-network coverage	80% (of the **recognized charge**) per visit
Non-emergency care in a **hospital** emergency room	50% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
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 the back of your ID card, and we will resolve any payment dispute with the **provider** over that amount. Make sure the member's ID number is on the bill.			
Urgent care			
Urgent medical care (at a non-**hospital** free standing facility)	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit

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

Eligible health services	In-network coverage* In the U.S.	Out-of-network coverage* In the U.S.	Outside the U.S.
Specific conditions			
Autism spectrum disorder			
Autism spectrum disorder treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Autism spectrum disorder diagnosis and testing	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Birthing center			
Inpatient	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission	80% (of the **recognized charge**) per admission
Diabetic equipment, supplies and education			
Diabetic equipment, supplies and education	Covered according to the type of benefit and the place where the service is received	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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Family planning services - other			
Voluntary sterilization for males			
Outpatient	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Abortion			
Outpatient	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Maternity and related newborn care			
Inpatient	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission	80% (of the **recognized charge**) per admission
The **deductible** amount for newborns will be waived for charges for the first 31 days of the newborn's life.			
Delivery services and postpartum care services			
Performed in a facility or at a **physician's** office	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) 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	Covered according to the type of benefit and the place where the service is received
Mental health treatment - inpatient			
Inpatient mental health treatment Inpatient **residential treatment facility** Coverage is provided under the same terms, conditions as any other **illness**.	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission	80% (of the **recognized charge**) per admission

Mental health treatment - outpatient			
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** includes **telemedicine** consultation Coverage is provided under the same terms, conditions as any other **illness**.	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Other outpatient mental health treatment (includes skilled behavioral health services in the home) **Partial hospitalization treatment** **Intensive outpatient program** The cost share doesn't apply to in-network peer counseling support services	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Substance related disorders treatment - inpatient			
Inpatient **substance abuse detoxification** during a **hospital** confinement Inpatient **substance abuse** rehabilitation during a **hospital** confinement Inpatient **residential treatment facility** during a **hospital** confinement Coverage is provided under the same terms, conditions as any other **illness**.	80% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission	80% (of the **recognized charge**) per admission

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

Substance related disorders treatment - outpatient: detoxification and rehabilitation			
Outpatient **substance abuse** office visits to a **physician** or **behavioral health provider** (includes **telemedicine** consultation) Coverage is provided under the same terms, conditions as any other **illness**.	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Other outpatient **substance abuse** services (includes skilled behavioral health services in the home) **Partial hospitalization treatment** **Intensive Outpatient Program** The cost share doesn't apply to in-network peer counseling support services.	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Oral and maxillofacial treatment (mouth, jaws and teeth)			
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	Covered according to the type of benefit and the place where the service is received
Reconstructive breast surgery			
Reconstructive breast **surgery**	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Reconstructive surgery and supplies			
Reconstructive **surgery** and supplies	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

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

Eligible health services	Network (IOE facility) In the U.S.	Network (Non-IOE facility) In the U.S.	Out-of-network coverage* In the U.S.	Outside the U.S.
Transplant services facility and non-facility				
Inpatient **hospital** transplant services	80% (of the **negotiated charge**) per transplant	60% (of the **negotiated charge**) per transplant	60% (of the **recognized charge**) per transplant	80% (of the **recognized charge**) 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	Covered according to the type of benefit and the place where the service is received

Eligible health services	In-network coverage* In the U.S.	Out-of-network coverage* In the U.S.	Outside the U.S.
Treatment of infertility			
Basic infertility			
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	Covered according to the type of benefit and the place where the service is received
Outpatient comprehensive infertility services			
	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Maximum number of ovulation induction cycles with menotropins per lifetime**	6	6	6
Maximum number of Intrauterine insemination cycles per lifetime**	6	6	6

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

Outpatient ART services			
	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Maximum number of cycles per lifetime**	6	6	6
As used for this benefit, "lifetime" is defined to include covered benefits paid under this plan or another plan underwritten and/or administered by **Aetna or any **Aetna** affiliate, with the same policyholder			
Eligible health services	**In-network coverage*** **In the U.S.**	**Out-of-network coverage*** **In the U.S.**	**Outside the U.S.**
Specific therapies and tests			
Outpatient diagnostic testing			
Diagnostic complex imaging services			
	80% (of the **negotiated** charge) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Diagnostic lab work			
	80% (of the **negotiated** charge) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Diagnostic radiological services			
	80% (of the **negotiated** charge) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
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.	Covered according to the type of benefit and the place where the service is received.
Outpatient infusion therapy			
	80% (of the **negotiated** charge) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Outpatient radiation therapy			
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.	Covered according to the type of benefit and the place where the service is received.

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

Short-term cardiac and pulmonary rehabilitation services			
Cardiac rehabilitation			
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	Covered according to the type of benefit and the place where the service is received
Pulmonary rehabilitation			
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	Covered according to the type of benefit and the place where the service is received

Short-term rehabilitation services			
Outpatient Physical and Occupational Therapies			
	100% per visit No **deductible** applies	75% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Outpatient Speech Therapy			
	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit

Outpatient Physical and Occupational Therapies Maximum			
Maximum visits per Calendar Year	Unlimited visits	Unlimited visits	Unlimited visits
Outpatient Speech Therapy Maximum			
Maximum visits per Calendar Year	60 visits	60 visits	60 visits
Spinal manipulation			
Spinal manipulation	100% per visit No **deductible** applies	75% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit

Habilitation therapy services			
Outpatient physical and occupational therapy			
	100% per visit No **deductible** applies	75% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Outpatient speech therapy			
	80% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit

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

Eligible health services	In-network coverage* In the U.S.	Out-of-network coverage* In the U.S.	Outside the U.S.
Other services			
Acupuncture			
Acupuncture	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
Ambulance service			
Ground, air or water **ambulance**	80% (of the **negotiated charge**) per trip	60% (of the **recognized charge**) per trip	80% (of the **recognized charge**) per trip
Clinical trial therapies (experimental or investigational)			
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	Covered according to the type of benefit and the place where the service is received
Clinical trials (routine patient costs)			
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	Covered according to the type of benefit and the place where the service is received
Durable medical equipment (DME)			
DME	80% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item	80% (of the **recognized charge**) per item
Hearing aids and exams			
Hearing aid exams Covered persons through age 23	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
Hearing aids Covered persons through age 23	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

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

Hearing aids	One per ear every 36 month consecutive period	One per ear every 36 month consecutive period	One per ear every 36 month consecutive period
Maximum per Calendar Year	$1,000	$1,000	$1,000

Non-preventive hearing exams			
For adults and children	100% per visit No **deductible** applies	60% per visit No **deductible** applies.	100% per visit No **deductible** applies

Maximum	One exam in any 24 consecutive month period.

Nutritional supplements			
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.	Covered according to the type of benefit and the place where the service is received.

Orthotic devices			
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	Covered according to the type of benefit and the place where the service is received

Scalp hair prosthesis			
Scalp hair prosthesis	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	X Covered according to the type of benefit and the place where the service is received

Vision care			
Routine vision exams (including refraction)			
Performed by a legally qualified ophthalmologist or optometrist	100% per visit No **deductible** applies	60% (of the **recognized charge**) per visit	80% (of the **recognized charge**) per visit
Maximum visits per 24 consecutive month period	1 visit	1 visit	1 visit

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

Eligible health services*	**Outside the U.S.**
Outpatient prescription drugs	
Prescription drugs	80% (of the **recognized charge**) **prescription** or refill
Family planning services - female contraceptives	
Female contraceptives that are **generic prescription drugs**: • Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches	80% (of the **recognized charge**) **prescription** or refill
Female contraceptives that are **brand-name prescription drugs**: • Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches	80% (of the **recognized charge**) **prescription** or refill
Female contraceptive generic devices and brand-name devices	80% (of the **recognized charge**) **prescription** or refill
FDA-approved female generic and brand-name emergency contraceptives	80% (of the **recognized charge**) **prescription** or refill
FDA-approved female generic and brand-name over-the-counter (OTC) emergency contraceptives	80% (of the **recognized charge**) **prescription** or refill

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

Preventive care drugs and supplements	
Preventive care drugs and supplements filled at a **pharmacy**	80% (of the **recognized charge**) per **prescription** or refill
Risk reducing breast cancer prescription drugs	
Risk reducing breast cancer **prescription drugs** filled at a **pharmacy**	80% (of the **recognized charge**) **prescription** or refill
Tobacco cessation prescription and over-the-counter drugs	
Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** for each 90 day supply	**Deductible** per supply of 80% of the **recognized charge**
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, contact Member Services by logging onto your secure member website at www.aetna.com or calling the number on your ID card.

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

Eligible health services	In-network coverage* In the U.S.	Out-of-network coverage* In the U.S.	Outside the U.S.
Outpatient prescription drugs			
Plan features	**Deductible/Copayment/Coinsurance/Maximums**		
Deductible waiver			
The calendar year **deductible** is waived for all **prescription drugs**.			
Deductible and copayment/coinsurance waiver for risk reducing breast cancer prescription drugs			
The Calendar Year **deductible** and the per **prescription copayment/coinsurance** will not apply to risk reducing breast cancer **prescription drugs** when obtained at a **network pharmacy**. This means that such risk reducing breast cancer **prescription drugs** will be paid at 100%.			
Deductible and copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs			
The Calendar Year **deductible** and the per **prescription copayment/coinsurance** will not apply to two 90-day treatment regimens for tobacco cessation **prescription drugs** and OTC drugs when obtained at a **network pharmacy**. This means that such **prescription drugs** and OTC drugs will be paid at 100%.			
Deductible and copayment/coinsurance waiver for contraceptives			
The Calendar Year **deductible** and the per **prescription copayment/coinsurance** will not apply to female contraceptive methods when obtained at a **network pharmacy**. This means that the following will be paid at 100%: • Certain over-the-counter (OTC) and generic contraceptive **prescription drugs** 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 **generic prescription drug** or device is not available for a certain method, you may obtain certain **brand-name prescription drugs** for that method paid at 100%. • We provide coverage for a supply of prescribed contraceptives intended to last over a 12-month duration. The prescribed contraceptive **prescription drug** may be filled all at once or over the course of the 12-month as prescribed by your provider. The Calendar Year **deductible** and the per **prescription copayment/coinsurance** continue to apply to **prescription drugs** that have a generic equivalent or generic alternative available within the same **therapeutic drug class** obtained at a **network pharmacy** unless you are granted a medical exception.			

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

Preferred generic prescription drugs (including specialty drugs)			
Per prescription copayment/coinsurance			
For each fill up to a 30 day supply filled at a **retail pharmacy**	$10 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No **Calendar Year deductible** applies	Not covered	Paid under Outside the U.S. outpatient prescription drug section
More than a 30 day supply but less than a 91 day supply filled at a **retail pharmacy** or **mail order pharmacy**	$30 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No **Calendar Year deductible** applies	Not covered	Paid under Outside the U.S. outpatient prescription drug section
Non-preferred generic prescription drugs (including specialty drugs)			
Per prescription copayment/coinsurance			
For each fill up to a 30 day supply filled at a **retail pharmacy**	**Copayment** is the greater of $150 or 50% (of the **negotiated charge**) but will be no more than $50 per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered	Paid under Outside the U.S. outpatient prescription drug section
More than a 30 day supply but less than a 91 day supply filled at a **retail pharmacy** or **mail order pharmacy**	**Copayment** is the greater of $150 or 50% (of the **negotiated charge**) but will be no more than $50 per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered	Paid under Outside the U.S. outpatient prescription drug section

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

Preferred brand-name prescription drugs (including specialty drugs)			
Per prescription copayment/coinsurance			
For each fill up to a 30 day supply filled at a **retail pharmacy**	**Copayment** is the greater of $60 or 30% (of the **negotiated charge**) but will be no more than $30 per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered	Paid under Outside the U.S. outpatient prescription drug section
More than a 30 day supply but less than a 91 day supply filled at a **retail pharmacy** or **mail order pharmacy**	**Copayment** is the greater of $60 or 30% (of the **negotiated charge**) but will be no more than $30 per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered	Paid under Outside the U.S. outpatient prescription drug section

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

Non-preferred brand-name prescription drugs (including specialty drugs)			
Per prescription copayment/coinsurance			
For each fill up to a 30 day supply filled at a **retail pharmacy**	**Copayment** is the greater of $150 or 50% (of the **negotiated charge**) but will be no more than $50 per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered	Paid under Outside the U.S. outpatient prescription drug section
More than a 30 day supply but less than a 91 day supply filled at a **retail pharmacy** or **mail order pharmacy**	**Copayment** is the greater of $150 or 50% (of the **negotiated charge**) but will be no more than $50 per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered	Paid under Outside the U.S. outpatient prescription drug section
Orally administered anti-cancer prescription drugs			
Per prescription copayment/coinsurance			
For each fill up to a 30 day supply filled at a **retail pharmacy**	$0 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered	Paid under Outside the U.S. outpatient prescription drug section
More than a 30 day supply but less than a 91 day supply filled at a **retail pharmacy** or **mail order pharmacy**	$0 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered	Paid under Outside the U.S. outpatient prescription drug section

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

Preventive care drugs and supplements			
Preventive care drugs and supplements filled at a **pharmacy**	100% per **prescription** or refill	Not covered	Paid under Outside the U.S. outpatient prescription drug section
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's secure member website at www.aetnainternational.com or calling the number on your ID card.		

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

Risk reducing breast cancer prescription drugs			
Risk reducing breast cancer **prescription drugs** filled at a **pharmacy**	100% per **prescription** or refill	Not covered	Paid under Outside the U.S. outpatient prescription drug section
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's secure member website at www.aetnainternational.com or calling the number on your ID card.		

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

Tobacco cessation prescription and over-the-counter drugs			
Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy**	$0 per **prescription** or refill No **deductible** applies	Not covered	Paid under Outside the U.S. outpatient prescription drug section
Maximums:	Coverage is permitted for two 90-day treatment regimens only. 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 **prescription drugs** and OTC drugs, contact Member Services by logging onto your Aetna's secure member website at www.aetnainternational.com or calling the number on your ID card.		
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** equivalent 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**.			

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

General coverage provisions

This section provides detailed explanations about the:

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

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

Deductible provisions

Eligible health services applied to the out-of-network **deductibles** will be applied to satisfy the in-network **deductibles**. **Eligible health services** applied to the in-network **deductibles** will be applied to satisfy the out-of-network **deductibles**.

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

Individual

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

Family

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

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

- The combined **eligible health services** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Copayments

Copayment

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

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

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 applied to the **out-of-network maximum out-of-pocket limit** will 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 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 **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 **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 **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.

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
- **Copayment**
- Any out of pocket costs for non-emergency use of the emergency room
- Any out of pocket costs for outpatient **prescription drugs** (except for **prescription drugs** purchased outside the U.S.)
- As it applies to out-of-network coverage: Charges, expenses or costs in excess of the **recognized charge**

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

Maximum provisions

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

Calculations; determination of recognized charge; determination of benefits provisions

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