Schedule of benefits

Prepared for:

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Schedule of benefits:	5A
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Third Party Administrative Services provided by Aetna Life Insurance Company

Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles**, **copayments** or **payment percentage**, if any apply to the **covered services** you receive under the plan. You should review this schedule to become aware of these and any limits that apply to these services.

The benefits shown in this schedule of benefits are available for your eligible out of area dependents.

How your cost share works

- The **deductibles** and **copayments**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
  - For the **covered services** under your medical plan, you will be responsible for the dollar amount
  - For pharmacy benefits where a percentage cost share acts like a **copayment**, you will be responsible for the percentage amount
- **Payment percentage** amounts, if any, listed in the schedule below are what the plan will pay for **covered services**.
- Sometimes your cost share shows a combination of your dollar amount **copayment** that you will be responsible for and the **payment percentage** that your plan will pay.
- You are responsible to pay any **deductibles**, **copayments** and remaining **payment percentage**, if they apply and before the plan will pay for any **covered services**.
- This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits. They may be:
  - Combined limits between **designated network** and **non-designated network providers**
  - Separate limits for **designated network** and **non-designated network providers**
  - Based on a rolling, 12 month period starting with the date of your most recent visit under this plan

  See the schedule for more information about limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.

For examples of how cost share and **deductible** work, go to the *Using your Aetna benefits* section under Individuals & Families at https://www.aetna.com/

Important note:
Covered services are subject to the Calendar Year **deductible**, **maximum out-of-pocket**, limits, **copayment** or **payment percentage** unless otherwise stated in this schedule.

Under this plan, you will:

1. Pay your **copayment**
2. Then pay any remaining **deductible**
3. Then pay your **payment percentage**

Your **copayment** does not apply to any **deductible**.

How your deductible works
The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **copayment** or **payment percentage** you pay when you get **covered services** from a **designated network** or **non-designated network provider**. This schedule shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **covered services**. You will continue to pay **copayments** or **payment percentage**, if any, for **covered services** after you meet your **deductible**.

How your PCP or physician office visit cost share works
You will pay the **PCP** cost share when you get **covered services** from any **PCP**.

How your maximum out-of-pocket works
This schedule shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of that year.

Contact us
We are here to answer questions. See the *Contact us* section in your booklet.

This schedule replaces any schedule of benefits previously in use. Keep it with your booklet.

Plan features

Deductible
You have to meet your **deductible** before this plan pays for benefits.

Deductible type	Designated network	Non-designated network
Individual	$0 per year	$1,500 per year
Family	$0 per year	$3,000 per year

Deductible waiver
There is no in-network **deductible** for the following **covered services**:

- Preventive care
- Family planning services – female contraceptives

Per admission copayment

Per admission copayment type	Designated network	Non-designated network
Per admission **copayment**	$150 per admission	$0 per admission

Deductible and cost share waiver for risk reducing breast cancer prescription drugs
The **prescription** drug **deductible** and per **prescription** cost share will not apply to risk reducing breast cancer **prescription** drugs when obtained at a network pharmacy. This means they will be paid at 100%.

Deductible and cost share waiver for contraceptives (birth control)

The **prescription** drug **deductible** and per **prescription** cost share will not apply to female contraceptive methods when obtained at a network pharmacy. This means they will be paid at 100%. This includes certain OTC and generic contraceptive **prescription** drugs and devices for each of the methods identified by the FDA. If a **generic prescription drug** is not available, the **brand-name prescription drug** for that method will be paid at 100%.

The **prescription** drug **deductible** and cost share will apply to **prescription** drugs that have a generic equivalent or alternative available within the same therapeutic drug class obtained at a network pharmacy unless we approve a medical exception. A therapeutic drug class is a group of drugs or medications that have a similar or identical mode of action or are used for the treatment of the same or similar disease or injury.

Deductible and cost share waiver for tobacco cessation prescription and OTC drugs

The **prescription** drug **deductible** and the per **prescription** cost share will not apply to the first two 90-day treatment programs for tobacco cessation **prescription** and OTC drugs when obtained at a network **retail pharmacy**. This means they will be paid at 100%. Your per **prescription** cost share will apply after those two programs have been exhausted.

Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	Designated network	Non-designated network
Individual	$2,500 per year	$4,500 per year
Family	$5,000 per year	$9,000 per year

Outpatient prescription drug maximum out-of-pocket limit

Individual	$4,000 per year
Family	$8,000 per year

General coverage provisions

This section explains the **deductible, maximum out-of-pocket limit** and limitations listed in this schedule.

Deductible provisions

Designated network **covered services** will apply only to the designated network **deductible**.

The **deductible** may not apply to some **covered services**. You still pay the **copayment** or **payment percentage**, if any, for these **covered services**.

Individual deductible

You pay for **covered services** each year before the plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. After the amount paid reaches the individual **deductible**, this plan starts to pay for **covered services** for the rest of the year.

Family deductible
You pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this family **deductible**, this plan starts to pay for **covered services** for the rest of the year. To satisfy this family **deductible** for the rest of the year, the combined **covered services** that you and each of your covered dependents incur toward the individual **deductible** must reach this family **deductible** in a year. When this happens in a year, the individual **deductibles** for you and your covered dependents are met for the rest of the year.

Deductible credit
If you paid part or all of your **deductible** under other coverage for the year that this plan went into effect, we will deduct the amount paid under the other coverage from the **deductible** on this plan for the same year. If we ask, you must submit a detailed explanation of benefits (EOB) showing the dates and amount of the **deductible** met from the other coverage in order to receive the credit.

Deductible carryover
Any amounts that you paid for **covered services** in the last 90 days of a year that apply toward that year's **deductible** will also count toward the following year's **deductible**.

Copayment
This is a flat fee you pay for certain visits or **covered services**. A copay can be a dollar amount or percentage. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Per admission copayment
This is the amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility.

Payment Percentage
This is the percentage of the bill you pay after you meet your **deductible**. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Per admission copayment
This is the amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility.

Individual maximum out-of-pocket limit
- This plan may have 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.
- After you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the year for that person.

Family maximum out-of-pocket limit
After you or your covered dependents meet the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the remainder of the year for all covered family members. The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members.

To satisfy this **maximum out-of-pocket limit** for the rest of the year, the following must happen:
- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit** amount.

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

- Out-of-pocket costs for outpatient expenses including **prescription** drugs
- All costs for non-covered services which are identified in the booklet and the schedule
- Costs for non-emergency use of the emergency room

- Costs for non-urgent use of an urgent care **provider**

Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of **covered services** on 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 year. Decisions regarding when benefits are covered are subject to the terms and conditions of the booklet.

Individual prescription drug maximum out-of-pocket limit

Once the amount of the cost share you have paid during the year for **covered services** meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that apply toward the limit for you for the remainder of the year.

Family prescription drug maximum out-of-pocket limit

After the amount of the cost share you and your covered dependent pay for **covered services** during the year meets the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charges for **covered services** that apply toward the limit for the rest of the year for all covered family members.

This plan has an individual and family **prescription** drug **maximum out-of-pocket limit**

To satisfy this family **maximum out-of-pocket limit** for the rest of the 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 **prescription** drug **maximum out-of-pocket limit** is met by a combination of family members with no single person in the family contributing more than the individual **maximum out-of-pocket limit** in a year.

When this happens, the individual **maximum out-of-pocket limit** is also met for the rest of the year.

The **maximum out-of-pocket limit** may not apply to certain **covered services**. If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit**.

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

- All costs for non-**covered services**

Covered services

Acupuncture

Description	Designated network	Non-designated network
Acupuncture	$15 then the plan pays 100% per visit, no **deductible** applies	$30 then the plan pays 100% per visit, no **deductible** applies

Ambulance services

Description	Designated network	Non-designated network
Emergency services	100% per trip, no **deductible** applies	100% per trip, no **deductible** applies
Non-emergency services	100% per trip, no **deductible** applies	100% per trip, no **deductible** applies

Applied behavior analysis

Description	Designated network	Non-designated network
Applied behavior analysis	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Autism spectrum disorder

Description	Designated network	Non-designated network
Diagnosis and testing	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Treatment	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Behavioral health

Mental health disorders treatment

Coverage provided is the same as for any other illness

Description	Designated network	Non-designated network
Inpatient services – **room and board**	$150 then the plan pays 100% per admission, no **deductible** applies	80% per admission, no **deductible** applies

Description	Designated network	Non-designated network
Outpatient office visit to a **physician** or **behavioral health provider**	$15 then the plan pays 100% per visit, no **deductible** applies	$30 then the plan pays 100% per visit, no **deductible** applies
Physician or **behavioral health provider telemedicine** consultation	$15 then the plan pays 100% per visit, no **deductible** applies	$30 then the plan pays 100% per visit, no **deductible** applies
Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received

Description	Designated network	Non-designated network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies

Description	Designated network	Non-designated network
Telemedicine provider mental health disorders consultation	Covered based on type of service and **provider** from which it is received	Not covered

Substance related disorders treatment

Includes **detoxification**, rehabilitation and **residential treatment facility**

Coverage provided is the same as for any other illness

Description	Designated network	Non-designated network
Inpatient services – **room and board**	$150 then the plan pays 100% per admission, no **deductible** applies	80% per admission, no **deductible** applies

Description	Designated network	Non-designated network
Outpatient office visit to a **physician** or **behavioral health provider**	$15 then the plan pays 100% per visit, no **deductible** applies	$30 then the plan pays 100% per visit, no **deductible** applies
Physician or **behavioral health provider telemedicine** consultation	$15 then the plan pays 100% per visit, no **deductible** applies	$30 then the plan pays 100% per visit, no **deductible** applies
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received

Description	Designated network	Non-designated network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies

Description	Designated network	Non-designated network
Telemedicine provider substance related disorders consultation	Covered based on type of service and **provider** from which it is received	Not covered

Clinical trials

Description	Designated network	Non-designated network
Experimental or investigational therapies	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Routine patient costs	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Diabetic services, supplies, equipment, and self-care programs

Description	Designated network	Non-designated network
Diabetic services	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic equipment	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic self-care programs	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Durable medical equipment (DME)

Description	Designated network	Non-designated network
DME	100% per item, no **deductible** applies	80% per item after **deductible**

Emergency services

Description	Designated network	Non-designated network	Out-of-network
Emergency room	$100 then the plan pays 100% per visit, no **deductible** applies	$100 then the plan pays 100% per visit, no **deductible** applies	Paid same as in-network

Description	Designated network	Non-designated network
Non-emergency care in a **hospital** emergency room	Not covered	Not covered

Emergency services important note:

- **Out-of-network providers** do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill.
- In the case of a surprise bill from an out-of-network provider, where you had no control of their participation in your **covered services**, you will pay the same cost share you would have if the **covered services** were received from a **network provider**. The cost share will be based on the median contracted rate. Contact us immediately if you receive such a bill.
- If you are admitted to the **hospital** for an inpatient **stay** right after you visit the emergency room, you will not pay your emergency room cost share if you have one. You will pay the inpatient **hospital** cost share, if any.

Foot orthotic devices

Description	Designated network	Non-designated network
Orthotic devices	$5 then the plan pays 100%per item, no **deductible** applies	$20 then the plan pays 100%per item, no **deductible** applies

Habilitation therapy services

Physical (PT) and occupational (OT) therapies

Description	Designated network	Non-designated network
PT, OT therapies	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Speech therapy (ST)

Description	Designated network	Non-designated network
ST	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Hearing aids

Description	Designated network	Non-designated network
Hearing aids	100% per item, no **deductible** applies	80% per item after **deductible**
Limit	One per ear every 24 months	One per ear every 24 months

Hearing exams

Description	Designated network	Non-designated network
Hearing exams	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Visit limit	1 visit every 24 months	1 visit every 24 months

Home health care

A visit is a period of 4 hours or less

Description	Designated network	Non-designated network
Home health care	$5 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies

Home health care important note:
Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits.

Hospice care

Description	Designated network	Non-designated network
Inpatient services - **room and board**	$150 then the plan pays 100% per admission, no **deductible** applies	100% per admission, no **deductible** applies

Description	Designated network	Non-designated network
Outpatient services	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies

Hospice important note:
This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8 hours a day.

Hospital care

Description	Designated network	Non-designated network
Inpatient services – **room and board**	$150 then the plan pays 100% per admission, no **deductible** applies	80% per admission after **deductible**

Infertility services

Basic infertility

Description	Designated network	Non-designated network
Treatment of basic **infertility**	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Comprehensive infertility services

Description	Designated network	Non-designated network
	$15 then the plan pays 100%per visit, no **deductible** applies	$30 then the plan pays 100% per visit, no **deductible** applies

Advanced reproductive technology (ART)

Description	Designated network	Non-designated network
Outpatient services	$15 then the plan pays 100%per visit, no **deductible** applies	$30 then the plan pays 100% per visit, no **deductible** applies

Maternity and related newborn care

Includes complications

Description	Designated network	Non-designated network
Inpatient services – **room and board**	$150 then the plan pays 100% per admission, no **deductible** applies	80% per admission after **deductible**
Services performed in **physician** or **specialist** office or a facility	100% per visit, no **deductible** applies	80% per visit after **deductible**
Other services and supplies	100% per visit, no **deductible** applies	80% per visit after **deductible**

Maternity and related newborn care important note:
Any cost share collected applies only to the delivery and postpartum care services provided by an OB, GYN or OB/GYN. Review the *Maternity* section of the certificate. It will give you more information about coverage for maternity care under this plan.

Nutritional support

Description	Designated network	Non-designated network
Nutritional support	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Obesity surgery

Description	Designated network	Non-designated network
Inpatient services - **room and board**	$150 then the plan pays 100% per admission, no **deductible** applies	80% per admission after **deductible**

Description	Designated network	Non-designated network
Outpatient services	$150 then the plan pays 100% per visit, no **deductible** applies	80% per visit after **deductible**

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	Designated network	Non-designated network
Treatment of mouth, jaws and teeth	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Outpatient prescription drugs

Generic prescription drugs

Description	In-network
30 day supply at a **retail pharmacy**	$15, no **deductible** applies
90 day supply at a **retail pharmacy**	$30, no **deductible** applies
90 day supply at a **mail order pharmacy**	$30, no **deductible** applies

Brand-name prescription drugs

Description	In-network
30 day supply at a **retail pharmacy**	$30, no **deductible** applies
90 day supply at a **retail pharmacy**	$60, no **deductible** applies
90 day supply at a **mail order pharmacy**	$60, no **deductible** applies

Contraceptives (birth control)

Brand-name prescription drugs and devices are covered at 100% when a generic is not available

Description	In-network
30 day supply of generic and OTC drugs and devices	$0, no **deductible** applies
30 day supply of **brand-name prescription drugs** and devices	Paid based on the tier of drug in the schedule

Preventive care drugs and supplements

Description	In-network
Preventive care drugs and supplements	$0, no **deductible** applies
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section

Risk reducing breast cancer drugs

Description	In-network
Risk reducing breast cancer **prescription** drugs	$0, no **deductible** applies
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of risk reducing breast cancer drugs or more information, see the *Contact us* section

Tobacco cessation drugs

Description	In-network
Tobacco cessation **prescription** and OTC drugs	$0, no **deductible** applies
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section. See the *Other services* section of this schedule for more information.

Outpatient surgery

Description	Designated network	Non-designated network
	$150 then the plan pays 100% per visit, no **deductible** applies	80% per visit after **deductible**

Physician and specialist services

Physician services-general or family practitioner

Description	Designated network	Non-designated network
Physician office hours (not surgical, not preventive)	$5 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies
Physician surgical services	$5 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies

Description	Designated network	Non-designated network
Physician telemedicine consultation	$5 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies
Description	**Designated network**	**Non-designated network**
Physician visit during inpatient **stay**	100% per visit, no **deductible** applies	80% per visit after **deductible**

Specialist

Description	Designated network	Non-designated network
Specialist office hours (not surgical, not preventive)	$15 then the plan pays 100% per visit, no **deductible** applies	$30 then the plan pays 100% per visit, no **deductible** applies
Description	**Designated network**	**Non-designated network**
Specialist telemedicine consultation	$15 then the plan pays 100% per visit, no **deductible** applies	$30 then the plan pays 100% per visit, no **deductible** applies

All other services not shown above

Description	Designated network	Non-designated network
All other services	100% per visit, no **deductible** applies	80% per visit after **deductible**

Preventive care

Description	Designated network	Non-designated network
Preventive care services	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Breast feeding counseling and support	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Breast feeding counseling and support limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 every 3 years Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 every 3 years Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 3 years to replace an existing electric pump	Electric pump: 3 years to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Counseling for alcohol or drug misuse visit limit	5 visits/12 months	5 visits/12 months
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Counseling for sexually transmitted infection visit limit	2 visits/12 months	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Counseling for tobacco cessation visit limit	8 visits/12 months	8 visits/12 months
Family planning services (female contraception)	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Family planning services (female contraception) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting

Immunizations	100%, no **deductible** applies	100% per visit, no **deductible** applies
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Routine cancer screenings	100%, no **deductible** applies	100% per visit, no **deductible** applies
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section
Lung cancer screening	100%, no **deductible** applies	100% per visit, no **deductible** applies
Routine lung cancer screening limit	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	100%, no **deductible** applies	100% per visit, no **deductible** applies
Routine physical exam limits	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 for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1/36 months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1/36 months

Well woman GYN exam	100%, no **deductible** applies	100% per visit, no **deductible** applies
Well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

Private duty nursing

Up to eight hours equals one shift

Description	Designated network	Non-designated network
Outpatient services	100% per visit, no **deductible** applies	80% per visit after **deductible**

Visit/shift limit per year	30	30

Prosthetic devices

Description	Designated network	Non-designated network
Prosthetic devices	$5 then the plan pays 100% per item, no **deductible** applies	80% per visit after **deductible**

Reconstructive surgery and supplies

Including breast **surgery**

Description	Designated network	Non-designated network
Surgery and supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Short-term rehabilitation services

A visit is equal to no more than 1 hour of therapy.

Cardiac rehabilitation

Description	Designated network	Non-designated network
Cardiac rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Pulmonary rehabilitation

Pulmonary	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Cognitive rehabilitation

Cognitive rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Physical and occupational therapies

Description	Designated network	Non-designated network
At the **physician** office	$5 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies
At facility that is not a **hospital**	$5 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies
At **hospital** outpatient department	$5 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies

Speech therapy (ST)

Description	Designated network	Non-designated network
At the **physician** office	$5 then the plan pays 100% per visit, no **deductible** applies	$15 then the plan pays 100% per visit, no **deductible** applies
At facility that is not a **hospital**	$5 then the plan pays 100% per visit, no **deductible** applies	$15 then the plan pays 100% per visit, no **deductible** applies
At **hospital** outpatient department	$5 then the plan pays 100% per visit, no **deductible** applies	$15 then the plan pays 100% per visit, no **deductible** applies

Physical and occupational therapies

Visit limit per year	30	30

Speech therapy (ST)

Visit limit per year	30	30

Spinal manipulation

Description	Designated network	Non-designated network
At the **physician** office	$15 then the plan pays 100% per visit, no **deductible** applies	$30 then the plan pays 100% per visit, no **deductible** applies
At facility that is not a **hospital**	$15 then the plan pays 100% per visit, no **deductible** applies	$30 then the plan pays 100% per visit, no **deductible** applies
At **hospital** outpatient department	$15 then the plan pays 100% per visit, no **deductible** applies	$30 then the plan pays 100% per visit, no **deductible** applies

Visit limit per year	25	25

Skilled nursing facility

Description	Designated network	Non-designated network
Inpatient services – **room and board**	$150 then the plan pays 100% per admission, no **deductible** applies	80% per admission after **deductible**

Day limit per year	100	100

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	Designated network	Non-designated network
	100% per visit, no **deductible** applies	80% per visit after **deductible**

Diagnostic lab work

Description	Designated network	Non-designated network
	100% per visit, no **deductible** applies	80% per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	Designated network	Non-designated network
	100% per visit, no **deductible** applies	80% per visit after **deductible**

Therapies

Chemotherapy

Description	Designated network	Non-designated network
Chemotherapy services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Gene-based, cellular and other innovative therapies (GCIT)

Description	Designated network (GCIT-designated facility/provider)	Out-of-network (Including **providers** who are otherwise part of Aetna's network but are not GCIT-designated facilities/**providers**)
Services and supplies	Covered based on type of service and where it is received	Not covered
Gene therapy products, **prescription** drugs	$50 then the plan pays 100% per visit, no **deductible** applies	Not covered

Infusion therapy

Outpatient services

Description	Designated network	Non-designated network
	100% per visit, no **deductible** applies	80% per visit after **deductible**

Radiation therapy

Description	Designated network	Non-designated network
Radiation therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Respiratory therapy

Description	Designated network	Non-designated network
Respiratory therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Transplant services

Description	Designated network (IOE facility)
Inpatient services and supplies	$150 then the plan pays 100% per transplant, no **deductible** applies
Physician services	Covered based on type of service and where it is received

Urgent care services

At a freestanding facility or **provider** that is not a **hospital**

A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

Description	Designated network	Non-designated network
Urgent care facility	$15 then the plan pays 100% per visit, no **deductible** applies	$30 then the plan pays 100% per visit, no **deductible** applies
Non-urgent use of an urgent care facility or **provider**	Not covered	Not covered

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Description	Designated network	Non-designated network
	$15 then the plan pays 100% per visit, no **deductible** applies	$30 then the plan pays 100% per visit, no **deductible** applies

Visit limit	1 visit per year	1 visit per year

Walk-in clinic

Not all preventive care services are available at a **walk-in clinic**. All services are available from a designated **network physician**.

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings
Non-emergency services	100% per visit, no **deductible** applies	$5 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies
Preventive care immunizations	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Preventive screening and counseling services	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Preventive screening and counseling limits	See the *Preventive care services* section of the schedule	See the *Preventive care services* section of the schedule	See the *Preventive care services* section of the schedule

Telemedicine consultation for non-**emergency services** through a **walk-in clinic**	100% per visit, no **deductible** applies	Covered based on type of service and where it is received
Telemedicine consultation for preventive screening and counseling services through a **walk-in clinic**	100% per visit, no **deductible** applies	Covered based on type of service and where it is received