# Schedule of Benefits

**Prepared for:**

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|---|---|
| Employer: | North Brunswick Township Board of Education |
| Contract number: | MSA-307281 |
| Plan name: | Choice POS II New Jersey Educator Health Plan |
| Schedule of benefits: | 3A |
| Plan effective date: | July 1, 2021 |
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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.

## 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 in-**network** and **out-of-network providers**
  - Separate limits for in-**network** and **out-of-network providers**
  - Based on a rolling, 12 month period starting with the date of your most recent visit under this plan

  See the schedule of benefits 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 **deductible**, **maximum out-of-pocket**, limits, **copayment** or **payment percentage** unless otherwise stated in this schedule of benefits.

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 an in-**network**, **out-of-network provider**. This schedule of benefits 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 of benefits 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.

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

| Deductible type | In-network | Out-of-network |
|---|---|---|
| Individual | $0 per year | $350 per year |
| Family | $0 per year | $700 per year |

### Maximum out-of-pocket limit

| Maximum out-of-pocket type | In-network | Out-of-network |
|---|---|---|
| Individual | $500 per year | $2,000 per year |
| Family | $1,000 per year | $5,000 per year |

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

### Deductible provisions
Out-of-network **covered services** will apply only to the out-of-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.

## 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.

## 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.

## Maximum out-of-pocket limit provisions

## Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **payment percentage** and **deductible**, if any, for **covered services**.

In-network **covered services** will apply only to the in-network **maximum out-of-pocket limit**. Out-of-network **covered services** will apply only to the out-of-network **maximum out-of-pocket limit**.

### 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:

- All costs for non-covered services which are identified in the booklet and the schedule
- Charges, expenses or costs in excess of the **allowable amount**
- Costs for non-emergency use of the emergency room
- Costs for non-urgent use of an urgent care **provider**

## Limit provisions

**Covered services** will apply to the in-network and out-of-network limits.

## 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.

## Covered services

### Acupuncture

| Description | In-network | Out-of-network |
|---|---|---|
| Acupuncture | $15 then the plan pays 100% per visit, no **deductible** applies | Lesser of $60 copayment per visit or 75% of the negotiated charge |

### Ambulance services

| Description | In-network | Out-of-network |
|---|---|---|
| **Emergency services** | 90% per trip, no **deductible** applies | 70% per trip after **deductible** |
| **Description** | **In-network** | **Out-of-network** |
| Non-emergency services | 90% per trip, no **deductible** applies | 70% per trip after **deductible** |

### Applied behavior analysis

| Description | In-network | Out-of-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 | In-network | Out-of-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 treatment

Coverage provided is the same as for any other illness

| Description | In-network | Out-of-network |
|---|---|---|
| Inpatient services-**room and board** including **residential treatment facility** | 100% per admission, no **deductible** applies | 70% per admission after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| Outpatient office visit to a **physician** or **behavioral health provider**<br>Includes **telemedicine** consultation | $15 then the plan pays 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| Outpatient mental health **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider** | $15 then the plan pays 100% per visit, no **deductible** applies | 70% per visit after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| Other outpatient services including:<br>• Behavioral health services in the home<br>• Partial hospitalization treatment<br>• Intensive outpatient program<br><br>The cost share doesn't apply to in-network peer counseling support services | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |

### Substance related disorders treatment

Includes **detoxification**, rehabilitation and **residential treatment facility**
Coverage provided is the same as for any other illness

| Description | In-network | Out-of-network |
|---|---|---|
| Inpatient services-**room and board** during a **hospital stay** | 100% per admission, no **deductible** applies | 70% per admission after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| Outpatient office visit to a **physician** or **behavioral health provider**<br>Includes **telemedicine** consultation | $15 then the plan pays 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider** | $15 then the plan pays 100% per visit, no **deductible** applies | 70% per visit after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| Other outpatient services including:<br>• Behavioral health services in the home<br>• Partial hospitalization treatment<br>• Intensive outpatient program<br><br>The cost share doesn't apply to in-network peer counseling support services | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |

## Clinical trials

| Description | In-network | Out-of-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 | In-network | Out-of-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 | In-network | Out-of-network |
|---|---|---|
| DME | 90% per item, no **deductible** applies | 70% per item after **deductible** |

## Emergency services

| Description | In-network | Out-of-network |
|---|---|---|
| Emergency room | $125 then the plan pays 100% per visit, no **deductible** applies | Paid same as in-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. 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.

## Habilitation therapy services

### Physical (PT), occupational (OT) therapies

| Description | In-network | Out-of-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 | In-network | Out-of-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 | In-network | Out-of-network |
|---|---|---|
| Hearing aids<br><br>Covered persons through age 15 years and younger | $10 then the plan pays 100% per visit, no **deductible** applies | 70% per item after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| Limit | One per ear every 24 months | One per ear every month |
| Limit | $1,000 | $1,000 |

## Hearing exams

| Description | In-network | Out-of-network |
|---|---|---|
| Hearing exams<br><br>Covered persons through age 15 years and younger | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Home health care

A visit is a period of 4 hours or less

| Description | In-network | Out-of-network |
|---|---|---|
| Home health care | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |

**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. Services must be provided within 10 days of discharge.

## Hospice care

| Description | In-network | Out-of-network |
|---|---|---|
| Inpatient services - **room and board** | 100% per admission, no **deductible** applies | 70% per admission after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| Outpatient services | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |

| | | |
|---|---|---|
| Limit per lifetime | unlimited | unlimited |

**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 | In-network | Out-of-network |
|---|---|---|
| Inpatient services – **room and board** | 100% per admission, no **deductible** applies | 70% per admission after **deductible** |

## Infertility services

### Basic infertility

| Description | In-network | Out-of-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 | In-network | Out-of-network |
|---|---|---|
| | $15 then the plan pays 100% per visit, no **deductible** applies | 70% per visit after **deductible** |

### Advanced reproductive technology (ART)

| Description | In-network | Out-of-network |
|---|---|---|
| | $15 then the plan pays 100% per visit, no **deductible** applies | 70% per visit after **deductible** |

## Jaw joint disorder

Includes TMJ

| Description | In-network | Out-of-network |
|---|---|---|
| **Jaw joint disorder** treatment | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Maternity and related newborn care

Includes complications

| Description | In-network | Out-of-network |
|---|---|---|
| Inpatient services – **room and board** | 100% per admission, no **deductible** applies | 70% per admission after **deductible** |
| Services performed in **physician** or **specialist** office or a facility | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| Other services and supplies | 100%, no **deductible** applies | 70% 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 | In-network | Out-of-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 | In-network | Out-of-network |
|---|---|---|
| Inpatient services – **room and board** | 100% per admission, no **deductible** applies | 70% per admission after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| Outpatient services | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |

## Oral and maxillofacial treatment (mouth, jaws and teeth)

| Description | In-network | Out-of-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 surgery

| Description | In-network | Out-of-network |
|---|---|---|
| At **hospital** outpatient department | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |

## Physician and specialist services

## Physician services-general or family practitioner

| Description | In-network | Out-of-network |
|---|---|---|
| **Physician** office hours (not-surgical, not preventive) | $10 then the plan pays 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| **Physician** surgical services | $10 then the plan pays 100% per visit, no **deductible** applies | 70% per visit after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| **Physician telemedicine** consultation | $10 then the plan pays 100% per visit, no **deductible** applies | 70% per visit after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| **Physician** visit during inpatient **stay** | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |

## Specialist

| Description | In-network | Out-of-network |
|---|---|---|
| **Specialist** office hours (not-surgical, not preventive) | $15 then the plan pays 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| **Specialist** surgical services | $15 then the plan pays 100% per visit, no **deductible** applies | 70% per visit after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| **Specialist telemedicine** consultation | $15 then the plan pays 100% per visit, no **deductible** applies | 70% per visit after **deductible** |

## All other services not shown above

| Description | In-network | Out-of-network |
|---|---|---|
| All other services | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |

## Preventive care

| Description | In-network | Out-of-network |
|---|---|---|
| Preventive care services | 100% per visit, no **deductible** applies | Not covered |
| Breast feeding counseling and support | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| Breast feeding counseling and support limit | 6 visits in a group or individual setting<br><br>Visits that exceed the limit are covered under the **physician** services office visit | 6 visits in a group or individual setting<br><br>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<br><br>Manual pump: 1 per pregnancy<br><br>Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump | Electric pump: 1 every 3 years<br><br>Manual pump: 1 per pregnancy<br><br>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 | Not covered |
| Counseling for alcohol or drug misuse visit limit | 5 visits/12 months | Not applicable |
| Counseling for obesity, healthy diet | 100% per visit, no **deductible** applies | Not covered |
| 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. | Not applicable |
| Counseling for sexually transmitted infection | 100% per visit, no **deductible** applies | Not covered |
| Counseling for sexually transmitted infection visit limit | 2 visits/12 months | Not applicable |
| Counseling for tobacco cessation | 100% per visit, no **deductible** applies | Not covered |
| Counseling for tobacco cessation visit limit | 8 visits/12 months | Not applicable |
| Family planning services (female contraception counseling) | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| Family planning services (female contraception counseling) 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 | Not covered |
| 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<br><br>For details, contact your **physician** | Not applicable |
| Routine mammogram | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| All other Routine cancer screenings | 100% per visit, no **deductible** applies | Not covered |
| Routine cancer screening limits | Subject to any age, family history and frequency guidelines as set forth in the most current:<br><br>Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF<br><br>The comprehensive guidelines supported by the Health Resources and Services Administration<br><br>For more information contact your **physician** or see the *Contact us* section | Not applicable |
| Generic preventive care contraceptives (birth control) | 100% | 100% |
| Preventive care drugs and supplements | 100% | 100% |
| Preventive care drugs and supplements limit | Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF<br><br>For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section | Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF<br><br>For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section |
| Preventive care risk reducing breast cancer **prescription** drugs | 100% | 100% |

| | | |
|---|---|---|
| Preventive care risk reducing breast cancer **prescription** drugs limit | Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF<br><br>For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section | Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF<br><br>For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section |
| Preventive care tobacco cessation **prescription** and OTC drugs | 100% | 100% |
| Limit | Two 90 day treatments only | Two 90 day treatments only |
| Lung cancer screening | 100% per visit, no **deductible** applies | Not covered |
| Routine lung cancer screening limit | 1 screening every 12 months<br><br>Screenings that exceed this limit covered as outpatient diagnostic testing | Not applicable |
| Routine physical exam | 100% per visit, no **deductible** applies | Not covered |
| 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<br><br>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 Calendar Year after that age, up to age 22; 1 exam every Calendar Year after age 22<br><br>High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months | Not applicable |
| Well woman GYN exam | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| 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 | In-network | Out-of-network |
|---|---|---|
| Outpatient services | 90% per visit, no **deductible** applies | Not covered |

### Prosthetic devices

| Description | In-network | Out-of-network |
|---|---|---|
| Prosthetic devices | $15 then the plan pays 100% per item thereafter, no **deductible** applies | 70% per item after **deductible** |

### Reconstructive surgery and supplies

Including breast **surgery**

| Description | In-network | Out-of-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

**Cardiac rehabilitation**

| Description | In-network | Out-of-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**

| Description | In-network | Out-of-network |
|---|---|---|
| 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**

| Description | In-network | Out-of-network |
|---|---|---|
| Cognitive rehabilitation | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

**Speech and occupational therapies**

| Description | In-network | Out-of-network |
|---|---|---|
| ST and OT | $15 then the plan pays 100% per visit no **deductible** applies | 70% per visit after **deductible** |

**Physical therapy (PT)**

| | | |
|---|---|---|
| PT | $15 then the plan pays 100% per visit no **deductible** applies | Lesser of $52 **copayment** per visit or 75% of the **negotiated charge** |

### Spinal manipulation

| Description | In-network | Out-of-network |
|---|---|---|
| Spinal manipulation | $15 then the plan pays 100% per visit, no **deductible** applies | Lesser of $35 **copayment** per visit or 75% of the **negotiated charge** |

| | | |
|---|---|---|
| Visit limit per year | 30 | 30 |

## Skilled nursing facility

| Description | In-network | Out-of-network |
|---|---|---|
| Inpatient services - **room and board** | 100% per admission no **deductible** applies | 70% per admission after **deductible** |
| Other inpatient services and supplies | 100% per admission no **deductible** applies | 70% per admission after **deductible** |

| | | |
|---|---|---|
| Day limit per year | 120 | 60 |

## Tests, images and labs – outpatient

### Diagnostic complex imaging services

| Description | In-network | Out-of-network |
|---|---|---|
| | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |

### Diagnostic lab work

| Description | In-network | Out-of-network |
|---|---|---|
| | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |

### Diagnostic x-ray and other radiological services

| Description | In-network | Out-of-network |
|---|---|---|
| | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |

## Therapies

### Chemotherapy

| Description | In-network | Out-of-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 | In-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 |

### Infusion therapy

Outpatient services

| Description | In-network | Out-of-network |
|---|---|---|
| In **physician** office | $15 then the plan pays 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| At an infusion location | $15 then the plan pays 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| In the home | $15 then the plan pays 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| At **hospital** outpatient department | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| At facility that is not a **hospital** | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |

### Radiation therapy

| Description | In-network | Out-of-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 | In-network | Out-of-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 | In-network (IOE facility) | Out-of-network (Includes **providers** who are otherwise part of Aetna's network but are non-IOE **providers**) |
|---|---|---|
| Inpatient services and supplies | 100% per transplant, no **deductible** applies | 70% per transplant after **deductible** |
| **Physician** services | Covered based on type of service and where it is received | 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 | In-network | Out-of- network |
|---|---|---|
| Urgent care facility | $15 then the plan pays 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| 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 | In-network | Out-of-network |
|---|---|---|
| | $15 then the plan pays 100% per visit, no **deductible** applies | Not covered |

| | | |
|---|---|---|
| Visit limit | 1 visit every Calendar Year | Not applicable |

## Walk-in clinic

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

| Description | In-network | Out-of-network |
|---|---|---|
| Non-emergency services | $15 then the plan pays 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| Preventive immunizations | 100% per visit, no **deductible** applies | Not covered |
| 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<br><br>For details, contact your **physician** | Not applicable |
| Screening and counseling services | 100% per visit, no **deductible** applies | Not covered |
| Screening and counseling limits | See the *Preventive care services* section of the SOB | Not applicable |