

Schedule of benefits

Prepared for:

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Managed Choice Garden State Health Plan
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Underwritten by Aetna Life Insurance Company in the state of New Jersey



Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles**, **copayments** or **coinsurance**, 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**.
- **Coinsurance** amounts, if any, listed in the schedule below are what you will pay for **covered services**. Sometimes for out-of-network services, your cost share shows a combination of your dollar amount **copayment** that you will be responsible for and the **coinsurance** percentage that your plan will pay.
- You are responsible to pay any **deductibles**, **copayments** and remaining **coinsurance**, if they apply and before the plan will pay for any **covered services**.
- When a **covered service** shows “no charge”, this means you have no responsibility for **deductibles**, **copayments** or **coinsurance**.
- 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 planSee 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.

Important note:

Covered services are subject to the Calendar Year **deductible**, **maximum out-of-pocket**, limits, **copayment** or **coinsurance** unless otherwise stated in this schedule of benefits.

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 **coinsurance** you pay when you get **covered services** from an in-network, **out-of-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 **coinsurance**, 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 certificate.

Aetna Life Insurance Company's group policy provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your certificate.

Plan features

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

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 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

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

Outpatient prescription drug maximum out-of-pocket limit

Maximum out-of-pocket type	In-network	Out-of-network
Individual	\$1,600 per calendar year	Unlimited
Family	\$3,200 per calendar year	Unlimited

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 **coinsurance**, 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 amount you pay for certain visits or **covered services**. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**.

Coinsurance

This is a percentage of the bill you pay for a **covered service** 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

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

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 certificate 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 – maximum out of pocket

Covered services applied to the in-network limit will not apply to the out-of-network limit. **Covered services** applied to the out-of-network limit will not apply to the in-network limit.

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 group policy.

Individual prescription drug maximum out-of-pocket limit

Once the amount of the cost share and **deductible** 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**

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.

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**.

All costs for non-covered services do not apply toward the **maximum out-of-pocket limit**.

Covered services

Description	In-network	Out-of-network
Acupuncture	\$15 copayment per visit, no deductible applies	Lesser of \$60 copayment or 75% of the allowable amount per visit

Ambulance services

Description	In-network	Out-of-network
Emergency services	10% of the negotiated charge per trip, no deductible applies	30% of the allowable amount per trip after deductible
Non-emergency services	Not covered	Not covered

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

Clinical trials

Description	In-network	Out-of-network
Experimental and 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

Dental care anesthesia

Description	In-network	Out-of-network
Hospital charges	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	10% of the negotiated charge , no deductible applies	30% of the allowable amount after the deductible
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	10% of the negotiated charge per item, no deductible applies	30% of the allowable amount per item after deductible

Emergency services

	In-network	Out-of-network
Hospital emergency room No copayment if admitted	\$125 copayment per visit, no deductible applies	\$125 copayment per visit, no deductible applies
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** as 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	In-network	Out-of-network
Orthotic devices	Covered based on type of service and where it is received	Covered based on type of service and where it is received

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

Description	In-network	Out-of-network
Speech therapy	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	\$10 copayment per item, no deductible applies	30% of the allowable amount per item after deductible
Age limit	Covered persons through age 15	Covered persons through age 15
Frequency limit	One per ear every 24 months	One per ear every 24 months
Benefit limit	\$1,000	\$1,000

Hearing exams

Description	In-network	Out-of-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 12 months	1 visit every 12 months

Home health care

A visit is a period of 4 hours or less

Description	In-network	Out-of-network
Home health care	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount 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.

Home hemophilia treatment

Description	In-network	Out-of-network
Home treatments	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount per visit after deductible

Hospice care

Description	In-network	Out-of-network
Inpatient services - room and board	0% of the negotiated charge per admission, no deductible applies	30% of the allowable amount per admission after deductible

Description	In-network	Out-of-network
Outpatient services	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount per visit, after deductible

Visit limit per year	unlimited	unlimited
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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	0% of the negotiated charge per admission, no deductible applies	30% of the allowable amount per admission after deductible

Description	In-network	Out-of-network
Infertility diagnosis and treatment of underlying medical condition	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.
Comprehensive infertility treatment	\$15 copayment per visit, no deductible applies	30% of the allowable amount after the deductible
ART	\$15 copayment per visit, no deductible applies	30% of the allowable amount after the deductible

Jaw joint disorder treatment

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	0% of the negotiated charge per admission, no deductible applies	30% of the allowable amount per admission after deductible
Services performed in physician office or a facility	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount per visit after deductible
Services performed in specialist office or a facility	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount per visit after deductible
Other services and supplies	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 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.

Mental health conditions

Mental health treatment

Coverage provided under the **same terms and conditions** as for any other condition

Description	In-network	Out-of-network
Inpatient services-room and board including residential treatment facility	0% of the negotiated charge per admission, no deductible applies	30% of the allowable amount per admission after deductible

Description	In-network	Out-of-network
Outpatient office visit to a physician or behavioral health provider	\$15 per visit, no deductible applies	30% of the allowable amount per visit after deductible
Physician or behavioral health provider telemedicine and/or telehealth consultation	\$15 per visit, no deductible applies	30% of the allowable amount per visit after deductible
Outpatient mental health telemedicine and/or telehealth cognitive therapy consultations by a physician or behavioral health provider	0% per visit, no deductible applies	Not covered

Description	In-network	Out-of-network
Other outpatient services including: <ul style="list-style-type: none"> Behavioral health services in the home Partial hospitalization treatment Intensive outpatient program <p>The cost share doesn't apply to in-network peer counseling support services</p>	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount per visit after deductible

Autism spectrum disorder or other developmental disabilities

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
Outpatient 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

Substance use disorders treatment

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

Coverage provided under the **same terms and conditions** as for any other condition

Description	In-network	Out-of-network
Inpatient services-room and board during a hospital stay	0% of the negotiated charge per admission, no deductible applies	30% of the allowable amount per admission after deductible

Description	In-network	Out-of-network
Outpatient office visit to a physician or behavioral health provider	\$15 per visit, no deductible applies	30% of the allowable amount per visit after deductible
Physician or behavioral health provider telemedicine and/or telehealth consultation	\$15 per visit, no deductible applies	30% of the allowable amount per visit after deductible
Outpatient telemedicine and/or telehealth cognitive therapy consultations by a physician or behavioral health provider	0% per visit, no deductible applies	Not covered

Description	In-network	Out-of-network
Other outpatient services including: <ul style="list-style-type: none"> • 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	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount per visit after deductible

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 and services

Description	In-network	Out-of-network
Inpatient services – room and board	0% of the negotiated charge per admission, no deductible applies	30% of the allowable amount per admission after deductible

Description	In-network	Out-of-network
Outpatient services	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount 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	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount per visit after deductible

Physician services
Your PCP

Description	In-network	Out-of-network
Physician office hours (not surgical, not preventive)	\$10 per visit, no deductible applies	30% of the allowable amount per visit after deductible
Allergy testing and treatment	Covered based on type of service and where it is received.	Covered based on type of service and where it is received.
Allergy injections	0% of the negotiated charge per visit, no deductible applies	Covered based on type of service and where it is received.
Physician home visit (not preventive)	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount per visit after deductible
Physician surgical services	\$10 per visit, no deductible applies	30% of the allowable amount per visit after deductible

Description	In-network	Out-of-network
Physician telemedicine and/or telehealth consultation	\$10 per visit, no deductible applies	30% of the allowable amount per visit after deductible

Description	In-network	Out-of-network
Physician visit during inpatient stay	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount per visit after deductible

Physician Services-Specialist

Description	In-network	Out-of-network
Specialist office hours (not surgical, not preventive)	\$15 per visit, no deductible applies	30% of the allowable amount per visit after deductible
Specialist home visit (not preventive)	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount per visit after deductible
Specialist surgical services	\$15 per visit, no deductible applies	30% of the allowable amount per visit after deductible

Description	In-network	Out-of-network
Specialist telemedicine and/or telehealth consultation	\$15 per visit, no deductible applies	30% of the allowable amount per visit after deductible

Physician services -all other services not shown above

Description	In-network	Out-of-network
All other services	Covered based on type of service and where it is received.	Covered based on type of service and where it is received.

Prescription drugs – outpatient

Generic prescription drugs

Description	In-network	Out-of-network
30 day supply filled at a retail pharmacy	\$5 copayment	\$5 copayment
31-60 day supply filled at a retail pharmacy	\$10 copayment	\$10 copayment
61-90 day supply from a retail pharmacy	\$15 copayment	\$15 copayment
For a 31-90 day supply from a CVS Caremark® mail order pharmacy	\$10 copayment	\$10 copayment

Non-preferred prescription drugs

Description	In-network	Out-of-network
30 day supply filled at a retail pharmacy	\$10 copayment	\$10 copayment
31-60 day supply filled at a retail pharmacy	\$20 copayment	\$20 copayment
61-90 day supply from a retail pharmacy	\$30 copayment	\$30 copayment
31-90 day supply from a CVS Caremark® mail order pharmacy	\$20 copayment	\$20 copayment
30 day supply filled at a specialty pharmacy	\$20 copayment	Not covered

Other covered services

Anti-cancer drugs taken by mouth including chemotherapy drugs

Description	In-network	Out-of-network
30 day supply filled at a retail pharmacy	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above
More than 60 day supply but less than 91 day supply at a retail pharmacy	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above
More than 30 day supply but less than 91 day supply at a mail order pharmacy	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above

Contraceptives (birth control)

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

Description	In-network	Out-of-network
30 day or 6 month supply of generic and OTC drugs and devices	\$0, no deductible applies	Paid according to the type of drug per the schedule of benefits, above
30 day or 6 month supply of brand-name prescription drugs and devices	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above

Preventive care drugs and supplements

Description	In-network	Out-of-network
Preventive care drugs and supplements	\$0, no deductible applies	Paid according to the type of drug per the schedule of benefits, above
Limits	<p>Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF)</p> <p>For a current list of covered preventive care drugs and supplements or more information, see the <i>Contact us</i> section</p>	<p>Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF)</p> <p>For a current list of covered preventive care drugs and supplements or more information, see the <i>Contact us</i> section</p>

Risk reducing breast cancer drugs

Description	In-network	Out-of-network
Risk reducing breast cancer prescription drugs	\$0, no deductible applies	Paid according to the type of drug per the schedule of benefits, above
Limits	<p>Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF)</p> <p>For a current list of risk reducing breast cancer drugs or more information, see the <i>Contact us</i> section</p>	<p>Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF)</p> <p>For a current list of risk reducing breast cancer drugs or more information, see the <i>Contact us</i> section</p>

Tobacco cessation drugs

Description	In-network	Out-of-network
Tobacco cessation prescription and OTC drugs	\$0, no deductible applies	Paid according to the type of drug per the schedule of benefits, above
Limits	<p>Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF.</p> <p>For a current list of covered tobacco cessation drugs or more information, see the <i>Contact us</i> section. See the <i>Other services</i> section of this schedule for more information.</p>	<p>Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF.</p> <p>For a current list of covered tobacco cessation drugs or more information, see the <i>Contact us</i> section. See the <i>Other services</i> section of this schedule for more information.</p>

Outpatient prescription drug important note:

If a **provider** prescribes a covered **brand-name prescription drug** when a **generic prescription drug** equivalent is available and specifies “Dispense As Written” (DAW), you will pay the cost share for the brand-name drug. If a **provider** does not specify DAW and you request a covered **brand-name prescription drug**, you will be responsible for the cost difference between the brand-name drug and the generic drug, plus the cost share that applies to the brand-name drug.

Preventive care

	In-network	Out-of-network
Routine physical exams performed at a physician office including screening for lead poisoning for children and follow up treatment for lead poisoned children.	0% of the negotiated charge per visit, no deductible applies	Not covered
Preventive care immunizations performed in a facility or at a physician's office	0% of the negotiated charge per visit, no deductible applies	Not covered except covered persons through age 12 months: 30% of the allowable amount no deductible applies
Routine gynecological exams (including pap smears)	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount after the deductible
Preventive screening and counseling services: <ul style="list-style-type: none"> • Obesity and/or healthy diet counseling • Substance use disorders • Sexually transmitted infection counseling • Genetic risk counseling for breast and ovarian cancer 	0% of the negotiated charge per visit, no deductible applies	Not covered
Routine mammograms	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount after the deductible
Prostate specific antigen tests	0% of the negotiated charge per visit, no deductible applies	Not covered
Digital rectal exams	0% of the negotiated charge per visit, no deductible applies	Not covered
Fecal occult blood tests	0% of the negotiated charge per visit, no deductible applies	Not covered
Sigmoidoscopies	0% of the negotiated charge per visit, no deductible applies	Not covered
Double contrast barium enemas	0% of the negotiated charge per visit, no deductible applies	Not covered
Colonoscopies	0% of the negotiated charge per visit, no deductible applies	Not covered

Computed tomography colonography every 5 years	0% of the negotiated charge per visit, no deductible applies	Not covered
Lung cancer screening	0% of the negotiated charge per visit, no deductible applies	Not covered
Prenatal care provided by OB, GYN or OB/GYN	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount after the deductible
Lactation counseling services	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount after the deductible
Breast pump supplies and accessories	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount after the deductible
Contraceptive counseling services	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount after the deductible
Contraceptive device provided, administered or removed	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount after the deductible
Voluntary sterilization	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount after the deductible
Routine hearing screening	0% of the negotiated charge per visit, no deductible applies	Not covered
Newborn hearing Loss screenings and periodic monitoring	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Private duty nursing - outpatient

Up to eight hours equals one shift

Description	In-network	Out-of-network
Outpatient services	10% of the negotiated charge per visit, no deductible applies	30% of the allowable amount per visit after deductible

Prosthetic Devices

Description	In-network	Out-of-network
Prosthetic devices	Covered based on type of service and where it is received	Covered based on type of service and where it is received

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 cardiac and pulmonary 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 rehabilitation	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

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

Spinal Manipulation

Description	In-network	Out-of-network
Therapeutic manipulation	\$15 copayment per visit, no deductible applies	Lesser of \$35 copayment or 75% of the negotiated charge per visit after deductible
Visit limit per year	30	30

Physical (PT), occupational (OT) and speech (ST) therapies

	In-network	Out-of-network
Outpatient speech and occupational therapy	\$15 copayment per visit	30% of the allowable amount after the deductible
Outpatient physical therapy	\$15 copayment per visit	Lesser of \$52 copayment per visit or 75% of the allowable amount

Sickle cell anemia

Description	In-network	Out-of-network
Medical expenses and prescription drugs for treatment	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Skilled nursing facility

Description	In-network	Out-of-network
Inpatient services - room and board	0% of the negotiated charge per admission, no deductible applies	30% of the allowable amount per admission after deductible
Other inpatient services and supplies	0% of the negotiated charge per admission, no deductible applies	30% of the allowable amount per admission after deductible
Day limit per year (Does not apply to Mental health conditions)	120	60

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network	Out-of-network
	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount per visit after deductible

Diagnostic lab work

Description	In-network	Out-of-network
	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount per visit after deductible

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network
	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount 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 per visit, no deductible applies	30% of the allowable amount per visit after deductible
At an infusion location	Covered based on type of service and where it is received	Covered based on type of service and where it is received
In the home	\$15 per visit, no deductible applies	30% of the allowable amount per visit after deductible
At hospital outpatient department	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount per visit after deductible
At facility that is not a hospital	0% of the negotiated charge per visit, no deductible applies	30% of the allowable amount 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 provider (IOE facility)	In-network provider (Non-IOE facility)	Out-of-network provider
Inpatient services and supplies	0% of the negotiated charge per transplant, no deductible applies	30% of the negotiated charge per transplant after deductible	30% of the allowable amount per transplant after deductible
Physician services	\$15 per visit, no deductible applies	30% of the negotiated charge per visit after deductible	30% of the allowable amount per visit after deductible

Transplant important note:

See the *Transplant services* benefit in the *Coverage and exclusions* section of the certificate for more information. The limit applies to all transplant services received while you are a member of an Aetna plan or one associated with us. The plan **lifetime maximum**, if any, will not apply to transplant services. The transplant limit will apply.

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 per visit, no deductible applies	30% of the allowable amount per visit after deductible

Non-urgent use of an urgent care facility or provider	Not covered	Not covered
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Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Description	In-network	Out-of-network
Routine vision exams including refraction	\$15 copayment per visit, no deductible applies	Not covered

Visit limit	1 visit every 12 months	Not covered
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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 per visit, no deductible applies	30% of the allowable amount per visit after deductible
Preventive immunizations	0% of the negotiated charge 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 For details, contact your physician	Not covered
Screening and counseling services	0% per visit, no deductible applies	Not covered
Screening and counseling limits	See the <i>Preventive care services</i> section of the SOB	Not covered