Schedule of benefits

Prepared for:

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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 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.

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

Precertification covered services reduction

This only applies to **out-of-network covered services**:
Your certificate contains a complete description of the **precertification** process. You will find details in the *Medical necessity and precertification* section.

If **precertification** for **covered services** isn't completed, when required, it can result in any of the following benefit reductions:

- A $400 benefit reduction applied separately to each type of **covered service**

You may have to pay an additional portion of the **allowable amount** because you didn't get **precertification**. This portion is not a **covered service** and doesn't apply to your **deductible** or **maximum out-of-pocket limit**.

Deductible

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

Deductible type	In-network	Out-of-network
Individual	$200 per year	$200 per year
Family	$400 per year	$400 per year

Deductible waiver

There is no in-network **deductible** for **covered services** under Preventive care.

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 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 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	$700 per year	$800 per year
Family	$1,400 per year	$0 per year

Outpatient prescription drug maximum out-of-pocket limit

Maximum out-of-pocket type	In-network	Out-of-network
Individual	$4,950 per year	$4,950 per year
Family	$9,900 per year	$9,900 per year

General coverage provisions

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

Deductible provisions

Covered services apply to the in-network and out-of-network **deductibles**

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.

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.

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**.

Covered services apply to the network and 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-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 per visit, no **deductible** applies	20% of the **allowable amount** per visit no **deductible**

Ambulance services

Description	In-network	Out-of-network
Emergency services	0% of the **negotiated charge** per trip after **deductible**	20% of the **allowable amount** per trip after **deductible**
Non-emergency services	0% of the **negotiated charge** per trip after **deductible**	20% of the **allowable amount** 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

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	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	0% of the **negotiated charge** per item after **deductible**	20% of the **allowable amount** per item after **deductible**

Emergency services

Description	In-network	Out-of-network
Emergency room	$25 per visit, no **deductible** applies	Paid same as in-network
Non-emergency care in a **hospital** emergency room	50% of the **negotiated charge** per visit after **deductible**	50% of the **allowable amount** per visit after **deductible**

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	0% of the **negotiated charge** per item, no **deductible** applies	20% of the **allowable amount** per item after **deductible**

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	$15 per visit, no **deductible** applies	20% 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 24 months	1 visit every 24 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 after **deductible**	20% of the **allowable amount** per visit after **deductible**
Visit limit per year	60	60

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 after **deductible**	20% 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 after **deductible**	20% of the **allowable amount** per admission after **deductible**

Description	In-network	Out-of-network
Outpatient services	0% of the **negotiated charge** per visit, after **deductible**	20% of the **allowable amount** per visit, after **deductible**

Visit limit per year	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**	0% of the **negotiated charge** per admission after **deductible**	20% of the **allowable amount** per admission after **deductible**

Infertility services

Description	In-network	Out-of-network
Treatment of **infertility**	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Advanced reproductive technology (ART)
For this benefit, lifetime means any covered benefits paid under this plan, another plan with **Aetna** or plan associated with **Us**, with the same policyholder.

Description	In-network	Out-of-network
	$15 per visit, no **deductible** applies	20% of the **allowable amount** per visit after **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 after **deductible**	20% of the **allowable amount** per admission after **deductible**
Services performed in **physician** office or a facility	$15 per visit no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Services performed in **specialist** office or a facility	$15 per visit no **deductible** applies	20% 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 after **deductible**	20% 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	20% of the **allowable amount** per visit after **deductible**
Physician or **behavioral health provider telemedicine** and/or **telehealth** consultation	$15 per visit, no **deductible** applies	20% 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: • 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	20% 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 after **deductible**	20% 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	20% of the **allowable amount** per visit after **deductible**
Physician or **behavioral health provider telemedicine** and/or **telehealth** consultation	$15 per visit, no **deductible** applies	20% 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: • 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	20% 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 after **deductible**	20% of the **allowable amount** per admission after **deductible**

Description	In-network	Out-of-network
Outpatient services	0% of the **negotiated charge** per visit after **deductible**	20% 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 after **deductible**	20% of the **allowable amount** per visit after **deductible**

Physician services

Physician services-general or family practitioner

Description	In-network	Out-of-network
Physician office hours (not surgical, not preventive)	$15 per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Physician home visit (not preventive)	0% of the **negotiated charge** per visit after **deductible**	20% of the **allowable amount** per visit after **deductible**
Physician surgical services	0% of the **negotiated charge** per visit after **deductible**	20% of the **allowable amount** per visit after **deductible**

Description	In-network	Out-of-network
Physician telemedicine and/or **telehealth** consultation	$15 per visit, no **deductible** applies	20% 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 after **deductible**	20% 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	20% of the **allowable amount** per visit after **deductible**
Specialist home visit (not preventive)	0% of the **negotiated charge** per visit after **deductible**	20% of the **allowable amount** per visit after **deductible**
Specialist surgical services	0% of the **negotiated charge** per visit after **deductible**	20% 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	20% 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**	$10, no **deductible** applies	$10 no **deductible** applies
More than a 60 day supply but less than a 91 day supply filled at a **retail pharmacy**	$20, no **deductible** applies	$20 no **deductible** applies
More than a 60 day supply but less than a 91 day supply at a **mail order pharmacy**	$10, no **deductible** applies	Not covered

Non-preferred prescription drugs

Description	In-network	Out-of-network
30 day supply filled at a **retail pharmacy**	$15, no **deductible** applies	$15 no **deductible** applies
More than 60 day supply but less than 91 day supply at a **retail pharmacy**	$30, no **deductible** applies	$30 no **deductible** applies
More than 60 day supply but less than 91 day supply at a **mail order pharmacy**	$15, no **deductible** applies	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	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	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	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	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	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	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	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	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.	*Other services* section of this schedule for more information.

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.

Description	In-network	Out-of-network
Preventive care services	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Breast-feeding support and counseling services	0% of the **negotiated charge** per visit, no **deductible** applies	0% of the **allowable amount** per visit, no **deductible** applies
Breast-feeding support and counseling services limit per year	6 visits in a group or individual setting **Telemedicine** and/or **telehealth** visits do not apply toward your visit limit. All other visits that exceed the limit are covered under the **physician** services office visit	6 visits in a group or individual setting **Telemedicine** and/or **telehealth** visits do not apply toward your visit limit. All other visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	**Important note:** You are limited to 2 breast pump kits per birth • The purchase of an electric or manual breast pump, including supplies and accessories • The purchase or rental of a multi-user breast pump, including supplies and accessories	
Breast pump waiting period	Electric pump: 1 year to replace an existing electric pump	Electric pump: 1 year to replace an existing electric pump
Counseling for substance use disorder	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Counseling substance use disorder visit limit	5 visits/12 months	5 visits/12 months
Counseling for genetic risk for breast and ovarian cancer	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Counseling for genetic risk for breast and ovarian cancer visit limit	5 visits/12 months	5 visits/12 months
Counseling for obesity, healthy diet	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Counseling for obesity, healthy diet visit limit	Age 0-22: unlimited visits. Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	Age 0-22: unlimited visits. 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	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Counseling for sexually transmitted infection visit limit	2 visits/12 months	2 visits/12 months
Family planning services (contraceptive counseling)	0% of the **negotiated charge** per visit	20% of the **allowable amount** per visit after **deductible**
Immunizations	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
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	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
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
Routine lung cancer screening	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
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 exams	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Routine physical exams 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	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 every 36 months	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 every 36 months
Well woman preventive visits	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Well woman preventive visits limits	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
Limit	1 visit	1 visit

Prosthetic devices

Description	In-network	Out-of-network
Prosthetic devices	0% of the **negotiated charge** per item, no **deductible** applies	20% of the **allowable amount** 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 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
Spinal manipulation	$15 per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**

Physical and occupational therapies

Description	In-network	Out-of-network
PT and OT	$15 per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**

Speech therapy

Speech therapy	$15 per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**

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	20% of the **allowable amount** per admission after **deductible**
Other inpatient services and supplies	0%of the **negotiated charge** per admission, no **deductible** applies	20% of the **allowable amount** per admission after **deductible**

Day limit per year (Does not apply to **Mental health conditions)**	90	90

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network	Out-of-network
	0% of the **negotiated charge** per visit after **deductible**	20% of the **allowable amount** per visit after **deductible**

Diagnostic lab work

Description	In-network	Out-of-network
	0% of the **negotiated charge** per visit after **deductible**	20% 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 after **deductible**	20% 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
	Covered based on type of service and where it is received	Covered based on type of service and where it is received

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 after **deductible**	20% of the **negotiated charge** per transplant after **deductible**	20% of the **allowable amount** per transplant after **deductible**
Physician services	$15 per visit no **deductible** applies	20% of the **negotiated charge** per visit after **deductible**	20% 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	0% of the **negotiated charge** per visit, no **deductible** applies	0% of the **allowable amount** per visit no **deductible** applies

Non-urgent use of an urgent care facility or **provider**	Not covered	20% of the **allowable amount** per visit after **deductible**

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Description	In-network	Out-of-network
	0% of the **negotiated charge** per visit after **deductible**	20% of the **allowable amount** per visit after **deductible**

Walk-in clinic

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

Description	Designated network	Non-designated network	Out-of-network
Non-emergency services	0% of the **negotiated charge** per visit, no **deductible** applies	$15 per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
Preventive care immunizations	0% of the **negotiated charge** per visit, no **deductible** applies	0% of the **negotiated charge** per visit, no **deductible** applies	20% of the **allowable amount** per visit after **deductible**
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**
Screening and counseling services	0% per visit, no **deductible** applies	0% per visit, no **deductible** applies	20% per visit after **deductible**
Screening and counseling limits	See the *Preventive care services* section of the SOB	See the *Preventive care services* section of the SOB	See the *Preventive care services* section of the SOB

Important note regarding Walk-in clinics:

Designated network provider

A **network provider** listed in the directory under *Best Results for your plan* as a **provider** for your plan.

Non-designated network provider

A **provider** listed in the directory under the *All other results* tab as a **provider** for your plan.
See the *Contact us* section if you have questions.

You will pay less cost share when you use a designated network walk-in clinic **provider**. Non-designated network walk-in clinic **providers** are available to you, but the cost share will be at a higher level when these **providers** are used.