Schedule of benefits

Prepared for:

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Schedule of benefits:	1A
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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**.
- **Other health care** coverage is care you get from an **out-of-network provider** when you could not reasonably get services and supplies from an in-network **provider**.
- 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 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. The *Surprise bill* section in the booklet explains your protections from a surprise bill.

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 shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **covered services**. You will continue to pay **copayments** or **payment percentage**, if any, for **covered services** after you meet your **deductible**.

How your PCP or physician office visit cost share works

You will pay the **PCP** cost share when you get **covered services** from any **PCP**.

How your maximum out-of-pocket works

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

Contact us

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

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

Plan features

Deductible

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

Deductible type	In-network	Out-of-network	Other health care
Individual	$1,500 per year	$1,500 per year	$1,500 per year
Family	$3,000 per year	$3,000 per year	$3,000 per year

Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	In-network	Out-of-network	Other health care
Individual	$4,500 per year	$7,500 per year	$4,500 per year
Family	$9,000 per year	$15,000 per year	$9,000 per year

For the HealthFund amount:

- The individual amounts apply to a person enrolled for self-only coverage with no dependent coverage
- The family amounts apply to a person enrolled with one or more dependents

Annual HealthFund amount

HealthFund amount	Amount
Individual	$1,250 per year
Family	$2,500 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 **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 the dollar amount you pay for **covered services**. In most plans, you pay this after you meet your **deductible** limit.

Payment Percentage
This is the percentage of the bill you pay after you meet your **deductible**.

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**.

Covered services apply to the in-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 booklet and the schedule
- Charges, expenses or costs in excess of the **recognized charge**
- Costs for non-emergency use of the emergency room
- All expenses related to Infertility services
- Charges, expenses or costs for any services administered by third-party vendor Lantern Care

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

Abortion

Description	In-network	Out-of-network	Other health care
Abortion	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Acupuncture

Description	In-network	Out-of-network	Other health care
Acupuncture	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Ambulance services

Description	In-network	Out-of-network	Other health care
Emergency services	90% per trip after **deductible**	90% per trip after **deductible**	Paid same as in-network
Non-**emergency services** ground, air, or water ambulance	Not covered	Not covered	Not covered

Applied behavior analysis

Description	In-network	Out-of-network	Other health care
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	Covered based on type of service and where it is received

Autism spectrum disorder

Description	In-network	Out-of-network	Other health care
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	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	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	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	Other health care
Inpatient services-**room and board** including **residential treatment facility**	90% per admission after **deductible**	70% per admission after **deductible**	80% per admission after **deductible**
Other inpatient services and supplies Other **residential treatment facility** services and supplies	90% per admission after **deductible**	70% per admission after **deductible**	80% per admission after **deductible**

Description	In-network	Out-of-network	Other health care
Outpatient office visit to a **physician** or **behavioral health provider**	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**
Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received

Description	In-network	Out-of-network	Other health care
Telemedicine provider/vendor (e.g. Teladoc) **mental health disorders** consultation	Covered based on type of service and **provider** from which it is received	Not covered	Not covered
Telemedicine cognitive therapy **mental health disorders** consultation by a **telemedicine provider**/vendor (e.g. Teladoc)	Covered based on type of service and **provider** from which it is received	Not covered	Not covered

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	Other health care
Inpatient services-**room and board** during a **hospital stay**	90% per admission after **deductible**	70% per admission after **deductible**	80% per admission after **deductible**
Other inpatient services and supplies during a **hospital stay**	90% per admission after **deductible**	70% per admission after **deductible**	80% per admission after **deductible**

Description	In-network	Out-of-network	Other health care
Outpatient office visit to a **physician** or **behavioral health provider**	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received

Description	In-network	Out-of-network	Other health care
Telemedicine provider/vendor (e.g. Teladoc) **substance related disorders** consultation	Covered based on type of service and **provider** from which it is received	Not covered	Not covered
Telemedicine cognitive therapy **substance related disorders** consultation by a **telemedicine provider**/vendor (e.g. Teladoc)	Covered based on type of service and **provider** from which it is received	Not covered	Not covered

Clinical trials

Description	In-network	Out-of- network	Other health care
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	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	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	Other health care
Diabetic services	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic supplies	$35 monthly cap then the plan pays 100%, no **deductible** applies	Covered based on type of service and where it is received	$35 monthly cap then the plan pays 100%, no **deductible** applies
Diabetic equipment	$35 monthly cap then the plan pays 100%, no **deductible** applies	Covered based on type of service and where it is received	$35 monthly cap then the plan pays 100%, no **deductible** applies
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	Covered based on type of service and where it is received
Solera Diabetes Prevention programs	100%, no **deductible** applies	Not covered	100%, no **deductible** applies
YMCA Diabetes Preventive Program	100%, no **deductible** applies	Not covered	100%, no **deductible** applies

Durable medical equipment (DME)

Description	In-network	Out-of-network	Other health care
DME	90% per item after **deductible**	70% per item after **deductible**	80% per item after **deductible**
Insulin pumps	100% per item, no **deductible** applies	Not covered	100% per item, no **deductible** applies

Emergency services

Description	In-network	Out-of-network	Other health care
Emergency room	90% per visit after **deductible**	Paid same as in-network	Paid same as in-network
Non-emergency care in a **hospital** emergency room	Not covered	Not covered	Not covered

Emergency services important note: Out-of-network providers do not have a contract with us. However, for out of network emergencies the federal No Surprises Act applies. 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.

Hearing aids

Description	In-network	Out-of-network	Other health care
Hearing aids	90% per item after **deductible**	70% per item after **deductible**	80% per item after **deductible**
Age limit	Covered persons through age 23	Covered persons through age 23	Covered persons through age 23
Limit One hearing aid for growth within 36 months period is allowed	One per ear every 3 years	One per ear every 3 years	One per ear every 3 years

Hearing exams

Description	In-network	Out-of-network	Other health care
Hearing exams	Covered based on type of service and where it is received	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	1 visit every 12 months

Home health care

A visit is a period of 4 hours or less

Description	In-network	Out-of-network	Other health care
Home health care	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**
Visit limit per year This limit is combined with the Private duty nursing visit/shift limit per year.	240	240	240

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

Hospice care

Description	In-network	Out-of-network	Other health care
Inpatient services - **room and board**	90% after **deductible**	70% after **deductible**	80% after **deductible**
Other inpatient services and supplies	90% per admission after **deductible**	70% after **deductible**	80% per admission after **deductible**

Description	In-network	Out-of-network	Other health care
Outpatient services	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**
Limit per lifetime	unlimited	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	Other health care
Inpatient services – **room and board**	90% after **deductible**	70% after **deductible**	80% after **deductible**
Other inpatient services and supplies	90% per admission after **deductible**	70% per admission after **deductible**	80% per admission after **deductible**

Infertility services

Basic infertility

Description	In-network	Out-of-network	Other health care
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	Covered based on type of service and where it is received

Advanced reproductive technology (ART)

Description	In-network	Out-of-network	Other health care
Outpatient services performed at ART **specialist** office	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Services performed at **hospital** outpatient department	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Services performed at a facility other than a **hospital** outpatient department	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Fertility preservation	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Limits

Description	In-network	Out-of-network	Other health care
Limit per lifetime	$30,000 Combined for in-network and out-of-network benefits	$30,000 Combined for in-network and out-of-network benefits	$30,000 Combined for in-network and out-of-network benefits

Institutes of Quality – Orthopedic Surgery

Description	In network (IOQ Facility)	In network (Non-IOQ Facility)	Out-of-network
Inpatient	90% per admission after **deductible**	90% per visit after **deductible**	Not Covered
Outpatient	90% per visit after **deductible**	90% per visit after **deductible**	Not Covered
Precertification may be required			
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Maternity and related newborn care

Includes complications

Description	In-network	Out-of-network	Other health care
Inpatient services – **room and board**	90% per admission after **deductible**	70% per admission after **deductible**	80% per admission after **deductible**
Other inpatient services and supplies	90% per admission after **deductible**	70% per admission after **deductible**	80% per admission after **deductible**
Services performed in **physician** or **specialist** office or a facility	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**
Other services and supplies	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**

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

Nutritional support

Description	In-network	Out-of-network	Other health care
Nutritional support	Covered based on type of service and where it is received	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	Other health care
Inpatient services – **room and board**	90% per admission after **deductible**	70% per admission after **deductible**	80% per admission after **deductible**
Other inpatient services and supplies	90% per admission after **deductible**	70% per admission after **deductible**	80% per admission after **deductible**

Description	In-network	Out-of-network	Other health care
Outpatient services	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	In-network	Out-of-network	Other health care
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	Covered based on type of service and where it is received

Outpatient surgery

Description	In-network	Out-of-network	Other health care
At **hospital** outpatient department	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**
At facility that is not a **hospital**	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**
At the **physician** office	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Physician and specialist services

Physician services-general or family practitioner

Including surgical services

Description	In-network	Out-of-network	Other health care
Physician office hours (not surgical, not preventive)	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**
Physician surgical services	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**

Description	In-network	Out-of-network	Other health care
Physician visit during inpatient **stay**	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**

Description	In-network	Out-of-network	Other health care
Physician telemedicine consultation	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**

Description	In-network	Out-of-network	Other health care
Telemedicine provider/vendor (e.g. Teladoc) consultation Basic medical services	Covered based on type of service and **provider** from which it is received	Not covered	Not covered

Specialist

Description	In-network	Out-of-network	Other health care
Specialist office hours (not-surgical, not preventive)	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**
Specialist surgical services	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**

Description	In-network	Out-of-network	Other health care
Specialist telemedicine consultation	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**

Description	In-network	Out-of-network	Other health care
Telemedicine provider/vendor (e.g. Teladoc) consultation **Specialist** services	Covered based on type of service and **provider** from which it is received	Not covered	Not covered

All other services not shown above

Description	In-network	Out-of-network	Other health care
All other services	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**

Preventive care

Description	In-network	Out-of-network	Other health care
Preventive care services	100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies.
Breast feeding counseling and support	100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Breast feeding counseling and support limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** or **specialist** services office visit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** or **specialist** services office visit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** or **specialist** services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 per birth Manual pump: 1 per birth Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 per birth Manual pump: 1 per birth Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 per birth Manual pump: 1 per birth Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 12 months to replace an existing electric pump	Electric pump: 12 months to replace an existing electric pump	Electric pump: 12 months to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Counseling for alcohol or drug misuse visit limit	5 visits/12 months	5 visits/12 months	5 visits/12 months
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.

Counseling for sexually transmitted infection	100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Counseling for sexually transmitted infection visit limit	2 visits/12 months	2 visits/12 months	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Counseling for tobacco cessation visit limit	8 visits/12 months	8 visits/12 months	8 visits/12 months
Family planning services (female contraception counseling)	100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
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	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting
Immunizations	100%, no **deductible** applies	70% after **deductible**	100%, no **deductible** applies
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	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**
Generic preventive care female contraceptives (birth control)	100%	100%	100%
Preventive care drugs and supplements	100%	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 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 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 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%	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 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 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 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%	100%
Limit	Two 90 day treatments only	Two 90 day treatments only	Two 90 day treatments only
Routine cancer screenings	100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section	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	100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Routine lung cancer screening limit	1 screening every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing	1 screening every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing	1 screening every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months
Well woman GYN exam	100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration	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 8 hours equals one shift

Description	In-network	Out-of-network	Other health care
Outpatient services	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**
Visit/shift limit per year This limit is combined with the Home health care visit limit per year.	240	240	240

Prosthetic devices

Description	In-network	Out-of-network	Other health care
Prosthetic devices	90% per item after **deductible**	70% per item after **deductible**	80% per item after **deductible**
Wigs limit	1 per year up to $1,000 maximum	1 per year up to $1,000 maximum	1 per year up to $1,000 maximum
Cooling Caps for Chemotherapy Patients limit	$1,000 per year	$1,000 per year	$1,000 per year

Reconstructive surgery and supplies

Including breast **surgery**

Description	In-network	Out-of-network	Other health care
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	Covered based on type of service and where it is received

Short-term rehabilitation services

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

Cardiac rehabilitation

Description	In-network	Out-of-network	Other health care
Cardiac rehabilitation	Covered based on type of service and where it is received	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	Other health care
Pulmonary rehabilitation	Covered based on type of service and where it is received	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	Other health care
Cognitive rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Physical and occupational therapies

Description	In-network	Out-of-network	Other health care
	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**

Speech therapy (ST)

Description	In-network	Out-of-network	Other health care
	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**

Spinal manipulation

Description	In-network	Out-of-network	Other health care
	90% per visit after **deductible**	75% per visit after **deductible**	80% per visit after **deductible**

Visit limit per year In-network and out-of-network combined	30	30	30
Visit limit for services billed for back pain	Not applicable	Not applicable	Not applicable

Skilled nursing facility

Description	In-network	Out-of-network	Other health care
Inpatient services - **room and board**	90% per admission after **deductible**	70% per admission after **deductible**	80% per admission after **deductible**
Other inpatient services and supplies	90% per admission after **deductible**	70% per admission after **deductible**	80% per admission after **deductible**

Day limit per year	120	120	120

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network	Out-of-network	Other health care
	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**

Diagnostic lab work

Description	In-network	Out-of-network	Other health care
	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network	Other health care
	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**

Therapies

Chemotherapy

Description	In-network	Out-of-network	Other health care
Chemotherapy services	Covered based on type of service and where it is received	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
Gene therapy products, **prescription** drugs	90% after **deductible**	Not covered

Infusion therapy

Outpatient services

Description	In-network	Out-of-network	Other health care
In **physician** office	90% per visit after **deductible**	70% per visit after **deductible**	80% 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	Covered based on type of service and where it is received
In the home	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**
At **hospital** outpatient department	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**
At facility that is not a **hospital**	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**

Radiation therapy

Description	In-network	Out-of-network	Other health care
Radiation therapy	Covered based on type of service and where it is received	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	Other health care
Respiratory therapy	Covered based on type of service and where it is received	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	90% per transplant after **deductible**	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	Other health care
Urgent care facility	90% per visit after **deductible**	70% per visit after **deductible**	80% 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	In-network	Out-of-network	Other health care
Non-**emergency services**	90% per visit after **deductible**	70% per visit after **deductible**	80% per visit after **deductible**
Preventive care immunizations	100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Preventive care immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Preventive screening and counseling services	100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Preventive screening and counseling limits	See the *Preventive care* section of the schedule	See the *Preventive care* section of the schedule	See the *Preventive care* section of the schedule