Schedule of benefits

Prepared for:

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Schedule of benefits:	2A
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Third Party Administrative Services provided by Aetna Life Insurance Company

Schedule of benefits

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

How your cost share works

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

  See the schedule 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.

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**.

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

Precertification covered services reduction

This only applies to out-of-network **covered services**:
Your booklet 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 results in the following benefit reduction:

- A 50% **payment percentage** reduction applied separately to the benefit provided for each **covered service**

You may have to pay an additional portion of the **recognized charge** 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**, if you have one.

General coverage provisions

This section explains the limitations listed in this schedule.

Copayment

This is the dollar amount you pay for **covered services**. In most plans, you pay this after you meet your **deductible** limit. In **prescription** drug plans, it is the amount you pay for covered drugs.

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**. The **maximum out-of-pocket limit** is unlimited.

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
Abortion	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
Acupuncture	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Visit limit per year	12	12

Ambulance services

Description	In-network	Out-of-network
Emergency services	100% per trip, no **deductible** applies	Paid same as in-network
Medically necessary non-**emergency services, such as transport to or from home or another facility, when precertified**	100% per trip, no **deductible** applies	100% per trip, no **deductible** applies
Not medically necessary non-emergency services, such as routine transportation	Not covered	Not covered

Applied behavior analysis

Description	In-network	Out-of-network
Applied behavior analysis	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Autism spectrum disorder

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

Behavioral health

Mental health treatment

Coverage provided is the same as for any other illness

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

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	100% per visit, no **deductible** applies	100% per visit, no **deductible applies**
Physician or **behavioral health provider telemedicine** consultation	100% per visit, no **deductible** applies	100% per visit , no **deductible applies**
Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received

Description	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	100% per visit, no **deductible** applies	100% per visit, no **deductible applies**

Description	In-network	Out-of-network
Telemedicine provider mental health disorders consultation	Covered based on type of service and **provider** from which it is received	Not covered
Telemedicine cognitive therapy **mental health disorders** consultation by a **telemedicine provider**	Covered based on type of service and **provider** from which it is received	Not covered

Substance related disorders treatment

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

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

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	100% per visit, no **deductible** applies	100% per visit, no **deductible applies**

Physician or **behavioral health provider telemedicine** consultation	100% per visit, no **deductible** applies	100% per visit, no **deductible applies**
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received

Description	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	100% per visit, no **deductible** applies	100% per visit, no **deductible applies**

Description	In-network	Out-of-network
Telemedicine provider substance related disorders consultation	Covered based on type of service and **provider** from which it is received	Not covered
Telemedicine cognitive therapy **substance related disorders** consultation by a **telemedicine provider**	Covered based on type of service and **provider** from which it is received	Not covered

Clinical trials

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

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

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

Durable medical equipment (DME)

Description	In-network	Out-of-network
DME	100% per item, no **deductible** applies	100% per item , no **deductible applies**

Emergency services

Description	In-network	Out-of-network
Emergency room	100% per visit, no **deductible** applies	Paid same as in-network
Non-emergency care in a **hospital** emergency room	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies

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.

Foot orthotic devices

Description	In-network	Out-of-network
Orthotic devices	100% per item, no **deductible** applies	100% per item, no **deductible applies**

Habilitation therapy services

Outpatient 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

Outpatient speech therapy (ST)

Description	In-network	Out-of-network
ST 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	100% per item, no **deductible** applies	100% per item, no **deductible** applies
Limit	$3,000 every 36 months	$3,000 every 36 months

Hearing exams

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

Home health care

A visit is a period of 4 hours or less

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

Home health care important note:

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

Hospice care

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

Description	In-network	Out-of-network
Outpatient services	100% per visit, no **deductible** applies	100% per visit, no **deductible applies**
Limit per lifetime	unlimited	unlimited

Hospice important note:

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

Hospital care

Description	In-network	Out-of-network
Inpatient services – **room and board**	100%, no **deductible** applies	100%, no **deductible applies**

Description	In-network	Out-of-network
Other inpatient services and supplies	100% per admission, no **deductible** applies	100% per admission, no **deductible applies**

Infertility services

Basic infertility

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

Advanced reproductive technology (ART)

Description	In-network	Out-of-network
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
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
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
Fertility preservation	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
Limit per lifetime	$20,000 Combined for in-network and out-of-network benefits	$20,000 Combined for in-network and out-of-network benefits

Maternity and related newborn care

Includes complications

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

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
Nutritional support	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Obesity surgery

Description	In-network	Out-of-network
Inpatient services – **room and board**	80% per admission, no **deductible** applies	80% per admission, no **deductible applies**
Other inpatient services and supplies	80% per admission, no **deductible** applies	80% per admission, no **deductible applies**

Description	In-network	Out-of-network
Outpatient services	80% per visit, no **deductible** applies	80% per visit, no **deductible applies**

Limit per lifetime	$10,000	$10,000

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	In-network	Out-of-network
Treatment of mouth, jaws and teeth	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Outpatient surgery

Description	In-network	Out-of-network
At **hospital** outpatient department	100% per visit, no **deductible** applies	100% per visit, no **deductible applies**
At facility that is not a **hospital**	100% per visit, no **deductible** applies	100% per visit, no **deductible applies**
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

Physician and specialist services

Physician services-general or family practitioner

Including surgical services

Description	In-network	Out-of-network
Physician office hours (not-surgical, not preventive)	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Physician surgical services	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies

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

Description	In-network	Out-of-network
Physician telemedicine consultation	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies

Description	In-network	Out-of-network
Telemedicine provider consultation Basic medical services	Covered based on type of service and **provider** from which it is received	Not covered

Specialist

Description	In-network	Out-of-network
Specialist office hours (not-surgical, not preventive)	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Specialist surgical services	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies

Description	In-network	Out-of-network
Specialist telemedicine consultation	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies

Description	In-network	Out-of-network
Telemedicine provider consultation **Specialist** services	Covered based on type of service and **provider** from which it is received	Not covered

All other services not shown above

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

Prescription drugs – outpatient

Generic prescription drugs(including specialty drugs)

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	$0, no **deductible** applies	$0 then the plan pays 100%, no **deductible** applies
90 day supply at a **retail pharmacy**	$0, no **deductible** applies	$0 then the plan pays 100%, no **deductible** applies
90 day supply at a **mail order pharmacy**	$0, no **deductible** applies	Not covered
*Specialty drugs – each prescription is limited to a maximum of 30-day supply		

Preferred brand-name prescription drugs (including specialty drugs*)

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	$0, no **deductible** applies	$0 then the plan pays 100%, no **deductible** applies
90 day supply at a **retail pharmacy**	$0, no **deductible** applies	$0 then the plan pays 100%, no **deductible** applies
90 day supply at a **mail order pharmacy**	$0, no **deductible** applies	Not covered
*Specialty drugs – each prescription is limited to a maximum of 30-day supply		

Non-preferred brand-name prescription drugs (including specialty drugs*)

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	$0, no **deductible** applies	$0 then the plan pays 100%, no **deductible** applies
90 day supply at a **retail pharmacy**	$0, no **deductible** applies	$0 then the plan pays 100%, no **deductible** applies
90 day supply at a **mail order pharmacy**	$0, no **deductible** applies	Not covered
*Specialty drugs – each prescription is limited to a maximum of 30-day supply		

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 supply or 12 month supply of generic and OTC drugs and devices	$0, no **deductible** applies	Paid based on the tier of drug in the schedule
30 day supply or 12 month supply of **brand-name prescription drugs** and devices	Paid based on the tier of drug in the schedule	Paid based on the tier of drug in the schedule

Infertility drugs

Description	In-network	Out-of-network
Infertility drugs	Paid based on the tier of drug in the schedule	Paid based on the tier of drug in the schedule

Weight loss drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	Paid based on the tier of drug in the schedule	Paid based on the tier of drug in the schedule
90 day supply at a **mail order pharmacy**	Paid based on the tier of drug in the schedule	Not covered

Preventive care drugs and supplements

Description	In-network	Out-of-network
Preventive care drugs and supplements	$0, no **deductible** applies	Paid based on the tier of drug in the schedule
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 prescription drugs

Description	In-network	Out-of-network
Risk reducing breast cancer **prescription** drugs	$0, no **deductible** applies	Paid based on the tier of drug in the schedule
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 prescription and OTC drugs (preventive care)

Description	In-network	Out-of-network
Tobacco cessation **prescription** and OTC drugs	$0, no **deductible** applies for the first two 90-day treatment programs. Additional treatment programs will be paid based on the tier of drug in the schedule.	Paid based on the tier of drug in the schedule
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section. See the *Other services* section of this schedule for more information.	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.

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 share that applies to the brand-name drug plus the cost difference between the generic drug and the brand-name drug.

Preventive care

Description	In-network	Out-of-network
Breast feeding counseling and support	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Breast feeding counseling and support limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 every 3 years Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 every 3 years Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 3 years to replace an existing electric pump	Electric pump: 3 years to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Counseling for alcohol or drug misuse visit limit	5 visits/12 months	5 visits/12 months
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Counseling for sexually transmitted infection visit limit	2 visits/12 months	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Counseling for tobacco cessation visit limit	8 visits/12 months	8 visits/12 months
Family planning services (female contraception counseling)	100% per visit, no **deductible** applies	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
Immunizations	100%, no **deductible** applies	100% 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 physical exam	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam per year 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 per year 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	100% per visit, no **deductible** applies
Well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

Private duty nursing

Up to 8 hours equals one shift

Description	In-network	Out-of-network
Outpatient services	100% per visit, no **deductible** applies	80% per visit, no **deductible applies**

Visit/shift limit per year	70	70

Prosthetic devices

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

Reconstructive surgery and supplies

Including breast **surgery**

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

Routine cancer screenings

Description	In-network	Out-of-network
Colonoscopy	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Digital rectal examination (DRE)	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Double contrast barium enemas (DCBE)	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Fecal occult blood test (FOBT)	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Mammogram	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Prostate specific antigen (PSA) test	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Sigmoidoscopy	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section
Lung cancer screening	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Limit	1 screening every 12 months Screenings that exceed this limit are covered as outpatient diagnostic testing	1 screening every 12 months Screenings that exceed this limit are covered as outpatient diagnostic testing

Short-term rehabilitation services

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

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

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

Physical, occupational, speech and massage therapies

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

Physical, occupational, speech and massage therapies

Description	In-network	Out-of-network
Visit limit per year Physical, occupational and speech therapies combined In-network and out-of-network combined	45	45

Spinal manipulation

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

Skilled nursing facility

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

Tests, images and labs – outpatient

Diagnostic complex imaging services

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

Diagnostic lab work

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

Diagnostic x-ray and other radiological services

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

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
Gene therapy products, **prescription** drugs	100%, no **deductible** applies	Not covered

Infusion therapy

Outpatient services

Description	In-network	Out-of-network
In **physician** office	Covered based on type of service and where it is received	Covered based on type of service and where it is received
At an infusion location	Covered based on type of service and where it is received	Covered based on type of service and where it is received
In the home	Covered based on type of service and where it is received	Covered based on type of service and where it is received
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
At facility that is not a **hospital**	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 (IOE facility)	Out-of-network (Includes **providers** who are otherwise part of Aetna's network but are non-IOE **providers**)
Inpatient services and supplies	100% per transplant, no **deductible** applies	100% per transplant, no **deductible** applies
Physician services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Urgent care services

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

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

Description	In-network	Out-of- network
Urgent care facility	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies

Walk-in clinic

Description	In-network	Out-of-network
Non-**emergency services**	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Preventive care immunizations	100% per visit, no **deductible** applies	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**