# Schedule of benefits

**Prepared for:**

| | |
|---|---|
| Employer: | The City of Seattle |
| Control number: | 0187731 |
| Contract number: | ASC-0100290 |
| Plan name: | Choice POS II - Local 77 Employees Preventive Plan |
| Schedule of benefits: | 7A |
| Plan effective date: | January 1, 2023 |
| Plan issue date: | March 31, 2023 |

**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. The *Surprise bill* section in the booklet explains your protections from a surprise bill.

Under this plan, you will:

1. Pay your **copayment**
2. Then pay any remaining **deductible**
3. Then pay your **payment percentage**

Your **copayment** does not apply to any **deductible**.

### How your deductible works

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **copayment** or **payment percentage** you pay when you get **covered services** from an in-network, **out-of-network provider**. This schedule 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 |
|---|---|---|
| Individual | $0 per year | $250 per year |
| Family | $0 per year | $750 per year |

| Common Accident Deductible | | |
|---|---|---|
| **Deductible type** | **In-network** | **Out-of-network** |
| Common Accident Deductible | $0 per year | $250 per year |

### Deductible and cost share waiver for risk reducing breast cancer prescription drugs

The **prescription** drug **deductible** and per **prescription** cost share will not apply to risk reducing breast cancer **prescription** drugs when obtained at a network pharmacy. This means they will be paid at 100%.

### Deductible and cost share waiver for contraceptives (birth control)

The **prescription** drug **deductible** and per **prescription** cost share will not apply to female contraceptive methods when obtained at a network pharmacy. This means they will be paid at 100%. This includes certain OTC and generic contraceptive **prescription** drugs and devices for each of the methods identified by the FDA. If a **generic prescription drug** is not available, the **brand-name prescription drug** for that method will be paid at 100%.

The **prescription** drug **deductible** and cost share will apply to **prescription** drugs that have a generic equivalent or alternative available within the same therapeutic drug class obtained at a network pharmacy unless we approve a medical exception. A therapeutic drug class is a group of drugs or medications that have a similar or identical mode of action or are used for the treatment of the same or similar disease or injury.

## Deductible and cost share waiver for tobacco cessation prescription and OTC drugs

The **prescription** drug **deductible** and the per **prescription** cost share will not apply to the first two 90-day treatment programs for tobacco cessation **prescription** and OTC drugs when obtained at a network **retail pharmacy**. This means they will be paid at 100%. Your per **prescription** cost share will apply after those two programs have been exhausted.

## Maximum out-of-pocket limit

Includes the **deductible**.

| Maximum out-of-pocket type | In-network | Out-of-network |
|---|---|---|
| Individual | $500 per year | $3,250 per year |
| Family | $1,000 per year | $6,500 per year |

## Outpatient prescription drug maximum out-of-pocket limit

| | |
|---|---|
| Individual | $1,200 per year |
| Family | $3,600 per year |

# General coverage provisions

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

## Deductible provisions

Out-of-network **covered services** will apply only to the out-of-network **deductible**.

The **deductible** may not apply to some **covered services**. You still pay the **copayment** or **payment percentage**, if any, for these **covered services**.

### Individual deductible

You pay for **covered services** each year before the plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. After the amount paid reaches the individual **deductible**, this plan starts to pay for **covered services** for the rest of the year.

### Family deductible

You pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this family **deductible**, this plan starts to pay for **covered services** for the rest of the year. To satisfy this family **deductible** for the rest of the year, the combined **covered services** that you and each of your covered dependents incur toward the individual **deductible** must reach this family **deductible** in a year. When this happens in a year, the individual **deductibles** for you and your covered dependents are met for the rest of the year.

| **Common Accident Deductible** |
| --- |
| This limit applies when two or more family members are injured in the same accident. The common accident deductible limit places a limit on your **deductible** expenses when covered expenses are applied toward the separate Calendar Year **deductibles**. When this occurs, and all covered expenses related to the accident in that Calendar Year exceed the common accident deductible limit, your plan will then pay the excess amount based on the plan **payment percentage**. The added benefit will be reduced by any family deductible limit benefit amount paid for the same covered expenses. |
| |

## Deductible carryover

Any amounts that you paid for **covered services** in the last 90 days of a year that apply toward that year's **deductible** will also count toward the following year's **deductible**.

## 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**.

**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**

## 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.

## Outpatient prescription drug maximum out-of-pocket limit provisions

**Covered services** that are subject to the **maximum out-of-pocket limit** include **covered services** provided under the medical plan and the **prescription** drug plan.

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**. This plan may have an individual and family **maximum out-of-pocket limit**.

For purposes of the following **maximum out-of-pocket limit** provisions:

- The individual **maximum out-of-pocket limit** applies to a person enrolled for self-only coverage with no dependent coverage
- The family **maximum out-of-pocket limit** applies to a person enrolled with one or more dependents
- The family **maximum out-of-pocket limit** is met by a combination of family members or by any single individual within the family

### Individual prescription drug maximum out-of-pocket limit

Once the amount of the cost share 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**

To satisfy this family **maximum out-of-pocket limit** for the rest of the year, the following must happen:

- 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.

When this happens, the individual **maximum out-of-pocket limit** is also met for the rest of the 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**.

Certain costs that you have do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-**covered services**

## Covered services

### Acupuncture

| Description | In-network | Out-of-network |
|---|---|---|
| Acupuncture | $10 then the plan pays 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| All acupuncture services are subject to ongoing review and approval by Aetna for medical necessity | | |

### Ambulance services

| Description | In-network | Out-of-network |
|---|---|---|
| **Emergency services** | 100% per trip, no **deductible** applies | Paid same as in-network |
| **Description** | **In-network** | **Out-of-network** |
| Non-emergency services | 100% per trip, no **deductible** applies | 100% per trip, no **deductible** applies |

### Applied behavior analysis

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

### Autism spectrum disorder

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

## Behavioral health

### Mental health treatment

Coverage provided is the same as for any other illness

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

| Description | In-network | Out-of-network |
|---|---|---|
| Outpatient office visit to a **physician** or **behavioral health provider** | $10 then the plan pays 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| **Physician** or **behavioral health provider telemedicine** consultation | $10 then the plan pays 100% per visit, no **deductible** applies | 70% 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 |

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

### Substance related disorders treatment

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

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

| Description | In-network | Out-of-network |
|---|---|---|
| Outpatient office visit to a **physician** or **behavioral health provider** | $10 then the plan pays 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| **Physician** or **behavioral health provider telemedicine** consultation | $10 then the plan pays 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider** | 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:<br>• Behavioral health services in the home<br>• Partial hospitalization treatment<br>• Intensive outpatient program<br><br>The cost share doesn't apply to in-network peer counseling support services | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |

## Clinical trials

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

## Durable medical equipment (DME)

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

## Emergency services

| Description | In-network | Out-of-network |
|---|---|---|
| Emergency room | $50 then the plan pays 100% per visit, no **deductible** applies | Paid same as in-network |
| Non-emergency care in a **hospital** emergency room | $50 then the plan pays 100% per visit, no **deductible** applies | $50 then the plan pays 70% 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 | 70% per item after **deductible** |
| Lifetime maximum limit | $500 | $500 |

## Habilitation therapy services

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

| Description | In-network | Out-of-network |
|---|---|---|
| PT, OT therapies | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

### Speech therapy (ST)

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

## Hearing aids

| Description | In-network | Out-of-network |
|---|---|---|
| Hearing aids | 100% per item , no **deductible** applies | 100% per item after **deductible** |
| Limit | One per ear every 36 months | One per ear every 36 months |
| Limit | $1,000 | $1,000 |

## Hearing exams

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

## Home health care

A visit is a period of 4 hours or less

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

| | | |
|---|---|---|
| Visit limit per year | 130 | 130 |

**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 | Not covered |

| Description | In-network | Out-of-network |
|---|---|---|
| Outpatient services | 100% per visit, no **deductible** applies | Not covered |

| | | |
|---|---|---|
| Maximum Benefit (inpatient and outpatient combined) | 6 months, 6 additional months if authorized | Not covered |
| Respite Care Maximum | 10 days in a 6 consecutive month period | Not covered |

**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 | 70% after **deductible** |
| Outpatient **hospital** | 100%, no **deductible** applies | 70% per visit after **deductible** |

## Infertility services

**Basic infertility**

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

## Maternity and related newborn care

Includes complications

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

**Maternity and related newborn care important note:**
Any cost share collected applies only to the delivery and postpartum care services provided by an OB, GYN or OB/GYN. Review the *Maternity* section of the 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 |

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

| Description | In-network | Out-of-network |
|---|---|---|
| Orthodontic treatment directly related to an orthognathic surgical procedure | 100% per visit, no **deductible** applies | 100% per visit, no **deductible** applies |
| Orthodontic treatment directly related to an orthognathic surgical procedure Lifetime Maximum | $10,000 | $10,000 |
| All other Oral and maxillofacial treatment (mouth, jaws and teeth) | 100% per visit, no **deductible** applies | 70% after **deductible** |
| Accidental injury treatment Maximum Benefit | $600 per occurrence | $600 per occurrence |

## Outpatient prescription drugs

### Generic prescription drugs

| Description | In-network | Out-of-network |
|---|---|---|
| 34 day supply or 100 unit doses, whichever is greater at a **retail pharmacy** | $10, no **deductible** applies | Not covered |
| 90 day supply or 300 unit doses, whichever is greater at a **mail order pharmacy** | $20, no **deductible** applies | Not covered |

### Preferred brand-name prescription drugs

| Description | In-network | Out-of-network |
|---|---|---|
| 34 day supply or 100 unit doses, whichever is greater at a **retail pharmacy** | $20, no **deductible** applies | Not covered |
| 90 day supply or 300 unit doses, whichever is greater at a **mail order pharmacy** | $40, no **deductible** applies | Not covered |

### Non-preferred brand-name prescription drugs

| Description | In-network | Out-of-network |
|---|---|---|
| 34 day supply or 100 unit doses, whichever is greater at a **retail pharmacy** | $40, no **deductible** applies | Not covered |
| 90 day supply or 300 unit doses, whichever is greater at a **mail order pharmacy** | $80, no **deductible** applies | Not covered |

### 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 |
|---|---|---|
| 34 day supply or 100 unit doses, whichever is greater of generic and OTC drugs and devices | $0, no **deductible** applies | Not covered |
| 34 day supply or 100 unit doses, whichever is greater of **brand-name prescription drugs** and devices | 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 | Not covered |
| Limits | Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF)<br><br>For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section | Not covered |

**Risk reducing breast cancer drugs**

| Description | In-network | Out-of-network |
|---|---|---|
| Risk reducing breast cancer **prescription** drugs | $0, no **deductible** applies | Not covered |
| Limits | Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF)<br><br>For a current list of risk reducing breast cancer drugs or more information, see the *Contact us* section | Not covered |

**Tobacco cessation drugs**

| Description | In-network | Out-of-network |
|---|---|---|
| Tobacco cessation **prescription** and OTC drugs | $0, no **deductible** applies | Not covered |
| Limits | Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF.<br><br>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. | Not covered |

## Outpatient surgery

| Description | In-network | Out-of-network |
|---|---|---|
| At **hospital** outpatient department | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| At facility that is not a **hospital** | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| 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

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

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

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

## Specialist

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

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

## All other services not shown above

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

## Preventive care

| Description | In-network | Out-of-network |
|---|---|---|
| Preventive care services | 100% per visit, no **deductible** applies | Not covered |
| Breast feeding counseling and support | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| Breast feeding counseling and support limit | 6 visits in a group or individual setting<br><br>Visits that exceed the limit are covered under the **physician** services office visit | 6 visits in a group or individual setting<br><br>Visits that exceed the limit are covered under the **physician** services office visit |
| Breast pump, accessories and supplies limit | Electric pump: 1 every 1 year<br><br>Manual pump: 1 per pregnancy<br><br>Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump | Electric pump: 1 every 1 year<br><br>Manual pump: 1 per pregnancy<br><br>Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump |
| Breast pump waiting period | Electric pump: 1 year to replace an existing electric pump | Electric pump: 1 year to replace an existing electric pump |
| Counseling for alcohol or drug misuse | 100% per visit, no **deductible** applies | Not covered |
| Counseling for alcohol or drug misuse visit limit | 5 visits/12 months | Not covered |
| Counseling for obesity, healthy diet | 100% per visit, no **deductible** applies | Not covered |
| Counseling for obesity, healthy diet visit limit | Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling. | Not covered. |
| Counseling for sexually transmitted infection | 100% per visit, no **deductible** applies | Not covered |
| Counseling for sexually transmitted infection visit limit | 2 visits/12 months | Not covered |
| Counseling for tobacco cessation | 100% per visit, no **deductible** applies | Not covered |
| Counseling for tobacco cessation visit limit | 8 visits/12 months | Not covered |
| Family planning services (female contraception counseling) | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| Family planning services (female contraception counseling) limit | Contraceptive counseling limited to 2 visits/12 months in a group or individual setting<br><br>Counseling's that exceed this limit are covered as a **physician** services office visit | Contraceptive counseling limited to 2 visits/12 months in a group or individual setting<br><br>Counseling's that exceed this limit are covered as a **physician** services office visit |
| Abortion Outpatient | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| Immunizations | 100%, no **deductible** applies | Not covered |

| | | |
|---|---|---|
| Immunizations limit | Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention<br><br>For details, contact your **physician** | Not covered |
| Mammograms | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| Mammogram limit | Subject to any age, family history and frequency guidelines as set forth in the most current:<br>Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF<br><br>The comprehensive guidelines supported by the Health Resources and Services Administration<br><br>For more information contact your **physician** or see the *Contact us* section | Subject to any age, family history and frequency guidelines as set forth in the most current:<br>Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF<br><br>The comprehensive guidelines supported by the Health Resources and Services Administration<br><br>For more information contact your **physician** or see the *Contact us* section |
| Other routine cancer screenings | 100% per visit, no **deductible** applies | Not covered |
| Routine cancer screening limits | Subject to any age, family history and frequency guidelines as set forth in the most current:<br>Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF<br><br>The comprehensive guidelines supported by the Health Resources and Services Administration<br><br>For more information contact your **physician** or see the *Contact us* section | Not covered |
| Routine lung cancer screening | 100% per visit, no **deductible** applies | Not covered |
| Routine lung cancer screening limit | 1 screenings every 12 months<br><br>Screenings that exceed this limit covered as outpatient diagnostic testing | Not covered |
| Routine physical exam | 100% per visit, no **deductible** applies | Not covered |
| Routine physical exam limits | Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and | Not covered |

| | | |
|---|---|---|
| | adolescents<br><br>Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22<br><br>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** |
| 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 | 70% per visit after **deductible** |

## Prosthetic devices

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

## Reconstructive surgery and supplies

Including breast **surgery**

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

## Short-term rehabilitation services

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

**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 massage, occupational, cardiac, and pulmonary therapies**

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

**Speech therapy (ST)**

| | | |
|---|---|---|
| | $10 then the plan pays 100% per visit, no **deductible** applies | 70% per visit after **deductible** |

### Physical, massage occupational, cardiac, and pulmonary therapies

| Description | In-network | Out-of-network |
|---|---|---|
| Visit limit per year<br><br>All therapies combined In-network and out-of-network combined | 20 | 20 |

### Speech Therapy (ST)

| Description | In-network | Out-of-network |
|---|---|---|
| Visit limit per year<br><br>In-network and out-of-network combined | 20 | 20 |

### Spinal manipulation

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

| | | |
|---|---|---|
| Visit limit per year<br><br>In-network and out-of-network combined | 20 | 20 |

### Skilled nursing facility

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

## Tests, images and labs – outpatient

### Diagnostic complex imaging services

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

### Diagnostic lab work

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

### Diagnostic x-ray and other radiological services

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

## Therapies

### Chemotherapy

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

### Gene-based, cellular and other innovative therapies (GCIT)

| Description | In-network (GCIT-designated facility/provider) | Out-of-network (Including **providers** who are otherwise part of Aetna's network but are not GCIT-designated facilities/**providers**) |
|---|---|---|
| Services and supplies | Covered based on type of service and where it is received | Not covered |

### Infusion therapy

Outpatient services

| Description | In-network | Out-of-network |
|---|---|---|
| In **physician** office | $10 then the plan pays 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| At an infusion location | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| In the home | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| At **hospital** outpatient department | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| At facility that is not a **hospital** | 100% per visit, no **deductible** applies | 70% per visit after **deductible** |

### Radiation therapy

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

### Respiratory therapy

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

### Transplant services

| Description | In-network (IOE facility) | Out-of-network (Includes **providers** who are otherwise part of Aetna's network but are non-IOE **providers**) |
|---|---|---|
| Inpatient services and supplies | 100% per transplant, no **deductible** applies | 70% per transplant after **deductible** |
| **Physician** services | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

## Urgent care services

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

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

| Description | In-network | Out-of- network |
|---|---|---|
| Urgent care facility | $35 then the plan pays 100% per visit, no **deductible** applies | 70% 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 |
|---|---|---|
| Non-emergency services | $10 then the plan pays 100% per visit, no **deductible** applies | 70% per visit after **deductible** |
| Preventive immunizations | 100% per visit, no **deductible** applies | Not covered |
| Immunization limits | Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention<br><br>For details, contact your **physician** | Not covered |
| Screening and counseling services | 100% per visit, no **deductible** applies | Not covered |
| Screening and counseling limits | See the *Preventive care services* section of the SOB | Not covered |