Schedule of benefits

Prepared for:

Employer:	The City of Seattle
Control numbers:	0187729, 0187730
Contract number:	ASC-0100290
Plan name:	Choice POS II Most City Preventive Plan Most City Employees Fire Chiefs Police Management Seattle Housing Authority
Schedule of benefits:	1A
Plan effective date:	January 1, 2023
Plan issue date:	August 24, 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	$100 per year	$450 per year
Family	$300 per year	$1,350 per year

Common Accident Deductible		
Deductible type	**In-network**	**Out-of-network**
Common Accident Deductible	$100 per year	$450 per year

Deductible waiver
There is no in-network **deductible** for the following **covered services**:
- Preventive care
- Family planning services – female contraceptives

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.

Maximum out-of-pocket limit
Includes the **deductible**.

Maximum out-of-pocket type	In-network	Out-of-network
Individual	$2,000 per year	$3,000 per year

Maximum out-of-pocket type	In-network	Out-of-network
Family	$4,000 per year	$6,000per 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

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.

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.

Per admission copayment

This is the amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility.

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

Per admission cost share or deductible
A separate cost share or **deductible** may apply per facility. This is in addition to any other cost share or **deductible** applicable under this plan. It may apply to each **stay** or on a per day basis up to a per admission maximum amount. If you are in the same type of facility more than once, and your **stays** are separated by less than 10 days (regardless of cause), only one per admission cost share or **deductible** will apply. Not more than three per admission cost shares or **deductibles** will apply for a facility type during the year. **Covered services** applied to the per admission **deductible** can't be applied to any other **deductible** required under the plan. **Covered services** applied to the plan's other **deductible** will not apply to the per admission **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:
- Amounts paid toward the **deductible**
- **Copayments** and **coinsurance**
- 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**
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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	$15 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**

Visit limit per year	20	20

Ambulance services

Description	In-network	Out-of-network
Emergency services	90% per trip after **deductible**	Paid same as in-network
Description	**In-network**	**Out-of-network**
Non-emergency services	90% per trip after **deductible**	90% per trip after **deductible**

Applied behavior analysis

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

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**	$200 then the plan pays 90% per admission, no **deductible** applies	$200 then the plan pays 60% per admission no **deductible applies**

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	$15 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	$15 then the plan pays 100% per visit, no **deductible** applies	60% 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: • 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	60% per visit after **deductible**

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

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**	$200 then the plan pays 90% per admission, no **deductible** applies	$200 then the plan pays 60% per admission no **deductible applies**

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	$15 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	$15 then the plan pays 100% per visit, no **deductible** applies	60% 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: • 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	60% per visit after **deductible**

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

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	90% per item after **deductible**	60% per item after **deductible**

Emergency services

Description	In-network	Out-of-network
Emergency room	$150 then the plan pays 90% per visit, no **deductible** applies	Paid same as in-network

Non-emergency care in a **hospital** emergency room	$150 then the plan pays 60% per visit, no **deductible** applies	$150 then the plan pays 60% 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	60% 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	100% per visit, no **deductible** applies	60% per item after **deductible**

Speech therapy (ST)

Description	In-network	Out-of-network
ST	100% per visit, no **deductible** applies	60% per item after **deductible**

Hearing aids

Description	In-network	Out-of-network
Hearing aids	90% per item , no **deductible** applies	90% per item no **deductible applies**

Limit	One per ear every 36 months	One per ear every 36 months
Limit	$1,500	$1,500

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	90% per visit after **deductible**	60% 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**	90% after **deductible**	Not covered
Outpatient services	90% per visit after **deductible**	Not covered
Limit per lifetime	unlimited	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**	$200 then the plan pays 90% per admission, no **deductible** applies	$200 then the plan pays 60% per admission no **deductible applies**
Visit limit per year	120	120

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

Comprehensive infertility services

Description	In-network	Out-of-network
	90% per visit after **deductible**	60% per visit after **deductible**

Advanced reproductive technology (ART)

Description	In-network	Out-of-network
	90% per visit after **deductible**	60% per visit after **deductible**

Limits

Description	In-network	Out-of-network
Limit per lifetime ART and Comprehensive services combined	$20,000 Combined for in-network and out-of-network benefits	$20,000 Combined for in-network and out-of-network benefits

Jaw joint disorder

Includes TMJ

Description	In-network	Out-of-network
Jaw joint disorder treatment	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Limit per lifetime	$5,000	$5,000

Maternity and related newborn care

Includes complications

Description	In-network	Out-of-network
Inpatient services – **room and board** **The per admission copay amount for newborns will be waived**	$200 then the plan pays 90% per admission, no **deductible** applies	$200 then the plan pays 60% per admission no **deductible applies**
Services performed in **physician** or **specialist** office or a facility	90% per visit after **deductible**	60% per visit after **deductible**
Other services and supplies	90% after **deductible**	60% 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.

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	In-network	Out-of-network
Orthodontic treatment directly related to an orthognathic surgical procedure	90% (of the **negotiated charge**) per visit after **deductible**	90% (of the **recognized charge**) per visit after **deductible**
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)	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Institutes of Quality – Bariatric Surgery

Description	In network (IOQ Facility)	In network (Non-IOQ Facility)	Out-of-network
Inpatient	$200 then the plan pays 90% per admission no **deductible applies**	Not covered	Not covered
Outpatient	90% per visit after **deductible**	Not covered	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.	Not covered	Not covered

Outpatient prescription drugs

Generic prescription drugs

Description	In-network	Out-of-network
31 day supply at a **retail pharmacy**	$10 or 30% whichever is greater but no more than $100, no **deductible** applies	Not covered
90 day supply at a **mail order pharmacy**	$20 or 30% whichever is greater but no more than $200, no **deductible** applies	Not covered

Brand-name prescription drugs

Description	In-network	Out-of-network
31 day supply at a **retail pharmacy**	$10 or 40% whichever is greater but no more than $100, no **deductible** applies	Not covered
90 day supply at a **mail order pharmacy**	$20 or 40% whichever is greater but no more than $200, no **deductible** applies	Not covered

Generic prescription drugs for smoking cessation, asthma and antihyperlipidemic (including specialty drugs)		
Per prescription copayment/payment percentage		
For each fill up to a 31 day supply filled at a **retail pharmacy**	$5 or 10% whichever is greater, but no more than $100 per supply, no **deductible** applies	Not covered
90 day supply at a **mail order pharmacy**	$10 or 20% whichever is greater, but no more than $200 per supply, no **deductible** applies	Not covered
Lifetime Maximum for Smoking Cessation Aids or Drugs	One 180 day supply	Not covered

Brand-name prescription drugs for smoking cessation, asthma and antihyperlipidemic (including specialty drugs)		
Per prescription copayment/payment percentage		
For each fill up to a 31 day supply filled at a **retail pharmacy**	$10 or 20% whichever is greater, but no more than $100 per supply, no **deductible** applies	Not covered
90 day supply at a **mail order pharmacy**	$20 or 40% whichever is greater, but no more than $200 per supply, no **deductible** applies	Not covered

Proton Pump Inhibitors and Non-Sedating Antihistamines		
Monthly Maximum Benefit paid by plan (applies to covered prescription strength and over-the-counter equivalent versions. See your Booklet for details.	$20	Not covered

Anti-cancer drugs taken by mouth

Description	In-network	Out-of-network
30 day supply	$0, no **deductible** applies	Not covered

Generic Diabetic supplies, drugs and insulin

Description	In-network	Out-of-network
31 day supply at a **retail pharmacy**	$5, no **deductible** applies	Not covered
90 day supply at a **mail order pharmacy**	$10, no **deductible** applies	Not covered

Brand Name Diabetic supplies, drugs and insulin

Description	In-network	Out-of-network
31 day supply at a **retail pharmacy**	$15, no **deductible** applies	Not covered
90 day supply at a **mail order pharmacy**	$30, no **deductible** applies	Not covered

Outpatient surgery

Description	In-network	Out-of-network
At **hospital** outpatient department	90% per visit after **deductible**	60% per visit after **deductible**
At facility that is not a **hospital**	90% per visit after **deductible**	60% 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)	$15 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**
Physician surgical services	$15 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**

Description	In-network	Out-of-network
Physician telemedicine consultation	$15 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**

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

Description	In-network	Out-of-network
Physician visit during inpatient **stay**	90% per visit after **deductible**	60% per visit after **deductible**

Specialist

Description	In-network	Out-of-network
Specialist office hours (not-surgical, not preventive)	$15 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**
Specialist surgical services	$15 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**

Description	In-network	Out-of-network
Specialist telemedicine consultation	$15 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**

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	90% per visit after **deductible**	60% per visit after **deductible**

Preventive care

Description	In-network	Out-of-network
Breast pump, accessories and supplies limit	Electric pump: 1 every 1 year Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Covered as part of durable medical equipment when medically necessary
Breast pump waiting period	Electric pump: 1 year to replace an existing electric pump	Covered as part of durable medical equipment when medically necessary
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies	Not covered
Counseling for alcohol or drug misuse visit limit	5 visits/per year	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 year, 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/per year	Not covered
Counseling for tobacco cessation	100% per visit, no **deductible** applies	Not covered
Counseling for tobacco cessation visit limit	8 visits/per year	Not covered
Family planning services (female contraception counseling)	$15 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**
Abortion Outpatient	90% (of the **negotiated charge**) per visit after deductible	60% (of the **recognized charge**) 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 For details, contact your **physician**	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 adolescents Under age 6 years: maximum visits unlimited per year; From age 6 years to age 12 years: maximum visits: 2 visits per year; From age 12 years and older maximum: 1 visit per year. High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months	Not covered
Well woman GYN exam	100% per visit, no **deductible** applies	60% 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	90% per visit after **deductible**	60% per visit after **deductible**

Prosthetic Devices

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

Reconstructive surgery and supplies

Including breast **surgery**

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

Routine cancer screenings

Description	In-network	Out-of-network
Colonoscopy	100% per visit, no **deductible** applies	60% per visit after **deductible**
Digital rectal examination (DRE)	100% per visit, no **deductible** applies	Not covered
Double contrast barium enemas (DCBE)	100% per visit, no **deductible** applies	Not covered
Fecal occult blood test (FOBT)	100% per visit, no **deductible** applies	Not covered
Mammogram	100% per visit, no **deductible** applies	60% per visit after **deductible**
Prostate specific antigen (PSA) test	100% per visit, no **deductible** applies	Not covered
Sigmoidoscopy	100% per visit, no **deductible** applies	Not covered
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	Not covered	Not covered
Limit	Not covered	Not covered

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
	$15 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**

Speech therapy (ST)

	$15 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**

Physical, massage, occupational, cardiac and pulmonary therapies

Description	In-network	Out-of-network
Visit limit per year All therapies combined In-network and out-of-network combined	25	25

Spinal manipulation

Description	In-network	Out-of-network
	$15 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**

Visit limit per year In-network and out-of-network combined	20	20

Skilled nursing facility

Description	In-network	Out-of-network
Inpatient services - **room and board**	$200 then the plan pays 90% per admission, no **deductible** applies	$200 then the plan pays 60% per admission, no **deductible** applies
Other inpatient services and supplies	90% per admission, no **deductible** applies	60% per admission, no **deductible** applies

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network	Out-of-network
	90% per visit after **deductible**	60% per visit after **deductible**

Diagnostic lab work

Description	In-network	Out-of-network
	90% per visit after **deductible**	60% per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network
	90% per visit after **deductible**	60% 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
Gene therapy products, **prescription** drugs	90% per visit after **deductible**	Not covered

Infusion therapy

Outpatient services

Description	In-network	Out-of-network
In **physician** office	$15 then the plan pays 100% per visit, no **deductible** applies	60% 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	90% per visit after **deductible**	60% per visit after **deductible**
At **hospital** outpatient department	90% per visit after **deductible**	60% per visit after **deductible**
At facility that is not a **hospital**	90% per visit after **deductible**	60% 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	$200 then the plan pays 90% per transplant, no **deductible** applies	$200 then the plan pays 60% 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	$15 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**

Walk-in clinic

Description	In-network	Out-of-network
Non-**emergency services**	$15 then the plan pays 100% per visit, no **deductible** applies	60% 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 For details, contact your **physician**	Not covered