

Schedule of benefits

Prepared for:

| | |
|-----------------------|---|
| Employer: | The City of Seattle |
| Control number: | 0187729, 0187730 |
| Contract number: | ASC-0100290 |
| Plan name: | Choice POS II - Most City Traditional Retiree Plan Most City Retiree Fire Chiefs Police Management Local 77 Library Seattle Housing Authority |
| Schedule of benefits: | 3A |
| Plan effective date: | January 1, 2024 |
| Plan issue date: | February 2, 2024 |

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 planSee 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.

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 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 | \$2,000 per year | \$3,000 per year |
| Family | \$4,000 per year | \$6,000 per year |

Prescription drug - outpatient maximum out-of-pocket limit

| Maximum out-of-pocket type | In-network |
|----------------------------|------------------|
| 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:

- 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.

Prescription drug – outpatient maximum out-of-pocket limit provisions

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

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 | \$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, no deductible applies | Paid same as in-network |
| Non-emergency services | 90% per trip, no deductible applies | 90% 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 | \$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 Other residential treatment facility services and supplies | 90% per admission, no deductible applies | 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: <ul style="list-style-type: none"> • 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 |
| 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 | \$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 during a hospital stay | 90% per admission, no deductible applies | 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: <ul style="list-style-type: none"> • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program <p>The cost share doesn't apply to in-network peer counseling support services</p> | 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 |
| 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 |

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 |
| Foot orthotics lifetime maximum benefit | \$500 | \$500 |

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 | 90% per item, no deductible applies | 90% per item, no deductible applies |

| | | |
|-------|-------------------------|-------------------------|
| Limit | \$1,500 every 36 months | \$1,500 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 | 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 |

| Description | In-network | Out-of-network |
|---------------------------------------|---|----------------|
| Other inpatient services and supplies | 90% per admission after deductible | Not covered |

| Description | In-network | Out-of-network |
|---------------------|---------------------------------------|----------------|
| Outpatient services | 90% per visit after deductible | Not covered |

| | | |
|--------------------|-----------|----------------|
| Limit per lifetime | unlimited | Not applicable |
|--------------------|-----------|----------------|

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 |

| Description | In-network | Out-of-network |
|---------------------------------------|---|----------------------------------|
| Other inpatient services and supplies | 90% per admission, no deductible applies | 60% 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 |

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 |

| | | |
|---------------------------------------|-----------|-----------|
| Non-surgical lifetime maximum benefit | \$5,000 | \$5,000 |
| Surgical lifetime maximum benefit | Unlimited | Unlimited |

Maternity and related newborn care

Includes complications

| 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 |
| 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% per visit after deductible | 60% per visit after deductible |

Maternity and related newborn care important note:

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

Oral and maxillofacial treatment (mouth, jaws and teeth)

| Description | In-network | Out-of-network |
|---|---------------------------------------|---------------------------------------|
| Treatment of mouth, jaws and teeth | 80% per visit after deductible | 80% 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) | 80% per visit after deductible | 80% per visit after deductible |

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 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 visit during inpatient stay | 90% per visit after deductible | 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 | Covered based on type of service and provider from which it is received | Not covered |
| Basic medical services | | |

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 |

Prescription drugs - outpatient

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 |

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 |
|---|--|----------------|
| 31 day supply of generic and OTC drugs and devices | \$0, no deductible applies | Not covered |
| 31 day supply of brand-name prescription drugs and devices | Paid based on the tier of drug in the schedule | Not covered |

Infertility drugs

| Description | In-network | Out-of-network |
|--------------------------|--|----------------|
| Infertility drugs | Paid based on the tier of drug in the schedule | Not covered |

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 |

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 |

Preventive care drugs and supplements

| Description | In-network | Out-of-network |
|---------------------------------------|---|----------------|
| Preventive care drugs and supplements | \$0, no deductible applies | Not covered |
| Limits | <p>Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF)</p> <p>For a current list of covered preventive care drugs and supplements or more information, see the <i>Contact us</i> section</p> | Not covered |

Risk reducing breast cancer prescription drugs

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

Tobacco cessation prescription and OTC drugs

| Description | In-network | Out-of-network |
|---|--|----------------|
| Tobacco cessation prescription and OTC drugs | \$0, no deductible applies | Not covered |
| Limits | <p>Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF.</p> <p>For a current list of covered tobacco cessation drugs or more information, see the <i>Contact us</i> section. See the <i>Other services</i> section of this schedule for more information.</p> | Not covered |

Preventive care

| Description | In-network | Out-of-network |
|--|---|---|
| Preventive care services | 100% per visit, no deductible applies | 60% per visit after deductible |
| Breast feeding counseling and support | 100% per visit, no deductible applies | 60% per visit after deductible |
| 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 12 months 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 12 months 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: 12 months to replace an existing electric pump | Electric pump: 12 months to replace an existing electric pump |
| Counseling for alcohol or drug misuse | 100% per visit, no deductible applies | 60% per visit after deductible |
| 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 | 60% per visit after deductible |
| 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 | 60% per visit after deductible |
| 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 | 60% per visit after deductible |
| 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 | 60% 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 Counseling that exceeds this limit covered as a physician services office visit | Contraceptive counseling limited to 2 visits/12 months in a group or individual setting Counseling that exceeds this limit are covered as a physician services office visit |
| Abortion Outpatient | 90% per visit after deductible | 60% per visit after deductible |

| | | |
|-------------------------------------|---|---|
| Immunizations | 100%, no deductible applies | 60% after deductible |
| Immunizations limit | Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician | Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician |
| Routine cancer screenings | 100% per visit, no deductible applies | 60% per visit after deductible |
| Routine cancer screening limits | Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your physician or see the <i>Contact us</i> 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 <i>Contact us</i> section |
| Routine lung cancer screening | 100% per visit, no deductible applies | 60% per visit after deductible |
| Routine lung cancer screening limit | 1 screening per year Screenings that exceed this limit covered as outpatient diagnostic testing | 1 screening per year Screenings that exceed this limit covered as outpatient diagnostic testing |
| Routine physical exam | 100% per visit, no deductible applies | 60% per visit after deductible |
| Routine physical exam limits | Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months | Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months |

| | | |
|---------------------------|--|--|
| 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 | 90% per item after deductible | 60% 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 |
|-------------|--|---------------------------------------|
| | \$15 then the plan pays 100% per visit, no deductible applies | 60% per visit after deductible |

Speech therapy (ST)

| Description | In-network | Out-of-network |
|-------------|--|---------------------------------------|
| | \$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 Physical, massage occupational, cardiac, and pulmonary therapies combined In-network and out-of-network combined First 25 visits per year regardless of medical necessity; thereafter medical necessity applies | 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

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 | \$15 then the plan pays 100% per visit, no deductible applies | 60% per visit after deductible |
| Preventive care immunizations | 100% per visit, no deductible applies | 60% per visit after deductible |
| 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 |
| Preventive screening and counseling services | 100% per visit, no deductible applies | 60% per visit after deductible |
| Preventive screening and counseling limits | See the <i>Preventive care services</i> section of the SOB | See the <i>Preventive care services</i> section of the SOB |