

Schedule of benefits

Prepared for:

Employer:	The City of Seattle
Control number:	0187733
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Plan name:	Open Choice (PPO Medical) - S.P.O.G. Traditional Plan
Schedule of benefits:	10A
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Plan issue date:	March 11, 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:
 - 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. The *Surprise bill* section in the certificate 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	Other health care
Individual	\$100 per year	\$150 per year	\$100 per year
Family	\$300 per year	\$450 per year	\$300 per year

Common Accident Deductible			
Common Accident Deductible	\$100	\$150	\$100

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

Excludes the **deductible**.

Maximum out-of-pocket type	In-network	Out-of-network	Other health care
Individual	\$400 per year	\$1,600 per year	\$400 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.

Payment Percentage

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

Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **payment percentage** and **deductible**, if any, for **covered services**.

Covered services apply to the in-network and out-of-network **maximum out-of-pocket limit**.

Individual maximum out-of-pocket limit

After the amount of the cost share and **deductible** 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 would apply toward the limit for you for the remainder of the year.

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
- Expenses incurred for physical, occupational, speech, and neurodevelopmental therapies
- 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	Other health care
Abortion	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Acupuncture

Description	In-network	Out-of-network	Other health care
Acupuncture	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible

Visit limit per year	12	12	12
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Ambulance services

Description	In-network	Out-of-network	Other health care
Emergency services	80% per trip after deductible	Paid same as in-network	Paid same as in-network
Non-emergency services	80% per trip after deductible	80% per trip after deductible	80% per trip after deductible

Applied behavior analysis

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

Autism spectrum disorder

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

Behavioral health

Mental health treatment

Coverage provided is the same as for any other illness

Description	In-network	Out-of-network	Other health care
Inpatient services- room and board including residential treatment facility	80% per admission after deductible	60% per admission after deductible	80% per admission after deductible
Other inpatient services and supplies Other residential treatment facility services and supplies	80% per admission after deductible	60% per admission after deductible	80% per admission after deductible

Description	In-network	Out-of-network	Other health care
Outpatient office visit to a physician or behavioral health provider	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible
Physician or behavioral health provider telemedicine consultation	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible
Outpatient mental health disorders telemedicine cognitive therapy consultations by a physician or behavioral health provider	Covered based on type of service and provider from which it is received	Covered based on type of service and provider from which it is received	Covered based on type of service and provider from which it is received

Description	In-network	Out-of-network	Other health care
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>	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible

Substance related disorders treatment

Includes **detoxification**, rehabilitation and **residential treatment facility**

Coverage provided is the same as for any other illness

Description	In-network	Out-of-network	Other health care
Inpatient services- room and board during a hospital stay	80% per admission after deductible	80% per admission after deductible	80% per admission after deductible
Other inpatient services and supplies during a hospital stay	80% per admission after deductible	80% per admission after deductible	80% per admission after deductible
Description	In-network	Out-of-network	Other health care
Outpatient office visit to a physician or behavioral health provider	80% per visit after deductible	80% per visit after deductible	80% per visit after deductible
Physician or behavioral health provider telemedicine consultation	80% per visit after deductible	80% per visit after deductible	80% per visit after deductible
Outpatient telemedicine cognitive therapy consultations by a physician or behavioral health provider	Covered based on type of service and provider from which it is received	Covered based on type of service and provider from which it is received	Covered based on type of service and provider from which it is received

Description	In-network	Out-of-network	Other health care
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>	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible

Clinical trials

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

Durable medical equipment (DME)

Description	In-network	Out-of-network	Other health care
DME	80% per item after deductible	80% per item after deductible	80% per item after deductible

Emergency services

Description	In-network	Out-of-network	Other health care
Emergency room	80% per visit after deductible	Paid same as in-network	Paid same as in-network

Non-emergency care in a hospital emergency room	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible
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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	Other health care
Orthotic devices	80% per item after deductible	60% per item after deductible	80% per item after deductible
Lifetime maximum limit	\$500	\$500	\$500

Habilitation therapy services

Outpatient physical (PT), occupational (OT) therapies

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

Outpatient speech therapy (ST)

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

Hearing aids

Description	In-network	Out-of-network	Other health care
Hearing aids	80% per item, no deductible applies	80% per item, no deductible applies	80% per item, no deductible applies

Limit	\$1,000 every 36 months	\$1,000 every 36 months	\$1,000 every 36 months
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Home health care

A visit is a period of 4 hours or less

Description	In-network	Out-of-network	Other health care
Home health care	90% per visit after deductible	90% per visit after deductible	90% per visit after deductible

Visit limit per year	130	130	130
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Home health care important note:

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

Hospice care

Description	In-network	Out-of-network	Other health care
Inpatient services - room and board	90% after deductible	90% after deductible	90% after deductible

Description	In-network	Out-of-network	Other health care
Other inpatient services and supplies	90% per admission after deductible	90% after deductible	90% per admission after deductible

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

Limit per lifetime	unlimited	unlimited	unlimited
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Hospice important note:

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

Hospital care

Description	In-network	Out-of-network	Other health care
Inpatient services – room and board	80% after deductible	60% after deductible	80% after deductible

Description	In-network	Out-of-network	Other health care
Other inpatient services and supplies	80% per admission after deductible	60% after per admission deductible	80% per admission after deductible

Infertility services

Basic infertility

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

Institutes of Quality – Bariatric Surgery

Description	In network (IOQ Facility)	In network (Non-IOQ Facility)	Out-of-network
Inpatient	80% per admission, no deductible applies	Not covered	Not covered
Outpatient	80% per visit after deductible	Not covered	Not covered
<i>Precertification may be required</i>			
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.	Not covered	Not covered

Maternity and related newborn care

Includes complications

Description	In-network	Out-of-network	Other health care
Inpatient services – room and board	80% per admission after deductible	60% per admission after deductible	80% per admission after deductible
Other inpatient services and supplies	80% per admission after deductible	60% per admission after deductible	80% per admission after deductible
Services performed in physician or specialist office or a facility	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible
Other services and supplies	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible

Maternity and related newborn care important note:

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

Nutritional support

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

Description	In-network	Out-of-network	Other health care
Oral and maxillofacial treatment (mouth, jaws and teeth)			
Orthodontic treatment directly related to an orthognathic surgical procedure	80% (of the negotiated charge) per visit after deductible	80% (of the recognized charge) per visit after deductible	80% (of the recognized charge) per visit after deductible
Orthodontic treatment directly related to an orthognathic surgical procedure Lifetime Maximum	\$10,000	\$10,000	\$10,000
All other Oral and maxillofacial treatment (mouth, jaws and teeth)	80% (of the negotiated charge) per visit after deductible	60% (of the recognized charge) per visit after deductible	80% (of the recognized charge) per visit after deductible
Accident related expenses covered with in 12 months of accident. Maximum per occurrence	\$600	\$600	\$600

Outpatient surgery

Description	In-network	Out-of-network	Other health care
At hospital outpatient department	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible
At facility that is not a hospital	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible
At the physician office	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Physician and specialist services

Physician services-general or family practitioner

Description	In-network	Out-of-network	Other health care
Physician office hours (not surgical, not preventive)	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible
Physician surgical services	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible

Description	In-network	Out-of-network	Other health care
Physician visit during inpatient stay	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible

Description	In-network	Out-of-network	Other health care
Physician telemedicine consultation	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible

Specialist

Description	In-network	Out-of-network	Other health care
Specialist office hours (not-surgical, not preventive)	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible
Specialist surgical services	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible

Description	In-network	Out-of-network	Other health care
Specialist telemedicine consultation	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible

All other services not shown above

Description	In-network	Out-of-network	Other health care
All other services	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible

Prescription drugs - outpatient

Generic prescription drugs

Description	In-network	Out-of-network
34 day supply or 100 unit doses, whichever is greater, at a retail pharmacy	\$5, no deductible applies	Not covered
90 day supply at a mail order pharmacy	\$10, no deductible applies	Not covered

Preferred brand-name prescription drugs

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

Non-preferred brand-name prescription drugs

Description	In-network	Out-of-network
34 day supply or 100 unit doses, whichever is greater, at a retail pharmacy	\$25, no deductible applies	Not covered
90 day supply at a mail order pharmacy	\$50, no deductible applies	Not covered

Preventive care

Description	In-network	Out-of-network	Other health care
Family planning services (female contraception counseling)	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible
Abortion	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible

Prosthetic devices

Description	In-network	Out-of-network	Other health care
Prosthetic devices	80% per item after deductible	60% per item after deductible	80% per item after deductible

Reconstructive surgery and supplies

Including breast surgery

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

Routine cancer screenings

Description	In-network	Out-of-network	Other health care
Mammogram	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible
Cancer screening limits	<p>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</p> <p>The comprehensive guidelines supported by the Health Resources and Services Administration</p> <p>For more information contact your physician or see the <i>Contact us</i> section</p>	<p>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</p> <p>The comprehensive guidelines supported by the Health Resources and Services Administration</p> <p>For more information contact your physician or see the <i>Contact us</i> section</p>	<p>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</p> <p>The comprehensive guidelines supported by the Health Resources and Services Administration</p> <p>For more information contact your physician or see the <i>Contact us</i> section</p>

Short-term rehabilitation services

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

Cognitive rehabilitation

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

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

Description	In-network	Out-of-network	Other health care
	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible

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

Description	In-network	Out-of-network	Other health care
Visit limit per year	35	35	35
Physical, occupational and speech therapies combined In-network and out-of-network combined			

Spinal manipulation

Description	In-network	Out-of-network	Other health care
	80% per visit after deductible	80% per visit after deductible	80% per visit after deductible
Visit limit per year	10	10	10
In-network and out-of-network combined			

Skilled nursing facility

Description	In-network	Out-of-network	Other health care
Inpatient services - room and board	80% per admission after deductible	60% per admission after deductible	80% per admission after deductible
Other inpatient services and supplies	80% per admission after deductible	60% per admission after deductible	80% per admission after deductible
Day limit per year	90	90	90

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network	Out-of-network	Other health care
	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible

Diagnostic lab work

Description	In-network	Out-of-network	Other health care
	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network	Other health care
	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible

Therapies

Chemotherapy

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

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

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

Infusion therapy

Outpatient services

Description	In-network	Out-of-network	Other health care
	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible

Radiation therapy

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

Respiratory therapy

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

Transplant services

Description	In-network (IOE facility)	Out-of-network (Includes providers who are otherwise part of Aetna's network but are non-IOE providers)
Inpatient services and supplies	80% per transplant after deductible	60% per transplant after deductible
Physician services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Urgent care services

At a freestanding facility or provider that is not a hospital

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

Description	In-network	Out-of-network	Other health care
Urgent care facility	\$35 then the plan pays 100% per visit, no deductible applies	60% per visit after deductible	\$35 then the plan pays 80% per visit, no deductible applies

Non-urgent use of an urgent care facility or provider	\$35 then the plan pays 100% per visit, no deductible applies	60% per visit after deductible	\$35 then the plan pays 80% per visit, no deductible applies
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Walk-in clinic

Description	In-network	Out-of-network	Other health care
Non-emergency services	80% per visit after deductible	60% per visit after deductible	80% per visit after deductible