Schedule of benefits

Prepared for:

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Plan name:	Choice POS II - Most City Traditional Retiree Plan Most City Retirees Fire Chiefs Police Management Local 77 Library Seattle Housing Authority
Schedule of benefits:	5A
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Third Party Administrative Services provided by Aetna Life Insurance Company

Schedule of benefits

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

How your cost share works

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

  See the schedule for more information about limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.

For examples of how cost share and **deductible** work, go to the *Using your Aetna benefits* section under Individuals & Families at https://www.aetna.com/

Important note:
Covered services are subject to the **deductible**, **maximum out-of-pocket**, limits, **copayment** or **payment percentage** unless otherwise stated in this schedule.

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	$400 per year	$1,000 per year
Family	$1,200 per year	$3,000 per year

Common Accident Deductible		
Deductible type	**In-network**	**Out-of-network**
Common Accident Deductible	$400 per year	$1,000 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	$1,000 per year	$2,000 per year
Family	$3,000 per year	$6,000 per year

Outpatient prescription drug maximum out-of-pocket limit

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

General coverage provisions

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

Deductible provisions

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.

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 a flat fee you pay for certain visits or **covered services**. A copay can be a dollar amount or percentage. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

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**. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

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.

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	80% per visit after **deductible**	60% per visit after **deductible**

Visit limit per year	12	12

Ambulance services

Description	In-network	Out-of-network
Emergency services	80% per trip after **deductible**	Paid same as in-network
Description	**In-network**	**Out-of-network**
Non-emergency services	80% per trip after **deductible**	80% 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 disorders 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 80% 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**	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**
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	80% per visit after **deductible**	80% 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 80% 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**	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**
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	80% per visit after **deductible**	80% 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	80% per item after **deductible**	60% per item after **deductible**

Emergency services

Description	In-network	Out-of-network
Emergency room	$150 then the plan pays 80% 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. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan. 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.
- In the case of a surprise bill from an out-of-network provider, where you had no control of their participation in your **covered services**, you will pay the same cost share you would have if the **covered services** were received from a **network provider**. The cost share will be based on the median contracted rate. Contact us immediately if you receive such a 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	80% per item after **deductible**	60% per item after **deductible**
Foot Orthotics Lifetime Maximum Benefit	$500	$500

Habilitation therapy services

Physical (PT), occupational (OT) therapies

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

Speech therapy (ST)

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

Hearing aids

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

Limit	One per ear every 36 months	One per ear every 36 months
Limit	$1,000	$1,000

Hearing exams

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

Home health care

A visit is a period of 4 hours or less

Description	In-network	Out-of-network
Home health care	80% 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**	80% after **deductible**	60% after **deductible**

Description	In-network	Out-of-network
Outpatient services	80% per visit after **deductible**	60% per visit after **deductible**

Limit per lifetime	unlimited	unlimited

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

Hospital care

Description	In-network	Out-of-network
Inpatient services – **room and board**	$200 then the plan pays 80% per admission, no **deductible** applies	$200 then the plan pays 60% per admission, no **deductible** applies

Infertility services

Basic infertility

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

Comprehensive infertility services

Description	In-network	Out-of-network
	80% per visit after **deductible**	60% per visit after **deductible**

Advanced reproductive technology (ART)

Description	In-network	Out-of-network
	80% 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

The cost share and **deductible** amount for newborns is waived for nursery charges during the newborn's initial routine **stay**. The nursery charges will apply for non-routine facility **stays**.

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 80% 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	80% per visit, no **deductible** applies	60% per visit after **deductible**
Other services and supplies	80%, no **deductible** applies	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 certificate. 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	80% per visit after **deductible**	60% 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**	60% per visit after **deductible**
Accidental injury treatment Maximum Benefit	$600 per occurrence	$600 per occurrence

Institutes of Quality – Bariatric Surgery

Description	In network (IOQ Facility)	In network (Non-IOQ Facility)	Out-of-network
Inpatient	$200 then the plan pays 80% per admission, no **deductible** applies	Not covered	Not covered
Outpatient	80% 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

Anti-cancer drugs taken by mouth

Description	In-network	Out-of-network
31 day supply at a **retail pharmacy**	$0, no **deductible** applies	Not covered
90 day supply at a **mail order pharmacy**	$0, no **deductible** applies	Not covered

Generic prescription drugs for smoking cessation, asthma and antihyperlipidemic		
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

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

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	80% per visit after **deductible**	60% per visit after **deductible**

Physician and specialist services

Physician services-general or family practitioner

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

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

Specialist

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

Description	In-network	Out-of-network
Specialist telemedicine consultation	80% per visit after **deductible**	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	80% 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 3 years Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Not covered
Breast pump waiting period	Electric pump: 3 years to replace an existing electric pump	Not covered
Family planning services (female contraception counseling)	80% per visit after **deductible**	60% per visit after **deductible**

Private duty nursing

Up to eight hours equals one shift

Description	In-network	Out-of-network
Outpatient services	80% 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
Mammogram	80% per visit after **deductible**	60% per visit after **deductible**
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

Short-term rehabilitation services

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
At the **physician** office	80% per visit after **deductible**	60% per visit after **deductible**

Speech therapy (ST)

Description	In-network	Out-of-network
At the office	80% per visit after **deductible**	60% per visit after **deductible**

Physical, massage, occupational, cardiac and pulmonary therapies

Description	In-network	Out-of-network
Visit limit per year First 25 visits per year regardless of medical necessity; thereafter medical necessity applies	25	25

Speech therapy (ST)

Description	In-network	Out-of-network
Visit limit per year	25	25

Spinal manipulation

Description	In-network	Out-of-network
At the **physician** office	80% per visit after **deductible**	60% per visit after **deductible**

Visit limit per year	10	10

Skilled nursing facility

Description	In-network	Out-of-network
Inpatient services - **room and board**	$200 then the plan pays 80% per admission, no **deductible** applies	$200 then the plan pays 60% per admission, no **deductible** applies
Other inpatient services and supplies	80% per admission, no **deductible** applies	60% per admission, no **deductible** applies

Day limit per year	90	90

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network	Out-of-network
	80% per visit after **deductible**	60% per visit after **deductible**

Diagnostic lab work

Description	In-network	Out-of-network
	80% per visit after **deductible**	60% per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network
	80% 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	80% per visit after **deductible**	Not covered

Infusion therapy

Outpatient services

Description	In-network	Out-of-network
	80% 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 80% 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	80% per visit after **deductible**	60% per visit after **deductible**

Walk-in clinic

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