

## **Schedule of benefits**

**Prepared for:**

Employer: The City of Seattle  
Contract number: ASC-0100290  
Plan name: Choice POS II - City Preventive Plan Local 77 – Most Employees  
Schedule of benefits: 12A  
Plan effective date: January 1, 2022  
Plan issue date: March 15, 2022

**Third Party Administrative Services provided by Aetna Life Insurance Company**

## Schedule of benefits

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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	\$2,100 per year	\$3,450 per year
Family	\$4,300 per year	\$7,350 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** that are subject to the **maximum out-of-pocket limit** include those provided under the medical plan and the outpatient **prescription** drug plan.

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

## Individual maximum out-of-pocket limit

- This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of you must meet your **maximum out-of-pocket limit** separately.
- After you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the year for that person.

## Family maximum out-of-pocket limit

After you or your covered dependents meet the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the remainder of the year for all covered family members. The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members.

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

- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit** amount.

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

- All costs for non-covered services which are identified in the booklet and the schedule
- Charges, expenses or costs in excess of the **recognized charge**

## Limit provisions

**Covered services** will apply to the in-network and out-of-network limits.

## **Your financial responsibility and decisions regarding benefits**

We base your financial responsibility for the cost of **covered services** on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the booklet.

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

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

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

## Covered services

### Acupuncture

Description	In-network	Out-of-network
Acupuncture	\$15 then the plan pays 100% per visit, no <b>deductible</b> applies	60% per visit after <b>deductible</b>

### Ambulance services

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

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

Description	In-network	Out-of-network
Outpatient office visit to a physician or behavioral health provider	100% per visit after deductible	60% per visit after deductible
Physician or behavioral health provider telemedicine consultation	100% per visit after deductible	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
<p>Other outpatient services including:</p> <ul style="list-style-type: none"> <li>Behavioral health services in the home</li> <li>Partial hospitalization treatment</li> <li>Intensive outpatient program</li> </ul> <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



### 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 <b>deductible</b> applies	\$200 then the plan pays 60% per admission, no <b>deductible</b> applies

Description	In-network	Out-of-network
Outpatient office visit to a <b>physician</b> or <b>behavioral health provider</b>	100% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>
<b>Physician</b> or <b>behavioral health provider telemedicine</b> consultation	100% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>
Outpatient <b>telemedicine</b> cognitive therapy consultations by a <b>physician</b> or <b>behavioral health provider</b>	Covered based on type of service and <b>provider</b> from which it is received	Covered based on type of service and <b>provider</b> from which it is received

Description	In-network	Out-of-network
Other outpatient services including: <ul style="list-style-type: none"> <li>Behavioral health services in the home</li> <li>Partial hospitalization treatment</li> <li>Intensive outpatient program</li> </ul> <p>The cost share doesn't apply to in-network peer counseling support services</p>	100% per visit, no <b>deductible</b> applies	60% per visit after <b>deductible</b>

### Clinical trials

Description	In-network	Out-of-network
<b>Experimental or investigational</b> 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 <b>deductible</b>	60% per item after <b>deductible</b>

## Emergency services

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

Non-emergency care in a <b>hospital</b> emergency room	\$150 then the plan pays 60% per visit, no <b>deductible</b> applies	\$150 then the plan pays 60% per visit, no <b>deductible</b> applies
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### 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	90% per item after <b>deductible</b>	60% per item after <b>deductible</b>
Lifetime maximum limit	\$500	\$500

## Habilitation therapy services

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

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

### Speech therapy (ST)

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

## Hearing aids

Description	In-network	Out-of-network
Hearing aids	90% per item, no <b>deductible</b> applies	90% per item, no <b>deductible</b> 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	90% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>

Visit limit per year	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
Inpatient services - <b>room and board</b>	90% after <b>deductible</b>	Not covered

Description	In-network	Out-of-network
Outpatient services	90% per visit after <b>deductible</b>	Not covered

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

### Hospice important note:

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

## Hospital care

Description	In-network	Out-of-network
Inpatient services – <b>room and board</b>	\$200 then the plan pays 90% per admission, no <b>deductible</b> applies	\$200 then the plan pays 60% per admission, no <b>deductible</b> applies
Outpatient <b>hospital</b>	90% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>

## Infertility services

### Basic infertility

Description	In-network	Out-of-network
Treatment of basic <b>infertility</b>	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Infertility Drugs (prescribed by a Network Physician)	80% per visit after <b>deductible</b>	Not covered
Infertility Drugs Maximum Benefit per Calendar Year	\$2,000	Not Covered

## 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 – <b>room and board</b>	\$200 then the plan pays 90% per admission, no <b>deductible</b> applies	\$200 then the plan pays 60% per admission, no <b>deductible</b> applies
Services performed in <b>physician</b> or <b>specialist</b> office or a facility	90% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>
Other services and supplies	90% after <b>deductible</b>	60% after <b>deductible</b>

### 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.

## Nutritional support

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

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

Description	In-network	Out-of-network
Orthodontic treatment directly related to an orthognathic surgical procedure	90% per visit after <b>deductible</b>	90% per visit after <b>deductible</b>
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)	90% per visit after <b>deductible</b>	90% per visit after <b>deductible</b>

### 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 <b>deductible</b> applies	Not covered	Not covered
Outpatient	90% per visit after <b>deductible</b>	Not covered	Not covered
<i>Precertification may be required</i>			
<b>Physician</b> 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 <b>retail pharmacy</b>	\$10 or 30%, whichever is greater but no more than \$100, no <b>deductible</b> applies	Not covered
90 day supply at a <b>mail order pharmacy</b>	\$20 or 30%, whichever is greater but no more than \$200, no <b>deductible</b> applies	Not covered

#### Brand-name prescription drugs

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

### Generic prescription drugs for smoking cessation, asthma and antihyperlipidemic

Description	In-network	Out-of-network
31 day supply at a <b>retail pharmacy</b>	\$5 or 10% whichever is greater, but no more than \$100 per supply, no <b>deductible</b> applies	Not covered
90 day supply at a <b>mail order pharmacy</b>	\$10 or 20% whichever is greater, but no more than \$200 per supply, no <b>deductible</b> applies	Not covered

### Brand-name prescription drugs for smoking cessation, asthma and antihyperlipidemic

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

### Proton Pump Inhibitors and Non-Sedating Antihistamines

Description	In-network	Out-of-network
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
31 day supply at a <b>retail pharmacy</b>	\$0, no <b>deductible</b> applies	Not covered
90 day supply at a <b>mail order pharmacy</b>	\$0, no <b>deductible</b> 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 <b>deductible</b> applies	Not covered
31 day supply of <b>brand-name prescription drugs</b> and devices	Paid based on the tier of drug in the schedule	Not covered

**Generic Diabetic supplies, drugs and insulin**

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

**Brand Name Diabetic supplies, drugs and insulin**

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

### Preventive care drugs and supplements

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

### Risk reducing breast cancer drugs

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

### Tobacco cessation drugs

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

### Outpatient surgery

Description	In-network	Out-of-network
At <b>hospital</b> outpatient department or outpatient facility	90% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>



## Physician and specialist services

### Physician services-general or family practitioner

Description	In-network	Out-of-network
<b>Physician</b> office hours (not-surgical, not preventive)	\$15 then the plan pays 100% per visit, no <b>deductible</b> applies	60% per visit after <b>deductible</b>
<b>Physician</b> surgical services	\$15 then the plan pays 100% per visit, no <b>deductible</b> applies	60% per visit after <b>deductible</b>

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

Description	In-network	Out-of-network
<b>Physician</b> visit during inpatient <b>stay</b>	90% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>

### Specialist

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

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

### All other services not shown above

Description	In-network	Out-of-network
All other services	90% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>

## Preventive care

Description	In-network	Out-of-network
Preventive care services	100% per visit, no <b>deductible</b> applies	Not covered
Breast feeding counseling and support	100% per visit, no <b>deductible</b> applies	60% per visit after <b>deductible</b>
Breast feeding counseling and support limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the <b>physician</b> services office visit	6 visits in a group or individual setting Visits that exceed the limit are covered under the <b>physician</b> services office visit
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	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
Breast pump waiting period	Electric pump: 3 years to replace an existing electric pump	Electric pump: 3 years to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no <b>deductible</b> applies	Not covered
Counseling for alcohol or drug misuse visit limit	5 visits/12 months	Not covered
Counseling for obesity, healthy diet	100% per visit, no <b>deductible</b> applies	Not covered
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	Not covered
Counseling for sexually transmitted infection	100% per visit, no <b>deductible</b> applies	Not covered
Counseling for sexually transmitted infection visit limit	2 visits/12 months	Not covered
Counseling for tobacco cessation	100% per visit, no <b>deductible</b> applies	Not covered
Counseling for tobacco cessation visit limit	8 visits/12 months	Not covered
Family planning services (female contraception counseling)	100% per visit, no <b>deductible</b> applies	60% per visit after <b>deductible</b>
Family planning services (female contraception counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting

Immunizations	100%, no <b>deductible</b> applies	Not covered
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention  For details, contact your <b>physician</b>	Not covered
Mammograms	100% per visit, no <b>deductible</b> applies	60% per visit after <b>deductible</b>
Mammogram limit	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 <b>physician</b> 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 <b>physician</b> or see the <i>Contact us</i> section
Other routine cancer screenings	100% per visit, no <b>deductible</b> applies	Not covered
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 <b>physician</b> or see the <i>Contact us</i> section	Not covered
Lung cancer screening	100% per visit, no <b>deductible</b> applies	Not covered
Routine lung cancer screening limit	1 screenings every 12 months  Screenings that exceed this limit covered as outpatient diagnostic testing	Not covered

Routine physical exam	100% per visit, no <b>deductible</b> applies	Not covered
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents  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	Not covered
Well woman GYN exam	100% per visit, no <b>deductible</b> applies	60% per visit after <b>deductible</b>
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 eight hours equals one shift

Description	In-network	Out-of-network
Outpatient services	100% per visit, no <b>deductible</b> applies	60% per visit after <b>deductible</b>

### Prosthetic devices

Description	In-network	Out-of-network
Prosthetic devices	90% per item after <b>deductible</b>	60% per item after <b>deductible</b>

### Reconstructive surgery and supplies

Including breast surgery

Description	In-network	Out-of-network
<b>Surgery</b> 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

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

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
At the <b>physician</b> office	\$15 then the plan pays 100% per visit no <b>deductible</b> applies	60% per visit after <b>deductible</b>

### **Speech therapy (ST)**

At the office	\$15 then the plan pays 100% per visit no <b>deductible</b> applies	60% per visit after <b>deductible</b>
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### **Spinal manipulation**

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
At the <b>physician</b> office	\$15 then the plan pays 100% per visit, no <b>deductible</b> applies	60% per visit after <b>deductible</b>

Visit limit per year	20	20
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### **Skilled nursing facility**

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

Day limit per year	120	120
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### **Tests, images and labs – outpatient**

#### **Diagnostic complex imaging services**

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
	90% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>

#### **Diagnostic lab work**

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
	90% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>

#### **Diagnostic x-ray and other radiological services**

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
	90% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>

### **Therapies**

#### **Chemotherapy**

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
Chemotherapy services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

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

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

### Infusion therapy

#### Outpatient services

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

### 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 after <b>deductible</b>	\$200 then the plan pays 60% per transplant after <b>deductible</b>
<b>Physician</b> 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 <b>deductible</b> applies	60% per visit after <b>deductible</b>

### Walk-in clinic

Not all preventive care services are available at a **walk-in clinic**. All services are available from a network **physician**.

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
Non-emergency services	\$15 then the plan pays 100% per visit, no <b>deductible</b> applies	60% per visit after <b>deductible</b>
Preventive immunizations	100% per visit, no <b>deductible</b> applies	Not covered
Immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention  For details, contact your <b>physician</b>	Not covered
Screening and counseling services	100% per visit, no <b>deductible</b> applies	Not covered
Screening and counseling limits	See the <i>Preventive care services</i> section of the SOB	Not covered