

Schedule of benefits

Prepared for:

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Contract number:	ASC-0100290
Plan name:	Choice POS II - Most City Preventive Retiree Plan Most City Retirees Fire Chiefs Police Management Local 77 Library Seattle Housing Authority
Schedule of benefits:	8A
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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 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 contraceptives (birth control)

The **prescription drug deductible** and per **prescription** cost share will not apply to female contraceptive methods when obtained at a network pharmacy. This means they will be paid at 100%. This includes certain OTC and generic contraceptive **prescription** drugs and devices for each of the methods identified by the FDA. If a **generic prescription drug** is not available, the **brand-name prescription drug** for that method will be paid at 100%.

The **prescription drug deductible** and cost share will apply to **prescription** drugs that have a generic equivalent or alternative available within the same therapeutic drug class obtained at a network pharmacy unless we approve a medical exception. A therapeutic drug class is a group of drugs or medications that have a similar or identical mode of action or are used for the treatment of the same or similar disease or injury.

Maximum out-of-pocket limit

Includes the **deductible**.

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

Maximum out-of-pocket type	In-network	Out-of-network
Family	\$4,000 per year	\$6,000 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	\$15 then the plan pays 100% per visit, no deductible applies	60% per visit after deductible
Visit limit per year	20	20

Ambulance services

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

Applied behavior analysis

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

Autism spectrum disorder

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

Behavioral health

Mental health 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	\$15 then the plan pays 100% per visit, no deductible applies	60% per visit after deductible
Physician or behavioral health provider telemedicine consultation	\$15 then the plan pays 100% per visit, no deductible applies	60% per visit after deductible
Outpatient mental health disorders telemedicine cognitive therapy consultations by a physician or behavioral health provider	Covered based on type of service and provider from which it is received	Covered based on type of service and provider from which it is received

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

Description	In-network	Out-of-network
Telemedicine provider mental health disorders consultation	Covered based on type of service and provider from which it is received	Not covered

Substance related disorders treatment

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

Coverage provided is the same as for any other illness

Description	In-network	Out-of-network
Inpatient services-room and board during a hospital stay	\$200 then the plan pays 90% per admission, no deductible applies	\$200 then the plan pays 60% per admission, no deductible applies

Description	In-network	Out-of-network
Outpatient office visit to a physician or behavioral health provider	\$15 then the plan pays 100% per visit, no deductible applies	60% per visit after deductible
Physician or behavioral health provider telemedicine consultation	\$15 then the plan pays 100% per visit, no deductible applies	60% per visit after deductible
Outpatient telemedicine cognitive therapy consultations by a physician or behavioral health provider	Covered based on type of service and provider from which it is received	Covered based on type of service and provider from which it is received

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

Description	In-network	Out-of-network
Telemedicine provider substance related disorders consultation	Covered based on type of service and provider from which it is received	Not covered

Clinical trials

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

Durable medical equipment (DME)

Description	In-network	Out-of-network
DME	90% per item after deductible	60% per item after deductible

Emergency services

Description	In-network	Out-of-network
Emergency room	\$150 then the plan pays 90% per visit, no deductible applies	Paid same as in-network
Non-emergency care in a hospital emergency room	\$150 then the plan pays 60% per visit, no deductible applies	\$150 then the plan pays 60% per visit, no deductible applies

Emergency services important note:

- **Out-of-network providers** do not have a contract with us. 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 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	90% per item , no deductible applies	90% per item after deductible

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 deductible	60% per visit after deductible

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 - room and board	90% after deductible	Not covered

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

Limit per lifetime	unlimited	Not covered
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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
Inpatient services – room and board	\$200 then the plan pays 90% per admission, no deductible applies	\$200 then the plan pays 60% per admission, no deductible applies
Visit limit per year	120	120

Infertility services

Basic infertility

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

Comprehensive infertility services

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

Advanced reproductive technology (ART)

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

Limits

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

Jaw joint disorder

Includes TMJ

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

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

Maternity and related newborn care

Includes complications

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

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
Treatment of mouth, jaws and teeth	90% 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)	90% per visit after deductible	60% per visit after deductible

Institutes of Quality – Bariatric Surgery

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

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
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Generic Diabetic supplies, drugs and insulin

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

Brand Name Diabetic supplies, drugs and insulin

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

Outpatient surgery

Description	In-network	Out-of-network
At hospital outpatient department	90% per visit after deductible	60% per visit after deductible

Physician and specialist services

Physician services-general or family practitioner

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

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

Description	In-network	Out-of-network
Telemedicine provider consultation Basic medical services	Covered based on type of service and provider from which it is received	Not covered

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

Specialist

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

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

Description	In-network	Out-of-network
Telemedicine provider consultation Specialist services	Covered based on type of service and provider from which it is received	Not covered

All other services not shown above

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

Preventive care

Description	In-network	Out-of-network
Breast pump, accessories and supplies limit	Electric pump: 1 every 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
Counseling for alcohol or drug misuse	100% per visit, no deductible applies	Not covered
Counseling for alcohol or drug misuse visit limit	5 visits/ per year	Not covered
Counseling for obesity, healthy diet	100% per visit, no deductible applies	Not covered
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per year, of which up to 10 visits may be used for healthy diet counseling.	Not covered
Counseling for sexually transmitted infection	100% per visit, no deductible applies	Not covered
Counseling for sexually transmitted infection visit limit	2 visits/ per year	Not covered
Counseling for tobacco cessation	100% per visit, no deductible applies	Not covered
Counseling for tobacco cessation visit limit	8 visits/ per year	Not covered
Family planning services (female contraception counseling)	\$15 then the plan pays 100% per visit, no deductible applies	60% per visit after deductible
Immunizations	100%, no deductible applies	Not covered

Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician	Not covered
Routine physical exam	100% per visit, no deductible applies	Not covered
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams per year age 1-2; 3 exams per year age 2-3; and 1 exam per year after that age, up to age 22; 1 exam per year 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 deductible applies	60% per visit after deductible
Well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

Private duty nursing

Up to eight hours equals one shift

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

Prosthetic Devices

Description	In-network	Out-of-network
Prosthetic devices	90% per item after deductible	60% per item after deductible

Reconstructive surgery and supplies

Including breast surgery

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

Routine cancer screenings

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

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

Speech therapy (ST)

At the office	\$15 then the plan pays 100% per visit no deductible applies	60% per visit after deductible
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Physical, massage, occupational, cardiac and pulmonary therapies

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

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

Visit limit per year	20	20
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Skilled nursing facility

Description	In-network	Out-of-network
Inpatient services - room and board	\$200 then the plan pays 90% per admission after deductible	\$200 then the plan pays 60% per admission after deductible
Other inpatient services and supplies	90% per admission after deductible	60% per admission after deductible

Tests, images and labs – outpatient

Diagnostic complex imaging services

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

Diagnostic lab work

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

Diagnostic x-ray and other radiological services

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

Therapies

Chemotherapy

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

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

Description	In-network (GCIT-designated facility/provider)	Out-of-network (Including providers who are otherwise part of Aetna's network but are not GCIT-designated facilities/ providers)
Services and supplies	Covered based on type of service and where it is received	Not covered
Gene therapy products, prescription drugs	90% per visit after deductible	Not covered

Infusion therapy

Outpatient services

Description	In-network	Out-of-network
In physician office	\$15 then the plan pays 100% per visit, no deductible applies	60% per visit after deductible
At an infusion location	Covered based on type of service and where it is received	Covered based on type of service and where it is received
In the home	90% per visit after deductible	60% per visit after deductible
At hospital outpatient department	90% per visit after deductible	60% per visit after deductible
At facility that is not a hospital	90% per visit after deductible	60% per visit after deductible

Radiation therapy

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

Respiratory therapy

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

Transplant services

Description	In-network (IOE facility)	Out-of-network (Includes providers who are otherwise part of Aetna's network but are non-IOE providers)
Inpatient services and supplies	\$200 then the plan pays 90% per transplant, no deductible applies	\$200 then the plan pays 60% per transplant, no deductible applies
Physician services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Urgent care services

At a freestanding facility or **provider** that is not a **hospital**

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

Description	In-network	Out-of-network
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Urgent care facility	\$15 then the plan pays 100% per visit, no deductible applies	60% per visit after deductible
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Walk-in clinic

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