Schedule of benefits

Prepared for:

Employer:	Anne Arundel County Community College
Control number:	0175058
Employer:	Anne Arundel County Public Library
Control number:	0175057
Employer:	Anne Arundel County Government
Control number:	0175078
Contract number:	MSA-0169626
Plan name:	PPO Open Choice
Schedule of benefits:	1A
Plan effective date:	January 1, 2024
Plan issue date:	February 28, 2024

Third Party Administrative Services provided by Aetna Life Insurance Company

Third Party Administrative Services provided by Aetna Life Insurance Company

Schedule of benefits

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

How your cost share works

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

Important note:
Covered services are subject to the **deductible**, maximum out-of-pocket, limits, **copayment** or **payment percentage** unless otherwise stated in this schedule. The *Surprise bill* section in the certificate explains your protections from a surprise bill.

Under this plan, you will:

1. Pay your **copayment**
2. Then pay any remaining **deductible**
3. Then pay your **payment percentage**

Your **copayment** does not apply to any **deductible**.

How your deductible works

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **copayment** or **payment percentage** you pay when you get **covered services** from an in-network, **out-of-network provider**. This schedule shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **covered services**. You will continue to pay **copayments** or **payment percentage**, if any, for **covered services** after you meet your **deductible**.

How your PCP or physician office visit cost share works

You will pay the **PCP** cost share when you get **covered services** from any **PCP**.

How your maximum out-of-pocket works

This schedule shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of the calendar year.

Contact us

We are here to answer questions. See the *Contact us* section in Booklet 1.

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 some benefits.

Deductible type	In-network	Out-of-network
Individual	$125 per year	$500 per year
Family	$250 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	$500 per year	$1,500 per year
Family	$1,000 per year	$3,000 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 credit

If you paid part or all of your **deductible** under other coverage for the year that this plan went into effect, we will deduct the amount paid under the other coverage from the **deductible** on this plan for the same year. If we ask, you must submit a detailed explanation of benefits (EOB) showing the dates and amount of the **deductible** met from the other coverage in order to receive the credit.

Deductible carryover

Any amounts that you paid for **covered services** in the last 90 days of a year that apply toward that year's **deductible** will also count toward the following year's **deductible**.

Copayment

This is the dollar amount you pay for **covered services**. In most plans, you pay this after you meet your **deductible** limit.

Payment Percentage

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

Maximum out-of-pocket limit

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

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

Individual maximum out-of-pocket limit

- 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 rest of the clendar 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**
- Costs for non-emergency use of the emergency room
- Costs for non-urgent use of an urgent care **provider**

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.

Covered services

Abortion

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

Acupuncture

Description	In-network	Out-of-network
Acupuncture	$35 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**

Ambulance services

Description	In-network	Out-of-network
Emergency services	100% per trip, no **deductible** applies	100% per trip, no **deductible** applies
Non-**emergency services**	100% per trip, no **deductible** applies	100% per trip, no **deductible** applies

Applied behavior analysis

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

Autism spectrum disorder

Description	In-network	Out-of-network
Diagnosis and testing	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Treatment	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	100% per visit, no **deductible** applies	70% per visit after **deductible**

Bariatric surgery

Description	In-network	Out-of-network
Inpatient services – **room and board**	95% per admission after **deductible**	70% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient services	95% per visit after **deductible**	70% per visit after **deductible**

Behavioral health

Mental health treatment

Coverage provided is the same as for any other illness

Description	In-network	Out-of-network
Inpatient services-**room and board** including **residential treatment facility**	95% per admission after **deductible**	70% per admission after **deductible**
Other inpatient services and supplies Other **residential treatment facility** services and supplies	95% per admission after **deductible**	70% per admission after **deductible**

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	70% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	$15 then the plan pays 100% per visit, no **deductible** applies	70% 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	100% per visit, no **deductible** applies	70% per visit after **deductible**

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

Substance related disorders treatment

Includes **detoxification**, rehabilitation and **residential treatment facility**
Coverage provided is the same as for any other illness

Description	In-network	Out-of-network
Inpatient services-**room and board** during a **hospital stay**	95% per admission after **deductible**	70% per admission after **deductible**
Other inpatient services and supplies during a **hospital stay**	95% per admission after **deductible**	70% per admission after **deductible**

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	70% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	$15 then the plan pays 100% per visit, no **deductible** applies	70% 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	100% per visit, no **deductible** applies	70% 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

Diabetic services, supplies, equipment, and self-care programs

Description	In-network	Out-of-network
Diabetic services	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic supplies	100% per item, no **deductible** applies	100% per item, no **deductible** applies
Diabetic equipment	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic self-care programs	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	95% per item, no **deductible** applies	95% per item, no **deductible** applies

Emergency services

Description	In-network	Out-of-network
Emergency room	$75 then the plan pays 100% per visit, no **deductible** applies	Paid same as in-network
Non-emergency care in a **hospital** emergency room	Not covered	Not covered

Emergency services important note: Out-of-network providers do not have a contract with us. However, for out of network emergencies the federal No Surprises Act applies. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill. If you are admitted to the **hospital** for an inpatient **stay** right after you visit the emergency room, you will not pay your emergency room cost share if you have one. You will pay the inpatient **hospital** cost share, if any.

Foot orthotic devices

Description	In-network	Out-of-network
Orthotic devices	$35 then the plan pays 100% per item, no **deductible** applies	95% per item, no **deductible** applies

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 therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Hearing aids

Description	In-network	Out-of-network
Hearing aids	100% per item, no **deductible** applies	100% per item, no **deductible applies**

Limit	Two hearing aids every 36 months	Two hearing aids every 36 months
Limit	$1,400 per hearing aid	$1,400 per hearing aid

Home health care

A visit is a period of 4 hours or less

Description	In-network	Out-of-network
Home health care	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies

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**	100%, no **deductible** applies	100%, no **deductible** applies

Description	In-network	Out-of-network
Other inpatient services and supplies	100% per admission, no **deductible** applies	100%, no **deductible** applies

Description	In-network	Out-of-network
Outpatient services	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies

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**	95% after **deductible**	70% after **deductible**

Outpatient Hospital care

Description	In-network	Out-of-network
At **hospital** outpatient department or ambulatory surgical center	95% per visit after **deductible**	70% after per visit after **deductible**
At a facility that is not a **hospital**	95% per visit after **deductible**	70% after per visit after **deductible**
Outpatient professional services	$15 PCP or $35 specialist then the plan pays 100% per visit, no **deductible** applies.	70% after per visit after **deductible**

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
	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Limits

Description	In-network	Out-of-network
Maximum number of ovulation induction cycles per lifetime while on medications to stimulate the ovaries	6	6
Maximum number of artificial insemination cycles per lifetime	6	6

Advanced reproductive technology (ART)

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

Limits

Description	In-network	Out-of-network
Limit per lifetime	$100,000, 3 cycles maximum This limit is combined for in-network and out-of-network benefits	$100,000, 3 cycles maximum This limit is combined for in-network and out-of-network benefits

Maternity and related newborn care

Includes complications

Description	In-network	Out-of-network
Inpatient services – **room and board**	95% per admission after **deductible**	70% per admission after **deductible**
Other inpatient services and supplies	95% per admission after **deductible**	70% per admission after **deductible**
Services performed in **physician** or **specialist** office or a facility	95% per visit after **deductible**	70% per visit after **deductible**
Other services and supplies	95% per visit after **deductible**	70% per visit after **deductible**
Pre-natal maternity	100%, no deductible applies	70% per after deductible

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

Nutritional support

Description	In-network	Out-of-network
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
Treatment of mouth, jaws and teeth	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Description	In-network	Out-of-network
At **hospital** outpatient department	95% per visit after **deductible**	70% per visit after **deductible**
At facility that is not a **hospital**	95% per visit after **deductible**	70% per visit after **deductible**
At the **physician** office	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Description	In-network	Out-of-network
Physician office hours (not-surgical, not preventive)	$15 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**
Physician surgical services	$15 then the plan pays 100% per visit no **deductible applies**	70% per visit after **deductible**

Description	In-network	Out-of-network
Physician visit during inpatient **stay**	95% per visit after **deductible**	70% per visit after **deductible**

Description	In-network	Out-of-network
Physician telemedicine consultation	$15 then the plan pays 100% per visit, no **deductible** applies	70% 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
Specialist office hours (not-surgical, not preventive)	$35 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**
Specialist surgical services	$35 then the plan pays 100% per visit no **deductible applies**	70% per visit after **deductible**

Description	In-network	Out-of-network

Specialist telemedicine consultation	$35 then the plan pays 100% per visit, no **deductible** applies	70% 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

Description	In-network	Out-of-network
All other services	95% per visit after **deductible**	70% per visit after **deductible**

Description	In-network	Out-of-network
Preventive care services	100% per visit, no **deductible** applies	70% per visit after **deductible**
Breast feeding counseling and support	100% per visit, no **deductible** applies	70% per visit after **deductible**
Breast feeding counseling and support limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	100% per visit, no **deductible** applies	95% per visit, no **deductible** applies
Breast pump, accessories and supplies limit	Electric pump: 1 every 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 every 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 12 months to replace an existing electric pump	Electric pump: 12 months to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies	70% per visit after **deductible**
Counseling for alcohol or drug misuse visit limit	5 visits/12 months	5 visits/12 months
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies	70% per visit after **deductible**
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no **deductible** applies	70% per visit after **deductible**
Counseling for sexually transmitted infection visit limit	2 visits/12 months	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no **deductible** applies	70% per visit after **deductible**
Counseling for tobacco cessation visit limit	8 visits/12 months	8 visits/12 months
Family planning services (female contraception counseling)	100% per visit, no **deductible** applies	70% per visit after **deductible**
Family planning services (female contraception counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting

Immunizations	100%, no **deductible** applies	70% after **deductible**
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Generic preventive care contraceptives (birth control)	100%, no **deductible** applies	100%, no **deductible** applies
Preventive care drugs and supplements	100%, no **deductible** applies	100%, no **deductible** applies
Preventive care drugs and supplements limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section
Preventive care risk reducing breast cancer **prescription** drugs	100%, no **deductible** applies	100%, no **deductible** applies
Preventive care risk reducing breast cancer **prescription** drugs limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section
Preventive care tobacco cessation **prescription** and OTC drugs	100%, no **deductible** applies	100%, no **deductible** applies
Limit	Two 90 day treatments only	Two 90 day treatments only

Routine cancer screenings	100% per visit, no **deductible** applies	70% per visit, no **deductible** applies
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *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
Routine lung cancer screening	100% per visit, no **deductible** applies	70% per visit after **deductible**
Routine lung cancer screening limit	1 screening every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing	1 screening every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	100% per visit, no **deductible** applies	70% per visit after **deductible**
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam per calendar year after that age, up to age 22; 1 exam per calendar year after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam per calendar year after that age, up to age 22; 1 exam per calendar year after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months

Well woman GYN exam	100% per visit, no **deductible** applies	70% 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

Prosthetic devices

Description	In-network	Out-of-network
Prosthetic devices	$35 then the plan pays 100% per item, no **deductible** applies	95% per item, no **deductible** applies

Reconstructive surgery and supplies

Including breast **surgery**

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

Short-term rehabilitation services

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

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

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, occupational and speech therapies

Description	In-network	Out-of-network
	$35 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**

Physical, occupational and speech therapies

Description	In-network	Out-of-network
Visit limit per year	300	300

Spinal manipulation

Description	In-network	Out-of-network
	$35 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**

Skilled nursing facility

Description	In-network	Out-of-network
Inpatient services - **room and board**	95% per admission after **deductible**	70% per admission after **deductible**
Other inpatient services and supplies	95% per admission after **deductible**	70% per admission after **deductible**

Day limit per year	Unlimited	120

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network	Out-of-network
	95% per visit after **deductible**	95% per visit after **deductible**

Diagnostic lab work

Description	In-network	Out-of-network
At independent lab	100% per visit, no **deductible** applies	**Not covered**
At **hospital** outpatient department	95% per visit after **deductible**	95% per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network
At free standing radiology center	100% per visit, no **deductible** applies	**Not covered**
At **hospital** outpatient department	95% per visit after **deductible**	95% 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	100% per visit after **deductible**	Not covered

Infusion therapy

Outpatient services

Description	In-network	Out-of-network
	95% per visit after **deductible**	95% 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 (Institute of Excellence facility only)	Out-of-network (Includes **providers** who are otherwise part of Aetna's network but are non-Institute of Excellence **providers**)
Inpatient services and supplies	95% per transplant after **deductible**	70% per transplant after **deductible**
Physician services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Description	In-network	Out-of- network
Urgent care facility	$35 then the plan pays 100% per visit, no **deductible** applies	$35 then the plan pays 100% per visit, no **deductible** applies

Non-urgent use of an urgent care facility or **provider**	Not covered	Not covered

Walk-in clinic

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

Description	Designated network - CVS Minute Clinic	Non-designated network	Out-of-network
Non-emergency services	100% per visit, no **deductible** applies	$15 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**
Preventive care immunizations	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	70% per visit after **deductible**
Preventive care immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician or Aetna**	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 or Aetna**	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 or Aetna**
Preventive screening and counseling services	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	70% per visit after **deductible**
Preventive screening and counseling limits	See the *Preventive care services* section of the schedule	See the *Preventive care services* section of the schedule	See the *Preventive care services* section of the schedule

Description	Designated network	Non-designated network	Out-of-network
Telemedicine consultation for non-**emergency services** through a **walk-in clinic**	100% per visit no **deductible** applies	Covered based on type of service and where it is received	Not covered
Telemedicine consultation for preventive screening and counseling services through a **walk-in clinic**	100% per visit no **deductible** applies	Covered based on type of service and where it is received	Not covered

Important note:
Key terms
Designated network provider
A **network provider** listed in the directory under *Best results for your plan* as a **provider** for your plan.

Non-designated network provider
A **provider** listed in the directory under the *All other results* tab as a **provider** for your plan.
See the *Contact us* section if you have questions.

You will pay less cost share when you use a designated network **walk-in clinic provider**. Non-designated network **walk-in clinic providers** are available to you, but the cost share will be at a higher level when these **providers** are used.