

Schedule of benefits

Prepared for:

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Plan name:	Choice POS II & Pharmacy
Schedule of benefits:	4A
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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. The *Surprise bill* section in the booklet explains your protections from a surprise bill.

Under this plan, you will:

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

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

How your deductible works

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

How your PCP or physician office visit cost share works

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

How your maximum out-of-pocket works

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

Contact us

We are here to answer questions. See the *Contact us* section in your booklet.

This schedule replaces any schedule of benefits previously in use. Keep it with your booklet.

Plan features

Deductible

You have to meet your **deductible** before this plan pays for benefits.

Deductible type	In-network (In the U.S.)	Out-of-network (In the U.S.)	Outside the U.S.
Individual	\$0 per year	\$250 per year	\$0 per year
Family	\$0 per year	\$750 per year	\$0 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 (In the U.S.)	Out-of-network (In the U.S.)	Outside the U.S.
Individual	\$1,000 per year	\$1,500 per year	\$1,000 per year
Family	\$3,000 per year	\$4,500 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

Out-of-network **covered services** will apply only to the out-of-network **deductible**.

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.

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.

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.

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.

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

Acupuncture

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Acupuncture	\$20 then the plan pays 100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies

Combined visit limit per year <i>(for par and non-par providers)</i>	\$1,000	\$1,000	\$1,000
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Ambulance services

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Emergency services	100% per trip, no deductible applies	Paid same as in-network	80% per trip, no deductible applies
Non-emergency services	100% per trip, no deductible applies	100% per trip, no deductible applies	80% per trip, no deductible applies

Applied behavior analysis

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Applied behavior analysis	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Autism spectrum disorder

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

Behavioral health

Mental health disorders treatment

Coverage provided is the same as for any other illness

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Inpatient services-room and board including residential treatment facility	100% per admission, no deductible applies	100% per admission after deductible	100% per admission, no deductible applies

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Outpatient office visit to a physician or behavioral health provider	\$20 then the plan pays 100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies
Physician or behavioral health provider telemedicine consultation	\$20 then the plan pays 100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies
Outpatient mental health disorders telemedicine cognitive therapy consultations by a physician or behavioral health provider	100% per visit, no deductible applies	Not covered	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 In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Inpatient services-room and board during a hospital stay	100% per admission, no deductible applies	100% per admission after deductible	100% per admission, no deductible applies

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Outpatient office visit to a physician or behavioral health provider	\$20 then the plan pays 100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies
Physician or behavioral health provider telemedicine consultation	\$20 then the plan pays 100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies
Outpatient telemedicine cognitive therapy consultations by a physician or behavioral health provider	100% per visit, no deductible applies	Not covered	Not covered

Clinical trials

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Experimental or investigational therapies	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Routine patient care	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Diabetic services, supplies, equipment and self-care programs

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Diabetic services	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic equipment	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
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	Covered based on type of service and where it is received

Durable medical equipment (DME)

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
DME	100% per item, no deductible applies	80% per item no deductible applies	80% per item, no deductible applies

Emergency services

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Emergency room	\$75 then the plan pays 100% per visit, no deductible applies	Paid same as in-network	\$75 then the plan pays 100% per visit, no deductible applies

Non -emergency care in a hospital emergency room	Not covered	Not covered	\$75 then the plan pays 100% per visit, no deductible applies
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Emergency services important note: Out-of-network providers do not have a contract with us. However, for out of network emergencies the federal No Surprises Act applies. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill. If you are admitted to the **hospital** for an inpatient **stay** right after you visit the emergency room, you will not pay your emergency room cost share if you have one. You will pay the inpatient **hospital** cost share, if any.

Foot orthotic devices

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Orthotic devices	100% per item, no deductible applies	Hospital: 100% per item, no deductible applies Other Facilities: 80% per item no deductible applies	80% per item, no deductible applies

Habilitation therapy services

Physical (PT), occupational (OT) therapies

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

Speech therapy (ST)

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
ST	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Hearing aids

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Hearing aids	80% per item, no deductible applies	80% per item after deductible	80% per item, no deductible applies

Limit	One per ear every 3 years	One per ear every 3 years	One per ear every 3 years
Limit maximum	\$750	\$750	\$750

Hearing exams

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Hearing exams	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Visit limit	1 visit every 36 months	1 visit every 36 months	1 visit every 36 months

Home health care

A visit is a period of 4 hours or less

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Home health care	100% per visit, no deductible applies	100% per visit, no deductible applies	100% per visit, no deductible applies

Visit limit per year	200	200	200
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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 In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Inpatient services - room and board	100% per admission, no deductible applies	100% per admission, no deductible applies	100% per admission, no deductible applies

Day limit per lifetime	210 days	210 days	210 days
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Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Outpatient services	100% per visit, no deductible applies	100% per visit, no deductible applies	100% per visit, no deductible applies

Limit per lifetime	unlimited	unlimited	unlimited
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Hospice important note:

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

Hospital care

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Inpatient services – room and board	100% per admission, no deductible applies	100% per admission, no deductible applies	100% per admission, no deductible applies

Infertility services

Basic infertility

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Treatment of basic infertility	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Comprehensive infertility services

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
	100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies

Limits

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Number of ovulation induction cycles per lifetime while on medications to stimulate the ovaries	6	6	6
Number of artificial insemination cycles per lifetime	6	6	6

Advanced reproductive technology (ART)

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
	100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies

Limits

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Limit per lifetime	\$25,000 This limit is combined for in-network and out-of-network benefits	\$25,000 This limit is combined for in-network and out-of-network benefits	\$25,000 This limit is combined for in-network and out-of-network benefits

Maternity and related newborn care

Includes complications

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Inpatient services – room and board	100% per admission, no deductible applies	100% per admission, no deductible applies	100% per admission, no deductible applies
Services performed in physician or specialist office or a facility	100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies
Other services and supplies	100%, no deductible applies	100%, no deductible applies	80%, 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.

Nutritional support

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Nutritional support	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Obesity surgery

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Inpatient services – room and board	100% per admission, no deductible applies	100% per admission, no deductible applies	100% per admission, no deductible applies

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Outpatient services at a specialist office	100% per visit, no deductible applies	100% per visit, no deductible applies	80% per visit, no deductible applies
Outpatient services at hospital outpatient department	100% per visit, no deductible applies	100% per visit, no deductible applies	100% per visit, no deductible applies
Outpatient services at a facility that is not a hospital	100% per visit, no deductible applies	100% per visit, no deductible applies	80% per visit, no deductible applies

Outpatient prescription drugs Out-of-network (In the U.S.) and Outside the U.S.

Description	Cost share	Cost share
	Out-of-network (In the U.S.)	Outside the U.S.
Prescription drugs	60% per supply after deductible	80% per supply no deductible applies

Outpatient prescription drugs in the U.S.

Generic prescription drugs

Description	In-network
Each 31 day supply up to 12 months at a retail pharmacy	20% whichever is greater but more than \$20 maximum and no less than \$5 minimum, no deductible applies
Each 31 day supply up to 12 months at a mail order pharmacy	20% whichever is greater but more than \$50 maximum and no less than \$20 minimum, no deductible applies

Brand-name prescription drugs

Description	In-network
Each 31 day supply up to 12 months at a retail pharmacy	25% whichever is greater but more than \$30 maximum, no deductible applies
Each 31 day supply up to 12 months at a mail order pharmacy	\$15 copay

Outpatient prescription drug important note:

If a **provider** prescribes a covered **brand-name prescription drug** when a **generic prescription drug** equivalent is available and specifies “Dispense As Written” (DAW), you will pay the cost share for the brand-name drug. If a **provider** does not specify DAW and you request a covered **brand-name prescription drug**, you will be responsible for the cost difference between the brand-name drug and the generic drug, plus the cost share that applies to the brand-name drug.

Outpatient surgery

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
At hospital outpatient department	100% per visit, no deductible applies	100% per visit, no deductible applies	100% per visit, no deductible applies
At facility that is not a hospital	100% per visit, no deductible applies	100% per visit, no deductible applies	80% per visit, no deductible applies
At the physician office	100% per visit, no deductible applies	100% per visit, no deductible applies	80% per visit, no deductible applies

Physician and specialist services**Physician services-general or family practitioner**

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Physician office hours (not-surgical, not preventive)	\$15 then the plan pays 100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies
Physician surgical services	\$15 then the plan pays 100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Physician telemedicine consultation	\$15 then the plan pays 100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies

Specialist

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Specialist office hours (not-surgical, not preventive)	\$20 then the plan pays 100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies
Specialist surgical services	\$20 then the plan pays 100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Specialist telemedicine consultation	\$20 then the plan pays 100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies

All other services not shown above

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
All other services	100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies

Preventive care

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Counseling for alcohol or drug misuse	100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies
Counseling for alcohol or drug misuse visit limit	5 visits/12 months	5 visits/12 months	5 visits/12 months
Counseling for obesity, healthy diet	100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies
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.	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	80% per visit after deductible	80% per visit, no deductible applies
Counseling for sexually transmitted infection visit limit	2 visits/12 months	2 visits/12 months	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies
Counseling for tobacco cessation visit limit	8 visits/12 months	8 visits/12 months	8 visits/12 months
Family planning services (female contraception, counseling)	100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies
Family planning services (female contraception, counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting Counselings that exceed this limit are covered as a physician services office visit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting Counselings that exceed this limit are covered as a physician services office visit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting Counselings that exceed this limit are covered as a physician services office visit
Immunizations	100%, no deductible applies	100%, no deductible applies	80% per visit, no deductible applies
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	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

Routine physical exam	100% per visit, no deductible applies	100% per visit, no deductible applies	80% per visit, no deductible applies
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 6 exams from age 0-1 year; 2 exams from age 1-2; 1 exam every 12 months age 2-7; and 1 exam every 12 months age 7-19; 1 exam every 12 months after age 19 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 6 exams from age 0-1 year; 2 exams from age 1-2; 1 exam every 12 months age 2-7; and 1 exam every 12 months age 7-19; 1 exam every 12 months after age 19 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 6 exams from age 0-1 year; 2 exams from age 1-2; 1 exam every 12 months age 2-7; and 1 exam every 12 months age 7-19; 1 exam every 12 months after age 19 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months
Well woman GYN exam	\$15 then the plan pays 100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies
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	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 In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Outpatient services	100% per visit, no deductible applies	100% per visit, no deductible applies	100% per visit, no deductible applies
Visit/shift limit per year	70	70	70
Limit per year	\$5,000	\$5,000	\$5,000
Limit per lifetime	\$10,000	\$10,000	\$10,000

Prosthetic devices

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Prosthetic devices	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Reconstructive surgery and supplies

Including breast surgery

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Surgery and supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Routine cancer screenings

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Colonoscopy	100% per test, no deductible applies	80% per test after deductible	80% per test, no deductible applies
Digital rectal examination (DRE)	\$15 then the plan pays 100% per exam, no deductible applies	80% per exam after deductible	80% per exam no deductible applies
Double contrast barium enemas (DCBE)	100% per test, no deductible applies	80% per test after deductible	80% per test, no deductible applies
Fecal occult blood test (FOBT)	100% per test, no deductible applies	80% per test after deductible	80% per test, no deductible applies
Mammogram	100% per test, no deductible applies	80% per test after deductible	80% per test, no deductible applies
Prostate specific antigen (PSA) test	\$15 then the plan pays 100% per test, no deductible applies	80% per test after deductible	80% per test, no deductible applies
Sigmoidoscopy	100% per test, no deductible applies	80% per test after deductible	80% per test, no deductible applies

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 <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 physician 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 physician or see the <i>Contact us</i> section
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Short-term rehabilitation services

Cardiac rehabilitation

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Cardiac rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Pulmonary rehabilitation

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Pulmonary rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Cognitive rehabilitation

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Cognitive rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Physical, occupational and speech therapies

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
	100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies

Spinal manipulation

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
	\$20 then the plan pays 100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies

Visit limit per year	\$1,000	\$1,000	\$1,000
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Skilled nursing facility

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Inpatient services - room and board	100% per admission no deductible applies	100% per admission, no deductible applies	100% per admission, no deductible applies
Other inpatient services and supplies	100% per admission, no deductible applies	100% per admission, no deductible applies	100% per admission, no deductible applies

Day limit per year	365	365	365
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Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
	100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies

Diagnostic lab work

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
	100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies

Diagnostic x-ray and other radiological services

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
	100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies

Therapies

Chemotherapy

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Chemotherapy services	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

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

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

Therapies**Chemotherapy**

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Chemotherapy services	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Radiation therapy

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Radiation therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Respiratory therapy

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Respiratory therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Transplant services

Description	In-network In the U.S.	Out-of-network (Includes providers who are otherwise part of Aetna's network but are non-IOE providers) In the U.S.	Outside the U.S.
Inpatient services and supplies	100% per transplant, no deductible applies	100% per transplant, no deductible applies	100% 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	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 In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Urgent care facility	\$20 then the plan pays 100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
	\$20 then the plan pays 100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies

Visit limit	1 visit every 12 months	1 visit every 12 months	1 visit every 12 months
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Walk-in clinic

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

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Non-emergency services	\$15 then the plan pays 100% per visit, no deductible applies	80% per visit after deductible	80% per visit no deductible applies
Preventive immunizations	\$15 then the plan pays 100% per visit, no deductible applies	80% per visit after deductible	80% per visit, no deductible applies
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	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	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