

Schedule of benefits

Prepared for:

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Schedule of benefits:	2A
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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:
 - 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.

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**.

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

General coverage provisions

This section explains the **deductible** and limitations listed in this schedule.

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**. The **maximum out-of-pocket limit** is unlimited.

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

Acupuncture

Description	In-network
Acupuncture	\$20 then the plan pays 100% per visit, no deductible applies

Ambulance services

Description	In-network
Emergency services	100% per trip, no deductible applies
Non- emergency services ground, air, or water ambulance	Not covered

Applied behavior analysis

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

Autism spectrum disorder

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

Behavioral health

Mental health treatment

Coverage provided is the same as for any other illness

Description	In-network
Inpatient services-room and board including residential treatment facility	100% per admission, no deductible applies
Other inpatient services and supplies Other residential treatment facility services and supplies	100% per admission, no deductible applies

Description	In-network
Outpatient office visit to a physician or behavioral health provider	\$20 then the plan pays 100% per visit, no deductible applies
Physician or behavioral health provider telemedicine consultation	\$20 then the plan pays 100% per visit, no deductible applies
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

Substance related disorders treatment

Includes detoxification, rehabilitation and residential treatment facility

Coverage provided is the same as for any other illness

Description	In-network
Inpatient services-room and board during a hospital stay	100% per admission, no deductible applies
Other inpatient services and supplies during a hospital stay	100% per admission, no deductible applies

Description	In-network
Outpatient office visit to a physician or behavioral health provider	\$20 then the plan pays 100% per visit, no deductible applies
Physician or behavioral health provider telemedicine consultation	\$20 then the plan pays 100% per visit, no deductible applies
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

Clinical trials

Description	In-network
Experimental or investigational therapies	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

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

Description	In-network
Diabetic services	Covered based on type of service and where it is received
Diabetic supplies	Covered based on type of service and where it is received
Diabetic equipment	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

Durable medical equipment (DME)

Description	In-network
DME	100% per item, no deductible applies

Emergency services

Description	In-network	Out-of-network
Emergency room	\$100 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
Orthotic devices	100% per item, no deductible applies

Habilitation therapy services

Outpatient physical (PT), occupational (OT) therapies

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

Outpatient speech therapy (ST)

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

Hearing aids

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

Limit	One hearing aid every 36 months
Limit	\$1,400 every 36 months

Hearing exams

Description	In-network
Hearing exams	Covered based on type of service and where it is received
Visit limit	1 visit every 24 months

Home health care

A visit is a period of 4 hours or less

Description	In-network
Home health care	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
Inpatient services - room and board	100%, no deductible applies

Other inpatient services and supplies	100% per admission, no deductible applies
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Description	In-network
Outpatient services	100% per visit, no deductible applies

Limit per lifetime	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
Inpatient services - room and board	100%, no deductible applies

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

Infertility services

Basic infertility

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

Maternity and related newborn care

Includes complications

Description	In-network
Inpatient services – room and board	100% per admission, no deductible applies
Other inpatient services and supplies	100% per admission, no deductible applies
Services performed in physician or specialist office or a facility	100% per visit, no deductible applies
Other services and supplies	100% per visit, 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 booklet. It will give you more information about coverage for maternity care under this plan.

Obesity surgery

Description	In-network
Inpatient services – room and board	100% per admission, no deductible applies
Other inpatient services and supplies	100% per admission, no deductible applies

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

Oral and maxillofacial treatment (mouth, jaws and teeth)

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

Outpatient surgery

Description	In-network
At hospital outpatient department	100% per visit, no deductible applies
At facility that is not a hospital	100% per visit, no deductible applies
At the physician office	Covered based on type of service and where it is received

Physician and specialist services

Physician services-general or family practitioner

Including surgical services

Description	In-network
Physician office hours (not-surgical, not preventive)	\$10 then the plan pays 100% per visit, no deductible applies
Physician surgical services	\$10 then the plan pays 100% per visit, no deductible applies

Description	In-network
Physician visit during inpatient stay	100% per visit no deductible applies

Description	In-network
Physician telemedicine consultation	\$10 then the plan pays 100% per visit, no deductible applies

Description	In-network
Telemedicine provider consultation	Covered based on type of service and provider from which it is received
Basic medical services	

Specialist

Description	In-network
Specialist office hours (not surgical, not preventive)	\$20 then the plan pays 100% per visit, no deductible applies
Specialist surgical services	\$20 then the plan pays 100% per visit, no deductible applies

Description	In-network
Specialist telemedicine consultation	\$20 then the plan pays 100% per visit, no deductible applies

All other services not shown above

Description	In-network
All other services	100% per visit, no deductible applies

Preventive care

Description	In-network
Breast feeding counseling and support	\$10 then the plan pays 100% per visit, no deductible applies
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
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
Breast pump waiting period	Electric pump: 12 months to replace an existing electric pump
Family planning services (female contraception counseling)	100% per visit, no deductible applies
Immunizations	\$10 then the plan pays 100%, 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
Routine physical exam	\$10 then the plan pays 100% 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 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months
Well woman GYN exam	\$10 then the plan pays 100% 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
Limit	Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22

Private duty nursing

Up to 8 hours equals one shift

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

Prosthetic devices

Description	In-network
Prosthetic devices	100% per item, no deductible applies

Reconstructive surgery and supplies

Including breast **surgery**

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

Routine cancer screenings

Description	In-network
Colonoscopy	100% per visit, no deductible applies
Digital rectal examination (DRE)	\$10 then the plan pays 100% per visit, no deductible applies
Double contrast barium enema (DCBE)	100% per visit, no deductible applies
Fecal occult blood test (FOBT)	100% per visit, no deductible applies
Mammogram	100% per visit, per visit, no deductible applies
Prostate specific antigen (PSA) test	\$10 then the plan pays 100% per visit, no deductible applies
Sigmoidoscopy	100% per visit, per visit, 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

Short-term rehabilitation services

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

Cardiac rehabilitation

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

Pulmonary Rehabilitation

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

Cognitive Rehabilitation

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

Physical, Occupational and Speech Therapies

Description	In-network
	\$20 then the plan pays 100% per visit, no deductible applies

Physical, occupational and speech therapies

Description	In-network
Visit limit per year	60
Physical, occupational and speech therapies combined	

Spinal Manipulation

Description	In-network
	\$20 then the plan pays 100% per visit, no deductible applies

Visit limit per year	20
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Skilled nursing facility

Description	In-network
Inpatient services - room and board	100% per admission, no deductible applies
Other inpatient services and supplies	100%per admission, no deductible applies

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network
	100% per visit, no deductible applies

Diagnostic lab work

Description	In-network
	100% per visit, no deductible applies

Diagnostic x-ray and other radiological services

Description	In-network
	100% per visit, no deductible applies

Therapies

Chemotherapy

Description	In-network
Chemotherapy services	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%, no deductible applies	Not covered

Infusion therapy

Outpatient services

Description	In-network
In physician office	\$20 then the plan pays 100% per visit, no deductible applies
At an infusion location	Covered based on type of service and where it is received
In the home	100% per visit, no deductible applies
At hospital outpatient department	100% per visit, no deductible applies
At facility that is not a hospital	100% per visit, no deductible applies

Radiation therapy

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

Respiratory therapy

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

Transplant services

Description	In-network (IOE facility)
Inpatient services and supplies	100% per transplant, no deductible applies
Physician services	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
Urgent care facility	\$25 then the plan pays 100% per visit, no deductible applies
Non-urgent use of an urgent care facility or provider	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	In-network
Non-emergency services	\$10 then the plan pays 100% per visit, no deductible applies
Preventive care immunizations	\$10 then the plan pays 100% per visit, no deductible applies
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