

Schedule of benefits

Prepared for:

Employer:	Howard County, Maryland
Contract number:	ASA-0622786
Plan name:	Open Choice Medical Plan
Schedule of benefits:	1A
Plan effective date:	January 1, 2026
Plan issue date:	March 17, 2026

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**.
- **Other health care** coverage is care you get from an **out-of-network provider** when you could not reasonably get services and supplies from an in-network **provider**.
- 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.

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

Precertification covered services reduction

This only applies to **out-of-network covered services**:

Your booklet contains a complete description of the **precertification** process. You will find details in the *Medical necessity and precertification* section.

If **precertification** for **covered services** isn't completed, when required, it results in the following benefit reduction:

- A \$300 benefit reduction applied separately to each type of **covered service**

You may have to pay an additional portion of the **recognized charge** because you didn't get **precertification**. This portion is not a **covered service** and doesn't apply to your **deductible** or **maximum out-of-pocket limit**, if you have one.

Deductible

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

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

Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	In-network	Out-of-network
Individual	\$1,500 per year	\$4,000 per year
Family	\$3,000 per year	\$8,000 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.

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 remainder of the year for all covered family members. The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members.

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

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

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

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

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

Limit provisions

Covered services applied to the in-network limit will not apply to the out-of-network limit. **Covered services** applied to the out-of-network limit will not apply to the in-network limit.

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	90% per visit, no deductible applies	90% per visit, no deductible applies

Ambulance services

Description	In-network	Out-of-network
Emergency services	90% per trip after deductible	Paid same as in-network
Non-emergency services ground, air, or water ambulance	70% per trip after deductible	Paid same as in-network

Applied behavior analysis

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

Autism spectrum disorder

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

Behavioral health

Mental health 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	90% per admission after deductible	70% per admission after deductible
Other inpatient services and supplies Other residential treatment facility services and supplies	90% 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	\$20 then the plan pays 90% per visit, no deductible applies	70% per visit after deductible
Physician or behavioral health provider telemedicine consultation	\$20 then the plan pays 90% 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

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	90% per admission after deductible	70% per admission after deductible
Other inpatient services and supplies during a hospital stay	90% 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	\$20 then the plan pays 90% per visit, no deductible applies	70% per visit after deductible
Physician or behavioral health provider telemedicine consultation	\$20 then the plan pays 90% 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

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	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
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	90% per item after deductible	70% per item after deductible

Emergency services

Description	In-network	Out-of-network
Emergency room	\$100 then the plan pays 90% per visit, no deductible applies	Paid same as in-network
Non-emergency care in a hospital emergency room	50% per visit after deductible	50% per visit after deductible

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	90% per item after deductible	70% per item after deductible

Habilitation therapy services

Outpatient 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

Outpatient 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	90% per item after deductible	70% per item after deductible

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

Hearing exams

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

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	70% per visit after deductible

Visit limit per year	120	120
----------------------	-----	-----

Home health care important note:

Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits.

Hospice care

Description	In-network	Out-of-network
Inpatient services - room and board	90% after deductible	70% after deductible

Other inpatient services and supplies	90% per admission after deductible	70% after deductible
---------------------------------------	---	-----------------------------

Description	In-network	Out-of-network
Outpatient services	90% per visit after deductible	70% per visit after deductible

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	90% after deductible	70% after deductible

Description	In-network	Out-of-network
Other inpatient services and supplies	90% per admission after deductible	70% after per admission 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

Maternity and related newborn care

Includes complications

Description	In-network	Out-of-network
Inpatient services – room and board	90% per admission after deductible	70% per admission after deductible
Other inpatient services and supplies	90% per admission after deductible	70% per admission after deductible
Services performed in physician or specialist office or a facility	90% per visit after deductible	70% per visit after deductible
Other services and supplies	90% per visit after deductible	70% per visit 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.

Obesity surgery

Description	In-network	Out-of-network
Inpatient services – room and board	90% per admission after deductible	70% per admission after deductible
Other inpatient services and supplies	90% per admission after deductible	70% per admission after deductible

Description	In-network	Out-of-network
Outpatient services	90% per visit after deductible	70% per visit after deductible

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

Outpatient surgery

Description	In-network	Out-of-network
At hospital outpatient department	90% per visit after deductible	70% per visit after deductible
At facility that is not a hospital	90% 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

Physician and specialist services

Physician services-general or family practitioner

Including surgical services

Description	In-network	Out-of-network
Physician office hours (not-surgical, not preventive)	\$20 then the plan pays 90% per visit, no deductible applies	70% per visit after deductible
Physician surgical services	90% per visit after deductible	70% per visit after deductible

Description	In-network	Out-of-network
Physician visit during inpatient stay	90% per visit after deductible	70% per visit after deductible

Description	In-network	Out-of-network
Physician telemedicine consultation	\$20 then the plan pays 90% 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

Specialist

Description	In-network	Out-of-network
Specialist office hours (not-surgical, not preventive)	\$20 then the plan pays 90% per visit, no deductible applies	70% per visit after deductible
Specialist surgical services	90% per visit after deductible	70% per visit after deductible

Description	In-network	Out-of-network
Specialist telemedicine consultation	\$20 then the plan pays 90% per visit, no deductible applies	70% per visit after deductible

All other services not shown above

Description	In-network	Out-of-network
All other services	90% per visit after deductible	70% per visit after deductible

Preventive care

Description	In-network	Out-of-network
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	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
Family planning services (female contraception counseling)	\$20 then the plan pays 90% per visit, no deductible applies	70% per visit after deductible
Immunizations	\$20 then the plan pays 90%, 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

Routine physical exam	\$20 then the plan pays 90% 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 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	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	\$20 then the plan pays 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
Limit	1 visit per Calendar Year	1 visit per Calendar Year

Private duty nursing

Up to 8 hours equals one shift

Description	In-network	Out-of-network
Outpatient services	90% per visit after deductible	70% per visit after deductible

Visit/shift limit per year	70	70
----------------------------	----	----

Prosthetic devices

Description	In-network	Out-of-network
Prosthetic devices	90% per item after deductible	70% per item after deductible

Reconstructive surgery and supplies

Including breast surgery

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

Routine cancer screenings

Description	In-network	Out-of-network
Colonoscopy	90% per visit after deductible	70% per visit after deductible
Digital rectal examination (DRE)	\$20 then the plan pays 90% per visit, no deductible applies	70% per visit after deductible
Double contrast barium enema (DCBE)	90% per visit after deductible	70% per visit after deductible
Fecal occult blood test (FOBT)	90% per visit after deductible	70% per visit after deductible
Mammogram	100% per visit, no deductible applies	70% per visit after deductible
Prostate specific antigen (PSA) test	\$20 then the plan pays 90% per visit, no deductible applies	70% per visit after deductible
Sigmoidoscopy	90% per visit after deductible	70% per visit after deductible
Cancer screening limits	<p>Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF</p> <p>The comprehensive guidelines supported by the Health Resources and Services Administration</p> <p>For more information contact your physician or see the <i>Contact us</i> section</p>	<p>Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF</p> <p>The comprehensive guidelines supported by the Health Resources and Services Administration</p> <p>For more information contact your physician or see the <i>Contact us</i> section</p>

Short-term rehabilitation services

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
	90% per visit after deductible	70% per visit after deductible

Physical, occupational and speech therapies

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

Spinal manipulation

Description	In-network	Out-of-network
	\$20 then the plan pays 90% per visit, no deductible applies	70% per visit after deductible

Visit limit per year	20	20
In-network and out-of-network combined		

Skilled nursing facility

Description	In-network	Out-of-network
Inpatient services - room and board	90% per admission after deductible	70% per admission after deductible
Other inpatient services and supplies	90% per admission after deductible	70% per admission after deductible

Day limit per year	120	120
--------------------	-----	-----

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network	Out-of-network
	90% per visit after deductible	70% per visit after deductible

Diagnostic lab work

Description	In-network	Out-of-network
	90% per visit after deductible	70% per visit after deductible

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network
	90% per visit after deductible	70% 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%, no deductible applies	Not covered

Infusion therapy

Outpatient services

Description	In-network	Out-of-network
In physician office	\$20 then the plan pays 90% per visit, no deductible applies	70% per visit after deductible
At an infusion location	Covered based on type of service and where it is received	Covered based on type of service and where it is received
In the home	100% per visit, no deductible applies	70% per visit after deductible
At hospital outpatient department	100% per visit, no deductible applies	70% per visit after deductible
At facility that is not a hospital	100% per visit, no deductible applies	70% per visit after deductible

Radiation therapy

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

Respiratory therapy

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

Transplant services

Description	In-network (IOE facility)	Out-of-network (Includes providers who are otherwise part of Aetna's network but are non-IOE providers)
Inpatient services and supplies	90% 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	\$25 then the plan pays 90% per visit, no deductible applies	70% per visit after deductible

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

Walk-in clinic

Description	In-network	Out-of-network
Non- emergency services	\$20 then the plan pays 90% per visit, no deductible applies	70% per visit after deductible
Preventive care immunizations	\$20 then the plan pays 90% 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	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