

## **Schedule of benefits**

If this is an ERISA plan, you may have certain rights under this plan. ERISA may not apply to a church or government group. Please contact the employer for additional information.

**Prepared for:**

Employer:	Baxter Credit Union
Contract number:	MSA-0232282
Plan name:	Choice POS II High Deductible Health Plan
Schedule of benefits:	1B
Plan effective date:	January 1, 2025
Plan issue date:	November 12, 2024

**Third Party Administrative Services provided by Aetna Life Insurance Company**

## Schedule of benefits

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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.

### 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 \$400 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	\$2,000 per year	\$4,000 per year
Family	\$4,000 per year	\$8,000 per year

### Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	In-network	Out-of-network
Individual	\$4,000 per year	\$8,000 per year
Family	\$8,000 per year	\$16,000 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** that are subject to the **deductible** include those provided under the medical plan and the **prescription drug plan**.

In-network **covered services** will apply only to the in-network **deductible**. 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. After the amount paid for **covered services** reaches this individual **deductible**, this plan starts to pay for **covered services** for the rest of the year. The individual **deductible** applies to a person who is enrolled for self-only coverage with no dependent coverage.

### Family deductible

You and your covered dependents 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. The family **deductible** applies to a person enrolled with one or more dependents.

### **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** that are subject to the **maximum out-of-pocket limit** include those provided under the medical plan and the outpatient **prescription** drug plan.

In-network **covered services** will apply only to the in-network **maximum out-of-pocket limit**. Out-of-network **covered services** will apply only to the out-of-network **maximum out-of-pocket limit**.

### **Individual maximum out-of-pocket limit**

After the amount of the cost share and **deductible** paid during the year for **covered services** meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for you for the remainder of the year.

### **Family maximum out-of-pocket limit**

After the amount of the cost share and **deductible** paid during the year for **covered services** meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the year.

For the purposes of the **maximum out-of-pocket limit** provision:

- The individual **maximum out-of-pocket limit** applies to a person enrolled for self-only coverage with no dependent coverage
- The family **maximum out-of-pocket limit** applies to a person enrolled with one or more dependents

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

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

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

### **Limit provisions**

**Covered services** will apply to the in-network and out-of-network limits.

### **Your financial responsibility and decisions regarding benefits**

We base your financial responsibility for the cost of **covered services** on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in

more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the booklet.

## Covered services

### Abortion

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

### Acupuncture

Description	In-network	Out-of-network
Acupuncture	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>

Visit limit per year	20	20
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### Ambulance services

Description	In-network	Out-of-network
<b>Emergency services</b>	80% per trip after <b>deductible</b>	Paid same as in-network
<b>Non-emergency services</b> ground, air, or water ambulance	Not covered	Not covered

### 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

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
Inpatient services- <b>room and board</b> including <b>residential treatment facility</b>	80% per admission after <b>deductible</b>	60% per admission after <b>deductible</b>
Other inpatient services and supplies Other <b>residential treatment facility</b> services and supplies	80% per admission after <b>deductible</b>	60% per admission after <b>deductible</b>

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
Outpatient office visit to a <b>physician</b> or <b>behavioral health provider</b>	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>
<b>Physician</b> or <b>behavioral health provider</b> <b>telemedicine</b> consultation	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>
Outpatient <b>mental health disorders</b> <b>telemedicine</b> cognitive therapy consultations by a <b>physician</b> or <b>behavioral health provider</b>	Covered based on type of service and <b>provider</b> from which it is received	Covered based on type of service and <b>provider</b> from which it is received

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
Other outpatient services including: <ul style="list-style-type: none"> <li>Behavioral health services in the home</li> <li>Partial hospitalization treatment</li> <li>Intensive outpatient program</li> </ul> <p>The cost share doesn't apply to in-network peer counseling support services after you meet</p>	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>



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

### **Substance related disorders treatment**

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

Coverage provided is the same as for any other illness

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
Inpatient services- <b>room and board</b> during a <b>hospital stay</b>	80% per admission after <b>deductible</b>	60% per admission after <b>deductible</b>
Other inpatient services and supplies during a <b>hospital stay</b>	80% per admission after <b>deductible</b>	60% per admission after <b>deductible</b>
<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
Outpatient office visit to a <b>physician</b> or <b>behavioral health provider</b>	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>
<b>Physician or behavioral health provider telemedicine consultation</b>	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>
Outpatient <b>telemedicine</b> cognitive therapy consultations by a <b>physician or behavioral health provider</b>	Covered based on type of service and <b>provider</b> from which it is received	Covered based on type of service and <b>provider</b> from which it is received

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
Other outpatient services including: <ul style="list-style-type: none"> <li>• Behavioral health services in the home</li> <li>• Partial hospitalization treatment</li> <li>• Intensive outpatient program</li> </ul> The cost share doesn't apply to in-network peer counseling support services after you meet your <b>deductible</b>	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>

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

### Clinical trials

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Experimental or investigational</b> 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

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
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)

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
DME	80% per item after <b>deductible</b>	60% per item after <b>deductible</b>

## Emergency services

Description	In-network	Out-of-network
Emergency room	80% per visit after <b>deductible</b>	Paid same as in-network
Non-emergency care in a <b>hospital</b> 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.

## 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	80% per item after <b>deductible</b>	60% per item after <b>deductible</b>
Limit	Two hearing aids and batteries every 24 months	Two hearing aids and batteries every 24 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	Not applicable	Not applicable

## Home health care

A visit is a period of 4 hours or less

Description	In-network	Out-of-network
Home health care	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>
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 - <b>room and board</b>	80% after <b>deductible</b>	60% after <b>deductible</b>

Other inpatient services and supplies	80% per admission after <b>deductible</b>	60% after <b>deductible</b>
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Description	In-network	Out-of-network
Outpatient services	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>

Limit per lifetime	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	Out-of-network
Inpatient services – <b>room and board</b>	80% after <b>deductible</b>	60% after <b>deductible</b>

Description	In-network	Out-of-network
Other inpatient services and supplies	80% per admission after <b>deductible</b>	60% after <b>deductible</b>

**Infertility services****Basic infertility**

Description	In-network	Out-of-network
Treatment of basic <b>infertility</b>	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

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
Inpatient services – <b>room and board</b>	80% per admission after <b>deductible</b>	60% per admission after <b>deductible</b>
Other inpatient services and supplies	80% per admission after <b>deductible</b>	60% per admission after <b>deductible</b>
Services performed in <b>physician</b> or <b>specialist</b> office or a facility	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>
Other services and supplies	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>

**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**

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
Inpatient services – <b>room and board</b>	80% per admission after <b>deductible</b>	60% per admission after <b>deductible</b>
Other inpatient services and supplies	80% per admission after <b>deductible</b>	60% per admission after <b>deductible</b>

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
Outpatient services	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>

**Oral and maxillofacial treatment (mouth, jaws and teeth)**

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
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**

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
At <b>hospital</b> outpatient department	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>
At facility that is not a <b>hospital</b>	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>
At the <b>physician</b> 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

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Physician</b> office hours (not-surgical, not preventive)	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>

<b>Physician</b> surgical services	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>
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<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Physician</b> visit during inpatient <b>stay</b>	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Physician</b> telemedicine consultation	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>

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

### Specialist

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Specialist</b> office hours (not-surgical, not preventive)	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>
<b>Specialist</b> surgical services	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Specialist</b> telemedicine consultation	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>

### All other services not shown above

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
All other services	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>

### Preventive care

<b>Description</b>	<b>In-network</b>	<b>Out-of-network</b>
Preventive care services	100% per visit, no <b>deductible</b> applies	60% per visit after <b>deductible</b>
Breast feeding counseling and support	100% per visit, no <b>deductible</b> applies	60% per visit after <b>deductible</b>
Breast feeding counseling and support limit	6 visits in a group or individual setting  Visits that exceed the limit are covered under the <b>physician</b> services office visit	6 visits in a group or individual setting  Visits that exceed the limit are covered under the <b>physician</b> 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
Counseling for alcohol or drug misuse	100% per visit, no <b>deductible</b> applies	60% per visit after <b>deductible</b>
Counseling for alcohol or drug misuse visit limit	5 visits/12 months	5 visits/12 months
Counseling for obesity, healthy diet	100% per visit, no <b>deductible</b> applies	60% per visit after <b>deductible</b>
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no <b>deductible</b> applies	60% per visit after <b>deductible</b>
Counseling for sexually transmitted infection visit limit	2 visits/12 months	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no <b>deductible</b> applies	60% per visit after <b>deductible</b>
Counseling for tobacco cessation visit limit	8 visits/12 months	8 visits/12 months
Family planning services (female contraception counseling)	100% per visit, no <b>deductible</b> applies	60% per visit after <b>deductible</b>
Family planning services (female contraception counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting

Immunizations	100%, no <b>deductible</b> applies	60% after <b>deductible</b>
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 <b>physician</b>	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 <b>physician</b>
Routine cancer screenings	100% per visit, no <b>deductible</b> applies	60% per visit after <b>deductible</b>
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current:  Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF  The comprehensive guidelines supported by the Health Resources and Services Administration  For more information contact your <b>physician</b> 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 <b>physician</b> or see the <i>Contact us</i> section
Generic preventive care female contraceptives (birth control)	100%	100%
Preventive care drugs and supplements	100%	100%
Preventive care drugs and supplements limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF  For a current list of covered preventive care drugs and supplements or more information, see the <i>Contact us</i> section	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF  For a current list of covered preventive care drugs and supplements or more information, see the <i>Contact us</i> section
Preventive care risk reducing breast cancer <b>prescription</b> drugs	100%	100%



Preventive care risk reducing breast cancer <b>prescription</b> drugs limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF  For a current list of covered preventive care drugs and supplements or more information, see the <i>Contact us</i> section	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF  For a current list of covered preventive care drugs and supplements or more information, see the <i>Contact us</i> section
Preventive care tobacco cessation <b>prescription</b> and OTC drugs	100%	100%
Limit	Two 90 day treatments only	Two 90 day treatments only
Routine lung cancer screening	100% per visit, no <b>deductible</b> applies	60% per visit after <b>deductible</b>
Routine lung cancer screening limit	1 screening every 12 months  Screenings that exceed this limit covered as outpatient diagnostic testing	1 screening every 12 months  Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	100% per visit, no <b>deductible</b> applies	60% per visit after <b>deductible</b>
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents  Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam per year after that age, up to age 22; 1 exam per year after age 22  High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents  Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam per year after that age, up to age 22; 1 exam per year after age 22  High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months
Well woman GYN exam	100% per visit, no <b>deductible</b> applies	60% per visit after <b>deductible</b>
Well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

### Private duty nursing

Up to 8 hours equals one shift

Description	In-network	Out-of-network
Outpatient services	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>
Visit/shift limit per year	120	120

**Prosthetic devices**

Description	In-network	Out-of-network
Prosthetic devices	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	Out-of-network
<b>Surgery</b> and supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received

**Short-term rehabilitation services**

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

**Cardiac rehabilitation**

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

**Pulmonary rehabilitation**

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

**Cognitive rehabilitation**

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

**Physical, occupational and speech therapies**

Description	In-network	Out-of-network
	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>

**Physical, occupational and speech therapies**

Description	In-network	Out-of-network
Visit limit per year	90	90
Physical, occupational and speech therapies combined		
In-network and out-of-network combined		

**Spinal manipulation**

Description	In-network	Out-of-network
	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>

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	80% per admission after <b>deductible</b>	60% per admission after <b>deductible</b>
Other inpatient services and supplies	80% per admission after <b>deductible</b>	60% per admission after <b>deductible</b>

Day limit per year	90	90
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### Tests, images and labs – outpatient

#### Diagnostic complex imaging services

Description	In-network	Out-of-network
	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>

#### Diagnostic lab work

Description	In-network	Out-of-network
	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>

#### Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network
	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>

### 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 <b>providers</b> who are otherwise part of Aetna's network but are not GCIT-designated facilities/ <b>providers</b> )
Services and supplies	Covered based on type of service and where it is received	Not covered
Gene therapy products, <b>prescription</b> drugs	80% after <b>deductible</b>	Not covered

## Infusion therapy

### Outpatient services

Description	In-network	Out-of-network
In <b>physician</b> office	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>
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	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>
At <b>hospital</b> outpatient department	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>
At facility that is not a <b>hospital</b>	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>

## 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 <b>providers</b> who are otherwise part of Aetna's network but are non-IOE <b>providers</b> )
Inpatient services and supplies	100% per transplant after <b>deductible</b>	60% per transplant after <b>deductible</b>
<b>Physician</b> services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

## Urgent care services

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

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

Description	In-network	Out-of-network
Urgent care facility	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>
Non-urgent use of an urgent care facility or <b>provider</b>	Not covered	Not covered

## Walk-in clinic

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

Description	Designated network	Non-designated network	Out-of-network
Non-emergency services	100% per visit after <b>deductible</b>	80% per visit after <b>deductible</b>	60% per visit after <b>deductible</b>
Preventive care immunizations	100% per visit, no <b>deductible</b> applies	100% per visit, no <b>deductible</b> applies	60% per visit after <b>deductible</b>
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 <b>physician</b>	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 <b>physician</b>	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 <b>physician</b>
Preventive screening and counseling services	100% per visit, no <b>deductible</b> applies	100% per visit, no <b>deductible</b> applies	60% per visit after <b>deductible</b>
Preventive screening and counseling limits	See the <i>Preventive care</i> section of the schedule	See the <i>Preventive care</i> section of the schedule	See the <i>Preventive care</i> section of the schedule

<b>Telemedicine</b> consultation for non-emergency services through a <b>walk-in clinic</b>	100% per visit after <b>deductible</b>	Covered based on type of service and where it is received	Not covered
<b>Telemedicine</b> consultation for preventive screening and counseling services through a <b>walk-in clinic</b>	100% per visit after <b>deductible</b>	Covered based on type of service and where it is received	Not covered

### Important note:

#### Key terms

##### Designated network provider

A **network provider** listed in the directory under *Best results for your plan* as a **provider** for your plan.

##### Non-designated network provider

A **provider** listed in the directory under the *All other results* tab as a **provider** for your plan.

See the *Contact us* section if you have questions.

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

