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 policyholder for additional information.

Prepared for:

Employer:	Wake Forest University
Contract number:	MSA-0181178
Plan name:	Choice POS II Low Option Plan
Schedule of benefits:	1B
Plan effective date:	January 1, 2023
Plan issue date:	April 18, 2023

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 plan

  See the schedule for more information about limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.

For examples of how cost share and **deductible** work, go to the *Using your Aetna benefits* section under Individuals & Families at https://www.aetna.com/

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	Out-of-network
Individual	$1,250 per year	$3,125 per year
Family	$3,125 per year	$7,800 per year

Deductible waiver
There is no in-network **deductible** for the following **covered services**:

- Preventive care
- Family planning services – female contraceptives

Cost share waiver for risk reducing breast cancer prescription drugs
The **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%.

Cost share waiver for contraceptives (birth control)
The **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 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.

Cost share waiver for tobacco cessation prescription and OTC drugs

The **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.

Deductible waiver provisions for preventive prescription drugs

No **deductible** will apply to preventive covered **prescription** drug expenses:

Preventive:
Preventive drugs as defined in guidance issued by the U.S. Department of the Treasury and Internal Revenue Service (IRS) for Health Savings Accounts (HSAs) and qualified High Deductible Health Plans (HDHPs). This list will be reviewed periodically and is subject to change as federal guidelines change.

Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	In-network	Out-of-network
Individual	$4,000 per year	$10,000 per year
Family	$10,000 per year	$25,000 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.

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. In **prescription** drug plans, it is the amount you pay for covered drugs.

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.

Covered services apply to the in-network and 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.

Outpatient prescription drug maximum out-of-pocket limit provisions

Covered services that are subject to the **maximum out-of-pocket limit** include **covered services** provided under the medical plan and the **prescription** drug plan.

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**. This plan may have an individual and family **maximum out-of-pocket limit**.

Covered services

Ambulance services

Description	In-network	Out-of-network
Emergency services	80% per trip after **deductible**	80% per trip after **deductible**
Description	**In-network**	**Out-of-network**
Non-emergency services	80% per trip after **deductible**	60% per trip, after **deductible**

Autism spectrum disorder

Description	In-network	Out-of-network
Diagnosis and testing	Contact Carolina Behavioral Health Alliance for details at 800-475-7900	Contact Carolina Behavioral Health Alliance for details at 800-475-7900
Treatment	Contact Carolina Behavioral Health Alliance for details at 800-475-7900	Contact Carolina Behavioral Health Alliance for details at 800-475-7900
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

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

Durable medical equipment (DME)

Description	In-network	Out-of-network
DME	80% per item after **deductible**	60% per item after **deductible**

Emergency services

Description	In-network	Out-of-network
Emergency room	$200 then the plan pays 100% per visit, no **deductible** applies	Paid same as in-network
Non-emergency care in a **hospital** emergency room	Not covered	Not covered

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

Foot orthotic devices

Description	In-network	Out-of-network
Orthotic devices	80% per item after **deductible**	60% per item after **deductible**

Habilitation therapy services

Physical (PT), occupational (OT) therapies

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

Speech therapy (ST)

Description	In-network	Out-of-network
ST	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 for covered persons to age 23	80% per item after **deductible**	60% per item after **deductible**
Limit per year Combined for in-network and out-of-network benefits	$2,500	$2,500

Hearing exams

Description	In-network	Out-of-network
Hearing exams for covered persons to age 23	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Visit limit per year	Unlimited	Unlimited

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 **deductible**	60% per visit after **deductible**
Visit limit per year Combined for in-network and out-of-network benefits	40	40

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**	80% after **deductible**	60% after **deductible**

Description	In-network	Out-of-network
Outpatient services	80% per visit after **deductible**	60% 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**	80% after **deductible**	60% after **deductible**

Infertility services

Basic infertility

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

Comprehensive infertility services

Description	In-network	Out-of-network
	80% per visit after **deductible**	60% per visit after **deductible**

Advanced reproductive technology (ART)

Description	In-network	Out-of-network
	80% per visit after **deductible**	60% per visit after **deductible**

Limits

Description	In-network	Out-of-network
Limit per lifetime ART and Comprehensive services combined	$10,000 Combined for in-network and out-of-network benefits	$10,000 Combined for in-network and out-of-network benefits

Maternity and related newborn care

Includes complications

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

Description	In-network	Out-of-network
Outpatient services	80% per visit after **deductible**	60% 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 prescription drugs
Maintenance Medications

Generic prescription drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	$15, no **deductible** applies	Not covered
All refills after the first refill of a 30 day supply at a **retail pharmacy**	Not covered	Not covered
90 day supply at a **mail order pharmacy** or a CVS pharmacy	$37.50, no **deductible** applies	Not covered

Preferred brand-name prescription drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	$30, no **deductible** applies	Not covered
All refills after the first refill of a 30 day supply at a **retail pharmacy**	Not covered	Not covered
90 day supply at a **mail order pharmacy** or a CVS pharmacy	$75, no **deductible** applies	Not covered

Non-preferred brand-name prescription drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	$60, no **deductible** applies	Not covered
All refills after the first refill of a 30 day supply at a **retail pharmacy**	Not covered	Not covered
90 day supply at a **mail order pharmacy** or a CVS pharmacy	$150, no **deductible** applies	Not covered

Brand-name specialty prescription drugs

Description	In-network	Out-of-network
30 day supply at a **specialty pharmacy**	$50 or 10% whichever is greater but no more than $100, no **deductible** applies	Not covered

Important note:
Your cost share for **specialty prescription drugs**, under the **copayment** assistance program, will not count toward your **deductible** or **maximum out-of-pocket limit**. This includes cost shares that you, the plan or the program pay.

Comprehensive oral and injectable infertility treatment drugs

Description	In-network	Out-of-network
Lifetime limit	$5,000	Not covered

Important note:
The comprehensive oral and injectable infertility treatment drugs lifetime limit applies to charges made by a network pharmacy for synthetic ovulation stimulant drugs taken by mouth or injected and prescribed as part of the comprehensive **infertility** and ART benefits

This lifetime limit does not apply to drugs prescribed for the diagnosis and treatment of basic **infertility**.

Contraceptives (birth control)

Brand-name prescription drugs and devices are covered at 100% when a generic is not available

Description	In-network	Out-of-network
30 day supply of generic and OTC drugs and devices	$0, no **deductible** applies	Not covered
30 day supply of **brand-name prescription drugs** and devices	Paid based on the tier of drug in the schedule	Not covered

Preventive care drugs and supplements

Description	In-network	Out-of-network
Preventive care drugs and supplements	$0, no **deductible** applies	Not covered
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Not covered

Risk reducing breast cancer drugs

Description	In-network	Out-of-network
Risk reducing breast cancer **prescription** drugs	$0, no **deductible** applies	Not covered
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of risk reducing breast cancer drugs or more information, see the *Contact us* section	Not covered

Tobacco cessation drugs

Description	In-network	Out-of-network
Tobacco cessation **prescription** and OTC drugs	$0, no **deductible** applies	Not covered
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section. See the *Other services* section of this schedule for more information.	Not covered

Outpatient prescription drug important note:
If you or your **provider** requests a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost difference between the generic drug and the brand-name drug, plus the cost share that applies to the brand-name drug. The cost difference does not apply toward your **prescription** drug **deductible** or **maximum out-of-pocket limit**.

Outpatient surgery

Description	In-network	Out-of-network
At **hospital** outpatient department	80% per visit after **deductible**	60% per visit after **deductible**
At facility that is not a **hospital**	80% per visit after **deductible**	60% 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

Description	In-network	Out-of-network
Physician office hours (not-surgical, not preventive)	$30 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**

Description	In-network	Out-of-network
Physician telemedicine consultation	$30 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**

Description	In-network	Out-of-network
Telemedicine provider consultation Basic medical services	$10 then the plan pays 100% per visit, no **deductible** applies	Not covered

Description	In-network	Out-of-network
Physician visit during inpatient **stay**	80% per visit after **deductible**	60% per visit after **deductible**

Specialist

Description	In-network	Out-of-network
Specialist office hours (not-surgical, not preventive)	$50 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**

Description	In-network	Out-of-network
Complex imaging, lab and radiology services during **physician** office visit	80% per visit after **deductible**	60% per visit after **deductible**
Complex imaging, lab and radiology services during **specialist** office visit	80% per visit after **deductible**	60% per visit after **deductible**

Description	In-network	Out-of-network
Physician surgical services	80% per visit after **deductible**	60% per visit after **deductible**
Specialist surgical services	80% per visit after **deductible**	60% per visit after **deductible**

Description	In-network	Out-of-network
Specialist telemedicine consultation	$50 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**

All other services not shown above

Description	In-network	Out-of-network
All other services	80% per visit after **deductible**	60% per visit after **deductible**

Preventive care

Description	In-network	Out-of-network
Preventive care services	100% per visit, no **deductible** applies	60% per visit after **deductible**
Breast feeding counseling and support	100% per visit, no **deductible** applies	60% 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 1 year 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 1 year 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: 1 year to replace an existing electric pump	Electric pump: 1 year to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies	60% per visit after **deductible**
Counseling for alcohol or drug misuse visit limit	5 visits/per year	5 visits/ per year
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies	60% per visit after **deductible**
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per year, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per year, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no **deductible** applies	60% per visit after **deductible**
Counseling for sexually transmitted infection visit limit	2 visits/ per year	2 visits/ per year
Counseling for tobacco cessation	100% per visit, no **deductible** applies	60% per visit after **deductible**
Counseling for tobacco cessation visit limit	8 visits/ per year	8 visits/ per year
Family planning services (female contraception counseling)	100% per visit, no **deductible** applies	60% per visit after **deductible**
Family planning services (female contraception counseling) limit	Contraceptive counseling limited to 2 visits/ per year in a group or individual setting Counseling's that exceed this limit are covered as a **physician** services office visit	Contraceptive counseling limited to 2 visits/ per year in a group or individual setting Counseling's that exceed this limit are covered as a **physician** services office visit

Immunizations	100%, no **deductible** applies	60% 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 cancer screenings	100% per visit, no **deductible** applies	60% per visit after **deductible**
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section
Routine lung cancer screening	100% per visit, no **deductible** applies	60% per visit after **deductible**
Routine lung cancer screening limit	1 screening per year Screenings that exceed this limit covered as outpatient diagnostic testing	1 screening per year Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	100% per visit, no **deductible** applies	60% 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 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 every 12 months after that age, up to age 22; 1 exam every year after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months

Well woman GYN exam	100% per visit, no **deductible** applies	60% per visit after **deductible**
Well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

Prosthetic Devices

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

Short-term rehabilitation services

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

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

Cognitive rehabilitation

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

Physical and occupational therapies

Description	In-network	Out-of-network
	80% per visit after **deductible**	60% per visit after **deductible**

Speech therapy (ST)

Description	In-network	Out-of-network
	80% per visit after **deductible**	60% per visit after **deductible**

Physical and occupational therapies

Description	In-network	Out-of-network
Visit limit per year Combined for in-network and out-of-network benefits	60	60

Speech Therapy (ST)

Description	In-network	Out-of-network
Visit limit per year Combined for in-network and out-of-network benefits	20	20

Spinal manipulation

Description	In-network	Out-of-network
Includes x-rays and evaluations	80% per visit after **deductible**	60% per visit after **deductible**

Maximum limit per year Combined for in-network and out-of-network benefits	$1,000	$1,000

Skilled nursing facility

Description	In-network	Out-of-network
Inpatient services - **room and board**	80% per admission after **deductible**	60% per admission after **deductible**
Other inpatient services and supplies	80% per admission after **deductible**	60% per admission after **deductible**

Day limit per year Combined for in-network and out-of-network benefits	90	90

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network	Out-of-network
	80% per visit after **deductible**	60% per visit after **deductible**

Diagnostic lab work

Description	In-network	Out-of-network
At facility that is not a **hospital (independent lab)**	100% per visit, no **deductible** applies	60% per visit after **deductible**
At **hospital** outpatient department	80% per visit after **deductible**	60% per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network
	80% per visit after **deductible**	60% 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	Out-of-network
Services and supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Infusion therapy

Outpatient services

Description	In-network	Out-of-network
	80% per visit after **deductible**	60% 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	80% per transplant after **deductible**	60% 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

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	$50 then the plan pays 100% per visit, no **deductible** applies	$50 then the plan pays 100% per visit no **deductible applies**
Non-urgent use of an urgent care facility or **provider**	Not covered	Not covered

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Description	In-network	Out-of-network
	$30 then the plan pays 100% per visit, no **deductible** applies	Not Covered

Visit limit	1 visit per year	Not applicable

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, no **deductible** applies	$30 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**
Preventive care immunizations	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	60% per visit after **deductible**
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	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	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**	**physician**	For details, contact your **physician**
Preventive screening and counseling services	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	60% per visit after **deductible**
Preventive screening and counseling limits	See the *Preventive care services* section of the schedule	See the *Preventive care services* section of the schedule	See the *Preventive care services* section of the schedule

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

Important Note:
Key terms

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

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

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