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:

Policyholder:	Bean Electrical, Inc.
Policyholder number:	GP-0175874
Group policy effective date:	November 1, 2021
Plan name:	Open Access Managed Choice $5,000 High Deductible Health Plan
Schedule of Benefits:	2A
Plan effective date:	November 1, 2021
Plan issue date:	November 9, 2021

Underwritten by Aetna Life Insurance Company in the state of Texas

Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles**, **copayments** or **coinsurance**, 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
- **Coinsurance** amounts, if any, listed in the schedule below are what you will pay for **covered services**.
- You are responsible to pay any **deductibles**, **copayments** or remaining **coinsurance**, 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 of benefits 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:
Instead of a specific **copayment**, you will sometimes see language that reads:
"Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*"

This means that your **copayment** will vary, depending on who provides the service to you and where you receive the service.

Example 1: When you receive *Allergy testing and treatment services* in a **specialist's** office, then you will pay the applicable **copayment** listed in the *Specialist office visits* section.

Example 2: When you receive *Reconstructive breast surgery services* in an outpatient setting, then you will pay the applicable **copayment** listed in the *Outpatient surgery* section. However, if you receive these services while inpatient in a **hospital**, then you will pay the applicable *Hospital care* **copayment**.

Important note:
Covered services are subject to the Calendar Year **deductible**, **maximum out-of-pocket**, limits, **copayment** or **coinsurance** unless otherwise stated in this schedule of benefits.

Under this plan, you will:

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

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 **coinsurance** you pay when you get **covered services** from an in-**network**, **out-of-network provider**. This schedule of benefits 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 **coinsurance**, 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 of benefits 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 certificate.

Aetna Life Insurance Company's group policy provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your certificate.

Plan features

Preauthorization covered services reduction

This only applies to **out-of-network covered services**:
Your certificate contains a complete description of the **preauthorization** process. You will find details in the *Medical necessity and preauthorization* section.

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

- **Covered services** reduced by the lesser of 50% of the benefit that would have been payable or $400

You may have to pay an additional portion of the **allowable amount** because you didn't get **preauthorization**. 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	$5,000 per year	$10,000 per year
Family	$10,000 per year	$30,000 per year

Deductible waiver

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

- Preventive care
- Family planning services – female contraceptives

Deductible and cost share waiver for risk reducing breast cancer prescription drugs

The **prescription** drug **deductible** and per **prescription** cost share will not apply to risk reducing breast cancer **prescription** drugs when obtained at a network pharmacy. This means they will be paid at 100%.

Deductible and cost share waiver for contraceptives (birth control)

The **prescription** drug **deductible** and per **prescription** cost share will not apply to female contraceptive methods when obtained at a network pharmacy. This means they will be paid at 100%. This includes certain OTC and generic contraceptive **prescription** drugs and devices for each of the methods identified by the FDA. If a **generic prescription drug** is not available, the **brand-name prescription drug** for that method will be paid at 100%.

The **prescription** drug **deductible** and cost share will apply to **prescription** drugs that have a generic equivalent or alternative available within the same therapeutic drug class obtained at a network pharmacy unless we approve a medical exception. A therapeutic drug class is a group of drugs or medications that have a similar or identical mode of action or are used for the treatment of the same or similar disease or injury.

Deductible and cost share waiver for tobacco cessation prescription and OTC drugs

The **prescription** drug **deductible** and the per **prescription** cost share will not apply to the first two 90-day treatment programs for tobacco cessation **prescription** and OTC drugs when obtained at a network **retail pharmacy**. This means they will be paid at 100%. Your per **prescription** cost share will apply after those two programs have been exhausted.

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

Maximum out-of-pocket type	In-network	Out-of-network
Individual	$6,000 per year	$15,000 per year
Family	$12,000 per year	$45,000 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 **coinsurance**, 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.

Deductible credit

If you paid part or all of your **deductible** under other coverage for the year that this plan went into effect, we will deduct the amount paid under the other coverage from the **deductible** on this plan for the same year. If we ask, you must submit a detailed explanation of benefits (EOB) showing the dates and amount of the **deductible** met from the other coverage in order to receive the credit.

Copayment

This is a flat fee you pay for certain visits or **covered services**. A copay can be a dollar amount or percentage. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Coinsurance

This is a percentage you pay for a **covered service**. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Maximum out-of-pocket limit provisions

Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **coinsurance** 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

- 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 certificate and the schedule
- Charges, expenses or costs in excess of the **allowable amount**
- 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 group policy.

Outpatient prescription drug deductible provisions

Covered services that are subject to the **deductible** include **covered services** provided under the medical plan and the **prescription** drug plan.

The **deductible** may not apply to certain **covered services**. You still pay the **copayment** or **coinsurance**, if any, for these **covered services**.

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**, **coinsurance** and **deductible**, if any, for **covered services**. This plan may have an individual and family **maximum out-of-pocket limit**.

Covered services

Acupuncture

Description	In-network	Out-of-network
Acupuncture	100% per visit after **deductible**	70% per visit after **deductible**
Visit limit per year	10	10

Alzheimer's disease

Description	In-network	Out-of-network
Alzheimer's disease	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of Benefits.*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of Benefits*

Ambulance services

Description	In-network	Out-of-network
Emergency services	100% per trip after **deductible**	Paid same as in-network
Non-emergency services	100% per trip after **deductible**	100% per trip after **deductible**

Applied behavior analysis

Description	In-network	Out-of-network
Applied behavior analysis	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Autism spectrum disorder

Description	In-network	Out-of-network
Diagnosis and testing	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*
Treatment	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

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**	100% per admission after **deductible**	70% per admission after **deductible**
Other inpatient services and supplies Other **residential treatment facility** services and supplies	100% 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** Includes **telemedicine** or **telehealth** consultation	100% per visit after **deductible**	70% per visit after **deductible**
Outpatient mental health **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	100% per visit after **deductible**	70% per visit after **deductible**

Description	In-network	Out-of-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services after you meet your **deductible**	100% per visit after **deductible**	70% per visit after **deductible**

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**	100% 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** Includes **telemedicine** or **telehealth** consultation	100% per visit after **deductible**	70% per visit after **deductible**
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	100% per visit after **deductible**	70% per visit after **deductible**

Description	In-network	Out-of-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services after you meet your **deductible**	100% per visit after **deductible**	70% per visit after **deductible**

Cardiovascular disease testing

Description	In-network	Out-of-network
Cardiovascular disease testing	100% per visit after **deductible**	70% per visit after **deductible**
Maximum visits	1 screening every 5 years Limited to: Men age 45 and over but less than 76 and women age 55 and over but less than 76	1 screening every 5 years Limited to: Men age 45 and over but less than 76 and women age 55 and over but less than 76

Clinical trials

Description	In-network	Out-of-network
Experimental or investigational therapies	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*
Routine patient costs	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Dental care services and anesthesia

Description	In-network	Out-of-network
Hospital or **surgery** center	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits.*	70% per visit after **deductible**

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

Description	In-network	Out-of-network
Diabetic services	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*
Diabetic supplies	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*
Diabetic equipment	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*
Diabetic self-care programs	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Diagnostic follow-up care related to newborn hearing screening

Description	In-network	Out-of-network
Diagnostic follow-up care related to newborn hearing screening	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Durable medical equipment (DME)

Description	In-network	Out-of-network
DME	100% per item after **deductible**	70% per item after **deductible**

Emergency services

Description	In-network	Out-of-network
Emergency room/freestanding emergency medical care facility or comparable emergency facility	100% per visit after **deductible**	Paid same as in-network
Non-emergency care in a **hospital** emergency room/free standing emergency medical care facility visit or comparable emergency facility	Not covered	Not covered

Emergency services important note:
Out-of-network providers do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan. 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.

Habilitation therapy services

Physical (PT), occupational (OT) therapies

Description	In-network	Out-of-network
PT, OT therapies	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Speech therapy (ST)

Description	In-network	Out-of-network
ST	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Hearing aids and cochlear implants and related services

Description	In-network	Out-of-network
Hearing aids and cochlear implants and related service	100% per item after **deductible**	70% per item after **deductible**
Limit for hearing aids	One per ear every 36 months	One per ear every 36 months
Limit for Replacements of cochlear implants external speech processor and controller components	One per ear every 36 months	One per ear every 36 months

Hearing exams

Description	In-network	Out-of-network
Hearing exams	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*
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 after **deductible**	70% per visit after **deductible**

Visit limit per year	60	60

Hospice care

Description	In-network	Out-of-network
Inpatient services - **room and board**	100% per admission after **deductible**	70% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient services	100% 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 8-12 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8-12 hours a day.

Hospital care

Description	In-network	Out-of-network
Inpatient services – **room and board**	100% per admission after **deductible**	70% per admission after **deductible**

Infertility services

Basic infertility

Description	In-network	Out-of-network
Treatment of basic **infertility**	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Jaw joint disorder

Includes TMJ

Description	In-network	Out-of-network
Jaw joint disorder treatment	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Maternity and related newborn care

Includes complications

Description	In-network	Out-of-network
Inpatient services – **room and board**	100% per admission after **deductible**	70% per admission after **deductible**
Services performed in **physician** or **specialist** office or a facility	100% per visit after **deductible**	70% per visit after **deductible**
Other services and supplies	100% after **deductible**	70% 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 certificate. It will give you more information about coverage for maternity care under this plan.

Nutritional support

Description	In-network	Out-of-network
Nutritional support	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	In-network	Out-of-network
Treatment of mouth, jaws and teeth	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Orthotic devices

Description	In-network	Out-of-network
Orthotic devices	100% per item after **deductible**	70% per item after **deductible**

Outpatient prescription drugs

Preferred generic prescription drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	$15 after **deductible**	$15 then the plan pays 70% after **deductible**
90 day supply at a **retail pharmacy**	$37.50 after **deductible**	$37.50 then the plan pays 70% after **deductible**
90 day supply at a **mail order pharmacy**	$37.50 after **deductible**	$37.50 then the plan pays 70% after **deductible**

Preferred brand-name prescription drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	$50 after **deductible**	$50 then the plan pays 70% after **deductible**
90 day supply at a **retail pharmacy**	$125 after **deductible**	$125 then the plan pays 70% after **deductible**
90 day supply at a **mail order pharmacy**	$125 after **deductible**	$125 then the plan pays 70% after **deductible**

Non-preferred generic prescription drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	$90 after **deductible**	$90 then the plan pays 70% after **deductible**
90 day supply at a **retail pharmacy**	$225 after **deductible**	$225 then the plan pays 70% after **deductible**
90 day supply at a **mail order pharmacy**	$225 after **deductible**	$225 then the plan pays 70% after **deductible**

Non-preferred brand-name prescription drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	$90 after **deductible**	$90 then the plan pays 70% after **deductible**
90 day supply at a **retail pharmacy**	$225 after **deductible**	$225 then the plan pays 70% after **deductible**
90 day supply at a **mail order pharmacy**	$225 after **deductible**	$225 then the plan pays 70% after **deductible**

Specialty prescription drugs

Description	In-network	Out-of-network
30 day supply at a **specialty pharmacy** or a **retail pharmacy**	$200 after **deductible**	$200 then the plan pays 70% after **deductible**

Anti-cancer drugs taken by mouth

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	$0 after **deductible**	$0 then the plan pays 70% after **deductible**
90 day supply at a **retail pharmacy**	$0 after **deductible**	$0 then the plan pays 70% after **deductible**
90 day supply at a **mail order pharmacy**	$0 after **deductible**	$0 then the plan pays 70% after **deductible**

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 after **deductible**	Paid based on the tier of drug in the schedule
30 day supply of **brand-name prescription drugs** and devices	Paid based on the tier of drug in the schedule	Paid based on the tier of drug in the schedule

Preventive care drugs and supplements

Description	In-network	Out-of-network
Preventive care drugs and supplements	$0, no **deductible** applies	Paid based on the tier of drug in the schedule
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	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

Risk reducing breast cancer drugs

Description	In-network	Out-of-network
Risk reducing breast cancer **prescription** drugs	$0, no **deductible** applies	Paid based on the tier of drug in the schedule
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	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

Tobacco cessation drugs

Description	In-network	Out-of-network
Tobacco cessation **prescription** and OTC drugs	$0, no **deductible** applies	Paid based on the tier of drug in the schedule
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.	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.

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.

Important note:
When you get **prescription drugs** from a **pharmacy**, the **pharmacy** will only require you at that time to pay the lowest amount out of the following:

- The applicable **copayment**
- The allowable claim amount for the **prescription drug**
- The amount you would pay for the **prescription drug** if you bought it without using your plan or any other **prescription drug** benefits or discounts

You may later have to pay additional cost sharing for these **prescription drugs**. For example, if you have not met your **prescription drug deductible** (if applicable), you may owe additional cost sharing.

Outpatient surgery

Description	In-network	Out-of-network
At **hospital** outpatient department	100% per visit after **deductible**	70% per visit after **deductible**

Physician and specialist services

Physician services-general or family practitioner

Description	In-network	Out-of-network
Physician office hours (not-surgical, not preventive) Includes **telemedicine** or **telehealth** consultation	100% per visit after **deductible**	70% per visit after **deductible**
Physician surgical services	100% per visit after **deductible**	70% per visit after **deductible**

Description	In-network	Out-of-network
Physician visit during inpatient **stay**	100% per visit after **deductible**	70% per visit after **deductible**

Specialist

Description	In-network	Out-of-network
Specialist office hours (not-surgical, not preventive) Includes **telemedicine** or **telehealth** consultation	100% per visit after **deductible**	70% per visit after **deductible**
Specialist surgical services	100% per visit after **deductible**	70% per visit after **deductible**

All other services not shown above

Description	In-network	Out-of-network
All other services	100% per visit after **deductible**	70% per visit after **deductible**

Preventive care

Description	In-network	Out-of-network
Preventive care services	100% per visit, no **deductible** applies	70% per visit after **deductible** No **deductible, copayment** or **coinsurance** applies to immunizations for children through age 6
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 3 years 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 3 years 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: 3 years to replace an existing electric pump	Electric pump: 3 years to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies	70% per visit after **deductible**
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 **deductible** applies	70% per visit after **deductible**
Counseling for obesity, healthy diet	Age 0-22: unlimited visits Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	Age 0-22: unlimited visits Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no **deductible** applies	70% per visit after **deductible**
Counseling for sexually transmitted infection visit limit	2 visits/12 months	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no **deductible** applies	70% per visit after **deductible**
Counseling for tobacco cessation visit limit	8 visits/12 months	8 visits/12 months
Family planning services (contraception counseling)	100% per visit, no **deductible** applies	70% per visit after **deductible**
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 **deductible** applies	70% after **deductible** No **deductible, copayment** or **coinsurance** applies to immunizations for children through age 6
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	70% per visit after **deductible**
Colorectal cancer maximums	For covered persons age 50 and older: One fecal occult blood test every 12 months and one flexible sigmoidoscopy every 5 years or For covered persons age 45 and older: One colonoscopy performed every 10 years.	For covered persons age 50 and older: One fecal occult blood test every 12 months and one flexible sigmoidoscopy every 5 years or For covered persons age 45 and older: One colonoscopy performed every 10 years.
Mammogram maximums	One low-dose mammogram every year, including digital mammography and breast tomosynthesis, for females age 35 or older For females of any age as described below for additional routine cancer screenings Diagnostic mammograms are not subject to any age or frequency limitation.	One low-dose mammogram every year, including digital mammography and breast tomosynthesis, for females age 35 or older For females of any age as described below for additional routine cancer screenings Diagnostic mammograms are not subject to any age or frequency limitation.
Prostate specific antigen (PSA) tests maximums	One PSA test every year for covered persons age 50 and over One PSA test every year for covered persons age 40 and older with a family history of prostate cancer, or other risk factor	One PSA test every year for covered persons age 50 and over One PSA test every year for covered persons age 40 and older with a family history of prostate cancer, or other risk factor

Additional 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
Lung cancer screening	100% per visit, no **deductible** applies	70% per visit after **deductible**
Routine lung cancer screening limit	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	100% 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	100% per visit, no **deductible** applies	70% per visit after **deductible**
Pap smear or screening using liquid based cytology methods	One pap smear every 12 months for women age 18 or older	One pap smear every 12 months for women age 18 or older
Gynecological exam that includes a rectovaginal pelvic exam	One exam every 12 months for women over age 25 who are at risk for ovarian cancer	One exam every 12 months for women over age 25 who are at risk for ovarian cancer
Diagnostic exam for the early detection of ovarian cancer, cervical cancer, and the CA 125 blood test	One exam every 12 months for women age 18 and older	One exam every 12 months for women age 18 and older
Additional well woman GYN exam limits	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	1 visit

Private duty nursing

Up to eight hours equals one shift

Description	In-network	Out-of-network
Outpatient services	100% 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	100% 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	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Short-term rehabilitation services

Cardiac rehabilitation

Description	In-network	Out-of-network
Cardiac rehabilitation	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Pulmonary rehabilitation

Description	In-network	Out-of-network
Pulmonary	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Cognitive rehabilitation

Description	In-network	Out-of-network
Cognitive rehabilitation	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Physical, occupational and speech therapies

Description	In-network	Out-of-network
PT, OT and ST	100% per visit after **deductible**	70% per visit after **deductible**

Physical, occupational and speech therapies

Description	In-network	Out-of-network
Visit limit per year	30	30

Spinal manipulation

Description	In-network	Out-of-network
Spinal manipulation	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Visit limit per year	20	20

Skilled nursing facility

Description	In-network	Out-of-network
Inpatient services - **room and board**	100% per admission after **deductible**	70% per admission after **deductible**
Other inpatient services and supplies	100% per admission after **deductible**	70% per admission after **deductible**

Day limit per year	60	60

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network	Out-of-network
	100% per visit after **deductible**	70% per visit after **deductible**

Diagnostic lab work

Description	In-network	Out-of-network
	100% per visit after **deductible**	70% per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network
	100% per visit after **deductible**	70% per visit after **deductible**

Therapies

Chemotherapy

Description	In-network	Out-of-network
Chemotherapy services	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*
Oral anti-cancer **prescription drugs**	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Infusion therapy

Outpatient services

Description	In-network	Out-of-network
	100% per visit after **deductible**	70% per visit after **deductible**

Radiation therapy

Description	In-network	Out-of-network
Radiation therapy	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

Respiratory therapy

Description	In-network	Out-of-network
Respiratory therapy	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

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	100% per transplant after **deductible**	70% per transplant after **deductible**
Physician services	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*	Depending upon where the **covered service** is provided, benefits will be the same as those stated under each **covered service** category in this *Schedule of benefits*

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	100% per visit after **deductible**	70% per visit after **deductible**
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
	100% per visit, no **deductible** applies	70% per visit after **deductible**
Visit limit	1 visit every 24 months	1 visit every 24 months

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 **deductible**	100% per visit after **deductible**	70% per visit after **deductible**
Preventive care immunizations	100% per visit, no **deductible** applies No **deductible, copayment** or **coinsurance** applies to immunizations for children through age 6	100% per visit, no **deductible** applies No **deductible, copayment** or **coinsurance** applies to immunizations for children through age 6	70% per visit after **deductible** No **deductible, copayment** or **coinsurance** applies to immunizations for children through age 6
Immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Preventive screening and counseling services	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	70% 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

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.