## Schedule of benefits

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

**Prepared for:**

| | |
|---|---|
| Employer: | ZOLL Medical Corporation |
| Contract number: | MSA-0869811 |
| Plan name: | Choice POS II |
| Schedule of benefits: | 1B |
| Plan effective date: | January 1, 2025 |
| Plan issue date: | April 22, 2025 |

**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.

## How your deductible works

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **copayment** or **payment percentage** you pay when you get **covered services** from an in-network, **out-of-network provider**. This schedule shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **covered services**. You will continue to pay **copayments** or **payment percentage**, if any, for **covered services** after you meet your **deductible**.

## How your PCP or physician office visit cost share works

You will pay the **PCP** cost share when you get **covered services** from any **PCP**.

### How your maximum out-of-pocket works

This schedule shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of that year.

## Contact us

We are here to answer questions. See the *Contact us* section in your booklet.

This schedule replaces any schedule of benefits previously in use. Keep it with your booklet.

## Plan features

### Precertification covered services reduction

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

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

- A $400 benefit reduction applied separately to each type of **covered service**

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

### Deductible

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

| Deductible type | In-network | Out-of-network |
|---|---|---|
| Individual | $2,000 per year | $4,000 per year |
| Family | $4,000 per year | $8,000 per year |

### Maximum out-of-pocket limit

Includes the **deductible**.

| Maximum out-of-pocket type | In-network | Out-of-network |
|---|---|---|
| Individual | $4,500 per year | $9,000 per year |
| Family | $9,000 per year | $18,000 per year |

## General coverage provisions

This section explains the **deductible, maximum out-of-pocket limit** and limitations listed in this schedule.

### Deductible provisions

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

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

#### Individual deductible

You pay for **covered services** each year before the plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. After the amount paid reaches the individual **deductible**, this plan starts to pay for **covered services** for the rest of the year.

### Family deductible

You pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this family **deductible**, this plan starts to pay for **covered services** for the rest of the year. To satisfy this family **deductible** for the rest of the year, the combined **covered services** that you and each of your covered dependents incur toward the individual **deductible** must reach this family **deductible** in a year. When this happens in a year, the individual **deductibles** for you and your covered dependents are met for the rest of the year.

## Copayment

This is the dollar amount you pay for **covered services**. In most plans, you pay this after you meet your **deductible** limit.

## Payment Percentage

This is the percentage of the bill you pay after you meet your **deductible**.

## Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **payment percentage** and **deductible**, if any, for **covered services**. **Covered services** 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 booklet and the schedule
- Charges, expenses or costs in excess of the **recognized charge**
- Costs for non-emergency use of the emergency room
- Costs for non-urgent use of an urgent care **provider**

## Limit provisions

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

## Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of **covered services** on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the booklet.

## Covered services

### Abortion

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

### Acupuncture

| Description | In-network | Out-of-network |
|---|---|---|
| Acupuncture | $30 then the plan pays 100% per visit, no **deductible** applies | 60% per visit after **deductible** |
| Limit per year | $1,000 | $1,000 |

### Ambulance services

| Description | In-network | Out-of-network |
|---|---|---|
| **Emergency services** | 80% per trip, no **deductible** applies | Paid same as in-network |
| Non-**emergency services** ground, air, or water ambulance | 80% per trip, no **deductible** applies | 60% per trip after **deductible** |

### Applied behavior analysis

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

### Autism spectrum disorder

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

## Behavioral health

### Mental health treatment

Coverage provided is the same as for any other illness

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

| Description | In-network | Out-of-network |
|---|---|---|
| Outpatient office visit to a **physician** or **behavioral health provider** | $30 then the plan pays 100% per visit, no **deductible** applies | 60% per visit after **deductible** |
| **Physician** or **behavioral health provider telemedicine** consultation | $30 then the plan pays 100% per visit, no **deductible** applies | 60% per visit after **deductible** |
| Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider** | Covered based on type of service and **provider** from which it is received | Covered based on type of service and **provider** from which it is received |

| Description | In-network | Out-of-network |
|---|---|---|
| Other outpatient services including:<br>• Behavioral health services in the home<br>• Partial hospitalization treatment<br>• Intensive outpatient program<br><br>The cost share doesn't apply to in-network peer counseling support services | $30 then the plan pays 100% per visit, no **deductible** applies | 60% 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** | 80% per admission after **deductible** | 60% per admission after **deductible** |
| Other inpatient services and supplies during a **hospital stay** | 80% per admission after **deductible** | 60% per admission after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| Outpatient office visit to a **physician** or **behavioral health provider** | $30 then the plan pays 100% per visit, no **deductible** applies | 60% per visit after **deductible** |
| **Physician** or **behavioral health provider telemedicine** consultation | $30 then the plan pays 100% per visit, no **deductible** applies | 60% per visit after **deductible** |
| Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider** | Covered based on type of service and **provider** from which it is received | Covered based on type of service and **provider** from which it is received |

| Description | In-network | Out-of-network |
|---|---|---|
| Other outpatient services including:<br>• Behavioral health services in the home<br>• Partial hospitalization treatment<br>• Intensive outpatient program<br><br>The cost share doesn't apply to in-network peer counseling support services | $30 then the plan pays 100% per visit, no **deductible** applies | 60% per visit after **deductible** |

### Clinical trials

| Description | In-network | Out-of-network |
|---|---|---|
| **Experimental or investigational** therapies | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| Routine patient costs | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

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

| Description | In-network | Out-of-network |
|---|---|---|
| Diabetic services | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| Diabetic supplies | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| Diabetic equipment | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| Diabetic self-care programs | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

### Durable medical equipment (DME)

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

## Emergency services

| Description | In-network | Out-of-network |
|---|---|---|
| Emergency room | 80% 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.

## Habilitation therapy services

### Outpatient physical (PT), occupational (OT) therapies

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

### Outpatient speech therapy (ST)

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

## Hearing aids

| Description | In-network | Out-of-network |
|---|---|---|
| Hearing aids | 90% per item after **deductible** | 60% per item after **deductible** |
| Limit | $4,000 every 36 months | $4,000 every 36 months |

## 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 | 60 | 60 |

**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** |
| Other inpatient services and supplies | 80% per admission 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** |
| Other inpatient services and supplies | 80% per admission 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 |

#### Limited infertility services

| Description | In-network | Out-of-network |
|---|---|---|
| Outpatient services performed at **infertility specialist** office | Covered based on type of service and where it is received | Not covered |
| Services performed at **hospital** outpatient department | Covered based on type of service and where it is received | Not covered |
| Services performed at a facility other than a **hospital** outpatient department | Covered based on type of service and where it is received | Not covered |

**Advanced reproductive technology (ART)**

| Description | In-network | Out-of-network |
|---|---|---|
| Outpatient services performed at ART **specialist** office | Covered based on type of service and where it is received | Not covered |
| Services performed at **hospital** outpatient department | Covered based on type of service and where it is received | Not covered |
| Services performed at a facility other than a **hospital** outpatient department | Covered based on type of service and where it is received | Not covered |
| Fertility preservation | Covered based on type of service and where it is received | Not covered |

**Limits**

| Description | In-network | Out-of-network |
|---|---|---|
| Limit per lifetime | $25,000<br><br>Combined for in-network and out-of-network benefits | Not covered |

## 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** |
| Other inpatient services and supplies | 80% per admission after **deductible** | 60% per admission after **deductible** |
| Services performed in **physician** or **specialist** office or a facility | 100% per visit after **deductible** | 60% per visit after **deductible** |
| Other services and supplies | 100% per visit after **deductible** | 60% per visit after **deductible** |

**Maternity and related newborn care important note:**
Any cost share collected applies only to the delivery and postpartum care services provided by an OB, GYN or OB/GYN. Review the *Maternity* section of the booklet. It will give you more information about coverage for maternity care under this plan.

### Obesity surgery

| Description | In-network | Out-of-network |
|---|---|---|
| Inpatient services – **room and board** | 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** |

| 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 surgery

| Description | In-network | Out-of-network |
|---|---|---|
| At **hospital** outpatient department | $150 then the plan pays 100% per visit, no **deductible** applies | 60% per visit after **deductible** |
| At facility that is not a **hospital** | $150 then the plan pays 100% per visit, no **deductible** applies | 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

Including surgical services

| 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** |
| **Physician** surgical services | $30 then the plan pays 100% per visit, no **deductible** applies | 60% per visit after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| **Physician** visit during inpatient **stay** | 100% per visit after **deductible** | 60% per visit after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| **Physician telemedicine** consultation | $15 then the plan pays 100% per visit, no **deductible** applies | 60% per visit after **deductible** |

### Specialist

| Description | In-network | Out-of-network |
|---|---|---|
| **Specialist** office hours (not-surgical, not preventive) | $45 then the plan pays 100% per visit, no **deductible** applies | 60% per visit after **deductible** |
| **Specialist** surgical services | $45 then the plan pays 100% per visit, no **deductible** applies | 60% per visit after **deductible** |

| Description | In-network | Out-of-network |
|---|---|---|
| **Specialist telemedicine** consultation | $15 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 | 100% 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<br><br>Visits that exceed the limit are covered under the **physician** services office visit | 6 visits in a group or individual setting<br><br>Visits that exceed the limit are covered under the **physician** services office visit |
| Breast pump, accessories and supplies limit | Electric pump: 1 every 12 months<br><br>Manual pump: 1 per pregnancy<br><br>Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump | Electric pump: 1 every 12 months<br><br>Manual pump: 1 per pregnancy<br><br>Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump |
| Breast pump waiting period | Electric pump: 12 months to replace an existing electric pump | Electric pump: 12 months to replace an existing electric pump |
| Counseling for alcohol or drug misuse | 100% per visit, no **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/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 | 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<br><br>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<br><br>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:<br><br>Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF<br><br>The comprehensive guidelines supported by the Health Resources and Services Administration<br><br>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:<br><br>Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF<br><br>The comprehensive guidelines supported by the Health Resources and Services Administration<br><br>For more information contact your **physician** or see the *Contact us* section |
| Generic preventive care female contraceptives (birth control) | 100% | 100% |
| Preventive care drugs and supplements | 100% | 100% |
| Preventive care drugs and supplements limit | Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF<br><br>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 USPSTF<br><br>For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section |
| Preventive care risk reducing breast cancer **prescription** drugs | 100% | 100% |

| | | |
|---|---|---|
| Preventive care risk reducing breast cancer **prescription** drugs limit | Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF<br><br>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 USPSTF<br><br>For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section |
| Preventive care tobacco cessation **prescription** and OTC drugs | 100% | 100% |
| Limit | Two 90 day treatments only | Two 90 day treatments only |
| Routine lung cancer screening | 100% per visit, no **deductible** applies | 60% per visit after **deductible** |
| Routine lung cancer screening limit | 1 screening every 12 months<br><br>Screenings that exceed this limit covered as outpatient diagnostic testing | 1 screening every 12 months<br><br>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<br><br>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 per year after age 22<br><br>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<br><br>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<br><br>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 | 80% per item after **deductible** | 60% per item after **deductible** |

## Reconstructive surgery and supplies

Including breast **surgery**

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

## 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 |
|---|---|---|
| | $30 then the plan pays 100% per visit, no **deductible** applies | 60% per visit after **deductible** |

**Speech therapy (ST)**

| Description | In-network | Out-of-network |
|---|---|---|
| | $45 then the plan pays 100% per visit, no **deductible** applies | 60% per visit after **deductible** |

## Physical and occupational therapies

| Description | In-network | Out-of-network |
|---|---|---|
| Visit limit per year<br><br>Physical, occupational therapies combined In-network and out-of-network combined | 40 | 40 |

**Spinal manipulation**

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

| | | |
|---|---|---|
| Visit limit per year<br><br>In-network and out-of-network combined | 40 | 40 |

**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 | 100 | 100 |

## 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 |
|---|---|---|
| | 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 (GCIT-designated facility/provider) | Out-of-network (Including **providers** who are otherwise part of Aetna's network but are not GCIT-designated facilities/**providers**) |
|---|---|---|
| Services and supplies | Covered based on type of service and where it is received | Not covered |
| Gene therapy products, **prescription** drugs | $50 then the plan pays 100%, no **deductible** applies | Not covered |

**Infusion therapy**
Outpatient services

| Description | In-network | Out-of-network |
|---|---|---|
| In **physician** office | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| At an infusion location | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| In the home | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| At **hospital** outpatient department | Covered based on type of service and where it is received | Covered based on type of service and where it is received |
| At facility that is not a **hospital** | Covered based on type of service and where it is received | Covered based on type of service and where it is received |

**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** | Not covered |
| **Physician** services | Covered based on type of service and where it is received | Not covered |

**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 | $30 then the plan pays 100% per visit, no **deductible** applies | 60% per visit after **deductible** |
| Non-urgent use of an urgent care facility or **provider** | Not covered | Not covered |

## Virtual primary care

**Telemedicine** consultation

| Description | In-network | Out-of-network |
|---|---|---|
| Preventive care consultations | 100% per visit no **deductible** applies | Not covered |
| All other basic medical services consultations | $15 per visit no **deductible** applies | Not covered |
| Routine physical check-up limit | 1 virtual visit per year | Not covered |

| Description | In-network | Out-of-network |
|---|---|---|
| Outpatient behavioral health consultations | $15 then the plan pays 100% per visit, no **deductible** applies | Not covered |

| Description | In-network | Out-of-network |
|---|---|---|
| Outpatient dermatology consultations | $45 then the plan pays 100% per visit, no **deductible** applies | Not covered |

## Walk-in clinic

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

| Description | Designated network | Non-designated network | Out-of-network |
|---|---|---|---|
| Non-emergency services | 100% per visit, 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** |
| Preventive care immunization limits | Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention<br><br>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<br><br>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<br><br>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* section of the schedule | See the *Preventive care* section of the schedule | See the *Preventive care* section of the schedule |

| Description | Designated network | Non-designated network | Out-of-network |
|---|---|---|---|
| **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 | 100% per visit, no **deductible** applies | 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.