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:	Walmart
Policyholder number:	GP-0895530
Group control number:	CN-0486824
Group policy effective date:	January 1, 2019
Plan name:	Open Access Managed Choice Plan
Schedule of Benefits:	1A
Plan effective date:	January 1, 2019
Plan issue date:	December 5, 2024
Plan revision effective date:	January 1, 2025

Underwritten by Aetna Life Insurance Company in the state of Arkansas

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 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 **coinsurance** percentage that your plan will pay.
- You are responsible to pay any **deductibles**, **copayments** and 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 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 Calendar Year **deductible**, maximum out-of-pocket, limits, **copayment** or **coinsurance** unless otherwise stated in this schedule. The *Surprise bill* section in the certificate 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 **coinsurance** you pay when you get **covered services** from an in-network or **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 **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 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

Precertification covered services reduction

This only applies to out-of-network **covered services**:
Your certificate contains a complete description of the **precertification** process. You will find details in the *How your plan works - Medical necessity and precertification requirements* 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 **allowable amount** 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	$300 per year	$1,000 per year
Family	$600 per year	$2,000 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.

Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	In-network	Out-of-network
Individual	$1,500 per year	$5,000 per year
Family	$3,000 per year	$10,000 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 **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.

Copayment

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

Coinsurance

This is the percentage of **covered services** you pay after your **deductible**.

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.

Prescription drug - outpatient 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	$15 then the plan pays 100% per visit, no **deductible** applies	75% per visit after **deductible**

Visit limit per year	10	10

Ambulance services

Description	In-network	Out-of-network
Emergency services	$50 then the plan pays 100% per trip, no **deductible** applies	Paid same as in-network
Non-**emergency services**	Not covered	Not covered

Applied behavior analysis

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

Autism spectrum disorder

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

Behavioral health

Mental health treatment

Coverage provided is the same as for any other illness

Description	In-network	Out-of-network
Inpatient services - **room and board** including **residential treatment facility**	90% per admission after **deductible**	65% per admission after **deductible**
Other inpatient services and supplies Other **residential treatment facility** services and supplies	90% per admission after **deductible**	65% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	$25 then the plan pays 100% per visit, no **deductible** applies	75% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	$25 then the plan pays 100% per visit, no **deductible** applies	75% per visit after **deductible**
Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	100% per visit, no **deductible** applies	Not covered

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	90% per visit after **deductible**	65% 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**	90% per admission after **deductible**	65% per admission after **deductible**
Other inpatient services and supplies during a **hospital stay**	90% per admission after **deductible**	65% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	$25 then the plan pays 100% per visit, no **deductible** applies	75% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	$25 then the plan pays 100% per visit, no **deductible** applies	75% per visit after **deductible**
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	100% per visit, no **deductible** applies	Not covered

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	90% per visit after **deductible**	65% 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	90% per item after **deductible**	65% per item after **deductible**

Emergency services

Description	In-network	Out-of-network
Emergency room	$50 then the plan pays 100% per visit, no **deductible** applies	Paid same as in-network
Non-emergency care in a **hospital** emergency room	Not covered	Not covered

Emergency services important note:
Out-of-network providers do not have a contract with us. 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. 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, no **deductible** applies	65% per item, no **deductible** applies
Limit per ear	One per ear every 2 years	One per ear every 2 years

Home health care

A visit is a period of 4 hours or less

Description	In-network	Out-of-network
Home health care	90% per visit after **deductible**	65% 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**	90% after **deductible**	65% after **deductible**
Other inpatient services and supplies	90% after **deductible**	65% after **deductible**

Description	In-network	Out-of-network
Outpatient services	90% per visit after **deductible**	65% per visit after **deductible**

Hospice important note:
This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8 hours a day.

Hospital care

Description	In-network	Out-of-network
Inpatient services – **room and board**	90% after **deductible**	65% after **deductible**
Other inpatient services and supplies	90% after **deductible**	65% 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

Limits

Description	In-network	Out-of-network
Elective cycle limit per lifetime	1	1

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	Covered based on type of service and where it is received
Services performed 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
Services performed at a facility other than a **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
Fertility preservation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Limits

Description	In-network	Out-of-network
Maximum number of ovulation induction cycles per lifetime while on medications to stimulate the ovaries	6	6
Limit per lifetime including elective oocyte retrieval and cryopreservation	$20,000	$20,000

Maternity and related newborn care

Includes complications

Description	In-network	Out-of-network
Inpatient services – **room and board**	90% per admission after **deductible**	65% per admission after **deductible**
Other inpatient services and supplies	90% per admission after **deductible**	65% per admission after **deductible**
Services performed in **physician** or **specialist** office or a facility	90% per visit after **deductible**	65% per visit after **deductible**
Other services and supplies	90% per visit after **deductible**	65% 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 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	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Obesity surgery

Description	In-network	Out-of-network
Inpatient services – **room and board**	90% per admission after **deductible**	65% per admission after **deductible**
Other inpatient services and supplies	90% per admission after **deductible**	65% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient services at a **specialist** office	90% per visit after **deductible**	65% per visit after **deductible**
Outpatient services at **hospital** outpatient department	90% per visit after **deductible**	65% per visit after **deductible**
Outpatient services at a facility that is not a **hospital**	90% per visit after **deductible**	65% per visit after **deductible**

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	In-network	Out-of-network
Treatment of mouth, jaws and teeth	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Outpatient surgery

Description	In-network	Out-of-network
At **hospital** outpatient department	90% per visit after **deductible**	65% per visit after **deductible**
At facility that is not a **hospital**	90% per visit after **deductible**	65% 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)	$15 then the plan pays 100% per visit, no **deductible** applies	75% per visit after **deductible**
Physician surgical services	$15 then the plan pays 100% per visit, no **deductible** applies	75% per visit after **deductible**

Description	In-network	Out-of-network
Physician visit during inpatient **stay**	90% per visit after **deductible**	65% per visit after **deductible**

Description	In-network	Out-of-network
Physician telemedicine consultation	$15 then the plan pays 100% per visit, no **deductible** applies	75% per visit after **deductible**

Specialist

Description	In-network	Out-of-network
Specialist office hours (not-surgical, not preventive)	$25 then the plan pays 100% per visit, no **deductible** applies	75% per visit after **deductible**
Specialist surgical services	$25 then the plan pays 100% per visit, no **deductible** applies	75% per visit after **deductible**

Description	In-network	Out-of-network
Specialist telemedicine consultation	$25 then the plan pays 100% per visit, no **deductible** applies	75% per visit after **deductible**

All other services not shown above

Description	In-network	Out-of-network
All other services	90% per visit after **deductible**	65% per visit after **deductible**

Prescription drugs - outpatient

Generic prescription drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	$10, no **deductible** applies	$10 then the plan pays 80%, no **deductible** applies
90 day supply at a **retail pharmacy**	$20, no **deductible** applies	$20 then the plan pays 80%, no **deductible** applies
90 day supply at a **mail order pharmacy**	$20, no **deductible** applies	$20 then the plan pays 80%, no **deductible** applies

Brand-name prescription drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	$30, no **deductible** applies	$30 then the plan pays 80%, no **deductible** applies
90 day supply at a **retail pharmacy**	$60, no **deductible** applies	$60 then the plan pays 80%, no **deductible** applies
90 day supply at a **mail order pharmacy**	$60, no **deductible** applies	$60 then the plan pays 80%, no **deductible** applies

Anti-cancer drugs taken by mouth

Description	In-network	Out-of-network
30 day supply	$0, no **deductible** applies	$0, then the plan pays 80%, no **deductible** applies

Contraceptives (birth control)

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

Description	In-network	Out-of-network
30 day supply of generic and OTC drugs and devices	$0, no **deductible** applies	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

Infertility drugs

Description	In-network	Out-of-network
Infertility drugs	Paid based on the tier of drug in the schedule	Paid based on the tier of drug in the schedule

Diabetic supplies, drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	Paid based on the tier of drug in the schedule	Paid based on the tier of drug in the schedule
90 day supply at a **retail pharmacy**	Paid based on the tier of drug in the schedule	Paid based on the tier of drug in the schedule
90 day supply at a **mail order pharmacy**	Paid based on the tier of drug in the schedule	Not covered

Preferred generic and brand name insulin

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	$25, no **deductible** applies	Paid based on the tier of drug in the schedule
90 day supply at a **retail pharmacy**	$75, no **deductible** applies	Paid based on the tier of drug in the schedule
90 day supply at a **mail order pharmacy**	$75, no **deductible** applies	Not covered

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 prescription 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 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 USPSTF. For a current list of risk reducing breast cancer drugs or more information, see the *Contact us* section.

Tobacco cessation prescription and OTC 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 as recommended by the USPSTF. For a current list of covered tobacco cessation 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 USPSTF. For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section.

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 share that applies to the brand-name drug plus the cost difference between the generic drug and the brand-name drug.

Preventive care

Description	In-network	Out-of-network
Preventive care services	100% per visit, no **deductible** applies	75% per visit after **deductible**
Newborn screening for spinal muscular atrophy	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Breast feeding counseling and support	100% per visit, no **deductible** applies	75% per visit after **deductible**
Breast feeding counseling and support limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 every 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 every 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 12 months to replace an existing electric pump	Electric pump: 12 months to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies	75% 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	75% per visit after **deductible**
Counseling for obesity, healthy diet visit limit	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	75% 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	75% per visit after **deductible**
Counseling for tobacco cessation visit limit	8 visits/12 months	8 visits/12 months
Family planning services (female contraception, counseling)	100% per visit, no **deductible** applies	75% 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 Counseling that exceeds this limit covered as a **physician** services office visit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting Counseling that exceeds this limit covered as a **physician** services office visit

Immunizations	100%, no **deductible** applies	75% after **deductible**
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Routine cancer screenings	100% per visit, no **deductible** applies	75% per visit, no **deductible** applies
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section
Routine lung cancer screening	100% per visit, no **deductible** applies	75% per visit after **deductible**
Routine lung cancer screening limit	1 screenings every 12 months Screening that exceeds this limit covered as outpatient diagnostic testing	1 screenings every 12 months Screening that exceeds this limit covered as outpatient diagnostic testing
Routine physical exam	100% per visit, no **deductible** applies	75% 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	75% 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

Private duty nursing

Up to 8 hours equals one shift

Description	In-network	Out-of-network
Outpatient services	90% per visit after **deductible**	65% per visit after **deductible**

Visit/shift limit per year	70	70

Prosthetic devices

Description	In-network	Out-of-network
Prosthetic devices	90% per item after **deductible**	65% 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

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

Cognitive rehabilitation

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

Physical, occupational and speech therapies

Description	In-network	Out-of-network
	$15 then the plan pays 100% per visit, no **deductible** applies	75% per visit after **deductible**

Physical, occupational and speech therapies

Description	In-network	Out-of-network
Visit limit per year Physical, occupational and speech therapies combined In-network and out-of-network combined	20	20

Spinal manipulation

Description	In-network	Out-of-network
	$15 then the plan pays 100% per visit, no **deductible** applies	75% per visit after **deductible**

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

Skilled nursing facility

Description	In-network	Out-of-network
Inpatient services - **room and board**	90% per admission after **deductible**	65% per admission after **deductible**
Other inpatient services and supplies	90% per admission after **deductible**	65% per admission after **deductible**

Day limit per year	60	60

Diagnostic breast ultrasound

Description	In-network	Out-of-network
	90% per visit after **deductible**	65% per visit after **deductible**

Diagnostic complex imaging services

Description	In-network	Out-of-network
	90% per visit after **deductible**	65% per visit after **deductible**

Diagnostic lab work

Description	In-network	Out-of-network
	90% per visit after **deductible**	65% per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network
	90% per visit after **deductible**	65% 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% after **deductible**	Not covered

Infusion therapy

Outpatient services

Description	In-network	Out-of-network
In **physician** office	90% per visit after **deductible**	65% per visit after **deductible**
At an infusion location	Covered based on type of service and where it is received	Covered based on type of service and where it is received
In the home	90% per visit after **deductible**	65% per visit after **deductible**
At **hospital** outpatient department	90% per visit after **deductible**	65% per visit after **deductible**
At facility that is not a **hospital**	90% per visit after **deductible**	65% per visit after **deductible**

Radiation therapy

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

Respiratory therapy

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

Transplant services

Description	In-network (IOE facility)	Out-of-network (Includes **providers** who are otherwise part of Aetna's network but are non-IOE **providers**)
Inpatient services and supplies	90% per transplant after **deductible**	65% per transplant after **deductible**
Physician services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Urgent care services

At a freestanding facility or **provider** that is not a **hospital**
A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

Description	In-network	Out-of- network
Urgent care facility	$50 then the plan pays 100% per visit, no **deductible** applies	75% 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	75% 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	In-network	Out-of-network
Non-**emergency services**	$15 then the plan pays 100% per visit no **deductible** applies	75% per visit after **deductible**
Preventive care immunizations	100% per visit, no **deductible** applies	75% per visit after **deductible**
Preventive care immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Preventive screening and counseling services	100% per visit, no **deductible** applies	75% 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