Schedule of benefits

Prepared for:

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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:
  - Based on a rolling, 12 month period starting with the date of your most recent visit under this plan

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

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

Important note:
Covered services are subject to the **deductible**, maximum out-of-pocket, limits, **copayment** or **payment percentage** unless otherwise stated in this schedule. The *Surprise bill* section in the booklet explains your protections from a surprise bill.

Under this plan, you will:

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

Your **copayment** does not apply to any **deductible**.

How your 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

Prescription drug - outpatient deductible

A separate **deductible** applies to **prescription** drugs.

Deductible type	In-network
Individual	$250 per year
Family	$500 per year

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.

Per admission copayment

Per admission copayment type	In-network
Per admission **copayment**	$500 per day up to 5 days per admission

Maximum out-of-pocket limit

Maximum out-of-pocket type	In-network
Individual	$5,000 per year

Family	$10,000 per year

Prescription drug - outpatient maximum out-of-pocket limit

Maximum out-of-pocket type	In-network
Individual	$2,000 per year
Family	$4,000 per year

General coverage provisions

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

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.

Per admission copayment

This is the amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility. This **copayment** is equal to a facility's **semi-private room rate** for one day.

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**.

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
- Costs for non-emergency use of the emergency room

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.

Family prescription drug deductible

You and your covered dependents pay for **covered services** each year before the plan begins to pay. After you reach this family **deductible**, this plan will begin to pay for **covered services** that you and your covered dependents have for the rest of the year.

To satisfy this **deductible** limit for the rest of the year, the combined expenses that you and each of your covered dependents incur toward the individual **deductible** must reach this family **prescription** drug **deductible** limit in a year. When this happens, the individual **deductibles** for you and your covered dependents are met for the rest of the year.

Prescription drug – outpatient maximum out-of-pocket limit provisions

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **payment percentage** and **deductible**, if any, for **covered services**. This plan may have an individual and family **maximum out-of-pocket limit**.

For purposes of the following **maximum out-of-pocket limit** provisions:

- The individual **maximum out-of-pocket limit** applies to a person enrolled for self-only coverage with no dependent coverage
- The family **maximum out-of-pocket limit** applies to a person enrolled with one or more dependents
- The family **maximum out-of-pocket limit** is met by a combination of family members or by any single individual within the family

Individual prescription drug maximum out-of-pocket limit

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

Family prescription drug maximum out-of-pocket limit

After the amount of the cost share and **deductible** you and your covered dependent pay for **covered services** during the year meets the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charges for **covered services** that apply toward the limit for the rest of the year for all covered family members.

This plan has an individual and family **prescription** drug **maximum out-of-pocket limit**

To satisfy this family **maximum out-of-pocket limit** for the rest of the year, the following must happen:

- The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members. The family **prescription** drug **maximum out-of-pocket limit** is met by a combination of family members with no single person in the family contributing more than the individual **maximum out-of-pocket limit** in a year.

When this happens, the individual **maximum out-of-pocket limit** is also met for the rest of the year.

The **maximum out-of-pocket limit** may not apply to certain **covered services**. 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**.

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

- All costs for non-**covered services**
- Amounts received from a third-party **copay** assistance program, like a manufacturer coupon or rebate, for a **specialty prescription drug**

Covered services

Acupuncture

Description	In-network
Acupuncture	100% per visit, no **deductible** applies

Ambulance services

Description	In-network
Emergency services	100% per trip, no **deductible** applies
Non-**emergency services**	Not covered

Applied behavior analysis

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

Autism spectrum disorder

Description	In-network
Diagnosis and testing	Covered based on type of service and where it is received
Treatment	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

Behavioral health

Mental health treatment

Coverage provided is the same as for any other illness

Description	In-network
Inpatient services-**room and board** including **residential treatment facility**	$500 per day for 5 days per admission then the plan pays 100%, no **deductible** applies
Other inpatient services and supplies Other **residential treatment facility** services and supplies	100% per admission, no **deductible** applies

Description	In-network
Outpatient office visit to a **physician** or **behavioral health provider**	$25 then the plan pays 100% per visit, no **deductible** applies
Physician or **behavioral health provider telemedicine** consultation	$25 then the plan pays 100% per visit, no **deductible** applies
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

Description	In-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	$25 then the plan pays 100% per visit, no **deductible** applies

Description	In-network
Telemedicine provider mental health disorders consultation	Covered based on type of service and **provider** from which it is received
Telemedicine cognitive therapy **mental health disorders** consultation by a **telemedicine provider**	Covered based on type of service and **provider** from which it is received

Substance related disorders treatment

Includes **detoxification**, rehabilitation and **residential treatment facility**
Coverage provided is the same as for any other illness

Description	In-network
Inpatient services-**room and board** during a **hospital stay**	$500 per day for 5 days per admission then the plan pays 100%, no **deductible** applies
Other inpatient services and supplies during a **hospital stay**	100% per admission, no **deductible** applies

Description	In-network
Outpatient office visit to a **physician** or **behavioral health provider**	$25 then the plan pays 100% per visit, no **deductible** applies
Physician or **behavioral health provider telemedicine** consultation	$25 then the plan pays 100% per visit, no **deductible** applies
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

Description	In-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	$25 then the plan pays 100% per visit, no **deductible** applies

Description	In-network
Telemedicine provider substance related disorders consultation	Covered based on type of service and **provider** from which it is received
Telemedicine cognitive therapy **substance related disorders** consultation by a **telemedicine provider**	Covered based on type of service and **provider** from which it is received

Clinical trials

Description	In-network
Experimental or investigational therapies	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

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

Description	In-network
Diabetic services	Covered based on type of service and where it is received
Diabetic supplies	Covered based on type of service and where it is received
Diabetic equipment	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

Durable medical equipment (DME)

Description	In-network
DME	$50 then the plan pays 100% per item, no **deductible** applies

Emergency services

Description	In-network	Out-of-network
Emergency room	$500 then the plan pays 100% per visit, no **deductible** applies	Paid same as in-network
Non-emergency care in a **hospital** emergency room	Not covered	Not covered

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

Habilitation therapy services

Outpatient physical (PT), occupational (OT) and speech (ST) therapies

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

Hearing exams

Description	In-network
Hearing exams	Covered based on type of service and where it is received

Home health care

A visit is a period of 4 hours or less

Description	In-network
Home health care	$25 then the plan pays 100% per visit, no **deductible** applies

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
Inpatient services - **room and board**	$500 per day for 5 days per admission then the plan pays 100%, no **deductible** applies

Description	In-network
Other inpatient services and supplies	100% per admission, no **deductible** applies

Description	In-network
Outpatient services	100% per visit, no **deductible** applies

Limit per lifetime	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
Inpatient services - **room and board**	$500 per day for 5 days per admission then the plan pays 100%, no **deductible** applies

Description	In-network
Other inpatient services and supplies	100% per admission, no **deductible** applies

Infertility services

Basic infertility

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

Maternity and related newborn care

Includes complications
The cost share and **deductible** amount for newborns is waived for nursery charges during the newborn's initial routine **stay**. The nursery charges will apply for non-routine facility **stays**.

Description	In-network
Inpatient services – **room and board**	$500 per day for 5 days per admission then the plan pays 100%, no **deductible** applies
Other inpatient services and supplies	100% per admission, no **deductible** applies
Services performed in **physician** or **specialist** office or a facility	100% per visit, no **deductible** applies
Other services and supplies	100% per visit, no **deductible** applies

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.

Nutritional support

Description	In-network
Nutritional support	Covered based on type of service and where it is received, $2,500 maximum per Calendar Year

Obesity surgery

Description	In-network
Inpatient services – **room and board**	$500 per day for 5 days per admission then the plan pays 100%, no **deductible** applies
Other inpatient services and supplies	100% per admission, no **deductible** applies

Description	In-network
Outpatient services	$500 then the plan pays 100% per visit, no **deductible** applies

Limit	One procedure per two years for inpatient and outpatient combined

Oral and maxillofacial treatment (mouth, jaws and teeth)

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

Outpatient surgery

Description	In-network
At **hospital** outpatient department	$500 then the plan pays 100% per visit, no **deductible** applies
At facility that is not a **hospital**	$500 then the plan pays 100% per visit, no **deductible** applies
At the **physician** office	Covered based on type of service and where it is received

Physician and specialist services

Physician services-general or family practitioner

Description	In-network
Physician office hours (not-surgical, not preventive)	$35 then the plan pays 100% per visit, no **deductible** applies
Physician surgical services	$35 then the plan pays 100% per visit, no **deductible** applies

Description	In-network
Physician visit during inpatient **stay**	100% per visit, no **deductible** applies

Description	In-network
Physician telemedicine consultation	$35 then the plan pays 100% per visit, no **deductible** applies

Description	In-network
Telemedicine provider consultation Basic medical services	Covered based on type of service and **provider** from which it is received

Specialist

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

Specialist

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

All other services not shown above

Description	In-network
All other services	100% per visit, no **deductible** applies

Prescription drugs - outpatient

Generic prescription drugs

Description	In-network
30 day supply at a **retail pharmacy**	$15 after **deductible**
90 day supply at a **mail order pharmacy** or a CVS pharmacy	$30 after **deductible**

Preferred brand-name prescription drugs

Description	In-network
30 day supply at a **retail pharmacy**	$60 after **deductible**
90 day supply at a **mail order pharmacy** or a CVS pharmacy	$120 after **deductible**

Non-preferred brand-name prescription drugs

Description	In-network
30 day supply at a **retail pharmacy**	$90 after **deductible**
90 day supply at a **mail order pharmacy** or a CVS pharmacy	$180 after **deductible**

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

Contraceptives (birth control)

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

Description	In-network
30 day supply of generic and OTC drugs and devices	$0, no **deductible** applies
30 day supply of **brand-name prescription drugs** and devices	Paid based on the tier of drug in the schedule

Preventive care drugs and supplements

Description	In-network
Preventive care drugs and supplements	$0, no **deductible** applies
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

Risk reducing breast cancer prescription drugs

Description	In-network
Risk reducing breast cancer **prescription** drugs	$0, no **deductible** applies
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

Tobacco cessation prescription and OTC drugs

Description	In-network
Tobacco cessation **prescription** and OTC drugs	$0, no **deductible** applies
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.

Prescription drug important note:
If a **provider** prescribes a covered **brand-name prescription drug** when a **generic prescription drug** equivalent is available and specifies “Dispense As Written” (DAW), you will pay the cost share for the brand-name drug. If a **provider** does not specify DAW and you request a covered **brand-name prescription drug**, 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
Preventive care services	100% per visit, no **deductible** applies
Breast feeding counseling and support	100% per visit, no **deductible** applies
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
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
Breast pump waiting period	Electric pump: 12 months to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies
Counseling for alcohol or drug misuse visit limit	5 visits/12 months
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no **deductible** applies
Counseling for sexually transmitted infection visit limit	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no **deductible** applies
Counseling for tobacco cessation visit limit	8 visits/12 months
Family planning services (female contraception counseling)	100% per visit, no **deductible** applies
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
Immunizations	100%, no **deductible** applies
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**
Routine cancer screenings	100% per visit, no **deductible** applies
Routine cancer	Subject to any age, family history and frequency guidelines as set forth in the most

screening limits	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
Routine lung cancer screening limit	1 screening every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	100% per visit, no **deductible** applies
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
Well woman GYN exam	100% per visit, no **deductible** applies
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

Prosthetic devices

Description	In-network
Prosthetic devices including wigs related to chemo and radiation treatment due to cancer	$50 then the plan pays 100% per item, no **deductible** applies

Reconstructive surgery and supplies

Including breast **surgery**

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

Pulmonary Rehabilitation

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

Cognitive Rehabilitation

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

Physical, Occupational and Speech Therapies

Description	In-network
	$25 then the plan pays 100% per visit; no **deductible** applies

Physical, occupational and speech therapies

Description	In-network
Visit limit per year Physical, occupational and speech therapies combined	60

Spinal Manipulation

Description	In-network
	$60 then the plan pays 100% per visit, no **deductible** applies

Visit limit per year	20

Skilled nursing facility

Description	In-network
Inpatient services - **room and board**	$500 per day for 5 days per admission then the plan pays 100%, no **deductible** applies
Other inpatient services and supplies	100% per admission, no **deductible** applies

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network
	$250 then the plan pays 100% per visit, no **deductible** applies

Diagnostic lab work

Description	In-network
	$25 then the plan pays 100% per visit, no **deductible** applies

Diagnostic x-ray and other radiological services

Description	In-network
	$50 then the plan pays 100% per visit, no **deductible** applies

Therapies

Chemotherapy

Description	In-network
Chemotherapy services	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	$60 then the plan pays 90% per visit, no **deductible** applies	Not covered

Infusion therapy

Outpatient services

Description	In-network
In **physician** office	$60 then the plan pays 100% per visit, no **deductible** applies
At an infusion location	Covered based on type of service and where it is received
In the home	100% per visit, no **deductible** applies
At **hospital** outpatient department	$500 then the plan pays 100% per visit, no **deductible** applies
At facility that is not a **hospital**	$500 then the plan pays 100% per visit, no **deductible** applies

Radiation therapy

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

Respiratory therapy

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

Transplant services

Description	In-network (IOE facility)
Inpatient services and supplies	$500 per day for 5 days per transplant then the plan pays 100%, no **deductible** applies
Physician services	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
Urgent care facility	$60 then the plan pays 100% per visit, no **deductible** applies

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
Non-**emergency services**	$35 then the plan pays 100% per visit, no **deductible** applies
Preventive care	100% per visit, no **deductible** applies

Description	In-network
immunizations	
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**
Preventive screening and counseling services	100% per visit, no **deductible** applies
Preventive screening and counseling limits	See the *Preventive care services* section of the SOB