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:	President and Board of Trustees of Santa Clara College DBA Santa Clara University
Policyholder number:	GP-0237642
Group policy effective date:	January 1, 2024
Plan name:	OA Managed Choice POS HDHP
Schedule of Benefits:	1A
Plan effective date:	January 1, 2024
Plan issue date:	November 11, 2025
Plan revision effective date:	January 1, 2026

Underwritten by Aetna Life Insurance Company in the state of California

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 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**; (the benefit reduction will never exceed the cost of the benefit)
- **Precertification** and/or **step therapy** for certain **prescription drugs** may be required. In this case, the **prescription drug** will not be covered until you get prior authorization.

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	$2,000 per year	$4,000 per year

Deductible waiver provisions for preventive prescription drugs

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

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

Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	In-network	Out-of-network
Individual	$4,000 per year	$8,000 per year

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

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

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

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

Individual deductible
You pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this individual **deductible**, this plan starts to pay for **covered services** for the rest of the year. The individual **deductible** applies to a person who is enrolled for self-only coverage with no dependent coverage.

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

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 applied to the in-network limit will not apply to the out-of-network limit. **Covered services** applied to the out-of-network limit will not apply to the in-network limit.

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 deductible provisions

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

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

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

Abortion

Description	In-network	Out-of-network
Abortion services (including pre-abortion and follow-up abortion related services)	100% per visit after **deductible**	Covered based on type of service and where it is received

Acupuncture

Description	In-network	Out-of-network
Acupuncture	90% per visit after **deductible**	70% per visit after **deductible**
Visit limit per year	20	20

Ambulance services

Description	In-network	Out-of-network
Emergency services	90% per trip after **deductible**	Paid same as in-network
Non-**emergency services** ground, air, or water ambulance	Not covered	Not covered

Behavioral health

Medically necessary treatment of **mental health conditions** and **substance use disorders** are covered under the same terms and conditions applied to other medical conditions and in accordance with the federal Mental Health Parity and Addiction Equity Act.

Mental health treatment

Description	In-network	Out-of-network
Inpatient services and supplies	90% per admission after **deductible**	70% per admission after **deductible** **Precertification** is required for **hospital, rehabilitation** or **residential treatment facility** stays

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	90% per visit after **deductible**	70% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	90% per visit after **deductible**	70% per visit after **deductible**

Outpatient **mental health conditions 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 (as described in your certificate) The cost share doesn't apply to in-network peer counseling support services after you meet your **deductible**	90% per visit after **deductible**	70% per visit after **deductible**

Description	In-network	Out-of-network
Telemedicine provider mental health conditions consultation	Covered based on type of service and **provider** from which it is received	Not covered
Telemedicine cognitive therapy **mental health conditions** consultation by a **telemedicine provider**	Covered based on type of service and **provider** from which it is received	Not covered

Substance use 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 and supplies	90% per admission after **deductible**	70% per admission after **deductible**
Description	**In-network**	**Out-of-network**
Outpatient office visit to a **physician** or **behavioral health provider**	90% per visit after **deductible**	70% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	90% per visit after **deductible**	70% 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 (as described in your certificate) The cost share doesn't apply to in-network peer counseling support services after you meet your **deductible**	90% per visit after **deductible**	70% per visit after **deductible**

Description	In-network	Out-of-network
Telemedicine provider substance use disorders consultation	Covered based on type of service and **provider** from which it is received	Not covered
Telemedicine cognitive therapy **substance use disorders** consultation by a **telemedicine provider**	Covered based on type of service and **provider** from which it is received	Not covered

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**	70% per item after **deductible**

Emergency services

Description	In-network	Out-of-network
Emergency room	90% per visit after **deductible**	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.

Foot orthotic devices

Description	In-network	Out-of-network
Orthotic devices	90% per item after **deductible**	70% per item after **deductible**

Gender affirming treatment

Description	In-network	Out-of-network
Gender affirming treatment	Covered based on the *Behavioral health* section	Covered based on the *Behavioral health* section

Habilitation services

Outpatient physical (PT), occupational (OT) services

Description	In-network	Out-of-network
PT, OT services	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 services	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**	70% per item after **deductible**
Limit	One per ear every 24 months	One per ear every 24 months

Home health care

A visit is a period of 4 hours or less

Description	In-network	Out-of-network
Home health care	90% per visit after **deductible**	70% per visit after **deductible**
Visit limit per year	Not applicable	120

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**	70% after **deductible** **Precertification** is required for hospice facility stays
Other inpatient services and supplies	90% after **deductible**	70% after **deductible**

Description	In-network	Out-of-network
Outpatient services	90% per visit after **deductible**	70% 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**	70% after **deductible** **Precertification** is required for **hospital** stays
Other inpatient services and supplies	90% after **deductible**	70% 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
Fertility preservation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Jaw joint disorder

Includes TMJ

Description	In-network	Out-of-network
Jaw joint disorder treatment	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Maternity and related newborn care

Includes complications

Description	In-network	Out-of-network
Inpatient services – **room and board**	90% per admission after **deductible**	70% per admission after **deductible**
Other inpatient services and supplies	90% per admission after **deductible**	70% per admission after **deductible**
Services performed in **physician** or **specialist** office or a facility	90% per visit after **deductible**	70% per visit after **deductible**
Other services and supplies	90% per visit after **deductible**	70% per visit after **deductible** **Precertification** is required for **hospital** stays

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**	Not covered
Other inpatient services and supplies	90% per admission after **deductible**	Not covered

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

Limit inpatient and outpatient per lifetime	$10,000	Not covered

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 **Precertification** is required

Outpatient surgery

Description	In-network	Out-of-network
At **hospital** outpatient department	90% per visit after **deductible**	70% per visit after **deductible** **Precertification** is required for certain services. See "Types of services that require precertification" under the **Precertification** section of the certificate for more information.
At facility that is not a **hospital**	90% per visit after **deductible**	70% per visit after **deductible** **Precertification** is required for certain services. See "Types of services that require precertification" under the **Precertification** section of the certificate for more information.
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 **Precertification** is required for certain services. See "Types of services that require precertification" under the **Precertification** section of the certificate for more information.

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)	90% per visit after **deductible**	70% per visit after **deductible**
Physician surgical services	90% per visit after **deductible**	70% per visit after **deductible**

Description	In-network	Out-of-network
Physician visit during inpatient **stay**	90% per visit after **deductible**	70% per visit after **deductible**

Description	In-network	Out-of-network
Physician telemedicine consultation	90% per visit after **deductible**	70% per visit after **deductible**

Description	In-network	Out-of-network
Telemedicine provider consultation Basic medical services	Covered based on type of service and **provider** from which it is received	Not covered

Specialist

Description	In-network	Out-of-network
Specialist office hours (not-surgical, not preventive)	90% per visit after **deductible**	70% per visit after **deductible**
Specialist surgical services	90% per visit after **deductible**	70% per visit after **deductible** **Precertification** is required for certain services. See "Types of services that require precertification" under the **Precertification** section of the certificate for more information.

Description	In-network	Out-of-network
Specialist telemedicine consultation	90% per visit after **deductible**	70% per visit after **deductible**

All other services not shown above

Description	In-network	Out-of-network
All other services	90% per visit after **deductible**	70% per visit after **deductible**

Prescription drugs - outpatient

Generic prescription drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	$5 after **deductible**	Not covered
90 day supply at a **mail order pharmacy**, a designated network pharmacy, or a CVS pharmacy	$10 after **deductible**	Not covered

Preferred brand-name prescription drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	$20 after **deductible**	Not covered
90 day supply at a **mail order pharmacy**, a designated network pharmacy, or a CVS pharmacy	$40 after **deductible**	Not covered

Non-preferred brand-name prescription drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	$40 after **deductible**	Not covered
90 day supply at a **mail order pharmacy**, a designated network pharmacy, or a CVS pharmacy	$80 after **deductible**	Not covered

Specialty prescription drugs

Description	In-network	Out-of-network
30 day supply at a **specialty pharmacy**	30% but no more than $250 after **deductible**	Not covered

Anti-cancer drugs taken by mouth

Description	In-network	Out-of-network
30 day supply	$0 after **deductible**	Not covered

Contraceptives (birth control)

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

Description	In-network	Out-of-network
30 day supply or up to 12 month supply of generic and OTC drugs and devices	$0, no **deductible** applies	Not covered
30 day supply or up to 12 month supply of **brand-name prescription drugs** and devices	Paid based on the tier of drug in the schedule	Not covered

Infertility drugs

Description	In-network	Out-of-network
Infertility drugs	Paid based on the tier of drug in the schedule	Not covered

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	Not covered
90 day supply at a **mail order pharmacy**, a designated network pharmacy, or a CVS 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	Not covered
90 day supply at a **mail order pharmacy**, a designated network pharmacy, or a CVS 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	Not covered

Risk reducing breast cancer prescription drugs

Description	In-network	Out-of-network
Risk reducing breast cancer **prescription** drugs	$0, no **deductible** applies	Not covered

Tobacco cessation prescription and OTC drugs (preventive care)

Description	In-network	Out-of-network
Tobacco cessation **prescription** and OTC drugs	$0, no **deductible** applies	Not covered

Weight loss drugs

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

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

We cover medically necessary preventive care services in accordance with state law and will not impose any limits except for those noted below.

Description	In-network	Out-of-network
Preventive care services	100% per visit, no **deductible** applies	70% per visit after **deductible**
Breast feeding support and counseling services, equipment, education and supplies	100% per visit, no **deductible** applies	70% per visit after **deductible**
Breast pump, accessories and supplies	100% per item, no **deductible** applies	70% per item after **deductible**
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies	70% per visit after **deductible**
Counseling for alcohol or drug misuse visit limit	5 visits/12 months	5 visits/12 months
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies	70% per visit after **deductible**
Counseling for obesity, healthy diet 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	70% per visit after **deductible**
Counseling for sexually transmitted infection visit limit	2 visits/12 months	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no **deductible** applies	70% per visit after **deductible**
Counseling for tobacco cessation visit limit	8 visits/12 months	8 visits/12 months
Family planning services (contraception, counseling)	100% per visit, no **deductible** applies	70% per visit after **deductible**
Family planning services - Vasectomy	100%, after **deductible**	70% after **deductible**
Immunizations	100%, no **deductible** applies	70% after **deductible**
Immunization limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician
Routine cancer screenings	100% per visit, no **deductible** applies	70% per visit after **deductible**
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current:	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	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 limit	1 screening every 12 months Screenings that exceed this limit are covered as outpatient diagnostic testing	1 screening every 12 months Screenings that exceed this limit are covered as outpatient diagnostic testing
Routine physical exam	100% per visit, no **deductible** applies	70% per visit after **deductible**
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22 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 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months
Well woman GYN exam	100% per visit, no **deductible** applies	70% per visit after **deductible**
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
Limit	1 Visit	1 Visit

Private duty nursing

Up to 8 hours equals one shift

Description	In-network	Out-of-network
Outpatient services	90% per visit after **deductible**	70% per visit after **deductible** **Precertification** is required
Visit/shift limit per year	120	120

Prosthetic devices

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

Reconstructive surgery and supplies

Including breast **surgery**

Description	In-network	Out-of-network
Surgery and supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received **Precertification** is required for certain services. See "Types of services that require precertification" under the **Precertification** section of the certificate for more information.

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 and occupational therapies

Description	In-network	Out-of-network
	90% per visit after **deductible**	70% per visit after **deductible**

Speech therapy (ST)

Description	In-network	Out-of-network
	90% per visit after **deductible**	70% per visit after **deductible**

Spinal manipulation

Description	In-network	Out-of-network
	90% per visit after **deductible**	70% per visit after **deductible**

Visit limit per year	Not applicable	20

Skilled nursing facility

Description	In-network	Out-of-network
Inpatient services - **room and board**	90% per admission after **deductible**	70% per admission after **deductible** **Precertification** is required for **skilled nursing facility** stays
Other inpatient services and supplies	90% per admission after **deductible**	70% per admission after **deductible**

Day limit per year	60	60

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network	Out-of-network
	90% per visit after **deductible**	70% per visit after **deductible** **Precertification** is required

Diagnostic lab work

Description	In-network	Out-of-network
	90% per visit after **deductible**	70% per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network
	90% per visit after **deductible**	70% 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	90% after **deductible**	Not covered

Infusion therapy

Outpatient services

Description	In-network	Out-of-network
In **physician** office	90% per visit after **deductible**	70% 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**	70% per visit after **deductible**
At **hospital** outpatient department	90% per visit after **deductible**	70% per visit after **deductible**
At facility that is not a **hospital**	90% per visit after **deductible**	70% 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**	70% per transplant after **deductible** **Precertification** is required for **hospital** stays
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	90% per visit after **deductible**	70% per visit after **deductible**
Non-urgent use of an urgent care facility or **provider**	Not covered	Not covered

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Description	In-network	Out-of-network
	100% per visit, no **deductible** applies	70% per visit after **deductible**

Visit limit	1 visit every 24 months	1 visit every 24 months

Walk-in clinic

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

Description	Designated network	Non-designated network	Out-of-network
Non-**emergency services**	100% per visit after **deductible**	90% per visit after **deductible**	70% per visit after **deductible**
Preventive care immunizations	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	70% 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**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Preventive screening and counseling services	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	70% per visit after **deductible**
Preventive screening and counseling limits	See the *Preventive care* section of the schedule	See the *Preventive care* section of the schedule	See the *Preventive care* section of the schedule

Important note:
Key terms
Designated network provider
A **network provider** listed in the directory under *Best results for your plan* as a **provider** for your plan.

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

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