

## Schedule of benefits

**Prepared for:**

Policyholder: City of Hialeah  
Policyholder number: GP-0170189  
Group policy effective date: January 1, 2021  
Plan name: Open Access Elect Choice  
Schedule of Benefits: 1A  
Plan effective date: January 1, 2022  
Plan issue date: January 21, 2022

**Underwritten by Aetna Life Insurance Company in the state of Florida**



## Schedule of benefits

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

Under this plan, you will:

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

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

### How your deductible works

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **copayment** or **coinsurance** you pay when you get **covered services** from an in-network **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

### Deductible

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

Deductible type	In-network
Individual	\$6,000 per year
Family	\$12,000 per year

### Deductible waiver

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

- Preventive care
- Family planning services – female contraceptives

### Deductible waiver provisions for child health supervision services

The **deductible** is waived for child health supervision services through age 16

### 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
Individual	\$7,900 per year
Family	\$15,800 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**.

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

### Individual deductible

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

### Family deductible

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

### Deductible credit

If you paid part or all of your **deductible** under other coverage in the past 90 days prior to the effective date of this plan, we will deduct the amount paid under the other coverage from the **deductible** on this plan. You must submit a detailed explanation of benefits (EOB) showing the dates and amount of the **deductible** met from the other coverage in order to receive the credit.

### Copayment

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

### Coinsurance

This is the percentage of the bill you pay after you meet your **deductible**. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

## Maximum out-of-pocket limit

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.

### 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
- Costs for non-emergency use of the emergency room
- Costs for non-urgent use of an urgent care **provider**

## Your financial responsibility and decisions regarding benefits

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

### Outpatient prescription drug 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
Acupuncture	\$10 then the plan pays 100% per visit, no <b>deductible</b> applies

Visit limit per year	10
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### Ambulance services

Description	In-network
Emergency services	100% per trip, no <b>deductible</b> applies
Description	In-network
Non-emergency services	100% per trip, no <b>deductible</b> applies

### 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 disorders treatment

Coverage provided is the same as for any other illness

Description	In-network
Inpatient services-room and board including residential treatment facility	70% per admission after <b>deductible</b>

Description	In-network
Outpatient office visit to a <b>physician</b> or <b>behavioral health provider</b>	\$60 then the plan pays 100% per visit, no <b>deductible</b> applies
<b>Physician</b> or <b>behavioral health provider telemedicine</b> consultation	\$60 then the plan pays 100% per visit, no <b>deductible</b> applies
Outpatient <b>mental health disorders telemedicine</b> cognitive therapy consultations by a <b>physician</b> or <b>behavioral health provider</b>	100% per visit, no <b>deductible</b> applies

Description	In-network
Other outpatient services including: <ul style="list-style-type: none"> <li>• Behavioral health services in the home</li> <li>• Partial hospitalization treatment</li> <li>• Intensive outpatient program</li> </ul> The cost share doesn't apply to in-network peer counseling support services	100% per visit, no <b>deductible</b> applies

### 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	70% per admission after <b>deductible</b>

Description	In-network
Outpatient office visit to a <b>physician</b> or <b>behavioral health provider</b>	\$60 then the plan pays 100% per visit, no <b>deductible</b> applies
<b>Physician</b> or <b>behavioral health provider telemedicine</b> consultation	\$60 then the plan pays 100% per visit, no <b>deductible</b> applies
Outpatient <b>telemedicine</b> cognitive therapy consultations by a <b>physician</b> or <b>behavioral health provider</b>	100% per visit, no <b>deductible</b> applies

Description	In-network
Other outpatient services including: <ul style="list-style-type: none"> <li>Behavioral health services in the home</li> <li>Partial hospitalization treatment</li> <li>Intensive outpatient program</li> </ul> <p>The cost share doesn't apply to in-network peer counseling support services</p>	100% per visit, no <b>deductible</b> applies

### Cleft lip and palate

Description	In-network
Treatment for a congenital cleft lip or cleft palate	Covered based on type of service and where it is received
Age limit	Covered persons through age 18

## 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	100% per item, no deductible applies

## Emergency services

Description	In-network	Out-of-network
Emergency room	\$350 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

### Physical (PT), occupational (OT) therapies

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

### Speech therapy (ST)

Description	In-network
ST	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	100% per visit, no <b>deductible</b> applies

Visit limit per year	60
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### 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 - <b>room and board</b>	100% per admission, no <b>deductible</b> applies

Description	In-network
Outpatient services	100% per visit, no <b>deductible</b> applies

Limit per lifetime	unlimited
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### 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 - <b>room and board</b>	70% per admission after <b>deductible</b>

## Infertility services

### Basic infertility

Description	In-network
Treatment of basic <b>infertility</b>	Covered based on type of service and where it is received

### Comprehensive infertility services

Description	In-network
	70% per visit after <b>deductible</b>

### Limits

Description	In-network
Number of ovulation induction cycles per lifetime while on medications to stimulate the ovaries	6
Number of artificial insemination cycles per lifetime	6

### Advanced reproductive technology (ART)

Description	In-network
	70% per visit after deductible

### Limits

Description	In-network
Limit per lifetime	3 cycles maximum per lifetime

### Jaw joint disorder

Includes TMJ

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

### Maternity and related newborn care

Includes complications

Description	In-network
Inpatient services – room and board	70% per admission after deductible
Services performed in physician or specialist office or a facility	70% per visit after deductible
Other services and supplies	70% after deductible

#### Maternity and related newborn care important note:

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

### Nutritional support

Description	In-network
Nutritional support	Covered based on type of service and where it is received
Limit per year	\$2,500

### 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 prescription drugs

#### Preferred generic prescription drugs

Description	In-network
30 day supply at a <b>retail pharmacy</b>	\$10, no <b>deductible</b> applies
90 day supply at a <b>mail order pharmacy</b>	\$20, no <b>deductible</b> applies

#### Preferred brand-name prescription drugs

Description	In-network
30 day supply at a <b>retail pharmacy</b>	\$50, no <b>deductible</b> applies
90 day supply at a <b>mail order pharmacy</b>	\$100, no <b>deductible</b> applies

#### Non-preferred generic prescription drugs

Description	In-network
30 day supply at a <b>retail pharmacy</b>	\$75, no <b>deductible</b> applies
90 day supply at a <b>mail order pharmacy</b>	\$150, no <b>deductible</b> applies

#### Non-preferred brand-name prescription drugs

Description	In-network
30 day supply at a <b>retail pharmacy</b>	\$75, no <b>deductible</b> applies
90 day supply at a <b>mail order pharmacy</b>	\$150, no <b>deductible</b> applies

#### Specialty prescription drugs

Description	In-network
30 day supply at a <b>specialty pharmacy</b> or a <b>retail pharmacy</b>	20%, no <b>deductible</b> applies

#### Anti-cancer drugs taken by mouth

30 day supply at a <b>retail pharmacy</b>	\$0, no <b>deductible</b> applies
90 day supply at a <b>mail order pharmacy</b>	\$0, no <b>deductible</b> applies

### 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 <b>deductible</b> applies
30 day supply of <b>brand-name prescription drugs</b> 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 <b>deductible</b> 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 <i>Contact us</i> section

### Risk reducing breast cancer drugs

Description	In-network
Risk reducing breast cancer <b>prescription</b> drugs	\$0, no <b>deductible</b> 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 <i>Contact us</i> section

### Tobacco cessation drugs

Description	In-network
Tobacco cessation <b>prescription</b> and OTC drugs	\$0, no <b>deductible</b> 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 <i>Contact us</i> section. See the <i>Other services</i> section of this schedule for more information.

### Outpatient prescription drug important note:

If you or your **provider** requests a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost difference between the generic drug and the brand-name drug, plus the cost share that applies to the brand-name drug.

### Outpatient surgery

Description	In-network
At <b>hospital</b> outpatient department	70% per visit after <b>deductible</b>
At facility that is not a <b>hospital</b>	\$250 then the plan pays 100% per visit, no <b>deductible</b> applies

### Physician and specialist services

#### Physician services-general or family practitioner

Description	In-network
<b>Physician</b> office hours (not-surgical, not preventive)	\$10 then the plan pays 100% per visit, no <b>deductible</b> applies
<b>Physician</b> surgical services	\$10 then the plan pays 100% per visit, no <b>deductible</b> applies

Description	In-network
<b>Physician telemedicine</b> consultation	\$10 then the plan pays 100% per visit, no <b>deductible</b> applies

Description	In-network
<b>Physician</b> visit during inpatient <b>stay</b>	70% per visit after <b>deductible</b>

#### Specialist

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

#### Specialist

Description	In-network
<b>Specialist telemedicine</b> consultation	\$60 then the plan pays 100% per visit, no <b>deductible</b> applies

#### All other services not shown above

Description	In-network
All other services	70% per visit after <b>deductible</b>

## Preventive care

Description	In-network
Preventive care services	100% per visit, no <b>deductible</b> applies
Breast feeding counseling and support	100% per visit, no <b>deductible</b> applies
Breast feeding counseling and support limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the <b>physician</b> services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 every 3 years  Manual pump: 1 per pregnancy  Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 3 years to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no <b>deductible</b> applies
Counseling for alcohol or drug misuse visit limit	5 visits/12 months
Counseling for obesity, healthy diet	100% per visit, no <b>deductible</b> applies
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.
Counseling for sexually transmitted infection	100% per visit, no <b>deductible</b> applies
Counseling for sexually transmitted infection visit limit	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no <b>deductible</b> applies
Counseling for tobacco cessation visit limit	8 visits/12 months
Family planning services (female contraception counseling)	100% per visit, no <b>deductible</b> applies
Family planning services (female contraception counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting
Immunizations	100%, no <b>deductible</b> 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 <b>physician</b>
Routine cancer screenings	100% per visit, no <b>deductible</b> 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 <b>physician</b> or see the <i>Contact us</i> section
Routine lung cancer screening	100% per visit, no <b>deductible</b> applies
Routine lung cancer screening limit	1 screenings every 12 months  Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	100% per visit, no <b>deductible</b> 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 <b>deductible</b> 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
Limit	1 visit

### Prosthetic devices

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

### Reconstructive surgery and supplies

Including breast surgery

Description	In-network
<b>Surgery</b> and supplies	Covered based on type of service and where it is received

### Short-term rehabilitation services

#### Cardiac Rehabilitation

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

#### Pulmonary Rehabilitation

Description	In-network
Pulmonary	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
	\$60 then the plan pays 100% per visit; no <b>deductible</b> applies

### Physical, occupational and speech therapies

Description	In-network
Visit limit per year	60
All therapies combined	

### Spinal Manipulation

Description	In-network
	\$60 then the plan pays 100% per visit, no <b>deductible</b> applies

Visit limit per year	60
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### Skilled nursing facility

Description	In-network
Inpatient services - <b>room and board</b>	100% per admission, no <b>deductible</b> applies
Other inpatient services and supplies	100% per admission, no <b>deductible</b> applies

Day limit per year	30
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### Tests, images and labs – outpatient

#### Diagnostic complex imaging services

Description	In-network
	\$75 then the plan pays 100% per visit, no <b>deductible</b> applies

#### Diagnostic lab work

Description	In-network
At facility that is not a <b>hospital</b>	100% per visit, no <b>deductible</b> applies
At <b>hospital</b> outpatient department	70% per visit after <b>deductible</b>

#### Diagnostic x-ray and other radiological services

Description	In-network
	100% per visit, no <b>deductible</b> 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

### Infusion therapy

#### Outpatient services

Description	In-network
In <b>physician</b> office	\$60 then the plan pays 100% per visit, no <b>deductible</b> applies
At an infusion location	Covered based on type of service and where it is received
In the home	\$60 then the plan pays 100% per visit, no <b>deductible</b> applies
At <b>hospital</b> outpatient department	70% per visit after <b>deductible</b>
At facility that is not a <b>hospital</b>	70% per visit after <b>deductible</b>

### 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	70% per transplant after <b>deductible</b>
<b>Physician</b> 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	Out-of-network
Urgent care facility	\$50 then the plan pays 100% per visit after <b>deductible</b>	Not covered
Non-urgent use of an urgent care facility or <b>provider</b>	Not covered	Not covered

## Walk-in clinic

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

Description	Designated network	Non-designated network
Non-emergency services	100% per visit, no <b>deductible</b> applies	\$10 then the plan pays 100% per visit, no <b>deductible</b> applies
Preventive immunizations	100% per visit, no <b>deductible</b> applies	100% per visit, no <b>deductible</b> applies
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 <b>physician</b>	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 <b>physician</b>
Preventive screening and counseling services	100% per visit, no <b>deductible</b> applies	100% per visit, no <b>deductible</b> applies
Preventive screening and counseling limits	See the <i>Preventive care services</i> section of the schedule	See the <i>Preventive care services</i> section of the schedule

### Important Note:

#### 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.