Schedule of benefits

Prepared for:

Employer:	State Teachers Retirement System of Ohio (STRS Ohio)
Contract number:	ASA-0351630-A
Control number:	232351
Plan name:	Retirees Choice POS II Medical Plan Not eligible for Medicare or enrolled in Medicare Part B living in the network area
Schedule of benefits:	3A
Plan effective date:	January 1, 2024
Plan issue date:	August 20, 2023

Third Party Administrative Services provided by Aetna Life Insurance Company

Schedule of benefits

This schedule of benefits (schedule) lists the **copayments, deductibles**, 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.

The schedule of benefits provides a summary of cost sharing and goes with the Medical Plan Description (MPD). Detailed descriptions of **covered services** are found in the MPD.

Words that are in bold are defined in the *Glossary* section of the Medical Plan Description (MPD).

How your cost share works

- The **copayments and deductibles**, if any, listed in the schedule below are the amounts that you pay for **covered services**, up to the **maximum out-of-pocket** amount.
  - For the **covered services** under your medical plan, you will be responsible for the dollar 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 **copayments, deductibles** and remaining **payment percentage**, if they apply and before the plan will pay for any **covered services**.
- This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits. They may be:
  - Combined limits between in-network and **out-of-network providers**
  - Separate limits for in-network and **out-of-network providers**
  - Based on a rolling, 12 month period starting with the date of your most recent visit under this plan

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

For examples of how cost share and **deductible** work, go to the *Using your Aetna benefits* section under Individuals & Families at https://www.aetna.com/. Simply click on the "Log in" button and follow the prompts.

Important note:
Covered services are subject to the **copayment, deductible**, **maximum out-of-pocket**, limits, or **payment percentage** 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 **payment percentage**

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 **payment percentage** you pay when you get **covered services** from an in-network and **out-of-network provider**. This schedule shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **covered services**. You will continue to pay **copayments** or **payment percentage**, if any, for **covered services** after you meet your **deductible**, up until you reach the **maximum out-of-pocket**.

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 Medical Plan Description.

This schedule replaces any schedule of benefits previously in use.

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

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

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

- A $200 benefit reduction applied separately to each type of **covered service**

The additional percentage or dollar amount of the **recognized charge** which you may pay as a penalty because you didn't get **precertification** is not a **covered service** and doesn't apply to your **deductible** or **maximum out-of-pocket limit**.

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

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

Deductible type	In-network	Out-of-network
Individual	$2,500 per year	$5,000 per year

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

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

Individual deductible

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

Deductible waiver

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

- **PCP**
- Preventive care
- Family planning services – female contraceptives

Payment Percentage

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

Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	In-network	Out-of-network
Individual	$6,500 per year	$13,000 per year

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

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** 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 Medical Plan Description (MPD) and the schedule
- Charges, expenses or costs in excess of the **recognized charge** (for **out-of-network providers**)

Limit provisions

Covered services will apply to any in-network and out-of-network benefit maximum limits shown in the "**Covered services**" section in the following pages.

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 Medical Plan Description.

No surprise billing

"Surprise billing" is an unexpected bill that can happen when you can't control who is involved in your care. For example, when you have an emergency, or when you schedule a visit to a **network provider** but are unexpectedly treated by an **out-of-network provider**.

The Federal No Surprises Act establishes patient protections, including surprise bills from **out-of-network providers** ("balance billing") for emergency care and other specified items or services described below. The plan will comply with these protections, including how claims from certain **out-of-network providers** are processed.

Out-of-network providers cannot balance bill you for these services. However, you are still responsible for paying any applicable **copayments**, **deductibles,** or **payment percentage**. The amount of that cost-sharing will be based upon the network level of benefits and will accumulate toward your in-network **maximum out-of-pocket limit**.

- **Emergency services**
- Air ambulance - **Covered services** received from an **out-of-network provider**
- Unanticipated **covered services** received from an **out-of-network provider** at a network **hospital** or ambulatory surgical center. This means:

    1. items and services related to **emergency services**;
    2. anesthesia, pathology, radiology, lab and neonatology;
    3. items and services provided by an assistant surgeon, hospitalist, or intensivist;
    4. diagnostic services, including radiology and lab services;
    5. any additional services required by applicable state or federal law or subsequent guidance issued thereto.

There may be occasions where you knowingly and purposefully seek care from an **out-of-network provider** and voluntarily give consent for services for which you can be balanced billed. For example, if you have a complex health condition and want to be treated by a **specialist** who is not in your plan's network, and that **specialist** will not treat you unless he or she can bill you directly, including any balance billing.

Before you can consent to be balanced billed, your **out-of-network provider** must give you, or your authorized representative, a written notice, in advance of performing the service, that includes detailed information designed to ensure that you knowingly accept out-of-pocket charges. The notice must also include an estimate of the **out-of-network provider**'s charge for the services. **If you voluntarily give written consent after receiving the notice, your copayments, deductibles, and payment percentage will be based on the out-of-network level of benefits, and you will also be responsible for any balance billing for the services received.**

Covered services

Abortion

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

Acupuncture

Description	In-network	Out-of-network
Acupuncture	80% per visit after **deductible**	50% per visit after **deductible**

Ambulance services

Description	In-network	Out-of-network
Emergency services	80% per trip after **deductible**	Paid same as in-network
Non-**emergency services**	80% per trip after **deductible**	50% per trip after **deductible**

Applied behavior analysis

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

Autism spectrum disorder

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

Behavioral health

Mental health treatment

Coverage provided is the same as for any other illness

Description	In-network	Out-of-network
Inpatient services-**room and board** including **residential treatment facility**	80% per admission after **deductible**	50% per admission after **deductible**
Other inpatient services and supplies Other **residential treatment facility** services and supplies	80% per admission after **deductible**	50% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	80% per visit after **deductible**	50% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	80% per visit after **deductible**	50% per visit after **deductible**
Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	80% per visit after **deductible**	50% per visit after **deductible**
* **Telemedicine** consultations are available from a number of different kinds of **providers** under your plan. Contact Member Services to get more information about your options, including specific cost sharing amounts.		

Description	In-network	Out-of-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program	80% per visit after **deductible**	50% per visit after **deductible**

Substance related disorders treatment

Includes **detoxification**, rehabilitation and **residential treatment facility**

Coverage provided is the same as for any other illness

Description	In-network	Out-of-network
Inpatient services-**room and board** during a **hospital stay**	80% per admission after **deductible**	50% per admission after **deductible**
Other inpatient services and supplies during a **hospital stay**	80% per admission after **deductible**	50% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	80% per visit after **deductible**	50% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	80% per visit after **deductible**	50% per visit after **deductible**
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	80% per visit after **deductible**	50% per visit after **deductible**
* **Telemedicine** consultations are available from a number of different kinds of **providers** under your plan. Contact Member Services to get more information about your options, including specific cost sharing amounts.		

Description	In-network	Out-of-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program	80% per visit after **deductible**	50% per visit after **deductible**

Clinical trials

Description	In-network	Out-of-network
Experimental or investigational therapies	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Experimental or investigational therapies lifetime maximum	$10,000	$10,000
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, 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 insulin pump equipment	80% per item after **deductible**	50% per item after **deductible**
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
For diabetic testing supplies, insulin, and syringes, see separate **prescription** drug plan.		

Durable medical equipment (DME)

Description	In-network	Out-of-network
DME	80% per item after **deductible**	50% per item after **deductible**

Emergency services

Description	In-network	Out-of-network
Emergency room	$150 then the plan pays 80% per visit after **deductible**	Paid same as in-network

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.

Family planning services

Female voluntary sterilization

Description	In-network	Out-of-network
Inpatient	100% per admission, no **deductible** applies	50% per visit after **deductible**
Outpatient	100% per visit, no **deductible** applies	50% per visit after **deductible**

Voluntary sterilization for males

Description	In-network	Out-of-network
Outpatient	100% per visit, no **deductible** applies	50% per visit after **deductible**

Habilitation therapy services

Outpatient physical (PT), occupational (OT) therapies

Description	In-network	Out-of-network
PT, OT therapies	80% per visit after **deductible**	50% per visit after **deductible**

Speech therapy (ST)

Description	In-network	Out-of-network
ST	80% per visit after **deductible**	50% per visit after **deductible**

Home health care

A visit is a period of 4 hours or less

Description	In-network	Out-of-network
Home health care	80% per visit after **deductible**	50% per visit after **deductible**

Home health care important note:
Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits.

Hospice care

Description	In-network	Out-of-network
Inpatient services - **room and board**	80% after **deductible**	50% after **deductible**

Description	In-network	Out-of-network
Other inpatient services and supplies	80% per admission after **deductible**	50% after **deductible**

Description	In-network	Out-of-network
Outpatient services	80% per visit after **deductible**	50% per visit after **deductible**

Limit per lifetime	unlimited	unlimited

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

Hospital care

Description	In-network	Out-of-network
Inpatient services – **room and board**	80% after **deductible**	50% after **deductible**

Description	In-network	Out-of-network
Other inpatient services and supplies	80% per admission after **deductible**	50% 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

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**	80% per admission after **deductible**	50% per admission after **deductible**
Other inpatient services and supplies	80% per admission after **deductible**	50% per admission after **deductible**
Services performed in **physician** or **specialist** office or a facility	80% per visit after **deductible**	50% per visit after **deductible**
Other services and supplies	80% after **deductible**	50% after **deductible**

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

Obesity surgery

Description	In-network	Out-of-network
Inpatient services – **room and board**	80% per admission after **deductible**	50% per admission after **deductible**
Other inpatient services and supplies	80% per admission after **deductible**	50% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient services	80% per visit after **deductible**	50% per visit after **deductible**

Oral and maxillofacial treatment (mouth, jaws and teeth)

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

Outpatient surgery

Description	In-network	Out-of-network
At **hospital** outpatient department	80% per visit after **deductible**	50% per visit after **deductible**
At facility that is not a **hospital**	80% per visit after **deductible**	50% per visit after **deductible**
At the **physician** office	80% per visit after **deductible**	50% per visit after **deductible**

Physician and specialist services

Physician - general or family practitioner

Description	In-network	Out-of-network
Physician office hours (not-surgical, not preventive)	$20 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**
Physician surgical services	80% per visit after **deductible**	50% per visit after **deductible**
Allergy injections, testing, and treatment	80% per visit after **deductible**	50% per visit after **deductible**

Description	In-network	Out-of-network
Physician visit during inpatient **stay**	80% per visit after **deductible**	50% per visit after **deductible**

Description	In-network	Out-of-network
Physician telemedicine consultation	$20 then the plan pays 100% per visit, no **deductible** applies	50% 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)	80% per visit after **deductible**	50% per visit after **deductible**
Specialist surgical services	80% per visit after **deductible**	50% per visit after **deductible**
Allergy injections, testing, and treatment	80% per visit after **deductible**	50% per visit after **deductible**

Description	In-network	Out-of-network
Specialist telemedicine consultation	80% per visit after **deductible**	50% per visit after **deductible**

All other services not shown above

Description	In-network	Out-of-network
All other services	80% per visit after **deductible**	50% per visit after **deductible**

Preventive care

Description	In-network	Out-of-network
Preventive care services	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Breast feeding counseling and support	100% per visit, no **deductible** applies	50% per visit after **deductible**
Breast feeding counseling and support limit	6 visits/12 months in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit	6 visits/12 months in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 every 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 every 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 12 months to replace an existing electric pump	Electric pump: 12 months to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Counseling for alcohol or drug misuse visit limit	5 visits/calendar year	5 visits/calendar year
Counseling for genetic risk for breast and ovarian cancer	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per calendar year, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per calendar year, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Counseling for sexually transmitted infection visit limit	2 visits/calendar year	2 visits/calendar year
Counseling for tobacco cessation	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Counseling for tobacco cessation visit limit	8 visits/calendar year	8 visits/calendar year

Description	In-network	Out-of-network
Family planning services (female contraception counseling)	100% per visit, no **deductible** applies	50% per visit after **deductible**
Family planning services (female contraception counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting
Female contraceptive device provided, administered, or removed, by a **physician** during an office visit	100%, no **deductible** applies	50% after **deductible**
Immunizations	100%, no **deductible** applies	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**	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	100% per visit, no **deductible** applies
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section
Routine lung cancer screening	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Routine lung cancer screening limit	1 screening every calendar year Screenings that exceed this limit covered as outpatient diagnostic testing	1 screening every calendar year Screenings that exceed this limit covered as outpatient diagnostic testing

Description	In-network	Out-of-network
Routine physical exam	100% per visit, no **deductible** applies	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 18; 1 exam every calendar year after age 18 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 18; 1 exam every calendar year after age 18 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months
Routine skin cancer screening	100% per visit, no **deductible** applies	Not covered
Routine skin cancer screening limit	1 screening every calendar year	Not applicable
Well woman GYN exam	100% per visit, no **deductible** applies	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	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

Private duty nursing

Up to 8 hours equals one shift

Description	In-network	Out-of-network
Outpatient services	80% per visit after **deductible**	50% per visit after **deductible**

Prosthetic devices

Description	In-network	Out-of-network
Prosthetic devices	80% per item after **deductible**	50% per item after **deductible**
Maximum benefit for wigs	1 every 3 years	1 every 3 years

Reconstructive surgery and supplies

Including breast **surgery**

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

Short-term rehabilitation services

A visit is equal to no more than 1 hour of therapy.

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

Cognitive rehabilitation

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

Physical and occupational therapies

Description	In-network	Out-of-network
	80% per visit after **deductible**	50% per visit after **deductible**

Speech therapy (ST)

Description	In-network	Out-of-network
	80% per visit after **deductible**	50% per visit after **deductible**

Spinal manipulation

Description	In-network	Out-of-network
	80% per visit after **deductible**	50% per visit after **deductible**

Skilled nursing facility

Description	In-network	Out-of-network
Inpatient services - **room and board**	80% per admission after **deductible**	50% per admission after **deductible**
Other inpatient services and supplies	80% per admission after **deductible**	50% per admission after **deductible**

Day limit per confinement	90	90

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network	Out-of-network
	80% per visit after **deductible**	50% per visit after **deductible**

Diagnostic lab work

Description	In-network	Out-of-network
	80% per visit after **deductible**	50% per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network
	80% per visit after **deductible**	50% per visit after **deductible**

Therapies

Chemotherapy

Description	In-network	Out-of-network
Chemotherapy services	80% per visit after **deductible**	50% per visit after **deductible**

Gene-based, cellular and other innovative therapies (GCIT)

Description	In-network (GCIT-designated facility/provider)	Out-of-network (Including **providers** who are otherwise part of Aetna's network but are not GCIT-designated facilities/**providers**)
Services and supplies	Covered based on type of service and where it is received	Not covered
Gene therapy products, **prescription** drugs	$50 then the plan pays 100% per visit after **deductible**	Not covered

Infusion therapy

Outpatient services

Description	In-network	Out-of-network
	80% per visit after **deductible**	50% per visit after **deductible**

Radiation therapy

Description	In-network	Out-of-network
Radiation therapy	80% per visit after **deductible**	50% per visit after **deductible**

Respiratory therapy

Description	In-network	Out-of-network
Respiratory therapy	80% per visit after **deductible**	50% per visit after **deductible**

Transplant services

Description	In-network (IOE facility)	Out-of-network (Includes **providers** who are otherwise part of Aetna's network but are non-IOE **providers**)
Inpatient services and supplies	80% per transplant after **deductible**	50% per transplant after **deductible**
Physician services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Urgent care services

At a freestanding facility or **provider** that is not a **hospital**

A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

Description	In-network	Out-of- network
Urgent care facility	$40 then the plan pays 80% per visit after **deductible**	$40 then the plan pays 80% per visit after **deductible**

Walk-in clinic

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

Description	In-network	Out-of-network
Non-**emergency services**	$20 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**
Preventive care immunizations	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Preventive care immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Preventive screening and counseling services	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Preventive screening and counseling limits	See the *Preventive care services* section of the SOB	See the *Preventive care services* section of the SOB