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:

Employer:	UVA J VISA Health Plan
Contract number:	ASC-706455
Plan name:	PPO Medical and Pharmacy
Schedule of benefits:	1A
Plan effective date:	January 1, 2022
Plan issue date:	October 26, 2021

Third Party Administrative Services provided by Aetna Life Insurance Company

Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles**, **copayments** or **payment percentage**, if any apply to the **covered services** you receive under the plan. You should review this schedule to become aware of these and any limits that apply to these services.

How your cost share works

- The **deductibles** and **copayments**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
  - For the **covered services** under your medical plan, you will be responsible for the dollar amount
  - For pharmacy benefits where a percentage cost share acts like a **copayment**, you will be responsible for the percentage amount
- **Payment percentage** amounts, if any, listed in the schedule below are what the plan will pay for **covered services**.
- Sometimes your cost share shows a combination of your dollar amount **copayment** that you will be responsible for and the **payment percentage** that your plan will pay.
- You are responsible to pay any **deductibles**, **copayments** and remaining **payment percentage**, if they apply and before the plan will pay for any **covered services**.
- **Other health care** coverage is care you get from an **out-of-network provider** when you could not reasonably get services and supplies from an in-**network provider**. This includes services you get from an **out-of-network provider** when you have a **stay** in an in-**network** hospital.
- 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 **deductible**, **maximum out-of-pocket**, limits, **copayment** 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**, **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**.

How your PCP or physician office visit cost share works
You will pay the **PCP** cost share when you get **covered services** from any **PCP**.

How your maximum out-of-pocket works
This schedule shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of that year.

Contact us
We are here to answer questions. See the *Contact us* section in your booklet.

This schedule replaces any schedule of benefits previously in use. Keep it with your booklet.

Plan features

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

Deductible type	In-network (In the U.S.)	Out-of-network (In the U.S.)	Outside the U.S.
Individual	$500 per year	Not covered	$500 per year
Family	$1,000 per year	Not covered	$1,000 per year

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

- Preventive care
- Family planning services – female contraceptives

Deductible and cost share waiver for risk reducing breast cancer prescription drugs
The **prescription** drug **deductible** and per **prescription** cost share will not apply to risk reducing breast cancer **prescription** drugs when obtained at a network pharmacy. This means they will be paid at 100%.

Deductible and cost share waiver for contraceptives (birth control)
The **prescription** drug **deductible** and per **prescription** cost share will not apply to female contraceptive methods when obtained at a network pharmacy. This means they will be paid at 100%. This includes certain OTC and generic contraceptive **prescription** drugs and devices for each of the methods identified by the FDA. If a **generic prescription drug** is not available, the **brand-name prescription drug** for that method will be paid at 100%.

The **prescription** drug **deductible** and cost share will apply to **prescription** drugs that have a generic equivalent or alternative available within the same therapeutic drug class obtained at a network pharmacy unless we approve a medical exception. A therapeutic drug class is a group of drugs or medications that have a similar or identical mode of action or are used for the treatment of the same or similar disease or injury.

Deductible and cost share waiver for tobacco cessation prescription and OTC drugs

The **prescription** drug **deductible** and the per **prescription** cost share will not apply to the first two 90-day treatment programs for tobacco cessation **prescription** and OTC drugs when obtained at a network **retail pharmacy**. This means they will be paid at 100%. Your per **prescription** cost share will apply after those two programs have been exhausted.

Maximum out-of-pocket limit

Maximum out-of-pocket type	In-network (In the U.S.)	Out-of-network (In the U.S.)	Outside the U.S.
Individual	$5,500 per year	$0 per year	$5,500 per year
Family	$11,000 per year	$0 per year	$11,000 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.

Covered services apply to the in-network and out-of-network **deductibles.**

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.

Family deductible

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

Copayment

This is 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.

Payment Percentage

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**, **payment percentage** 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.

Covered services apply to the in-network and out-of-network **maximum out-of-pocket limit**.

Individual maximum out-of-pocket limit

- This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of you must meet your **maximum out-of-pocket limit** separately.
- After you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the year for that person.

Family maximum out-of-pocket limit

After you or your covered dependents meet the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the remainder of the year for all covered family members. The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members.

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

- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit** amount.

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

- All costs for non-covered services which are identified in the booklet and the schedule
- Charges, expenses or costs in excess of the **recognized charge**

Limit provisions

Covered services will apply to the in-network and out-of-network limits.

Your financial responsibility and decisions regarding benefits

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

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**, **payment percentage** 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 In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Acupuncture	Covered based on type of service and where it is received	Not covered	Covered based on type of service and where it is received

Ambulance services

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Emergency services	80% per trip after **deductible**	80% per trip after **deductible**	80% per trip after **deductible**
Non-emergency services	80% per trip after **deductible**	Not covered	80% per trip after **deductible**

Applied behavior analysis

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Applied behavior analysis	Covered based on type of service and where it is received	Not covered	Covered based on type of service and where it is received

Autism spectrum disorder

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Diagnosis and testing	Covered based on type of service and where it is received	Not covered	Covered based on type of service and where it is received
Treatment	Covered based on type of service and where it is received	Not covered	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	Not covered	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 In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Inpatient services-**room and board** including **residential treatment facility**	80% per admission after **deductible**	Not covered	80% per admission after **deductible**

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Outpatient office visit to a **physician** or **behavioral health provider**	$50 then the plan pays 100% per visit, no **deductible** applies	Not covered	80% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	$50 then the plan pays 100% per visit, no **deductible** applies	Not covered	80% per visit after **deductible**
Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	100% per visit, no **deductible** applies	Not covered	Not covered

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services	80% per visit after **deductible**	Not covered	80% 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 In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Inpatient services-**room and board** during a hospital stay	80% per admission after **deductible**	Not covered	80% per admission after **deductible**

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Outpatient office visit to a **physician** or **behavioral health provider**	$50 then the plan pays 100% per visit, no **deductible** applies	Not covered	80% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	$50 then the plan pays 100% per visit, no **deductible** applies	Not covered	80% per visit after **deductible**
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	100% per visit, no **deductible** applies	Not covered	Not covered

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services	80% per visit after **deductible**	Not covered	80% per visit after **deductible**

Clinical trials

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Experimental or investigational therapies	Covered based on type of service and where it is received	Not covered	Covered based on type of service and where it is received
Routine patient care	Covered based on type of service and where it is received	Not covered	Covered based on type of service and where it is received

Diabetic services, supplies, equipment and self-care programs

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Diabetic services	Covered based on type of service and where it is received	Not covered	Covered based on type of service and where it is received
Diabetic supplies	Covered based on type of service and where it is received	Not covered	Covered based on type of service and where it is received
Diabetic equipment	Covered based on type of service and where it is received	Not covered	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	Not covered	Covered based on type of service and where it is received

Durable medical equipment (DME)

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
DME	80% per item after **deductible**	Not covered	80% per item after **deductible**

Emergency services

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Emergency room	75% per visit after **deductible**	Paid same as in-network	75% per visit after **deductible**
Non -emergency care in a **hospital** emergency room	50% per visit after **deductible**	Not covered	75% per visit after **deductible**

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.

Habilitation therapy services

Physical (PT), occupational (OT) therapies

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
PT, OT therapies	Covered based on type of service and where it is received	Not covered	Covered based on type of service and where it is received

Speech therapy (ST)

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
ST	Covered based on type of service and where it is received	Not covered	Covered based on type of service and where it is received

Hearing aids

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Hearing aids	80% per item after **deductible**	Not covered	80% per item after **deductible**
Limit	One per ear every 3 years	Not covered	One per ear every 3 years
Limit	$1,000	Not applicable	$1,000

Hearing exams

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Hearing exams	Covered based on type of service and where it is received	Not covered	Covered based on type of service and where it is received
Visit limit	1 visit every 24 months	Not applicable	1 visit every 24 months

Home health care

A visit is a period of 4 hours or less

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Home health care	80% per visit after **deductible**	Not covered	80% per visit after **deductible**

Visit limit per year	120	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 In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Inpatient services - **room and board**	80% per admission after **deductible**	Not covered	80% per admission after **deductible**

Day limit per lifetime	30 days	Not applicable	30 days

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Outpatient services	80% per visit after **deductible**	Not covered	80% per visit after **deductible**

Limit per lifetime	unlimited	Not applicable	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 In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Inpatient services – **room and board**	80% per admission after **deductible**	Not covered	80% per admission after **deductible**

Infertility services

Basic infertility

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Treatment of basic **infertility**	Covered based on type of service and where it is received	Not covered	Covered based on type of service and where it is received

Maternity and related newborn care

Includes complications

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Inpatient services – **room and board**	80% per admission after **deductible**	Not covered	80% per admission after **deductible**
Services performed in **physician** or **specialist** office or a facility	80% per visit after **deductible**	Not covered	80% per visit after **deductible**
Other services and supplies	80% after **deductible**	Not covered	80% 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.

Outpatient prescription drugs in the U.S.

Generic prescription drugs

Description	In-network
Each 30 day supply up to 12 months at a **retail pharmacy**	$20, no **deductible** applies
Each 30 day supply up to 12 months at a **mail order pharmacy**	$20, no **deductible** applies

Brand-name prescription drugs

Description	In-network
Each 30 day supply up to 12 months at a **retail pharmacy**	$40, no **deductible** applies
Each 30 day supply up to 12 months at a **mail order pharmacy**	$40, no **deductible** applies

Non-preferred brand-name prescription drugs

Description	In-network
Each 30 day supply up to 12 months at a **retail pharmacy**	$70, no **deductible** applies
Each 30 day supply up to 12 months at a **mail order pharmacy**	$70, no **deductible** applies

Specialty prescription drugs

Description	In-network
30 day supply at a **UVA specialty pharmacy** only	$20 Generic, no **deductible** applies $40 Preferred Brand, no **deductible** applies $70 Non-Preferred Brand, no **deductible** applies

Anti-cancer drugs taken by mouth

Description	In-network
Each 30 day supply up to 12 months at a **retail pharmacy**	$0, no **deductible** applies
Each 30 day supply up to 12 months at a **mail order pharmacy**	$0, no **deductible** applies

Contraceptives (birth control)

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

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

Preventive care drugs and supplements

Description	In-network
Preventive care drugs and supplements	$0, no **deductible** applies
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section

Risk reducing breast cancer drugs

Description	In-network
Risk reducing breast cancer **prescription** drugs	$0, no **deductible** applies
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of risk reducing breast cancer drugs or more information, see the *Contact us* section

Tobacco cessation drugs

Description	In-network
Tobacco cessation **prescription** and OTC drugs	$0, no **deductible** applies
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section. See the *Other services* section of this schedule for more information.

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 In the U.S.	Out-of-network In the U.S.	Outside the U.S.
At **hospital** outpatient department	80% per visit after **deductible**	Not covered	80% per visit after **deductible**

Physician and specialist services

Physician services-general or family practitioner

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Physician office hours (not-surgical, not preventive)	$30 then the plan pays 100% per visit, no **deductible** applies	Not covered	80% per visit after **deductible**
Physician surgical services	80% per visit after **deductible**	Not covered	80% per visit after **deductible**

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Physician telemedicine consultation	$30 then the plan pays 100% per visit, no **deductible** applies	Not covered	80% per visit after **deductible**

Specialist

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Specialist office hours (not-surgical, not preventive)	$50 then the plan pays 100% per visit, no **deductible** applies	Not covered	80% per visit after **deductible**
Specialist surgical services	80% per visit after **deductible**	Not covered	80% per visit after **deductible**

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Specialist telemedicine consultation	$50 then the plan pays 100% per visit, no **deductible** applies	Not covered	80% per visit after **deductible**

All other services not shown above

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
All other services	80% per visit after **deductible**	Not covered	80% per visit after **deductible**

Preventive care

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Preventive care services	100% per visit, no **deductible** applies	Not covered	80% per visit after **deductible**
Breast feeding counseling and support	100% per visit, no **deductible** applies	Not covered	80% per visit after **deductible**
Breast feeding counseling and support limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit	Not applicable	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 every 3 years Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Not applicable	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	Not applicable	Electric pump: 3 years to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies	Not covered	80% per visit after **deductible**
Counseling for alcohol or drug misuse visit limit	5 visits/12 months	Not applicable	5 visits/12 months
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies	Not covered	80% per visit after **deductible**
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	Not applicable	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	Not covered	80% per visit after **deductible**
Counseling for sexually transmitted infection visit limit	2 visits/12 months	Not applicable	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no **deductible** applies	Not covered	80% per visit after **deductible**
Counseling for tobacco cessation visit limit	8 visits/12 months	Not applicable	8 visits/12 months

Family planning services (female contraceptive counseling)	100% per visit, no **deductible** applies	Not covered	80% per visit after **deductible**
Family planning services (female contraceptive counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting	Not applicable	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting
Immunizations	100%, no **deductible** applies	Not covered	80% per visit after **deductible**
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Not applicable	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	Not covered	80% per visit after **deductible**
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	Not applicable	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
Lung cancer screening	100% per visit, no **deductible** applies	Not covered	80% per visit after **deductible**
Routine lung cancer screening limit	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing	Not applicable	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing

Routine physical exam	100% per visit, no **deductible** applies	Not covered	80% per visit after **deductible**
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months	Not applicable	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months
Well woman GYN exam	100% per visit, no **deductible** applies	Not covered	80% 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	Not applicable	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

Preventive care and wellness maximum

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
For all preventive services listed above - Adult maximum per year	Not applicable	Not applicable	$1,000

Prosthetic devices

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Prosthetic devices	Covered based on type of service and where it is received	Not covered	Covered based on type of service and where it is received

Reconstructive surgery and supplies

Including breast surgery

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Surgery and supplies	Covered based on type of service and where it is received	Not covered	Covered based on type of service and where it is received

Short-term rehabilitation services

Cardiac rehabilitation

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Cardiac rehabilitation	Covered based on type of service and where it is received	Not covered	Covered based on type of service and where it is received

Pulmonary rehabilitation

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Pulmonary rehabilitation	Covered based on type of service and where it is received	Not covered	Covered based on type of service and where it is received

Cognitive rehabilitation

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Cognitive rehabilitation	Covered based on type of service and where it is received	Not covered	Covered based on type of service and where it is received

Physical, occupational and speech therapies

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
At the **physician** office	80% per visit after **deductible**	Not covered	80% per visit after **deductible**
At facility that is not a **hospital**	80% per visit after **deductible**	Not covered	80% per visit after **deductible**
At **hospital** outpatient department	80% per visit after **deductible**	Not covered	80% per visit after **deductible**

Physical, occupational and speech therapies

Description	**In-network In the U.S.**	**Out-of-network In the U.S.**	**Outside the U.S.**
Limit per year	60 visits	60 visits	60 visits

Spinal manipulation

Description	**In-network In the U.S.**	**Out-of-network In the U.S.**	**Outside the U.S.**
At the **physician** office	80% per visit after **deductible**	Not covered	80% per visit after **deductible**

Skilled nursing facility

Description	**In-network In the U.S.**	**Out-of-network In the U.S.**	**Outside the U.S.**
Inpatient services - **room and board**	80% per admission after **deductible**	Not covered	80% per admission after **deductible**
Other inpatient services and supplies	80% per admission after **deductible**	Not covered	80% per admission after **deductible**
Day limit per year	120	Not applicable	120

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	**In-network In the U.S.**	**Out-of-network In the U.S.**	**Outside the U.S.**
	80% per visit after **deductible**	Not covered	80% per visit after **deductible**

Diagnostic lab work

Description	**In-network In the U.S.**	**Out-of-network In the U.S.**	**Outside the U.S.**
	80% per visit after **deductible**	Not covered	80% per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	**In-network In the U.S.**	**Out-of-network In the U.S.**	**Outside the U.S.**
	80% per visit after **deductible**	Not covered	80% per visit after **deductible**

Therapies

Chemotherapy

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Chemotherapy services	Covered based on type of service and where it is received	Not covered	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) In the U.S.	Out-of-network (Including **providers** who are otherwise part of Aetna's network but are not GCIT-designated facilities/**providers**) In the U.S.	Outside the U.S.
Services and supplies	Covered based on type of service and where it is received	Not covered	Not covered

Infusion therapy

Outpatient services

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
In **physician** office	$50 then the plan pays 100% per visit, no **deductible** applies	Not covered	80% per visit after **deductible**
At an infusion location	$50 then the plan pays 100% per visit, no **deductible** applies	Not covered	80% per visit after **deductible**
In the home	$50 then the plan pays 100% per visit, no **deductible** applies	Not covered	80% per visit after **deductible**
At **hospital** outpatient department	80% per visit after **deductible**	Not covered	80% per visit after **deductible**
At facility that is not a **hospital**	80% per visit after **deductible**	Not covered	80% per visit after **deductible**

Radiation therapy

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Radiation therapy	Covered based on type of service and where it is received	Not covered	Covered based on type of service and where it is received

Respiratory therapy

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Respiratory therapy	Covered based on type of service and where it is received	Not covered	Covered based on type of service and where it is received

Transplant services

Description	In-network In the U.S.	Out-of-network (Includes **providers** who are otherwise part of Aetna's network but are non-IOE **providers**) In the U.S.	Outside the U.S.
Inpatient services and supplies	80% per transplant after **deductible**	Not covered	Not covered
Physician services	Covered based on type of service and where it is received	Not covered	Not covered

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 In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Urgent care facility	80% per visit after **deductible**	Not covered	80% per visit after **deductible**
Non-urgent use of an urgent care facility or **provider**	50% per visit after **deductible**	Not covered	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 In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Non-emergency services	$30 then the plan pays 100% per visit, no **deductible** applies	Not covered	80% per visit after **deductible**
Preventive immunizations	100% per visit, no **deductible** applies	Not covered	80% per visit after **deductible**
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**
Screening and counseling services	100% per visit, no **deductible** applies	Not covered	80% per visit after **deductible**
Screening and counseling limits	See the *Preventive care services* section of the SOB	See the *Preventive care services* section of the SOB	See the *Preventive care services* section of the SOB