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: Yale University
Contract number: ASA-0877076
Plan name: Choice POS II with Base Prescription Drug Plan
Yale Police Benevolent Association
Schedule of benefits: 7A
Plan effective date: January 1, 2023
Plan issue date: May 12, 2023

Third Party Administrative Services provided by Aetna Life Insurance Company
This schedule of benefits (schedule) lists the **deductibles**, **copayments** or **payment percentage**, if any apply to the **covered services** you receive under the plan. You should review this schedule to become aware of these and any limits that apply to these services.

**How your cost share works**

- The **deductibles** and **copayments**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
  - For the **covered services** under your medical plan, you will be responsible for the dollar amount.
  - For pharmacy benefits where a percentage cost share acts like a **copayment**, you will be responsible for the percentage amount.
- **Payment percentage** amounts, if any, listed in the schedule below are what the plan will pay for **covered services**.
- Sometimes your cost share shows a combination of your dollar amount **copayment** that you will be responsible for and the **payment percentage** that your plan will pay.
- You are responsible to pay any **deductibles**, **copayments** and remaining **payment percentage**, if they apply and before the plan will pay for any **covered services**.
- This plan doesn’t cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits. They may be:
  - 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/](https://www.aetna.com/)

**Important note:**

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

Under this plan, you will:

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

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

**How your 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

Precertification covered services reduction
This only applies to out-of-network covered services:
Your booklet 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

You may have to pay an additional portion of the recognized charge because you didn’t get precertification. This portion is not a covered service and doesn’t apply to your deductible or maximum out-of-pocket limit, if you have one.

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

<table>
<thead>
<tr>
<th>Deductible type</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$0 per year</td>
<td>$250 per year</td>
</tr>
<tr>
<td>Family</td>
<td>$0 per year</td>
<td>$750 per year</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Maximum out-of-pocket type</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$6,350 per year</td>
<td>$1,000 per year</td>
</tr>
<tr>
<td>Family</td>
<td>$12,700 per year</td>
<td>$3,000 per year</td>
</tr>
</tbody>
</table>

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. 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.

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 the dollar amount you pay for covered services. In most plans, you pay this after you meet your deductible limit. In prescription drug plans, it is the amount you pay for covered drugs.
Per admission copayment
This is the amount you are required to pay when you or a covered dependent have a stay in an inpatient facility.

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

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

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

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

- All costs for non-covered services
## Covered services

### Acupuncture

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>$20 then the plan pays 100% per visit, no <strong>deductible</strong> applies</td>
<td>70% per visit after <strong>deductible</strong></td>
</tr>
</tbody>
</table>

Visit limit per year: 10

## Ambulance services

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency services (Including Air Ambulance)</td>
<td>100% per trip, no <strong>deductible</strong> applies</td>
<td>Paid same as in-network</td>
</tr>
<tr>
<td>Non-emergency services (Including Air Ambulance)</td>
<td>100% per trip, no <strong>deductible</strong> applies</td>
<td>70% per trip after <strong>deductible</strong></td>
</tr>
</tbody>
</table>

## Applied behavior analysis

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applied behavior analysis</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

## Autism spectrum disorder

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis and testing</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
<tr>
<td>Treatment</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
<tr>
<td>Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>
# Behavioral health

## Mental health treatment

Coverage provided is the same as for any other illness

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services-<strong>room and board</strong> including residential treatment facility</td>
<td>100% per admission, no <strong>deductible</strong> applies</td>
<td>70% per admission after <strong>deductible</strong></td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td><strong>In-network</strong></td>
<td><strong>Out-of-network</strong></td>
</tr>
<tr>
<td>Outpatient office visit to a physician or behavioral health provider</td>
<td>$20 then the plan pays 100% per visit, no <strong>deductible</strong> applies</td>
<td>70% per visit after <strong>deductible</strong></td>
</tr>
<tr>
<td>Physician or behavioral health provider telemedicine consultation</td>
<td>$20 then the plan pays 100% per visit, no <strong>deductible</strong> applies</td>
<td>70% per visit after <strong>deductible</strong></td>
</tr>
<tr>
<td>Outpatient mental health disorders telemedicine cognitive therapy consultations by a physician or behavioral health provider</td>
<td>Covered based on type of service and <strong>provider</strong> from which it is received</td>
<td>Covered based on type of service and <strong>provider</strong> from which it is received</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telemedicine provider mental health disorders consultation</td>
<td>Covered based on type of service and <strong>provider</strong> from which it is received</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

## Substance related disorders treatment

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

Coverage provided is the same as for any other illness

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services-<strong>room and board</strong> during a hospital stay</td>
<td>100% per admission, no <strong>deductible</strong> applies</td>
<td>70% per admission after <strong>deductible</strong></td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td><strong>In-network</strong></td>
<td><strong>Out-of-network</strong></td>
</tr>
<tr>
<td>Outpatient office visit to a physician or behavioral health provider</td>
<td>$20 then the plan pays 100% per visit, no <strong>deductible</strong> applies</td>
<td>70% per visit after <strong>deductible</strong></td>
</tr>
<tr>
<td>Description</td>
<td>In-network</td>
<td>Out-of-network</td>
</tr>
<tr>
<td>-------------</td>
<td>------------</td>
<td>---------------</td>
</tr>
<tr>
<td><strong>Physician or behavioral health provider telemedicine consultation</strong></td>
<td>$20 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td><strong>Outpatient telemedicine cognitive therapy consultations by a physician or behavioral health provider</strong></td>
<td>Covered based on type of service and provider from which it is received</td>
<td>Covered based on type of service and provider from which it is received</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Telemedicine provider substance related disorders consultation</strong></td>
<td>Covered based on type of service and provider from which it is received</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**Clinical trials**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Experimental or investigational therapies</strong></td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
<tr>
<td><strong>Routine patient costs</strong></td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

**Durable medical equipment (DME)**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DME</strong></td>
<td>100% per item, no deductible applies</td>
<td>70% per item after deductible</td>
</tr>
</tbody>
</table>

**Emergency services**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency room</strong></td>
<td>$100 then the plan pays 100% per visit, no deductible applies</td>
<td>Paid same as in-network</td>
</tr>
<tr>
<td><strong>Non-emergency care in a hospital emergency room</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**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.

**Foot orthotic devices**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Orthotic devices</strong></td>
<td>100% per item, no deductible applies</td>
<td>70% per item after deductible</td>
</tr>
</tbody>
</table>

**Habilitation therapy services**

Physical (PT), occupational (OT) therapies
<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT, OT therapies</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

**Speech therapy (ST)**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

**Hearing exams**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing exams</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
<tr>
<td>Visit limit</td>
<td>1 visit every 24 months</td>
<td>1 visit every 24 months</td>
</tr>
</tbody>
</table>

**Home health care**

A visit is a period of 4 hours or less

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care</td>
<td>100% per visit, no <strong>deductible</strong> applies</td>
<td>70% per visit after <strong>deductible</strong></td>
</tr>
</tbody>
</table>

| Visit limit per year  | 120                                                                         | 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

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services - room and board</td>
<td>100%, no deductible applies</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Outpatient services</td>
<td>100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services – room and board</td>
<td>100%, no deductible applies</td>
<td>70% after deductible</td>
</tr>
</tbody>
</table>

### Infertility services

**Basic infertility**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of basic infertility</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

**Comprehensive infertility services**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>$30 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
<td></td>
</tr>
</tbody>
</table>

### Limits

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of ovulation induction cycles per lifetime while on medications to stimulate the ovaries</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Number of artificial insemination cycles per lifetime</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Maximum per lifetime</td>
<td>$20,000</td>
<td>$20,000</td>
</tr>
</tbody>
</table>
### Advanced reproductive technology (ART)

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-network</td>
<td>$30 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
</tbody>
</table>

### Limits

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum number of cycles per lifetime</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>This limit is combined for in-network and out-of-network benefits</td>
<td>This limit is combined for in-network and out-of-network benefits</td>
<td></td>
</tr>
</tbody>
</table>

### Maternity and related newborn care
Includes complications

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services – room and board</td>
<td>100% per admission, no deductible applies</td>
<td>70% per admission after deductible</td>
</tr>
<tr>
<td>Services performed in physician or specialist office or a facility</td>
<td>100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Other services and supplies</td>
<td>100%, no deductible applies</td>
<td>70% after deductible</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services – room and board</td>
<td>100% per admission, no deductible applies</td>
<td>70% per admission after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient services</td>
<td>100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
</tbody>
</table>

### Oral and maxillofacial treatment (mouth, jaws and teeth)

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of mouth, jaws and teeth</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>
### Outpatient prescription drugs

#### Preferred prescription drugs

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 day supply at a retail pharmacy</td>
<td>$10, no deductible applies</td>
<td>$0 then the plan pays 80%, no deductible applies</td>
</tr>
<tr>
<td>100 day supply at a mail order pharmacy or a CVS pharmacy</td>
<td>$20, no deductible applies</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

#### Alternative prescription drugs

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 day supply at a retail pharmacy</td>
<td>$30 no deductible applies</td>
<td>$0 then the plan pays 80% no deductible applies</td>
</tr>
<tr>
<td>100 day supply at a mail order pharmacy or a CVS pharmacy</td>
<td>$60, no deductible applies</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

#### Non-preferred generic prescription drugs

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 day supply at a retail pharmacy</td>
<td>$50 no deductible applies</td>
<td>$0 then the plan pays 80%, no deductible applies</td>
</tr>
<tr>
<td>100 day supply at a mail order pharmacy or a CVS pharmacy</td>
<td>$100, no deductible applies</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

#### Contraceptives (birth control)

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

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 day supply of generic and OTC drugs and devices</td>
<td>$0, no deductible applies</td>
<td>Paid according to the type of drug per the schedule of benefits, above</td>
</tr>
<tr>
<td>30 day supply of brand-name prescription drugs and devices</td>
<td>Paid based on the tier of drug in the schedule</td>
<td>Paid based on the tier of drug in the schedule</td>
</tr>
</tbody>
</table>
### Preventive care drugs and supplements

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive care drugs and supplements</td>
<td>$0, no <strong>deductible</strong> applies</td>
<td>Paid based on the tier of drug in the schedule</td>
</tr>
<tr>
<td>Limits</td>
<td>Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF)</td>
<td>Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF)</td>
</tr>
<tr>
<td></td>
<td>For a current list of covered preventive care drugs and supplements or more information, see the Contact us section</td>
<td>For a current list of covered preventive care drugs and supplements or more information, see the Contact us section</td>
</tr>
</tbody>
</table>

### Risk reducing breast cancer drugs

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk reducing breast cancer prescription drugs</td>
<td>$0, no <strong>deductible</strong> applies</td>
<td>Paid based on the tier of drug in the schedule</td>
</tr>
<tr>
<td>Limits</td>
<td>Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF)</td>
<td>Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF)</td>
</tr>
<tr>
<td></td>
<td>For a current list of risk reducing breast cancer drugs or more information, see the Contact us section</td>
<td>For a current list of risk reducing breast cancer drugs or more information, see the Contact us section</td>
</tr>
</tbody>
</table>

### Tobacco cessation drugs

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco cessation prescription and OTC drugs</td>
<td>$0, no <strong>deductible</strong> applies</td>
<td>Paid based on the tier of drug in the schedule</td>
</tr>
<tr>
<td>Limits</td>
<td>Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF.</td>
<td>Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td>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.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>At hospital outpatient department</td>
<td>100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>At facility that is not a hospital</td>
<td>100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>At the physician office</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

### Physician and specialist services

**Physician services-general or family practitioner**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician office hours (not-surgical, not preventive)</td>
<td>$20 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Physician surgical services</td>
<td>$20 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
</tbody>
</table>

**Physician telemedicine consultation**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician visit during inpatient stay</td>
<td>100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
</tbody>
</table>

### Specialist

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist office hours (not-surgical, not preventive)</td>
<td>$30 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Specialist surgical services</td>
<td>$30 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Description</td>
<td>In-network</td>
<td>Out-of-network</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>------------------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Specialist telemedicine consultation</td>
<td>$30 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telemedicine provider consultation</td>
<td>Covered based on type of service and provider from which it is received</td>
<td>Not covered</td>
</tr>
<tr>
<td>Specialist services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### All other services not shown above

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>All other services</td>
<td>100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Preventive care</td>
<td>In-network</td>
<td>Out-of-network</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>----------------------------------------------------</td>
</tr>
<tr>
<td>Preventive care services</td>
<td>100% per visit, no deductible applies</td>
<td>Not covered</td>
</tr>
<tr>
<td>Breast feeding counseling and support</td>
<td>100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Breast feeding counseling and support limit</td>
<td>6 visits in a group or individual setting Visits that exceed the limit are covered under the physician services office visit</td>
<td>6 visits in a group or individual setting Visits that exceed the limit are covered under the physician services office visit</td>
</tr>
<tr>
<td>Breast pump, accessories and supplies limit</td>
<td>Electric pump: 1 every 1 year Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump</td>
<td>Electric pump: 1 every 1 year Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump</td>
</tr>
<tr>
<td>Breast pump waiting period</td>
<td>Electric pump: 1 year to replace an existing electric pump</td>
<td>Electric pump: 1 year to replace an existing electric pump</td>
</tr>
<tr>
<td>Counseling for alcohol or drug misuse</td>
<td>100% per visit, no deductible applies</td>
<td>Not covered</td>
</tr>
<tr>
<td>Counseling for alcohol or drug misuse visit limit</td>
<td>5 visits/Calendar Year</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Counseling for obesity, healthy diet</td>
<td>100% per visit, no deductible applies</td>
<td>Not covered</td>
</tr>
<tr>
<td>Counseling for obesity, healthy diet visit limit</td>
<td>Age 22 and older: 26 visits per Calendar Year, of which up to 10 visits may be used for healthy diet counseling.</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Counseling for sexually transmitted infection</td>
<td>100% per visit, no deductible applies</td>
<td>Not covered</td>
</tr>
<tr>
<td>Counseling for sexually transmitted infection visit limit</td>
<td>2 visits/Calendar Year</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Counseling for tobacco cessation</td>
<td>100% per visit, no deductible applies</td>
<td>Not covered</td>
</tr>
<tr>
<td>Counseling for tobacco cessation visit limit</td>
<td>8 visits/Calendar Year</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Family planning services (female contraception counseling)</td>
<td>100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Family planning services (female contraception counseling) limit</td>
<td>Contraceptive counseling limited to 2 visits/12 months in a group or individual setting Counseling’s that exceed this limit are covered as a physician services office visit</td>
<td>Contraceptive counseling limited to 2 visits/12 months in a group or individual setting Counseling’s that exceed this limit are covered as a physician services office visit</td>
</tr>
<tr>
<td>Immunizations</td>
<td>100%, no deductible applies</td>
<td>Not covered</td>
</tr>
<tr>
<td>Immunizations limit</td>
<td>Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Service</td>
<td>Coverage</td>
<td>Deductible Information</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------------------------------------------</td>
<td>--------------------------------------------------------------</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Routine mammogram</td>
<td>100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Breast ultrasound</td>
<td>100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>All other routine cancer screenings</td>
<td>100% per visit, no deductible applies</td>
<td>70% per visit no deductible applies</td>
</tr>
<tr>
<td>Routine cancer screenings</td>
<td>100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Routine cancer screening limits</td>
<td>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</td>
<td>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</td>
</tr>
<tr>
<td>Routine lung cancer screening</td>
<td>100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Routine lung cancer screening limit</td>
<td>1 screenings every Calendar Year</td>
<td>Screenings that exceed this limit covered as outpatient diagnostic testing</td>
</tr>
<tr>
<td>Routine physical exam</td>
<td>100% per visit, no deductible applies</td>
<td>Not covered</td>
</tr>
<tr>
<td>Routine physical exam limits</td>
<td>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 Calendar Year after that age, up to age 22; 1 exam every Calendar Year after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Well woman GYN exam</td>
<td>100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Well woman GYN exam limit</td>
<td>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 women</td>
<td>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 women</td>
</tr>
</tbody>
</table>
guidelines supported by the Health Resources and Services Administration guidelines supported by the Health Resources and Services Administration

**Private duty nursing**
Up to 8 hours equals one shift

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient services</td>
<td>100% per visit, no <strong>deductible</strong> applies</td>
<td>70% per visit after <strong>deductible</strong></td>
</tr>
</tbody>
</table>

**Prosthetic Devices**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthetic devices</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

**Reconstructive surgery and supplies**
Including breast surgery

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery and supplies</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

**Short-term rehabilitation services**
A visit is equal to no more than 1 hour of therapy.

**Cardiac rehabilitation**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac rehabilitation</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

**Pulmonary rehabilitation**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulmonary</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

**Cognitive rehabilitation**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive rehabilitation</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

**Physical, occupational and speech therapies**

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>$30 then the plan pays 100% per visit, no <strong>deductible</strong> applies</td>
<td>70% per visit after <strong>deductible</strong></td>
<td></td>
</tr>
</tbody>
</table>
## Early Intervention Services

<table>
<thead>
<tr>
<th>Description</th>
<th>Covered according to the type of benefit and the place where service is received</th>
<th>Covered according to the type of benefit and the place where service is received</th>
</tr>
</thead>
<tbody>
<tr>
<td>For children age 3 and under (Deductible will apply for high deductible plans only)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Spinal manipulation

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$30 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
</tbody>
</table>

## Skilled nursing facility

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services - room and board</td>
<td>100% per admission no deductible applies</td>
<td>70% per admission after deductible</td>
</tr>
<tr>
<td>Other inpatient services and supplies</td>
<td>100% per admission no deductible applies</td>
<td>70% per admission after deductible</td>
</tr>
</tbody>
</table>

Day limit per year | 90 | 90 |

## Tests, images and labs – outpatient

### Diagnostic complex imaging services

<table>
<thead>
<tr>
<th>Description</th>
<th>Tier 1 In-network coverage</th>
<th>Tier 2 network coverage</th>
<th>Tier 3 - network Coverage</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Magnetic resonance imaging (MRI), Magnetic resonance angiogram (MRA), Computed tomography (CT) scans, Positron emission tomography (PET) scans</td>
<td>100% per visit, no deductible applies</td>
<td>$50 then the plan pays 100% per visit, no deductible applies</td>
<td>$50 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>All other outpatient diagnostic complex imaging services</td>
<td>100% per visit, no deductible applies</td>
<td>100% per visit, no deductible applies</td>
<td>100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
</tbody>
</table>
### Diagnostic lab work

<table>
<thead>
<tr>
<th>Description</th>
<th>Tier 1 In-network coverage</th>
<th>Tier 2 network coverage</th>
<th>Tier 3 - network Coverage</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% per visit, no deductible applies</td>
<td>100% per visit, no deductible applies</td>
<td>100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
</tbody>
</table>

### Diagnostic x-ray and other radiological services

<table>
<thead>
<tr>
<th>Description</th>
<th>Tier 1 In-network coverage</th>
<th>Tier 2 network coverage</th>
<th>Tier 3 - network Coverage</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% per visit, no deductible applies</td>
<td>100% per visit, no deductible applies</td>
<td>100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
</tbody>
</table>

### Therapies

#### Chemotherapy

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapy services</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network (GCIT-designated facility/provider)</th>
<th>Out-of-network (Including providers who are otherwise part of Aetna’s network but are not GCIT-designated facilities/providers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services and supplies</td>
<td>Covered based on type of service and where it is received</td>
<td>Not covered</td>
</tr>
<tr>
<td>Gene therapy products, prescription drugs</td>
<td>$30 then the plan pays 100% per visit, no deductible applies</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### Infusion therapy

#### Outpatient services

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>In physician office</td>
<td>$30 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>At an infusion location</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
<tr>
<td>In the home</td>
<td>$30 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>At hospital outpatient department</td>
<td>100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>At facility that is not a hospital</td>
<td>100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td>Radiation therapy</td>
<td>Description</td>
<td>In-network</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Radiation therapy</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respiratory therapy</th>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Respiratory therapy</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transplant services</th>
<th>Description</th>
<th>In-network (IOE facility)</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inpatient services and supplies</td>
<td>100% per transplant, no deductible applies</td>
<td>70% per transplant after deductible</td>
</tr>
<tr>
<td></td>
<td>Physician services</td>
<td>Covered based on type of service and where it is received</td>
<td>Covered based on type of service and where it is received</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urgent care services</th>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urgent care facility</td>
<td>$30 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
</tr>
<tr>
<td></td>
<td>Non-urgent use of an urgent care facility or provider</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vision care</th>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$30 then the plan pays 100% per visit, no deductible applies</td>
<td>70% per visit after deductible</td>
<td></td>
</tr>
</tbody>
</table>

| Visit limit                  | 1 visit every 12 months | 1 visit every 12 months |
**Walk-in clinic**

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

<table>
<thead>
<tr>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-emergency services</td>
<td>$20 then the plan pays 100% per visit, no <strong>deductible</strong> applies</td>
<td>70% per visit after <strong>deductible</strong></td>
</tr>
<tr>
<td>Preventive immunizations</td>
<td>100% per visit, no <strong>deductible</strong> applies</td>
<td>Not covered</td>
</tr>
<tr>
<td>Immunization limits</td>
<td>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 <strong>physician</strong></td>
<td>Not applicable</td>
</tr>
<tr>
<td>Screening and counseling services</td>
<td>100% per visit, no <strong>deductible</strong> applies</td>
<td>Not covered</td>
</tr>
<tr>
<td>Screening and counseling limits</td>
<td>See the <strong>Preventive care services</strong> section of the SOB</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>