Schedule of benefits

Prepared for:

Employer:	Community High School District 155
Contract number:	MSA-0176675
Plan name:	Choice POS II Plan
Schedule of benefits:	2A
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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**.
- 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. 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 $400 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.

Deductible type	In-network	Out-of-network
Individual	$1,500 per year	$1,500 per year
Family	$3,000 per year	$3,000 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 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.

Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	In-network	Out-of-network
Individual	$3,500 per year	$4,100 per year
Family	$7,000 per year	$8,200 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 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 the dollar amount you pay for **covered services**. In most plans, you pay this after you meet your **deductible** limit.

Payment Percentage

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

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**.

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

Individual maximum out-of-pocket limit

- 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.

Covered services

Abortion

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

Ambulance services

Description	In-network	Out-of-network
Emergency services	$200 then the plan pays 80% per trip after **deductible**	Paid same as in-network
Non-**emergency services**	Not covered	Not covered

Applied behavior analysis

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

Autism spectrum disorder

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

Behavioral health

Mental health treatment

Coverage provided is the same as for any other illness

Description	In-network	Out-of-network
Inpatient services-**room and board** including **residential treatment facility**	80% per admission after **deductible**	60% per admission after **deductible**
Other inpatient services and supplies Other **residential treatment facility** services and supplies	80% per admission after **deductible**	60% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	$40 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	$40 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**
Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received

Description	In-network	Out-of-network
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	100% per visit, no **deductible** applies	60% per visit after **deductible**

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

Substance related disorders treatment

Includes **detoxification**, rehabilitation and **residential treatment facility**
Coverage provided is the same as for any other illness

Description	In-network	Out-of-network
Inpatient services-**room and board** during a **hospital stay**	80% per admission after **deductible**	60% per admission after **deductible**
Other inpatient services and supplies during a **hospital stay**	80% per admission after **deductible**	60% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	$40 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	$40 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received

Description	In-network	Out-of-network
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	100% per visit, no **deductible** applies	60% per visit after **deductible**

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

Clinical trials

Description	In-network	Out-of-network
Experimental or investigational therapies	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Routine patient costs	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Durable medical equipment (DME)

Description	In-network	Out-of-network
DME	80% per item after **deductible**	60% per item after **deductible**

Emergency services

Description	In-network	Out-of-network
Emergency room	$200 then the plan pays 80% per visit after **deductible**	Paid same as in-network
Non-emergency care in a **hospital** emergency room	Not covered	Not covered

Emergency services important note: Out-of-network providers do not have a contract with us. 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

Description	In-network	Out-of-network
Orthotic devices	80% per item after **deductible**	60% per item after **deductible**

Habilitation therapy services

Outpatient physical (PT), occupational (OT) therapies

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

Outpatient speech therapy (ST)

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

Hearing aids

Description	In-network	Out-of-network
Hearing aids	80% per item after **deductible**	80% per item after **deductible**
Limit	$5,000 every 24 months	$5,000 every 24 months

Hearing exams

Description	In-network	Out-of-network
Hearing exams	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Visit limit	1 visit every 24 months	1 visit every 24 months

Home health care

A visit is a period of 4 hours or less

Description	In-network	Out-of-network
Home health care	80% per visit after **deductible**	60% per visit after **deductible**
Visit limit per year	100	100

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

Hospice care

Description	In-network	Out-of-network
Inpatient services - **room and board**	80% after **deductible**	60% after **deductible**
Other inpatient services and supplies	80% per admission after **deductible**	60% after **deductible**
Outpatient services	80% per visit after **deductible**	60% per visit after **deductible**
Limit per lifetime	unlimited	unlimited

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

Hospital care

Description	In-network	Out-of-network
Inpatient services – **room and board**	80% after **deductible**	60% after **deductible**

Description	In-network	Out-of-network
Other inpatient services and supplies	80% per admission after **deductible**	60% after **deductible**

Infertility services

Basic infertility

Description	In-network	Out-of-network
Treatment of basic **infertility**	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Comprehensive infertility services

Description	In-network	Out-of-network
	80% per visit after **deductible**	60% per visit after **deductible**

Advanced reproductive technology (ART)

Description	In-network	Out-of-network
	80% per visit after **deductible**	60% per visit after **deductible**

Limits

Description	In-network	Out-of-network
For treatment that includes oocyte retrieval, maximum number of retrievals	4, however if a live birth follows a completed oocyte retrieval, 2 additional egg retrievals will be covered.	4, however if a live birth follows a completed oocyte retrieval, 2 additional egg retrievals will be covered.

Maternity and related newborn care

Includes complications

Description	In-network	Out-of-network
Inpatient services – **room and board**	80% per admission after **deductible**	60% per admission after **deductible**
Other inpatient services and supplies	80% per admission after **deductible**	60% per admission after **deductible**
Services performed in **physician** or **specialist** office or a facility	80% per visit after **deductible**	60% per visit after **deductible**
Other services and supplies	80% per visit after **deductible**	60% per visit after **deductible**

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

Obesity surgery

Description	In-network	Out-of-network
Inpatient services – **room and board**	80% per admission after **deductible**	60% per admission after **deductible**
Other inpatient services and supplies	80% per admission after **deductible**	60% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient services	80% per visit after **deductible**	60% per visit after **deductible**

Oral and maxillofacial treatment (mouth, jaws and teeth)

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

Outpatient surgery

Description	In-network	Out-of-network
At **hospital** outpatient department	80% per visit after **deductible**	50% per visit after **deductible**
At facility that is not a **hospital**	80% per visit after **deductible**	50% per visit after **deductible**
At the **physician** office	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Physician and specialist services

Physician services-general or family practitioner

Description	In-network	Out-of-network
Physician office hours (not-surgical, not preventive)	$40 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**
Physician surgical services	$40 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**

Description	In-network	Out-of-network
Physician visit during inpatient **stay**	80% per visit after **deductible**	60% per visit after **deductible**

Description	In-network	Out-of-network
Physician telemedicine consultation	$40 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**

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

Specialist

Description	In-network	Out-of-network
Specialist office hours (not-surgical, not preventive)	$60 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**
Specialist surgical services	$60 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**

Description	In-network	Out-of-network
Specialist telemedicine consultation	$60 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**

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

All other services not shown above

Description	In-network	Out-of-network
All other services	80% per visit after **deductible**	60% per visit after **deductible**

Preventive care

Description	In-network	Out-of-network
Preventive care services	100% per visit, no **deductible** applies	Not covered
Breast feeding counseling and support	100% per visit, no **deductible** applies	Not covered
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 covered
Breast pump, accessories and supplies limit	Electric pump: 1 every 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Not covered
Breast pump waiting period	Electric pump: 12 months to replace an existing electric pump	Not covered
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies	Not covered
Counseling for alcohol or drug misuse visit limit	5 visits/12 months	Not covered
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies	Not covered
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 covered
Counseling for sexually transmitted infection	100% per visit, no **deductible** applies	Not covered
Counseling for sexually transmitted infection visit limit	2 visits/12 months	Not covered
Counseling for tobacco cessation	100% per visit, no **deductible** applies	Not covered
Counseling for tobacco cessation visit limit	8 visits/12 months	Not covered
Family planning services (female contraception counseling)	100% per visit, no **deductible** applies	60% per visit after **deductible**
Family planning services (female contraception counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting

Immunizations	100%, no **deductible** applies	Not covered
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 covered
Routine cancer screenings	100% per visit, no **deductible** applies	Not covered
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 covered
Generic preventive care female contraceptives (birth control)	100%	Not covered
Preventive care drugs and supplements	100%	Not covered
Preventive care drugs and supplements limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Not covered
Preventive care risk reducing breast cancer **prescription** drugs	100%	Not covered

Preventive care risk reducing breast cancer **prescription** drugs limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Not covered
Preventive care tobacco cessation **prescription** and OTC drugs	100%	Not covered
Limit	Two 90 day treatments only	Not covered
Routine lung cancer screening	100% per visit, no **deductible** applies	Not covered
Routine lung cancer screening limit	1 screening every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing	Not covered
Routine physical exam	100% per visit, no **deductible** applies	Not covered
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 covered
Well woman GYN exam	100% per visit, no **deductible** applies	Not covered
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 covered

Prosthetic devices

Description	In-network	Out-of-network
Prosthetic devices	80% per item after **deductible**	60% per item after **deductible**

Reconstructive surgery and supplies

Including breast **surgery**

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

Short-term rehabilitation services

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

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

Cognitive rehabilitation

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

Physical and occupational therapies

Description	In-network	Out-of-network
	80% per visit after **deductible**	60% per visit after **deductible**

Speech therapy (ST)

Description	In-network	Out-of-network
	80% per visit after **deductible**	60% per visit after **deductible**

Spinal manipulation

Description	In-network	Out-of-network
	80% per visit after **deductible**	60% per visit after **deductible**

Skilled nursing facility

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

Day limit per year	90	90

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network	Out-of-network
	$40 then the plan pays 100% per visit, no **deductible** applies	Not covered

Diagnostic lab work

Description	In-network	Out-of-network
	$40 then the plan pays 100% per visit, no **deductible** applies	Not covered

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network
	$40 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**

Therapies

Chemotherapy

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

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

Description	In-network (GCIT-designated facility/provider)	Out-of-network (Including **providers** who are otherwise part of Aetna's network but are not GCIT-designated facilities/**providers**)
Services and supplies	Covered based on type of service and where it is received	Not covered
Gene therapy products, **prescription** drugs	80% per visit after **deductible**	Not covered

Infusion therapy

Outpatient services

Description	In-network	Out-of-network
In **physician** office	$60 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**
At an infusion location	Covered based on type of service and where it is received	Covered based on type of service and where it is received
In the home	$60 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**
At **hospital** outpatient department	80% per visit after **deductible**	50% per visit after **deductible**
At facility that is not a **hospital**	80% per visit after **deductible**	50% per visit after **deductible**

Radiation therapy

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

Respiratory therapy

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

Transplant services

Description	In-network (IOE facility)	Out-of-network (Includes **providers** who are otherwise part of Aetna's network but are non-IOE **providers**)
Inpatient services and supplies	80% per transplant after **deductible**	60% per transplant after **deductible**
Physician services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Urgent care services

At a freestanding facility or **provider** that is not a **hospital**
A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

Description	In-network	Out-of- network
Urgent care facility	80% per visit after **deductible**	60% per visit after **deductible**
Non-urgent use of an urgent care facility or **provider**	Not covered	Not covered

Walk-in clinic

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

Description	Designated network	Non-designated network	Out-of-network
Non-emergency services	100% per visit, no **deductible** applies	$40 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**
Preventive care immunizations	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	Not covered
Preventive care immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Not covered
Preventive screening and counseling services	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	Not covered
Preventive screening and counseling limits	See the *Preventive care services* section of the schedule	See the *Preventive care services* section of the schedule	Not covered

Description	Designated network	Non-designated network	Out-of-network
Telemedicine consultation for non-**emergency services** through a **walk-in clinic**	100% per visit, no **deductible** applies	Covered based on type of service and where it is received	Not covered
Telemedicine consultation for preventive screening and counseling services through a **walk-in clinic**	100% per visit, no **deductible** applies	Covered based on type of service and where it is received	Not covered

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

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

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