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:	Inova Health System
Contract number:	MSA-0697819
Plan name:	Outside NOVA - PPO Option
Schedule of benefits:	3C
Plan effective date:	January 1, 2023
Plan issue date:	February 27, 2023

Third Party Administrative Services provided by Innovation Health 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. It does not include those services that an **out-of-network provider** cannot balance bill you for. See the *Involuntary Services and Surprise Bills* section in your booklet for more information.
- 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 **Innovation Health** benefits* section under Individuals & Families at https://www.innovationhealth.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 *Involuntary Services and Surprise Bills* 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	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Individual	$250 per year	$250 per year	$250 per year	$1,000 per year	$250 per year
Family	$500 per year	$500 per year	$500 per year	$2,000 per year	$500 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.

Per admission copayment (waived for newborns)

Per admission type	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Per admission **copayment**	$100 per admission	$100 per admission	$250 per admission	Not applicable	Not applicable
Per admission **deductible**	Not applicable	Not applicable	Not applicable	$1,000 per admission	$250 per admission

Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Individual	$3,500 per year	$3,500 per year	$3,500 per year	$6,000 per year	$3,500 per year
Family	$7,000 per year	$7,000 per year	$7,000 per year	$13,000 per year	$7,000 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 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.

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**.

Per admission cost share or deductible
A separate cost share or **deductible** may apply per facility. This is in addition to any other cost share or **deductible** applicable under this plan. It may apply to each **stay** or on a per day basis up to a per admission maximum amount. If you are in the same type of facility more than once, and your **stays** are separated by less than 10 days (regardless of cause), only one per admission cost share or **deductible** will apply. Not more than three per admission cost shares or **deductibles** will apply for a facility type during the year. **Covered services** applied to the per admission **deductible** can't be applied to any other **deductible** required under the plan. **Covered services** applied to the plan's other **deductible** will not apply to the per admission **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**.

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**
- 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

Acupuncture

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Acupuncture	$20 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies	$50 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**	80% per visit, no **deductible** applies
Visit limit per year In-network and out-of-network combined	20	20	20	20	20

Ambulance services

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Emergency services	80% per trip after **deductible**	80% per trip after **deductible**	80% per trip after **deductible**	50% per trip after **deductible**	80% per trip after **deductible**
Non-emergency services	80% per trip after **deductible**	80% per trip after **deductible**	80% per trip after **deductible**	50% per trip after **deductible**	80% per trip after **deductible**

Applied behavior analysis

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
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	Covered based on type of service and where it is received	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	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
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	Covered based on type of service and where it is received	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	Covered based on type of service and where it is received	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	Covered based on type of service and where it is received	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	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Inpatient services-**room and board** including **residential treatment facility**	$100 then the plan pays 80% per admission after **deductible**	$100 then the plan pays 80% per admission after **deductible**	$250 then the plan pays 80% per admission after **deductible**	$1,000 then the plan pays 60% per admission after **deductible**	$250 then the plan pays 80% per admission after **deductible**

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Outpatient office visit to a **physician** or **behavioral health provider**	$20 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies	$50 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**	80% per visit, no **deductible** applies
Physician or **behavioral health provider telemedicine** consultation	$20 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies	$50 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**	80% per visit, no **deductible** applies
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	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	Covered based on type of service and **provider** from which it is received

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
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 after you meet your **deductible**	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	60% per visit after **deductible**	100% per visit, no **deductible** applies

Substance related disorders treatment

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

Coverage provided is the same as for any other illness

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Inpatient services-**room and board**	$100 then the plan pays 80% per admission after **deductible**	$100 then the plan pays 80% per admission after **deductible**	$250 then the plan pays 80% per admission after **deductible**	$1,000 then the plan pays 60% per admission after **deductible**	$250 then the plan pays 80% per admission after **deductible**

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Outpatient office visit to a **physician** or **behavioral health provider**	$20 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies	$50 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**	80% per visit, no **deductible** applies
Physician or **behavioral health provider telemedicine** consultation	$20 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies	$50 then the plan pays 100% per visit, no **deductible** applies	60% per visit after **deductible**	80% per visit, no **deductible** applies
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	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	Covered based on type of service and **provider** from which it is received

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
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 after you meet your **deductible**	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	60% per visit after **deductible**	100% per visit, no **deductible** applies

Clinical trials

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
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	Covered based on type of service and where it is received	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	Covered based on type of service and where it is received	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	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
DME	80% per item after **deductible**	80% per item after **deductible**	80% per item after **deductible**	50% per item after **deductible**	80% per item after **deductible**

Emergency services

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Emergency room	$150 then the plan pays 80% per visit after **deductible**	$150 then the plan pays 80% per visit after **deductible**	$150 then the plan pays 80% per visit after **deductible**	Paid same as in-network	Paid same as in-network

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Non-emergency care in a **hospital** emergency room	Not covered	Not covered	Not covered	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	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out of network	Other health care
Orthotic devices	80% per item after **deductible**	80% per item after **deductible**	80% per item after **deductible**	50% per item after **deductible**	80% per item after **deductible**

Habilitation therapy services

Physical (PT) and occupational (OT) therapies

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
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	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Speech therapy (ST)

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
ST	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received	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	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Hearing aids	80% per item after **deductible**	80% per item after **deductible**	80% per item after **deductible**	50% per item after **deductible**	80% per item after **deductible**
Limit	One per ear every 1 year	One per ear every 1 year	One per ear every year	One per ear every 1 year	One per ear every year

Hearing exams

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Hearing exams	Covered based on type of service and where it is received	Covered based on type of service and where it is received	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 12 months	1 visit every 12 months	1 visit every 12 months	Not applicable	1 visit every 12 months

Home health care

A visit is a period of 4 hours or less

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Home health care	80% per visit after **deductible**	80% per visit after **deductible**	80% per visit after **deductible**	50% per visit after **deductible**	80% per visit after **deductible**
Visit limit per year	120	120	120	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

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Inpatient services - **room and board**	$100 then the plan pays 80% per admission after **deductible**	$100 then the plan pays 80% per admission after **deductible**	$250 then the plan pays 80% per admission after **deductible**	$1,000 then the plan pays 50% per admission after **deductible**	$250 then the plan pays 80% per admission after **deductible**

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Outpatient services	80% per visit after **deductible**	80% per visit after **deductible**	80% per visit after **deductible**	50% per visit after **deductible**	80% per visit after **deductible**
Limit per lifetime	unlimited	unlimited	unlimited	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	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Inpatient services – **room and board**	$100 then the plan pays 80% per admission after **deductible**	$100 then the plan pays 80% per admission after **deductible**	$250 then the plan pays 80% per admission after **deductible**	$1,000 then the plan pays 50% per admission after **deductible**	$250 then the plan pays 80% per admission after **deductible**

Infertility services

Basic infertility

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
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	Covered based on type of service and where it is received	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	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out of network	Other health care
	80% per visit after **deductible**	80% per visit after **deductible**	80% per visit after **deductible**	50% per visit after **deductible**	80% per visit after **deductible**

Advanced reproductive technology (ART)

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out of network	Other health care
Outpatient services	80% per visit after **deductible**	80% per visit after **deductible**	80% per visit after **deductible**	50% per visit after **deductible**	80% per visit after **deductible**

Limits

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Limit per lifetime ART and Comprehensive services combined	$25,000 Combined for in-network and out-of-network benefits	$25,000 Combined for in-network and out-of-network benefits	$25,000 Combined for in-network and out-of-network benefits	$25,000 Combined for in-network and out-of-network benefits	$25,000 Combined for in-network and out-of-network benefits

Maternity and related newborn care

Includes complications

The Per admission copayment and per admission **deductible** amount for newborns is waived for nursery charges during the newborn's initial routine **stay**. The nursery charges will apply for non-routine facility **stays**.

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Inpatient services – **room and board**	$100 then the plan pays 80% per admission after **deductible**	$100 then the plan pays 80% per admission after **deductible**	$250 then the plan pays 80% per admission after **deductible**	$1,000 then the plan pays 50% per admission after **deductible**	$250 then the plan pays 80% per admission after **deductible**
Services performed in **physician** or **specialist** office or a facility	80% per visit after **deductible**	80% per visit after **deductible**	80% per visit after **deductible**	50% per visit after **deductible**	80% per visit after **deductible**
Other services and supplies	80% per visit after **deductible**	80% per visit after **deductible**	80% per visit after **deductible**	50% per visit after **deductible**	80% 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	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Inpatient services - **room and board**	$100 then the plan pays 80% per admission after **deductible**	$100 then the plan pays 80% per admission after **deductible**	$250 then the plan pays 80% per admission after **deductible**	$1,000 then the plan pays 50% per admission after **deductible**	$250 then the plan pays 80% per admission after **deductible**

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Outpatient services	80% per visit after **deductible**	80% per visit after **deductible**	80% per visit after **deductible**	50% per visit after **deductible**	80% per visit after **deductible**

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
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	Covered based on type of service and where it is received	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	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
At **hospital** outpatient department	90% per visit after **deductible**	80% per visit after **deductible**	80% per visit after **deductible**	50% per visit after **deductible**	80% per visit after **deductible**
At facility that is not a **hospital**	90% per visit after **deductible**	80% per visit after **deductible**	80% per visit after **deductible**	50% per visit after **deductible**	80% 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	Covered based on type of service and where it is received	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	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Physician office hours (not surgical, not preventive)	100% per visit, no **deductible** applies	$15 then the plan pays 100% per visit, no **deductible** applies	$25 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**	80% per visit, no **deductible** applies
Physician surgical services	80% per visit after **deductible**	80% per visit after **deductible**	80% per visit after **deductible**	50% per visit after **deductible**	80% per visit after **deductible**

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Physician telemedicine consultation	100% per visit, no **deductible** applies	$15 then the plan pays 100% per visit, no **deductible** applies	$25 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**	80% per visit, no **deductible** applies

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Physician visit during inpatient **stay**	80% per visit after **deductible**	80% per visit after **deductible**	80% per visit after **deductible**	50% per visit after **deductible**	80% per visit after **deductible**

Specialist

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Specialist office hours (not surgical, not preventive)	$20 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies	$50 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**	80% per visit, no **deductible** applies
Specialist surgical services	80% per visit after **deductible**	80% per visit after **deductible**	80% per visit after **deductible**	50% per visit after **deductible**	80% per visit after **deductible**

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Specialist telemedicine consultation	$20 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies	$50 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**	80% per visit, no **deductible** applies

All other services not shown above

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
All other services	80% per visit after **deductible**	80% per visit after **deductible**	80% per visit after **deductible**	50% per visit after **deductible**	80% per visit after **deductible**

Preventive care

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Preventive care services	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	Not covered	100% per visit, no **deductible** applies
Breast feeding counseling and support	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	50% per visit after **deductible**	100% per visit, no **deductible** applies
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	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit	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 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 every 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 every 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 every 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 every 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 1 year to replace an existing electric pump	Electric pump: 1 year to replace an existing electric pump	Electric pump: 1 year to replace an existing electric pump	Electric pump: 1 year to replace an existing electric pump	Electric pump: 1 year to replace an existing electric pump

Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	Not covered	100% per visit, no **deductible** applies
Counseling for alcohol or drug misuse visit limit	5 visits/year	5 visits/year	5 visits/year	Not applicable	5 visits/year
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	Not covered	100% per visit, no **deductible** applies
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per year, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per year, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per year, of which up to 10 visits may be used for healthy diet counseling.	Not applicable	Age 22 and older: 26 visits per year, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	Not covered	100% per visit, no **deductible** applies
Counseling for sexually transmitted infection visit limit	2 visits/year	2 visits/year	2 visits/year	Not applicable	2 visits/year
Counseling for tobacco cessation	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	Not covered	100% per visit, no **deductible** applies
Counseling for tobacco cessation visit limit	8 visits/year	8 visits/year	8 visits/year	Not applicable	8 visits/year
Family planning services (female contraception)	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	50% per visit after **deductible**	100% per visit, no **deductible** applies
Family planning services (female contraception) 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	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	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting

Immunizations	100%, no **deductible** applies	100%, no **deductible** applies	100%, no **deductible** applies	Not covered	100%, no **deductible** applies
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	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**
Generic preventive care contraceptives (birth control)	100%	100%	100%	100%	100%
Preventive care drugs and supplements	100%	100%	100%	Not covered	100%
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	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	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 applicable	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

Preventive care risk reducing breast cancer **prescription** drugs	100%	100%	100%	Not covered	100%
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	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	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 applicable	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
Preventive care tobacco cessation **prescription** and OTC drugs	100%	100%	100%	Not covered	100%
Limit	Two 90 day treatments only	Two 90 day treatments only	Two 90 day treatments only	Not applicable	Two 90 day treatments only

Routine cancer screenings	100%, no **deductible** applies	100%, no **deductible** applies	100%, no **deductible** applies	Not covered	100%, no **deductible** applies
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommend-ations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommend-ations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommend-ations 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 recommend-ations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section
Routine lung cancer screening	100%, no **deductible** applies	100%, no **deductible** applies	100%, no **deductible** applies	Not covered	100%, no **deductible** applies
Routine lung cancer screening limit	1 screening every year Screenings that exceed this limit covered as outpatient diagnostic testing	1 screening every year Screenings that exceed this limit covered as outpatient diagnostic testing	1 screening every year Screenings that exceed this limit covered as outpatient diagnostic testing	Not applicable	1 screening every year Screenings that exceed this limit covered as outpatient diagnostic testing

Routine physical exam	100%, no **deductible** applies	100%, no **deductible** applies	100%, no **deductible** applies	Not covered	100%, no **deductible** applies
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every year after that age, up to age 18; 1 exam every year after age 18 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1/36 months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every year after that age, up to age 18; 1 exam every year after age 18 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1/36 months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every year after that age, up to age 18; 1 exam every year after age 18 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1/36 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 year after that age, up to age 18; 1 exam every year after age 18 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1/36 months

Well woman GYN exam	100%, no **deductible** applies	100%, no **deductible** applies	100%, no **deductible** applies	Not covered	100%, no **deductible** applies
Well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration	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

Private duty nursing

Up to 8 hours equals one shift

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Outpatient services	80% per visit after **deductible**	80% per visit after **deductible**	80% per visit after **deductible**	50% per visit after **deductible**	80% per visit after **deductible**
Visit/shift limit per year	70	70	70	70	70

Prosthetic devices

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Prosthetic devices	80% per item after **deductible**	80% per item after **deductible**	80% per item after **deductible**	50% per item after **deductible**	80% per item after **deductible**

Reconstructive surgery and supplies

Including breast **surgery**

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
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	Covered based on type of service and where it is received	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	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Cardiac rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received	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	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Pulmonary	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received	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	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Cognitive rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Physical, occupational and speech therapies

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
At the **physician** office	80% per visit after **deductible**	80% per visit after **deductible**	80% per visit after **deductible**	50% per visit after **deductible**	80% per visit after **deductible**
At facility that is not a **hospital**	80% per visit after **deductible**	80% per visit after **deductible**	80% per visit after **deductible**	50% per visit after **deductible**	80% per visit after **deductible**
At **hospital** outpatient department	80% per visit after **deductible**	80% per visit after **deductible**	80% per visit after **deductible**	50% per visit after **deductible**	80% per visit after **deductible**

Visit limit per year for all therapies combined	90	90	90	90	90

Spinal manipulation

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out of network	Other health care
At the **physician** office	$20 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies	$50 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**	80% per visit, no **deductible** applies
At facility that is not a **hospital**	$20 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies	$50 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**	80% per visit, no **deductible** applies
At **hospital** outpatient department	$20 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies	$50 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**	80% per visit, no **deductible** applies

Visit limit per year	30	30	30	30	30

Skilled nursing facility

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Inpatient services – **room and board**	$100 then the plan pays 80% per admission after **deductible**	$100 then the plan pays 80% per admission after **deductible**	$250 then the plan pays 80% per admission after **deductible**	$1,000 then the plan pays 50% per admission after **deductible**	$250 then the plan pays 80% per admission after **deductible**

Day limit per year	120	120	120	120	120

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
	$100 then the plan pays 100% per visit, no **deductible** applies	$100 then the plan pays 100% per visit, no **deductible** applies	$100 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**	80% per visit, no **deductible** applies

Diagnostic lab work

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
	80% per visit after **deductible**	80% per visit after **deductible**	80% per visit after **deductible**	50% per visit after **deductible**	80% per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
	$25 then the plan pays 100% per visit, no **deductible** applies	$25 then the plan pays 100% per visit, no **deductible** applies	$25 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**	80% per visit, no **deductible** applies

Therapies

Chemotherapy

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Chemotherapy services	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received	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	Designated network (GCIT-designated facility/provider)	Out-of-network (Including **providers** who are otherwise part of Innovation Health's network but are not GCIT-designated facilities/**providers**)
Services and supplies	Covered based on type of service and where it is received	Not covered

Infusion therapy

Outpatient services

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
In **physician** office	100% per visit, no **deductible** applies	$15 then the plan pays 100% per visit, no **deductible** applies	$25 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**	100% per visit, no **deductible** applies
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	Covered based on type of service and where it is received	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	100% per visit, no **deductible** applies	$15 then the plan pays 100% per visit, no **deductible** applies	$25 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**	100% per visit, no **deductible** applies
At **hospital** outpatient department	90% per visit after **deductible**	80% per visit after **deductible**	80% per visit after **deductible**	50% per visit after **deductible**	80% per visit after **deductible**
At facility that is not a **hospital**	90% per visit after **deductible**	80% per visit after **deductible**	80% per visit after **deductible**	50% per visit after **deductible**	80% per visit after **deductible**

Radiation therapy

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Radiation therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received	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	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Respiratory therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received	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	Designated network (IOE facility)			Out-of-network (Includes **providers** who are otherwise part of Innovation Health's network but are non-IOE **providers**)
	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	
Inpatient services and supplies	$100 then the plan pays 80% per transplant after **deductible**	$100 then the plan pays 80% per transplant after **deductible**	$250 then the plan pays 80% per transplant after **deductible**	$1,000 then the plan pays 50% per transplant after **deductible**
Physician services	Covered based on type of service and where it is received			Covered based on type of service and where it is received

Urgent care services

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

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

Description	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Urgent care facility	$20 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**	80% per visit, no **deductible** applies
Non-urgent use of an urgent care facility or **provider**	Not covered	Not covered	Not covered	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	Maximum savings providers	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings	Out-of-network	Other health care
Non-emergency services	100% per visit, no **deductible** applies	$15 then the plan pays 100% per visit, no **deductible** applies	$25 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**	80% per visit, no **deductible** applies
Preventive immunizations	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	Not covered	100% per visit, no **deductible** applies
Immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **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**	Not applicable	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	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	Not covered	100% per visit, no **deductible** applies
Screening and counseling limits	See the *Preventive care services* section of the schedule	See the *Preventive care services* section of the schedule	See the *Preventive care services* section of the schedule	Not applicable	See the *Preventive care services* section of the schedule