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:

Policyholder:	Adobe Inc.
Policyholder number:	447926
Group policy effective date:	January 1, 2021
Plan name:	PPO Medical and Pharmacy, Schedule of Benefits: 1A
Plan effective date:	January 1, 2021
Plan issue date:	February 9, 2024
Plan revision effective date:	January 1, 2024

Underwritten by Aetna Life Insurance Company in the state of Delaware

Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles**, **copayments** or **coinsurance**, 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
- **Coinsurance** 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 **coinsurance** percentage that your plan will pay.
- You are responsible to pay any **deductibles**, **copayments** and remaining **coinsurance**, 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 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 Calendar Year **deductible**, **maximum out-of-pocket**, limits, **copayment** or **coinsurance** unless otherwise stated in this schedule. The *Surprise bill* section in the certificate 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 **coinsurance**

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 **coinsurance** you pay when you get **covered services** from an in-network or **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 **coinsurance**, 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 certificate.

Aetna Life Insurance Company's group policy provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your certificate.

Plan features

Precertification covered services reduction
This only applies to out-of-network **covered services**:
Your certificate contains a complete description of the **precertification** process. You will find details in the *How your plan works - Medical necessity and precertification requirements* 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 **allowable amount** 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 (In the U.S.)	Out-of-network (In the U.S.)	Outside the U.S.
Individual	$100 per year	$300 per year	$0 per year
Family	$300 per year	$900 per year	$0 per year

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

Deductible and cost share waiver for contraceptives (birth control)

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

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

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

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

Per admission deductible

Per admission deductible type	In-network (In the U.S.)	Out-of-network (In the U.S.)	Outside the U.S.
Per admission **deductible**	Not applicable	$250 per admission	Not applicable

Maximum out-of-pocket limit

Includes the **deductible.**

Maximum out-of-pocket type	In-network (In the U.S.)	Out-of-network (In the U.S.)	Outside the U.S.
Individual	$500 per year	$1,500 per year	$0 per year
Family	$1,500 per year	$4,500 per year	$0 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 **coinsurance**, 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.

Deductible credit
If you paid part or all of your **deductible** under other coverage for the year that this plan went into effect, we will deduct the amount paid under the other coverage from the **deductible** on this plan for the same year. If we ask, you must submit a detailed explanation of benefits (EOB) showing the dates and amount of the **deductible** met from the other coverage in order to receive the credit.

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

Coinsurance
This is the percentage of **covered services** you pay after 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**, **coinsurance** and **deductible**, if any, for **covered services**. **Covered services** that are subject to the **maximum out-of-pocket limit** include those provided under the medical plan and the outpatient **prescription** drug plan.

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

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

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

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

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

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

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

- All costs for non-covered services which are identified in the certificate and the schedule
- Charges, expenses or costs in excess of the **allowable amount**

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 group policy.

Outpatient prescription drug maximum out-of-pocket limit provisions

Covered services that are subject to the **maximum out-of-pocket limit** include **covered services** provided under the medical plan and the **prescription** drug plan.

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **coinsurance** and **deductible**, if any, for **covered services**. This plan may have an individual and family **maximum out-of-pocket limit**.

Covered services

Acupuncture

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Acupuncture	$10 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies

Visit limit per year	10	10	10

Ambulance services

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Emergency services	90% per trip, no **deductible** applies	Paid same as in-network	100% per trip, no **deductible** applies
Non-emergency services	90% per trip, no **deductible** applies	90% per trip, no **deductible** applies	100% per trip, no **deductible** applies

Applied behavior analysis

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Applied behavior analysis	Covered based on type of service and where it is received	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 In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Diagnosis and testing	Covered based on type of service and where it is received	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
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

Behavioral health

Mental health treatment

Coverage provided is the same as for any other illness

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Inpatient services-**room and board** including **residential treatment facility**	90% per admission after **deductible**	$250 then the plan pays 70% per admission after **deductible**	100% per admission, no **deductible** applies

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Outpatient office visit to a **physician** or **behavioral health provider**	$10 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Physician or **behavioral health provider telemedicine** consultation	$10 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	100% per visit, no **deductible** applies	Not covered	Not covered

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services	90% per visit after **deductible**	70% per visit after **deductible**	100% per visit, no **deductible** applies

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Telemedicine provider mental health disorders consultation	Covered based on type of service and **provider** from which it is received	Not covered	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 In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Inpatient services-**room and board** during a **hospital stay**	90% per admission after **deductible**	$250 then the plan pays 70% per admission after **deductible**	100% per admission, no **deductible** applies

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Outpatient office visit to a **physician** or **behavioral health provider**	$10 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Physician or **behavioral health provider telemedicine** consultation	$10 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	100% per visit, no **deductible** applies	Not covered	Not covered

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services	90% per visit after **deductible**	70% per visit after **deductible**	100% per visit, no **deductible** applies

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Telemedicine provider substance related disorders consultation	Covered based on type of service and **provider** from which it is received	Not covered	Not covered

Clinical trials

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Experimental or investigational therapies	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Routine patient care	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Diabetic services, supplies, equipment and self-care programs

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Diabetic services	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic 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
Diabetic equipment	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
Diabetic self-care programs	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Durable medical equipment (DME)

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
DME	90% per item after **deductible**	70% per item after **deductible**	100% per item, no **deductible** applies

Emergency services

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Emergency room	90% per visit, no **deductible** applies	Paid same as in-network	100% per visit, no **deductible** applies
Non -emergency care in a **hospital** emergency room	50% per visit after **deductible**	50% per visit after **deductible**	100% per visit, no **deductible** applies

Emergency services important note:
Out-of-network providers do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill.

Habilitation therapy services

Physical (PT), occupational (OT) therapies

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
PT, OT therapies	Covered based on type of service and where it is received	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	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
ST	Covered based on type of service and where it is received	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 In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Hearing aids	90% per item after **deductible**	70% per item after **deductible**	100% per item, no **deductible** applies
Age limit	Covered persons through age 24	Covered persons through age 24	Covered persons through age 24
Limit	One per ear every 36 months	One per ear every 36 months	One per ear every 36 months
Limit	$1,000	$1,000	$1,000

Hearing exams

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Hearing exams	Covered based on type of service and where it is received	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	1 visit every 24 months

Home health care

A visit is a period of 4 hours or less

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Home health care	90% per visit after **deductible**	70% per visit after **deductible**	100% per visit, no **deductible** applies
Visit limit per year	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	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Inpatient services - **room and board**	90% per admission after **deductible**	$250 then the plan pays 70% per admission after **deductible**	100% per admission, no **deductible** applies
Day limit per lifetime	30 days	30 days	30 days

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Outpatient services	90% per visit after **deductible**	70% per visit after **deductible**	100% per visit, no **deductible** applies
Limit per lifetime	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	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Inpatient services – **room and board**	90% per admission after **deductible**	$250 then the plan pays 70% per admission after **deductible**	100% per admission, no **deductible** applies

Infertility services

Basic infertility

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Treatment of basic **infertility**	Covered based on type of service and where it is received	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 In the U.S.	Out-of-network In the U.S.	Outside the U.S.
	90% per visit after **deductible**	70% per visit after **deductible**	100% per visit, no **deductible** applies

Limits

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Number of ovulation induction cycles per lifetime while on medications to stimulate the ovaries	6	6	6
Number of artificial insemination cycles per lifetime	6	6	6

Advanced reproductive technology (ART)

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
	90% per visit after **deductible**	70% per visit after **deductible**	100% per visit, no **deductible** applies

Limits

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Cycle limit per lifetime	6 Combined for in-network and out-of-network benefits	6 Combined for in-network and out-of-network benefits	6 Combined for in-network and out-of-network benefits

Jaw joint disorder

Includes TMJ

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Jaw joint disorder treatment	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Maternity and related newborn care

Includes complications

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Inpatient services – **room and board**	90% per admission after **deductible**	$250 then the plan pays 70% per admission after **deductible**	100% per admission, no **deductible** applies
Services performed in **physician** or **specialist** office or a facility	90% per visit after **deductible**	70% per visit after **deductible**	100% per visit, no **deductible** applies
Other services and supplies	90% after **deductible**	70% after **deductible**	100%, no **deductible** applies

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

Nutritional support

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Nutritional support	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

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
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

Outpatient prescription drugs Out-of-network (In the U.S.) and Outside the U.S.

Description	Cost share	Cost share
	Out-of-network (In the U.S.)	**Outside the U.S.**
Prescription drugs	70% per supply after **deductible**	100% per supply, no **deductible** applies

Outpatient prescription drugs in the U.S.

Generic prescription drugs

Description	In-network
Each 30 day supply up to 12 months at a **retail pharmacy**	$10, no **deductible** applies
Each 30 day supply up to 12 months at a **retail** or **mail order pharmacy**	$10, no **deductible** applies

Brand-name prescription drugs

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

Anti-cancer drugs taken by mouth

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

Preventive care drugs and supplements

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

Risk reducing breast cancer drugs

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

Tobacco cessation drugs

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

Outpatient prescription drug important note:
If a **provider** prescribes a covered **brand-name prescription drug** when a **generic prescription drug** equivalent is available and specifies "Dispense As Written" (DAW), you will pay the cost share for the brand-name drug. If a **provider** does not specify DAW and you request a covered **brand-name prescription drug**, you will be responsible for the cost difference between the brand-name drug and the generic drug, plus the cost share that applies to the brand-name drug.

Outpatient surgery

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
At **hospital** outpatient department	90% per visit after **deductible**	70% per visit after **deductible**	100% per visit, no **deductible** applies
At facility that is not a **hospital**	90% per visit after **deductible**	70% per visit after **deductible**	100% per visit, no **deductible** applies
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

Physician and specialist services

Physician services-general or family practitioner

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Physician office hours (not-surgical, not preventive)	$10 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Physician surgical services	90% per visit after **deductible**	70% per visit after **deductible**	100% per visit, no **deductible** applies

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Physician visit during inpatient **stay**	90% per visit after **deductible**	70% per visit after **deductible**	100% per visit, no **deductible** applies

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Physician telemedicine consultation	$10 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies

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

Specialist

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Specialist office hours (not-surgical, not preventive)	$10 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Specialist surgical services	90% per visit after **deductible**	70% per visit after **deductible**	100% per visit, no **deductible** applies

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Specialist telemedicine consultation	$10 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies

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

All other services not shown above

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
All other services	90% per visit after **deductible**	70% per visit after **deductible**	100% per visit, no **deductible** applies

Preventive care

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Breast feeding counseling and support	100% per visit, no **deductible** applies	70% 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
Breast pump, accessories and supplies limit	Electric pump: 1 every 1 year Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 every 1 year Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 every 1 year Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
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
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Counseling for alcohol or drug misuse visit limit	5 visits/12 months	5 visits/12 months	5 visits/12 months
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
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.	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Counseling for sexually transmitted infection visit limit	2 visits/12 months	2 visits/12 months	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Counseling for tobacco cessation visit limit	8 visits/12 months	8 visits/12 months	8 visits/12 months
Family planning services (female contraception, counseling)	100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies

Family planning services (female contraception, counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting Counselings that exceed this limit are covered as a **physician** services office visit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting Counselings that exceed this limit are covered as a **physician** services office visit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting Counselings that exceed this limit are covered as a **physician** services office visit
Immunizations	100%, no **deductible** applies	70% after **deductible**	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**
Routine physical exam	100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 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	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	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months

Well woman GYN exam	100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

Preventive care and wellness maximum

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

Prosthetic devices

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Prosthetic devices	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Reconstructive surgery and supplies

Including breast surgery

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Surgery and supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Routine cancer screenings

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Colonoscopy	100% per test, no **deductible** applies	70% per test after **deductible**	100% per test, no **deductible** applies
Digital rectal examination (DRE)	100% per exam, no **deductible** applies	70% per exam after **deductible**	100% per exam, no **deductible** applies
Double contrast barium enemas (DCBE)	100% per test, no **deductible** applies	70% per test after **deductible**	100% per test, no **deductible** applies
Fecal occult blood test (FOBT)	100% per test, no **deductible** applies	70% per test after **deductible**	100% per test, no **deductible** applies
Mammogram	100% per test, no **deductible** applies	70% per test after **deductible**	100% per test, no **deductible** applies
Prostate specific antigen (PSA) test	100% per test, no **deductible** applies	70% per test after **deductible**	100% per test, no **deductible** applies
Sigmoidoscopy	100% per test, no **deductible** applies	70% per test after **deductible**	100% per test, no **deductible** applies

Cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section
Lung cancer screening	100% per test, no **deductible** applies	70% per test after **deductible**	100% per test, no **deductible** applies
Limit	1 screening every 12 months Screenings that exceed this limit are covered as outpatient diagnostic testing	1 screening every 12 months Screenings that exceed this limit are covered as outpatient diagnostic testing	1 screening every 12 months Screenings that exceed this limit are covered as outpatient diagnostic testing

Short-term rehabilitation services

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

Cardiac rehabilitation

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Cardiac rehabilitation	Covered based on type of service and where it is received	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 In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Pulmonary rehabilitation	Covered based on type of service and where it is received	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 In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Cognitive rehabilitation	Covered based on type of service and where it is received	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 In the U.S.	Out-of-network In the U.S.	Outside the U.S.
	$10 then the plan pays 100% per visit, no **deductible** applies	75% per visit after **deductible**	100% per visit, no **deductible** applies

Speech therapy (ST)

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
	$10 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies

Physical and Occupational Therapies

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Visit limit per year	Unlimited	Unlimited	Unlimited

Speech Therapy

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Visit limit per year	60	60	60

Spinal manipulation

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
	$10 then the plan pays 100% per visit, no **deductible** applies	75% per visit after **deductible**	100% per visit, no **deductible** applies

Skilled nursing facility

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Inpatient services - **room and board**	90% per admission after **deductible**	$250 then the plan pays 70% per admission after **deductible**	100% per admission, no **deductible** applies
Other inpatient services and supplies	90% per admission after **deductible**	70% per admission after **deductible**	100% per admission, no **deductible** applies

Day limit per year	120	120	120

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
	90% per visit after **deductible**	70% per visit after **deductible**	100% per visit, no **deductible** applies

Diagnostic lab work

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
	90% per visit after **deductible**	70% per visit after **deductible**	100% per visit, no **deductible** applies

Diagnostic x-ray and other radiological services

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
	90% per visit after **deductible**	70% per visit after **deductible**	100% per visit, no **deductible** applies

Therapies

Chemotherapy

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

Infusion therapy

Outpatient services

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
In **physician** office	$10 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
At an infusion location	$10 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
In the home	$10 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
At **hospital** outpatient department	90% per visit after **deductible**	70% per visit after **deductible**	100% per visit, no **deductible** applies
At facility that is not a **hospital**	90% per visit after **deductible**	70% per visit after **deductible**	100% per visit, no **deductible** applies

Radiation therapy

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Radiation therapy	Covered based on type of service and where it is received	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 In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Respiratory therapy	Covered based on type of service and where it is received	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 In the U.S.	Out-of-network (Includes **providers** who are otherwise part of Aetna's network but are non-IOE **providers**) In the U.S.	Outside the U.S.
Inpatient services and supplies	90% per transplant after **deductible**	$250 then the plan pays 70% per transplant after **deductible**	100% per transplant, no **deductible** applies
Physician 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

Urgent care services

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

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

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Urgent care facility	90% per visit after **deductible**	70% per visit after **deductible**	100% per visit, no **deductible** applies
Non-urgent use of an urgent care facility or **provider**	50% per visit after **deductible**	50% per visit after **deductible**	100% per visit, no **deductible** applies

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
	100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Visit limit	1 visit every 24 months	1 visit every 24 months	1 visit every 24 months

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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 In the U.S.	Non-designated network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Non-**emergency services**	100% per visit, no **deductible** applies	$10 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Preventive care immunizations	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Preventive care immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Preventive screening and counseling services	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	70% per visit after **deductible**	100% per visit, no **deductible** applies
Preventive 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	See the *Preventive care services* section of the SOB

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.