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 employer for additional information.

Prepared for:

Employer:	BAYADA Home Health Care, Inc.
Contract number:	MSA-109056
Control numbers:	0109056, 0169649
Plan name:	Choice POSII – High Deductible Health Plan Joint Venture Innovation Health - Multi Tier Plans
Schedule of benefits:	2B
Plan effective date:	January 1, 2025
Plan issue date:	March 28, 2025

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**.
- 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 designated **network** and **non-designated network providers**
  - Separate limits for designated **network** and **non-designated 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 calendar year **deductible**, maximum out-of-pocket, limits, **copayment** or **payment percentage** unless otherwise stated in this schedule. The *Surprise bill* section in the booklet explains your protections from a surprise bill.

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 a designated **network**, **non-designated 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 **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 non-designated and out-of-network **covered services**:

Your booklet 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 $500 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	Standard Savings (Aetna network)	Out-of-network
Individual	$1,750 per year	$2,500 per year	$5,000 per year
Family	$3,500 per year	$5,000 per year	$10,000 per year

Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	Designated network	Non-designated network	Out-of-network
Individual	$4,500 per year	$7,000 per year	$15,000 per year
Family	$9,000 per year	$14,000 per year	$30,000 per year

General coverage provisions

This section explains the **deductible, maximum out-of-pocket limit** and limitations listed in this schedule.

Deductible provisions

Covered services that are subject to the **deductible** include those provided under the medical plan and the **prescription** drug plan.

Covered services apply to the designated network, non-designated 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. After the amount paid for **covered services** reaches this individual **deductible**, this plan starts to pay for **covered services** for the rest of the year. The individual **deductible** applies to a person who is enrolled for self-only coverage with no dependent coverage.

Family deductible
You and your covered dependents 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. The family **deductible** applies to a person enrolled with one or more dependents.

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

Maximum out-of-pocket limit
The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **payment percentage** and **deductible**, if any, for **covered services**. **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 designated network, and non-designated-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-urgent use of an urgent care **provider**

Limit provisions
Covered services will apply separately to the designated network, and non-designated 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.

Prescription drug – outpatient maximum out-of-pocket limit provisions

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

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

Covered services

Abortion

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Abortion	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Ambulance services

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Emergency services	80% per trip after **deductible**	Paid same as designated network	Paid same as designated network
Non-**emergency services** ground, air, or water ambulance	Not covered	Not covered	Not covered

Applied behavior analysis

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Applied behavior analysis	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**

Autism spectrum disorder

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Diagnosis and testing	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**
Treatment	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**

Behavioral health

Mental health treatment

Coverage provided is the same as for any other illness

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Inpatient services-**room and board** including **residential treatment facility**	80% per admission after **deductible**	60% per admission after **deductible**	50% per admission after **deductible**
Other inpatient services and supplies Other **residential treatment facility** services and supplies	80% per admission after **deductible**	60% per admission after **deductible**	50% per admission after **deductible**

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**
Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services after you meet your **deductible**	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**

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

Substance related disorders treatment

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

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Inpatient services-**room and board**	80% per admission after **deductible**	60% per admission after **deductible**	50% per admission after **deductible**
Other inpatient services and supplies during a **hospital stay**	80% per admission after **deductible**	60% per admission after **deductible**	50% per admission after **deductible**

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services after you meet your **deductible**	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Telemedicine provider substance related disorders consultation	100% per visit after **deductible**	100% per visit after **deductible**	Not covered
Telemedicine cognitive therapy **substance related disorders** consultation by a **telemedicine provider**	100% per visit after **deductible**	100% per visit after **deductible**	Not covered

Clinical trials

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of- network
Experimental or investigational therapies	Covered based on type of service and where it is received	Covered based on type of service and where it is received	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

Durable medical equipment (DME)

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
DME	80% per item after **deductible**	60% per item after **deductible**	50% per item after **deductible**

Emergency services

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Emergency room	80% per visit after **deductible**	Paid same as designated network	Paid same as designated network

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Non-emergency care in a **hospital** emergency room	80% per visit after **deductible**	80% per visit after **deductible**	80% per visit after **deductible**

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	Standard Savings (Aetna network)	Out-of-network
Orthotic devices	80% per item after **deductible**	60% per item after **deductible**	50% per item after **deductible**

Habilitation therapy services

Outpatient physical (PT) and occupational (OT) therapies

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
PT, OT therapies	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**

Outpatient speech therapy (ST)

Description	Designated network	Non-designated network	Out-of-network
ST therapy	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**

Hearing aids

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Hearing aids	100% per item after **deductible**	100% per item after **deductible**	100% per item after **deductible**
Limit per ear	$3,000 every 24 months	$3,000 every 24 months	$3,000 every 24 months

Hearing exams

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Hearing exams	Covered based on type of service and where it is received	Covered based on type of service and where it is received	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	Maximum Savings	Maximum Savings	Out-of-network
Home health care	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**

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	Standard Savings (Aetna network)	Out-of-network
Inpatient services - **room and board**	80% after **deductible**	60% after **deductible**	50% after **deductible**
Other inpatient services and supplies	80% per admission after **deductible**	60% per admission after **deductible**	50% after **deductible**

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Outpatient services	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**
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	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Inpatient services – **room and board**	80% after **deductible**	60% after **deductible**	50% after **deductible**
Other inpatient services and supplies	80% per admission after **deductible**	60% per admission after **deductible**	50% after **deductible**

Infertility services

Basic infertility

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Treatment of basic **infertility**	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Limited infertility services

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Outpatient services performed at **infertility specialist** office	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**
Services performed at **hospital** outpatient department	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**
Services performed at a facility other than a **hospital** outpatient department	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**

Advanced reproductive technology (ART)

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Outpatient services performed at ART **specialist** office	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**
Services performed at **hospital** outpatient department	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**
Services performed at a facility other than a **hospital** outpatient department	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**
Fertility preservation	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**

Limits

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Limit per lifetime ART and Limited services combined	$15,000 Combined for in-network and out-of-network benefits	$15,000 Combined for in-network and out-of-network benefits	$15,000 Combined for in-network and out-of-network benefits

Maternity and related newborn care

Includes complications

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Inpatient services - **room and board**	80% per admission after **deductible**	60% per admission after **deductible**	50% per admission after **deductible**
Other inpatient services and supplies	80% per admission after **deductible**	60% per admission after **deductible**	50% per admission after **deductible**
Services performed in **physician** or **specialist** office or a facility	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**
Other services and supplies	80% per visit after **deductible**	60% per visit after **deductible**	50% 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	Standard Savings (Aetna network)	Out-of-network
Inpatient services - **room and board**	80% per admission after **deductible**	60% per admission after **deductible**	50% per admission after **deductible**
Other inpatient services and supplies	80% per admission after **deductible**	60% per admission after **deductible**	50% per admission after **deductible**

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Outpatient services	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of- network
Treatment of mouth, jaws and teeth	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Outpatient surgery

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of- network
At **hospital** outpatient department	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**
At facility that is not a **hospital**	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**
At the **physician** office	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Physician and specialist services

Physician services-general or family practitioner

Including surgical services

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Physician office hours (not surgical, not preventive)	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**
Physician surgical services	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of- network
Physician visit during inpatient **stay**	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**

Description	Maximum Savings	Standard Savings (Aetna network)- designated network	Out-of-network
Physician telemedicine consultation	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Telemedicine provider consultation Basic medical services	Covered based on type of service and **provider** from which it is received	Not covered	Not covered

Specialist

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Specialist office hours (not surgical, not preventive)	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**
Specialist surgical services	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Specialist telemedicine consultation	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
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	Designated network	Non-designated network	Out-of-network
All other services	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**

Preventive care

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Preventive care services	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	50% per visit after **deductible**
Breast feeding counseling and support	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	50% per visit after **deductible**
Breast feeding counseling and support limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit	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
Breast pump waiting period	Electric pump: 12 months to replace an existing electric pump	Electric pump: 12 months to replace an existing electric pump	Electric pump: 12 months to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	50% per visit after **deductible**
Counseling for alcohol or drug misuse visit limit	5 visits/per year	5 visits/per year	5 visits/per year
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	50% per visit after **deductible**
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.
Counseling for sexually transmitted infection	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	50% per visit after **deductible**
Counseling for sexually transmitted infection visit limit	2 visits/per year	2 visits/per year	2 visits/per year
Counseling for tobacco cessation	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	50% per visit after **deductible**
Counseling for tobacco cessation visit limit	8 visits/per year	8 visits/per year	8 visits/per year
Family planning services	100% per visit, no	100% per visit, no	50% per visit after

(female contraception)	**deductible** applies	**deductible** applies	**deductible**
Family planning services (female contraception) limit	Contraceptive counseling limited to 2 visits/per year in a group or individual setting	Contraceptive counseling limited to 2 visits/per year in a group or individual setting	Contraceptive counseling limited to 2 visits/per year in a group or individual setting
Immunizations	100%, no **deductible** applies	100%, no **deductible** applies	50% per visit after **deductible**
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	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**
Generic preventive care contraceptives (birth control)	100%	100%	100%
Preventive care drugs and supplements	100%	100%	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
Preventive care risk reducing breast cancer **prescription** drugs	100%	100%	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

Preventive care tobacco cessation **prescription** and OTC drugs	100%	100%	100%
Limit	Two 90 day treatments only	Two 90 day treatments only	Two 90 day treatments only
Routine cancer screenings	100%, no **deductible** applies	100%, no **deductible** applies	50% per visit after **deductible**
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section	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
Routine lung cancer screening	100%, no **deductible** applies	100%, no **deductible** applies	50% per visit after **deductible**
Routine lung cancer screening limit	1 screenings per year Screenings that exceed this limit covered as outpatient diagnostic testing	1 screenings per year Screenings that exceed this limit covered as outpatient diagnostic testing	1 screenings per year Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	100%, no **deductible** applies	100%, no **deductible** applies	50% per visit after **deductible**
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2;	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;	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 per year after that age, up to age 22; 1 exam per year after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1/36 months	3 exams every 12 months age 2-3; and 1 exam per year after that age, up to age 22; 1 exam per year after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1/36 months	3 exams every 12 months age 2-3; and 1 exam per year after that age, up to age 22; 1 exam per year after age 22 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	50% per visit after **deductible**
Well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration	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

Prosthetic devices

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Prosthetic devices	80% per item after **deductible**	60% per item after **deductible**	50% per item after **deductible**

Reconstructive surgery and supplies

Including breast **surgery**

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Surgery and supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received	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	Standard Savings (Aetna network)	Out-of-network
Cardiac rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Pulmonary rehabilitation

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

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	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**

Speech therapy (ST)

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**

Spinal manipulation

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
At the **physician** office	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**

Skilled nursing facility

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Inpatient services – **room and board**	80% per admission after **deductible**	60% per admission after **deductible**	50% per admission after **deductible**
Other inpatient services and supplies	80% per admission after **deductible**	60% per admission after **deductible**	50% per admission after **deductible**

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**

Diagnostic lab work

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of- network
	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**

Therapies

Chemotherapy

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of- network
Chemotherapy services	Covered based on type of service and where it is received	Covered based on type of service and where it is received	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
Gene therapy products, **prescription** drugs	80% after **deductible**	Not covered

Infusion therapy

Outpatient services

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
In **physician** office	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**
At an infusion location	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
In the home	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**
At **hospital** outpatient department	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**
At facility that is not a **hospital**	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**

Radiation therapy

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Radiation therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Respiratory therapy

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Respiratory therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received	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**)
Inpatient services and supplies	80% per transplant after **deductible**	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	Standard Savings (Aetna network)	Out-of- network
Urgent care facility	80% per visit after **deductible**	80% per visit after **deductible**	50% per visit after **deductible**
Non-urgent use of an urgent care facility or **provider**	Not covered	Not covered	Not covered

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
	100% per visit no **deductible** applies	100% per visit no **deductible** applies	50% per visit after **deductible**
Visit limit	1 visit every year	1 visit every year	1 visit every year

Walk-in clinic

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

Description	Maximum savings providers (Minute Clinic)	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Non-**emergency services**	100% per visit after **deductible**	80% per visit after **deductible**	60% per visit after **deductible**	50% per visit after **deductible**
Preventive care immunizations	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	50% per visit after **deductible**
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	100% per visit, no **deductible** applies	50% per visit after **deductible**
Preventive screening and counseling limits	See the *Preventive care* section of the schedule	See the *Preventive care* section of the schedule	See the *Preventive care* section of the schedule	See the *Preventive care* section of the schedule

Description	Maximum Savings	Standard Savings (Aetna network)	Out-of-network
Telemedicine consultation for non-**emergency services** through a **walk-in clinic**	100% per visit after **deductible**	Covered based on type of service and where it is received	Not covered
Telemedicine consultation for preventive screening and counseling services through a **walk-in clinic**	100% per visit after **deductible**	Covered based on type of service and where it is received	Not covered

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

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

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