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:	BorgWarner Inc.
Policyholder number:	468847
Group policy effective date:	January 1, 2023
Plan name:	Passive PPO Medical and Prescription Drug,
Schedule of Benefits: 2A	
Plan effective date:	January 1, 2023
Plan issue date:	March 15, 2023
Plan revision effective date:	January 1, 2023

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**.

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.

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**.

Maximum out-of-pocket limit
The **maximum out-of-pocket limit** is unlimited.

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 deductible provisions

The **deductible** may not apply to certain **covered services**. You still pay the **copayment** or **coinsurance**, if any, for these **covered services**.

For purposes of the following **prescription** drug **deductible** provisions:

- The individual **deductible** applies to a person enrolled for self-only coverage with no dependent coverage
- The family **deductible** applies to a person enrolled with one or more dependents
- The family **deductible** is met by a combination of family members or by any single individual within the family

Covered services

Acupuncture

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Acupuncture	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	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	100% per trip, no **deductible** applies	Paid same as in-network	100% per trip, no **deductible** applies
Non-emergency services	100% per trip, no **deductible** applies	100% 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**	100% per admission, no **deductible** applies	100% per admission, no **deductible** applies	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**	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Physician or **behavioral health provider telemedicine** consultation	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	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	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies

Substance related disorders treatment

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

Coverage provided is the same as for any other illness

Description	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**	100% per admission, no **deductible** applies	100% per admission, no **deductible** applies	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**	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Physician or **behavioral health provider telemedicine** consultation	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	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	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies

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	100% per item, no **deductible** applies	100% per item, no **deductible** applies	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	100% 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, no **deductible** applies	50% per visit, no **deductible** applies	50% 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	100% per item, no **deductible** applies	100% per item, no **deductible** applies	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 3 years	One per ear every 3 years	One per ear every 3 years
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	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	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**	100% per admission, no **deductible** applies	100% per admission, no **deductible** applies	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	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	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**	100% per admission, no **deductible** applies	100% per admission, no **deductible** applies	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.
	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	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.
	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	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**	100% per admission, no **deductible** applies	100% per admission, no **deductible** applies	100% per admission, no **deductible** applies

Services performed in **physician** or **specialist** office or a facility	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Other services and supplies	100%, no **deductible** applies	100%, no **deductible** applies	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	100% per supply, no **deductible** applies	100% per supply, no **deductible** applies

Outpatient prescription drugs in the U.S.

Generic prescription drugs

Description	In-network
Each 31 day supply up to 12 months at a **retail pharmacy**	100%, no **deductible** applies
Each 30 day supply up to 12 months at a **retail** or **mail order pharmacy**	100%, no **deductible** applies

Brand-name prescription drugs

Description	In-network
Each 31 day supply up to 12 months at a **retail pharmacy**	$0, no **deductible** applies
Each 30 day supply up to 12 months at a **mail order pharmacy**	$0, 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	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
At facility that is not a **hospital**	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	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)	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Physician surgical services	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	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	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	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**	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies

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)	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Specialist surgical services	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	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	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies

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	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	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	100% per visit, no **deductible** applies	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 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	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	100% per visit, no **deductible** applies	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	100% per visit, no **deductible** applies	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	100% per visit, no **deductible** applies	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	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Family planning services	Contraceptive counseling	Contraceptive counseling	Contraceptive counseling

(female contraception, counseling) limit	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	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	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	100%, no **deductible** applies	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	100% per visit, no **deductible** applies	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	100% per visit, no **deductible** applies	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

Private duty nursing

Up to 8 hours equals one shift

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
Outpatient services	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Visit/shift limit per year	70	70	70

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	100% per test, no **deductible** applies	100% per test, no **deductible** applies
Digital rectal examination (DRE)	100% per exam, no **deductible** applies	100% per exam, no **deductible** applies	100% per exam, no **deductible** applies
Double contrast barium enemas (DCBE)	100% per test, no **deductible** applies	100% per test, no **deductible** applies	100% per test, no **deductible** applies
Fecal occult blood test (FOBT)	100% per test, no **deductible** applies	100% per test, no **deductible** applies	100% per test, no **deductible** applies

Mammogram	100% per test, no **deductible** applies	100% per test, no **deductible** applies	100% per test, no **deductible** applies
Prostate specific antigen (PSA) test	100% per test, no **deductible** applies	100% per test, no **deductible** applies	100% per test, no **deductible** applies
Sigmoidoscopy	100% per test, no **deductible** applies	100% per test, no **deductible** applies	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	100% per test, no **deductible** applies	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, occupational and speech therapies

Description	In-network In the U.S.	Out-of-network In the U.S.	Outside the U.S.
	100% per visit no **deductible** applies	100% per visit no **deductible** applies	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.
	100% per visit, no **deductible** applies	100% per visit no **deductible** applies	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**	100% per admission no **deductible** applies	100% per admission no **deductible** applies	100% per admission no **deductible** applies
Other inpatient services and supplies	100% per admission, no **deductible** applies	100% per admission no **deductible** applies	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.
	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	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.
	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	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.
	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	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.
	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	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	100% per transplant, no **deductible** applies	100% per transplant, no **deductible** applies	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	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	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	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies

Visit limit	1 visit every 24 months	1 visit every 24 months	1 visit every 24 months

Walk-in clinic

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

Description	In-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	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Preventive immunizations	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies

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**