Schedule of benefits

If this is an ERISA plan, you may have certain rights under this plan. ERISA may not apply to a church or government group. Please contact the policyholder for additional information.

Prepared for:

Employer:	University of Chicago Health Plan Ingalls Health System EPO
Contract number:	MSA-0285549
Control number:	0181136
Plan name:	Aetna Select Medical Plan
Schedule of benefits:	1A
Plan effective date:	July 1, 2022
Plan issue date:	July 15, 2022

Third Party Administrative Services provided by Aetna Life Insurance Company

Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles**, **copayments** or **payment percentage**, if any apply to the **covered services** you receive under the plan. You should review this schedule to become aware of these and any limits that apply to these services.

The benefits shown in this schedule of benefits are available for your eligible out of area dependents.

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 Aetna benefits* section under Individuals & Families at https://www.aetna.com/

Important note:
Covered services are subject to the Plan Year **deductible**, **maximum out-of-pocket**, limits, **copayment** or **payment percentage** unless otherwise stated in this schedule.

Under this plan, you will:

1. Pay your **copayment**
2. Then pay any remaining **deductible**
3. Then pay your **payment percentage**

Your **copayment** does not apply to any **deductible**.

How your deductible works

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **copayment** or **payment percentage** you pay when you get **covered services** from a **designated network** or **non-designated 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 the **PCP** you select. You will pay a higher cost share when you get **covered services** from a **PCP** that is not your **PCP**. If you did not select a **PCP**, you will pay a higher cost share for **covered services** from any **PCP**, network **physician** or **specialist**.

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

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%.

Per admission copayment

Per admission copayment type	Designated network	Non-designated network
Per admission **copayment**	$250 per day up to 3 days	Not applicable

Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	Designated network	Non-designated network
Individual	$2,500 per year	Not applicable
Family	$5,000 per year	Not applicable

General coverage provisions

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

Copayment
This is a flat fee you pay for certain visits or **covered services**. A copay can be a dollar amount or percentage. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Per admission copayment
This is the amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility.

Payment Percentage
This is the percentage of the bill you pay after you meet your **deductible**. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

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
- Costs for non-emergency use of the emergency room
- Costs for non-urgent use of an urgent care **provider**

Your financial responsibility and decisions regarding benefits
We base your financial responsibility for the cost of **covered services** on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the booklet.

Covered services

Ambulance services

Description	Designated network	Non-designated network
Emergency services	90% per trip, no **deductible** applies	Not covered
Non-emergency services	90% per trip, no **deductible** applies	Not covered

Applied behavior analysis

Description	Designated network	Non-designated network
Applied behavior analysis	Covered based on type of service and where it is received	Not covered

Autism spectrum disorder

Description	Designated network	Non-designated network
Diagnosis and testing	Covered based on type of service and where it is received	Not covered
Treatment	Covered based on type of service and where it is received	Not covered
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	Covered based on type of service and where it is received	Not covered

Behavioral health

Mental health disorders treatment

Coverage provided is the same as for any other illness

Description	Designated network	Non-designated network
Inpatient services – **room and board**	$250 per day then the plan pays 100% for 3 days per admission then the plan pays 100% no **deductible** applies	Not covered

Description	Designated network	Non-designated network
Outpatient office visit to a **physician** or **behavioral health provider**	$20 then the plan pays 100% per visit, no **deductible** applies	Not covered
Physician or **behavioral health provider telemedicine** consultation	$20 then the plan pays 100% per visit, no **deductible** applies	Not covered
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	Not covered

Description	Designated network	Non-designated 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	100% per visit, no **deductible** applies	Not covered

Substance related disorders treatment

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

Coverage provided is the same as for any other illness

Description	Designated network	Non-designated network
Inpatient services – **room and board**	$250 per day then the plan pays 100% for 3 days per admission then the plan pays 100% no **deductible** applies	Not covered

Description	Designated network	Non-designated network
Outpatient office visit to a **physician** or **behavioral health provider**	$20 then the plan pays 100% per visit, no **deductible** applies	Not covered
Physician or **behavioral health provider telemedicine** consultation	$20 then the plan pays 100% per visit, no **deductible** applies	Not covered
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	Not covered

Description	Designated network	Non-designated 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	100% per visit, no **deductible** applies	Not covered

Clinical trials

Description	Designated network	Non-designated network
Experimental or investigational therapies	Covered based on type of service and where it is received	Not covered
Routine patient costs	Covered based on type of service and where it is received	Not covered

Diabetic services, supplies, equipment, and self-care programs

Description	Designated network	Non-designated network
Diabetic services	Covered based on type of service and where it is received	Not covered
Diabetic supplies	Covered based on type of service and where it is received	Not covered
Diabetic equipment	Covered based on type of service and where it is received	Not covered
Diabetic self-care programs	Covered based on type of service and where it is received	Not covered

Durable medical equipment (DME)

Description	Designated network	Non-designated network
DME	90% per item, no **deductible** applies	Not covered

Emergency services

Description	Designated network	Non-designated network	Out-of-network
Emergency room	$150 then the plan pays 90% per visit, no **deductible** applies	Not covered	Not applicable

Description	Designated network	Non-designated network
Non-emergency care in a **hospital** emergency room	Not covered	Not covered

Emergency services important note:

- **Out-of-network providers** do not have a contract with us. 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.
- In the case of a surprise bill from an out-of-network provider, where you had no control of their participation in your **covered services**, you will pay the same cost share you would have if the **covered services** were received from a **network provider**. The cost share will be based on the median contracted rate. Contact us immediately if you receive such a bill.

Foot orthotic devices

Description	Designated network	Non-designated network
Orthotic devices	90% per item, no **deductible** applies	Not covered

Hearing aids

Description	Designated network	Non-designated network
Hearing aids	100% per item, no **deductible** applies	Not covered
Limit	$1,500 per 2 years	Not covered

Hearing exams

Description	Designated network	Non-designated network
Hearing exams	Covered based on type of service and where it is received	Not covered

Home health care

A visit is a period of 4 hours or less

Description	Designated network	Non-designated network
Home health care	100% per visit, no **deductible** applies	Not covered

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	Designated network	Non-designated network
Inpatient services - **room and board**	100% per visit, no **deductible** applies	Not covered
Outpatient services	100% per visit, no **deductible** applies	Not covered

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	Designated network	Non-designated network
Inpatient services – **room and board**	$250 per day then the plan pays 100% for 3 days per admission then the plan pays 100% no **deductible** applies	Not covered

Infertility services

Basic infertility

Description	Designated network	Non-designated network
Treatment of basic **infertility**	Covered based on type of service and where it is received	Not covered

Comprehensive infertility services

Description	Designated network	Non-designated network
	100% per visit, no **deductible** applies	Not covered

Advanced reproductive technology (ART)

Description	Designated network	Non-designated network
Outpatient services	100% per visit, no **deductible** applies	Not covered

Maternity and related newborn care

Includes complications

Description	Designated network	Non-designated network
Inpatient services – **room and board**	$250 per day then the plan pays 100% for 3 days per admission then the plan pays 100% no **deductible** applies	Not covered
Services performed in **physician** or **specialist** office or a facility	90% per visit, no **deductible** applies	Not covered
Other services and supplies	90% per visit, no **deductible** applies	Not covered

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	Designated network	Non-designated network
Inpatient services - **room and board**	$250 per day then the plan pays 100% for 3 days per admission then the plan pays 100% no **deductible** applies	Not covered

Description	Designated network	Non-designated network
Outpatient services	90% per visit, no **deductible** applies	Not covered

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	Designated network	Non-designated network
Treatment of mouth, jaws and teeth	Covered based on type of service and where it is received	Not covered

Outpatient surgery

Description	Designated network	Non-designated network
	90% per visit, no **deductible** applies	Not covered

Physician and specialist services

Physician services-general or family practitioner

Description	Designated network	Non-designated network
Physician office hours (not surgical, not preventive)	$20 then the plan pays 100% per visit, no **deductible** applies	Not covered
Physician surgical services	$20 then the plan pays 100% per visit, no **deductible** applies	Not covered

Description	Designated network	Non-designated network
Physician telemedicine consultation	$20 then the plan pays 100% per visit, no **deductible** applies	Not covered

Description	Designated network	Non-designated network
Physician visit during inpatient **stay**	90% per visit, no **deductible** applies	Not covered

Specialist

Description	Designated network	Non-designated network
Specialist office hours (not surgical, not preventive)	$30 then the plan pays 100% per visit, no **deductible** applies	Not covered
Specialist surgical services	$30 then the plan pays 100% per visit, no **deductible** applies	Not covered

Description	Designated network	Non-designated network
Specialist telemedicine consultation	$30 then the plan pays 100% per visit, no **deductible** applies	Not covered

All other services not shown above

Description	Designated network	Non-designated network
All other services	90% per visit, no **deductible** applies	Not covered

Preventive care

Description	Designated network	Non-designated network
Preventive care services	100% per visit, no **deductible** applies	Not covered
Breast feeding counseling and support	100% per visit, no **deductible** applies	Not covered
Breast feeding counseling and support limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit	Not covered
Breast pump, accessories and supplies limit	Electric pump: 1 every 1 year Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Not covered
Breast pump waiting period	Electric pump: 1 year to replace an existing electric pump	Not covered
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies	Not covered
Counseling for alcohol or drug misuse visit limit	5 visits per year	Not covered
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies	Not covered
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per year, of which up to 10 visits may be used for healthy diet counseling.	Not covered
Counseling for sexually transmitted infection	100% per visit, no **deductible** applies	Not covered
Counseling for sexually transmitted infection visit limit	2 visits per year	Not covered
Counseling for tobacco cessation	100% per visit, no **deductible** applies	Not covered
Counseling for tobacco cessation visit limit	8 visits per year	Not covered
Family planning services (female contraception)	100% per visit, no **deductible** applies	Not covered
Family planning services (female contraception) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting	Not covered
Immunizations	100%, no **deductible** applies	Not covered
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention	Not covered

	For details, contact your **physician**	
Generic preventive care contraceptives (birth control)	100%	Not covered
Preventive care drugs and supplements	100%	Not covered
Preventive care drugs and supplements limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Not covered
Preventive care risk reducing breast cancer **prescription** drugs	100%	Not covered
Preventive care risk reducing breast cancer **prescription** drugs limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Not covered
Preventive care tobacco cessation **prescription** and OTC drugs	100%	Not covered
Limit	Two 90 day treatments only	Not covered
Routine cancer screenings	100%, no **deductible** applies	Not covered
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section	Not covered
Routine lung cancer screening	100%, no **deductible** applies	Not covered
Routine lung cancer screening limit	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing	Not covered

Routine physical exam	100%, no **deductible** applies	Not covered
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams per year age 1-2; 3 exams per year 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	Not covered
Well woman GYN exam	100%, no **deductible** applies	Not covered
Well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration	Not covered

Prosthetic devices

Description	Designated network	Non-designated network
Prosthetic devices	90% per item, no **deductible** applies	Not covered

Reconstructive surgery and supplies

Including breast **surgery**

Description	Designated network	Non-designated network
Surgery and supplies	Covered based on type of service and where it is received	Not covered

Short-term rehabilitation services

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

Cardiac rehabilitation

Description	Designated network	Non-designated network
Cardiac rehabilitation	Covered based on type of service and where it is received	Not covered

Pulmonary rehabilitation

Pulmonary	Covered based on type of service and where it is received	Not covered

Cognitive rehabilitation

Cognitive rehabilitation	Covered based on type of service and where it is received	Not covered

Physical and occupational therapies

Description	Designated network	Non-designated network
	90% per visit, no **deductible** applies	Not covered

Speech therapy (ST)

Description	Designated network	Non-designated network
	90% per visit, no **deductible** applies	Not covered

Physical and occupational therapies

Visit limit per year	60	Not covered

Speech therapy (ST)

Visit limit per year	60	Not covered

Spinal manipulation

Description	Designated network	Non-designated network
At the **physician** office	$20 then the plan pays 100% per visit, no **deductible** applies	Not covered

Visit limit per year	20	Not covered

Skilled nursing facility

Description	Designated network	Non-designated network
Inpatient services – **room and board**	100% admission, no **deductible** applies	Not covered

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	Designated network	Non-designated network
	90% per visit, no **deductible** applies	Not covered

Diagnostic lab work

Description	Designated network	Non-designated network
	90% per visit, no **deductible** applies	Not covered

Diagnostic x-ray and other radiological services

Description	Designated network	Non-designated network
	90% per visit, no **deductible** applies	Not covered

Therapies

Chemotherapy

Description	Designated network	Non-designated network
Chemotherapy services	Covered based on type of service and where it is received	Not covered

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 Aetna's network but are not GCIT-designated facilities/**providers**)
Services and supplies	Covered based on type of service and where it is received	Not covered

Infusion therapy

Outpatient services

Description	Designated network	Non-designated network
	90% per visit, no **deductible** applies	Not covered

Radiation therapy

Description	Designated network	Non-designated network
Radiation therapy	Covered based on type of service and where it is received	Not covered

Respiratory therapy

Description	Designated network	Non-designated network
Respiratory therapy	Covered based on type of service and where it is received	Not covered

Transplant services

Description	Designated network (IOE facility)
Inpatient services and supplies	$250 per day then the plan pays 100% for 3 days per transplant then the plan pays 100% no **deductible** applies
Physician services	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	Designated network	Non-designated network
Urgent care facility	$150 then the plan pays 100% per visit, no **deductible** applies	Not covered

Non-urgent use of an urgent care facility or **provider**	Not covered	Not covered

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Description	Designated network	Non-designated network
	$20 then the plan pays 100%per visit, no **deductible** applies	Not covered

Visit limit	1 visit per year	Not covered

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	Aetna Network providers with standard savings plus	Aetna Network providers with standard savings
Non-emergency services	100% per visit, no **deductible** applies	$30 then the plan pays 100% per visit, no **deductible** applies	Not covered
Preventive care immunizations	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	Not covered
Immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Not applicable
Preventive screening and counseling services	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	Not covered
Preventive screening and counseling limits	See the *Preventive care services* section of the schedule	See the *Preventive care services* section of the schedule	Not applicable