

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:	Recreational Equipment, Inc.
Contract number:	MSA-0393630
Plan name:	Choice POS II Choice Health Plan
Schedule of benefits:	1A
Plan effective date:	January 1, 2023
Plan issue date:	April 10, 2023

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.

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 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 planSee 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 **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.

Under this plan, you will:

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

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

How your deductible works

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **copayment** or **payment percentage** you pay when you get **covered services** from an in-network, **out-of-network provider**. This schedule shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **covered services**. You will continue to pay **copayments** or **payment percentage**, if any, for **covered services** after you meet your **deductible**.

How your PCP or physician office visit cost share works

You will pay the **PCP** cost share when you get **covered services** from any **PCP**.

How your maximum out-of-pocket works

This schedule shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of that year.

Contact us

We are here to answer questions. See the *Contact us* section in your booklet.

This schedule replaces any schedule of benefits previously in use. Keep it with your booklet.

Plan features

Precertification covered services reduction

This only applies to **out-of-network covered services**:

Your booklet contains a complete description of the **precertification** process. You will find details in the *Medical necessity and precertification* section.

If **precertification** for **covered services** isn't completed, when required, it results in the following benefit reduction:

- A \$300 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	In-network	Out-of-network
Individual	\$500 per year	\$1,500 per year
Family	\$1,000 per year	\$3,000 per year

Deductible waiver

There is no in-network **deductible** for the following **covered services**:

- Preventive care
- Family planning services – female contraceptives

Deductible and cost share waiver for contraceptives (birth control)

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

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

Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	In-network	Out-of-network
Individual	\$3,000 per year	None
Family	\$6,000 per year	None

General coverage provisions

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

Deductible provisions

Covered services apply to the in-network and out-of-network **deductibles**

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

Individual deductible

You pay for **covered services** each year before the plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. After the amount paid reaches the individual **deductible**, this plan starts to pay for **covered services** for the rest of the year.

Family deductible

You pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this family **deductible**, this plan starts to pay for **covered services** for the rest of the year. To satisfy this family **deductible** for the rest of the year, the combined **covered services** that you and each of your covered dependents incur toward the individual **deductible** must reach this family **deductible** in a year. When this happens in a year, the individual **deductibles** for you and your covered dependents are met for the rest of the year.

Deductible carryover

Any amounts that you paid for **covered services** in the last 90 days of a year that apply toward that year's **deductible** will also count toward the following year's **deductible**.

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

Individual maximum out-of-pocket limit

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

Family maximum out-of-pocket limit

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

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

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

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

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

- All costs for non-covered services which are identified in the booklet and the schedule
- Charges, expenses or costs in excess of the **recognized charge**

Limit provisions

Covered services will apply to the in-network and out-of-network limits.

Your financial responsibility and decisions regarding benefits

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

Covered services

Acupuncture

Description	In-network	Out-of-network
Acupuncture	80% per visit after deductible	50% per visit after deductible

Ambulance services

Description	In-network	Out-of-network
Emergency services	80% per trip after deductible	50% per trip after deductible
Description	In-network	Out-of-network
Non-emergency services	80% per trip after deductible	50% per trip, after deductible

Applied behavior analysis

Description	In-network	Out-of-network
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

Autism spectrum disorder

Description	In-network	Out-of-network
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
Treatment	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

Behavioral health

Mental health treatment

Coverage provided is the same as for any other illness

Description	In-network	Out-of-network
Inpatient services- room and board including residential treatment facility	90% per admission after deductible	50% per admission after deductible

Description	In-network	Out-of-network
Outpatient office visit to a physician or behavioral health provider	90% per visit after deductible	50% per visit after deductible
Physician or behavioral health provider telemedicine consultation	90% 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

Description	In-network	Out-of-network
Other outpatient services including: <ul style="list-style-type: none"> • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program <p>The cost share doesn't apply to in-network peer counseling support services</p>	90% per visit after deductible	50% per visit after deductible

Description	In-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

Substance related disorders treatment

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

Coverage provided is the same as for any other illness

Description	In-network	Out-of-network
Inpatient services-room and board during a hospital stay	90% per admission after deductible	50% per admission after deductible

Description	In-network	Out-of-network
Outpatient office visit to a physician or behavioral health provider	90% per visit after deductible	50% per visit after deductible
Physician or behavioral health provider telemedicine consultation	90% 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

Description	In-network	Out-of-network
Other outpatient services including: <ul style="list-style-type: none"> Behavioral health services in the home Partial hospitalization treatment Intensive outpatient program <p>The cost share doesn't apply to in-network peer counseling support services</p>	90% per visit after deductible	50% per visit after deductible

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

Clinical trials

Description	In-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
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

Durable medical equipment (DME)

Description	In-network	Out-of-network
DME	80% per item after deductible	50% per item after deductible

Emergency services

Description	In-network	Out-of-network
Emergency room	80% per visit after deductible	Paid same as in-network
Non-emergency care in a hospital emergency room	50% per visit after deductible	50% 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	In-network	Out-of-network
Orthotic devices	80% per item after deductible	50% per item after deductible

Habilitation therapy services

Physical (PT), occupational (OT) therapies

Description	In-network	Out-of-network
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

Speech therapy (ST)

Description	In-network	Out-of-network
ST	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	Out-of-network
Hearing aids	80% per item after deductible	50% per item after deductible

Limit	One per ear every 36 months	One per ear every 36 months
Limit	\$3,000	\$3,000

Hearing exams

Description	In-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
Visit limit	1 visit every Calendar Year	1 visit every Calendar Year

Home health care

A visit is a period of 4 hours or less

Description	In-network	Out-of-network
Home health care	80% per visit after deductible	50% per visit after deductible

Visit limit per year	130	130
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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	Out-of-network
Inpatient services - room and board	80% after deductible	50% after deductible

Description	In-network	Out-of-network
Outpatient services	80% per visit after deductible	50% per visit after deductible

Limit per lifetime	unlimited	unlimited
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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	Out-of-network
Inpatient services – room and board	80% after deductible	50% after deductible

Infertility services

Basic infertility

Description	In-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

Comprehensive infertility services

Description	In-network	Out-of-network
	80% per visit after deductible	Not covered

Limits

Description	In-network	Out-of-network
Number of ovulation induction cycles per year while on medications to stimulate the ovaries	6	Not applicable
Number of artificial insemination cycles per year	6	Not applicable

Advanced reproductive technology (ART)

Description	In-network	Out-of-network
	80% per visit after deductible	Not covered

Limits

Description	In-network	Out-of-network
Limit per lifetime	3	Not applicable

Institutes of Quality – Bariatric Surgery

Description	In network (IOQ Facility)	In network (Non-IOQ Facility)	Out-of-network
Inpatient	80% per admission after deductible	Not covered	Not covered
Outpatient	80% per visit after deductible	Not covered	Not covered
<i>Precertification may be required</i>			
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.	Not covered	Not covered
Lifetime Maximum	\$25,000	Not applicable	Not applicable

Jaw joint disorder

Includes TMJ

Description	In-network	Out-of-network
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

Maternity and related newborn care

Includes complications

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

Description	In-network	Out-of-network
Inpatient services – room and board	80% per admission after deductible	50% per admission after deductible
Services performed in physician or specialist office or a facility	80% per visit after deductible	50% per visit after deductible
Other services and supplies	80% after deductible	50% 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.

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	In-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

Outpatient surgery

Description	In-network	Out-of-network
At hospital outpatient department	80% per visit after deductible	50% per visit after deductible
At facility that is not a hospital	80% 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

Physician and specialist services

Physician services-general or family practitioner

Description	In-network	Out-of-network
Physician office hours (not-surgical, not preventive)	80% per visit after deductible	50% per visit after deductible
Physician surgical services	80% per visit after deductible	50% per visit after deductible

Description	In-network	Out-of-network
Physician telemedicine consultation	80% per visit after deductible	50% per visit after deductible

Description	In-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

Description	In-network	Out-of-network
Physician visit during inpatient stay	80% per visit after deductible	50% per visit after deductible

Specialist

Description	In-network	Out-of-network
Specialist office hours (not-surgical, not preventive)	80% per visit after deductible	50% per visit after deductible
Specialist surgical services	80% per visit after deductible	50% per visit after deductible

Description	In-network	Out-of-network
Specialist telemedicine consultation	80% per visit after deductible	50% per visit after deductible

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

All other services not shown above

Description	In-network	Out-of-network
All other services	80% per visit after deductible	50% per visit after deductible

Preventive care

Description	In-network	Out-of-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 applicable
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 applicable
Breast pump waiting period	Electric pump: 1 year to replace an existing electric pump	Not applicable
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 applicable
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 applicable
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 applicable
Counseling for tobacco cessation	100% per visit, no deductible applies	Not covered
Counseling for tobacco cessation visit limit	8 visits/per year	Not applicable
Family planning services (female contraception counseling)	100% per visit, no deductible applies	Not covered
Family planning services (female contraception counseling) limit	Contraceptive counseling limited to 2 visits/per year in a group or individual setting	Not applicable

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 For details, contact your physician	Not applicable
Routine cancer screenings	100% per visit, 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 <i>Contact us</i> section	Not applicable
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 <i>Contact us</i> section	Not applicable
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 <i>Contact us</i> section	Not applicable
Preventive care tobacco cessation prescription and OTC drugs	100%	Not covered
Limit	Two 90 day treatments only	Not covered
Routine lung cancer screening	100% per visit, no deductible applies	50% per visit after deductible
Routine lung cancer screening limit	1 screening per year Screenings that exceed this limit covered as outpatient diagnostic testing	1 screening per year Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	100% per visit, 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 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 18; 1 exam per year after age 18 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months	Not applicable
Well woman GYN exam	100% per visit, 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 applicable

Prosthetic devices

Description	In-network	Out-of-network
Prosthetic devices	80% per item after deductible	50% per item after deductible

Reconstructive surgery and supplies

Including breast surgery

Description	In-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

Short-term rehabilitation services

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

Cardiac rehabilitation

Description	In-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

Pulmonary rehabilitation

Description	In-network	Out-of-network
Pulmonary rehabilitation	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	Out-of-network
Cognitive rehabilitation	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	Out-of-network
	90% per visit after deductible	50% per visit after deductible

Physical, occupational and speech therapies

Description	In-network	Out-of-network
Visit limit per year	60	60
All therapies combined In-network and out-of-network combined		

Spinal manipulation

Description	In-network	Out-of-network
	80% per visit after deductible	50% per visit after deductible
Limit per year Spinal Manipulation, Acupuncture and Massage therapy services combined In-network and out-of-network combined	60	60

Skilled nursing facility

Description	In-network	Out-of-network
Inpatient services - room and board	80% per admission after deductible	50% per admission after deductible
Other inpatient services and supplies	80% per admission after deductible	50% per admission after deductible
Day limit per year	120	120

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network	Out-of-network
	80% per visit after deductible	50% per visit after deductible

Diagnostic lab work

Description	In-network	Out-of-network
	80% per visit after deductible	50% per visit after deductible

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network
	80% per visit after deductible	50% per visit after deductible

Therapies

Chemotherapy

Description	In-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

Gene-based, cellular and other innovative therapies (GCIT)

Description	In-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
Gene therapy products, prescription drugs	80% per visit after deductible	Not covered

Infusion therapy

Outpatient services

Description	In-network	Out-of-network
	90% per visit after deductible	50% per visit after deductible

Radiation therapy

Description	In-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

Respiratory therapy

Description	In-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

Transplant services

Description	In-network (IOE facility)	Out-of-network (Includes providers who are otherwise part of Aetna'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	In-network	Out-of-network
Urgent care facility	80% per visit after deductible	50% per visit after deductible

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Description	In-network	Out-of-network
	80% per visit after deductible	50% per visit after deductible

Visit limit	1 visit every Calendar Year	1 visit every Calendar Year
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Walk-in clinic

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

Description	In-network	Out-of-network
Non-emergency services	80% per visit after deductible	50% per visit after deductible
Preventive immunizations	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	Not applicable
Screening and counseling services	100% per visit, no deductible applies	Not covered
Screening and counseling limits	See the <i>Preventive care services</i> section of the SOB	Not applicable