

Eligible health services	In-network coverage	Out-of-network coverage
Other outpatient treatment (includes skilled behavioral health services in the home)	100% (of the negotiated charge) per visit	Not covered
Eligible health services	In-network coverage (IOE facility)*	Out-of-network coverage (Includes providers who are otherwise part of Aetna's network but are non-IOE providers)
Transplant services		
Inpatient and outpatient transplant facility services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Inpatient and outpatient transplant physician and specialist services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Transplant services-travel and lodging	Covered	Covered
Lifetime Maximum payable for Travel and Lodging Expenses for any one transplant, including tandem transplants	\$10,000	\$10,000
Maximum payable for Lodging Expenses per IOE patient	\$50 per night	\$50 per night
Maximum payable for Lodging Expenses per companion	\$50 per night	\$50 per night
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> • Services and supplies furnished to a donor when the recipient is not a covered person • Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness • Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness 		
Treatment of infertility		
Basic infertility services Inpatient and outpatient care - basic infertility	Covered according to the type of benefit and the place where the service is received.	Not Covered
Fertility preservation services		
Fertility preservation	Covered according to the type of benefit and the place where the service is received.	Not Covered
<p>The following are not covered services under the infertility treatment benefit:</p> <ul style="list-style-type: none"> • Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists. • All charges associated with: <ul style="list-style-type: none"> - Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father 		

- Thawing of cryopreserved (frozen) eggs, embryos or sperm
- The care of the donor in a donor egg cycle which includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers
- The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which the person is not genetically related
- Obtaining sperm from a person not covered under this plan for ART services
- Home ovulation prediction kits or home pregnancy tests
- The purchase of donor embryos, donor oocytes, or donor sperm
- Reversal of voluntary sterilizations, including follow-up care
- Ovulation induction with menotropins, Intrauterine insemination and any related services, products or procedures
- In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery)
- ART services are not provided for out-of-network care

Eligible health services	In-network coverage	Out-of-network coverage
Specific therapies and tests		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	Not Covered
Diagnostic lab work and radiological services performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	Not Covered
Outpatient Chemotherapy, Radiation & Respiratory Therapy	80% (of the negotiated charge) per visit	Not Covered
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	Covered according to the type of benefit and the place where the service is received.	Not Covered
The following are not covered under this benefit:		
<ul style="list-style-type: none"> • Enteral nutrition • Blood transfusions and blood products 		
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy)	80% (of the negotiated charge) per visit	Not Covered
Combined for short-term rehabilitation services and habilitation therapy services		
Acupuncture therapy	80% (of the negotiated charge) per visit	Not Covered

