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:	Aristocrat Technologies, Inc.
Contract number:	MSA-0231720
Plan name:	Aetna Select
Schedule of benefits:	6A
Plan effective date:	January 1, 2024
Plan issue date:	November 29, 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:
  - 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 **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 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

Per admission copayment

Per admission copayment type	In-network
Per admission **copayment**	$300 per admission for first 3 days

Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	In-network
Individual	$3,000 per year
Family	$6,000 per year

General coverage provisions

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

Copayment

This is the dollar amount you pay for **covered services**. In most plans, you pay this after you meet your **deductible** limit.

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**.

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**.

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

Abortion

Description	In-network
Abortion	Covered based on type of service and where it is received

Acupuncture

Description	In-network
Acupuncture	$20 then the plan pays 100% per visit, no **deductible** applies

Visit limit per year	20

Ambulance services

Description	In-network
Emergency services	$200 then the plan pays 100% per trip, no **deductible** applies
Non-**emergency services**	Not covered

Applied behavior analysis

Description	In-network
Applied behavior analysis	Covered based on type of service and where it is received

Autism spectrum disorder

Description	In-network
Diagnosis and testing	$0 then the plan pays 100% per visit, no **deductible** applies
Treatment	$0 then the plan pays 100% per visit, no **deductible** applies
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	$0 then the plan pays 100% per visit, no **deductible** applies

Behavioral health

Mental health treatment

Coverage provided is the same as for any other illness

Description	In-network
Inpatient services-**room and board** including **residential treatment facility**	$300 per day then the plan pays 100% for first 3 days per admission then the plan pays 100% no **deductible** applies
Other inpatient services and supplies Other **residential treatment facility** services and supplies	100% per admission, no **deductible** applies

Description	In-network
Outpatient office visit to a **physician** or **behavioral health provider**	$0 then the plan pays 100% per visit, no **deductible** applies
Physician or **behavioral health provider telemedicine** consultation	$0 then the plan pays 100% per visit, no **deductible** applies
Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	$0 then the plan pays 100% per visit, no **deductible** applies

Description	In-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services	100% per visit, no **deductible** applies

Description	In-network
Telemedicine provider mental health disorders consultation	Covered based on type of service and **provider** from which it is received
Telemedicine cognitive therapy **mental health disorders** consultation by a **telemedicine provider**	Covered based on type of service and **provider** from which it is received

Substance related disorders treatment

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

Description	In-network
Inpatient services-**room and board** during a **hospital stay**	$300 per day then the plan pays 100% for first 3 days per admission then the plan pays 100% no **deductible** applies
Other inpatient services and supplies during a **hospital stay**	100% per admission, no **deductible** applies

Description	In-network
Outpatient office visit to a **physician** or **behavioral health provider**	$0 then the plan pays 100% per visit, no **deductible** applies
Physician or **behavioral health provider telemedicine** consultation	$0 then the plan pays 100% per visit, no **deductible** applies
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	$0 then the plan pays 100% per visit, no **deductible** applies

Description	In-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services	100% per visit, no **deductible** applies

Description	In-network
Telemedicine provider substance related disorders consultation	Covered based on type of service and **provider** from which it is received
Telemedicine cognitive therapy **substance related disorders** consultation by a **telemedicine provider**	Covered based on type of service and **provider** from which it is received

Clinical trials

Description	In-network
Experimental or investigational therapies	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

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

Description	In-network
Diabetic services	Covered based on type of service and where it is received
Diabetic supplies	Covered based on type of service and where it is received
Diabetic equipment	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

Durable medical equipment (DME)

Description	In-network
DME	50% per item, no **deductible** applies

Emergency services

Description	In-network	Out-of-network
Emergency room	$200 then the plan pays 100% per visit, no **deductible** applies	Paid same as in-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. 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.

Habilitation therapy services

Outpatient physical (PT), occupational (OT) and speech (ST) therapies

Description	In-network
PT, OT and ST therapies	$0 then the plan pays 100% per visit, no **deductible** applies

Home health care

A visit is a period of 4 hours or less

Description	In-network
Home health care	$35 then the plan pays 100% per visit, no **deductible** applies
Visit limit per year	60

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
Inpatient services - **room and board**	$300 per day then the plan pays 100% for first 3 days per admission then the plan pays 100% no **deductible** applies

Description	In-network
Other inpatient services and supplies	100% per admission, no **deductible** applies

Description	In-network
Outpatient services	$50 then the plan pays 100% per visit, no **deductible** applies

Limit per lifetime	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
Inpatient services - **room and board**	$300 per day then the plan pays 100% for first 3 days per admission then the plan pays 100% no **deductible** applies

Description	In-network
Other inpatient services and supplies	100% per admission, no **deductible** applies

Infertility services

Basic infertility

Description	In-network
Treatment of basic **infertility**	Covered based on type of service and where it is received

Comprehensive infertility services

Description	In-network
Outpatient services performed at **infertility specialist** office	$40 then the plan pays 100% per visit, no **deductible** applies
Services performed at **hospital** outpatient department	100% per visit, no **deductible** applies
Services performed at a facility other than a **hospital** outpatient department	100% per visit, no **deductible** applies

Limits

Description	In-network
Limit per lifetime	$15,000

Jaw joint disorder

Includes TMJ

Description	In-network
Jaw joint disorder treatment	Covered based on type of service and where it is received

Maternity and related newborn care

Includes complications

Description	In-network
Inpatient services – **room and board**	$300 per day then the plan pays 100% for first 3 days per admission then the plan pays 100%, no **deductible** applies
Other inpatient services and supplies	100% per admission, no **deductible** applies
Services performed in **physician** or **specialist** office or a facility	100% per visit, no **deductible** applies
Other services and supplies	100% per visit, 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 booklet. It will give you more information about coverage for maternity care under this plan.

Nutritional support

Description	In-network
Nutritional support	Covered based on type of service and where it is received

Obesity surgery

Description	In-network
Inpatient services – **room and board**	$300 per day then the plan pays 100% for first 3 days per admission then the plan pays 100%, no **deductible** applies
Other inpatient services and supplies	100% per admission, no **deductible** applies

Description	In-network
Outpatient services	100% per visit, no **deductible** applies

Limit per lifetime	$10,000

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	In-network
Treatment of mouth, jaws and teeth	Covered based on type of service and where it is received

Outpatient surgery

Description	In-network
At **hospital** outpatient department	100% per visit, no **deductible** applies
At facility that is not a **hospital**	100% per visit, no **deductible** applies
At the **physician** office	Covered based on type of service and where it is received

Physician and specialist services

Physician services-general or family practitioner

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

Description	In-network
Physician visit during inpatient **stay**	100% per visit, no **deductible** applies

Description	In-network
Physician telemedicine consultation	$20 then the plan pays 100% per visit, no **deductible** applies

Description	In-network
Telemedicine provider consultation Basic medical services	Covered based on type of service and **provider** from which it is received

Specialist

Description	In-network
Specialist office hours (not surgical, not preventive)	$40 then the plan pays 100% per visit, no **deductible** applies
Specialist surgical services	$40 then the plan pays 100% per visit, no **deductible** applies

Specialist

Description	In-network
Specialist telemedicine consultation	$40 then the plan pays 100% per visit, no **deductible** applies

Description	In-network
Telemedicine provider consultation **Specialist** services	Covered based on type of service and **provider** from which it is received

All other services not shown above

Description	In-network
All other services	100% per visit, no **deductible** applies

Preventive care

Description	In-network
Preventive care services	100% per visit, no **deductible** applies
Breast feeding counseling and support	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
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
Breast pump waiting period	Electric pump: 12 months to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies
Counseling for alcohol or drug misuse visit limit	5 visits/12 months
Counseling for obesity, healthy diet	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.
Counseling for sexually transmitted infection	100% per visit, no **deductible** applies
Counseling for sexually transmitted infection visit limit	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no **deductible** applies
Counseling for tobacco cessation visit limit	8 visits/12 months
Family planning services (female contraception counseling)	100% per visit, no **deductible** applies
Family planning services (female contraception counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting
Immunizations	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**
Generic preventive care female contraceptives (birth control)	100%

Preventive care drugs and supplements	100%
Preventive care drugs and supplements limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section
Preventive care risk reducing breast cancer **prescription** drugs	100%
Preventive care risk reducing breast cancer **prescription** drugs limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section
Preventive care tobacco cessation **prescription** and OTC drugs	100%
Limit	Two 90 day treatments only
Routine cancer screenings	100% per visit, no **deductible** applies
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
Routine lung cancer screening	100% per visit, no **deductible** applies
Routine lung cancer screening limit	1 screening every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	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
Well woman GYN exam	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

Prosthetic devices

Description	In-network
Prosthetic devices	Covered based on type of service and where it is received

Reconstructive surgery and supplies

Including breast **surgery**

Description	In-network
Surgery and supplies	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
Cardiac rehabilitation	Covered based on type of service and where it is received

Pulmonary Rehabilitation

Description	In-network
Pulmonary rehabilitation	Covered based on type of service and where it is received

Cognitive Rehabilitation

Description	In-network
Cognitive Rehabilitation	Covered based on type of service and where it is received

Physical, Occupational and Speech Therapies

Description	In-network
	$20 then the plan pays 100% per visit; no **deductible** applies

Physical, occupational and speech therapies

Description	In-network
Visit limit per year Physical, occupational and speech therapies combined	60

Spinal Manipulation

Description	In-network
	$50 then the plan pays 100% per visit, no **deductible** applies

Visit limit per year	20

Skilled nursing facility

Description	In-network
Inpatient services - **room and board**	$300 per day then the plan pays 100% for first 3 days per admission then the plan pays 100%, no **deductible** applies
Other inpatient services and supplies	100% per admission, no **deductible** applies

Day limit per year	60

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network
	$50 then the plan pays 100% per visit, no **deductible** applies

Diagnostic lab work

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

Diagnostic x-ray and other radiological services

Description	In-network
	$25 then the plan pays 100% per visit, no **deductible** applies

Therapies

Chemotherapy

Description	In-network
Chemotherapy services	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	$50 then the plan pays 100% per visit, no **deductible** applies	Not covered

Infusion therapy

Outpatient services

Description	In-network
In **physician** office	$40 then the plan pays 100% per visit, no **deductible** applies
At an infusion location	Covered based on type of service and where it is received
In the home	$40 then the plan pays 100% per visit, no **deductible** applies
At **hospital** outpatient department	100% per visit, no **deductible** applies
At facility that is not a **hospital**	100% per visit, no **deductible** applies

Radiation therapy

Description	In-network
Radiation therapy	Covered based on type of service and where it is received

Respiratory therapy

Description	In-network
Respiratory therapy	Covered based on type of service and where it is received

Transplant services

Description	In-network (IOE facility)
Inpatient services and supplies	$300 per day then the plan pays 100% for first 3 days per admission 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	In-network
Urgent care facility	$25 then the plan pays 100% per visit, no **deductible** applies

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

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

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

Visit limit	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
Non-**emergency services**	$20 then the plan pays 100% per visit, no **deductible** applies
Preventive care immunizations	100% per visit, no **deductible** applies
Preventive care immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Preventive screening and counseling services	100% per visit, no **deductible** applies
Preventive screening and counseling limits	See the *Preventive care services* section of the SOB