Schedule of benefits

Prepared for:
Contract holder: TERRAKOTTA, INC. DBA LAGUNA CLAY COMPANY
Contract holder number: 0269319
HMO group agreement effective date: June 01, 2026
Plan name: HMO
Plan effective date: June 01, 2026

Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles**, **copayments** or **coinsurance**, if any apply to the **covered benefits** 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**, **copayments** and **coinsurance**, if any, listed in the schedule below are the amounts that you pay for **covered benefits**.
- You are responsible to pay any **deductibles**, **copayments** and **coinsurance** if they apply and before the plan will pay for any **covered benefits**.
- 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 benefit**.
- This plan has limits for some **covered benefits**. For example, these could be visit, day or dollar limits.
  See the schedule of benefits for more information about limits.
- Your cost share may vary if the **covered benefit** 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 benefits are subject to the calendar year **deductible**, **maximum out-of-pocket**, limits, **copayment** or **coinsurance** unless otherwise noted in this schedule of benefits. The *Surprise bill* section in the certificate explains your protections from a surprise bill

How your PCP or physician office visit cost share works

You will pay the **PCP** cost share for **covered benefits** from your selected **PCP.** If you do not select a PCP, we will choose one for you.

How your maximum out-of-pocket works

This schedule of benefits 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 benefits** for the remainder of that year.

Contact us

We are here to answer questions. See the *Contact us* section in your evidence of coverage (EOC).

Aetna Health of California Inc.'s HMO group agreement provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your EOC.

Plan features

Maximum out-of-pocket limit

Maximum out-of-pocket type	In-network
Individual	$4,500 per calendar year
Family	$9,000 per calendar year

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 benefits**. 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.

Coinsurance

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.

Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **coinsurance** and **deductible**, if any, for **covered benefits**.

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 benefits** 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 benefits** 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 benefit**, 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 benefits** which are identified in the EOC and the SOB

Your financial responsibility and decisions regarding benefits

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

Covered benefits

Cost share based on type of service and where or **health care provider** from which it is received means your cost share is determined by the **health care provider** who provides your **covered benefit.**

Your **telemedicine** cost share will not be more than your in-person visit for the same **covered benefit**.

Abortion

Description	In-network
Abortion	$0 per visit no **deductible** applies

Acupuncture

Description	In-network
Acupuncture	$30 per visit
	no **deductible** applies
Visit limit per year	20

Ambulance services

Description	In-network
Emergency services and care	$150 per trip
	no **deductible** applies
Non-**emergency services and care**	Not covered

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**	30% per admission
	no **deductible** applies
Other inpatient services and supplies Other **residential treatment facility** services and supplies	No charge
Outpatient office visit to a **physician** or **behavioral health provider**	$60 per visit no **deductible** applies

Physician or **behavioral health provider telemedicine** consultation	$60 per visit no **deductible** applies

Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	$60 per visit no **deductible** applies

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	$0 per visit

	no **deductible** applies

Telemedicine health care provider mental health disorders consultation	Cost share based on type of service and **health care provider** from which it is received

*988 center or mobile crisis team services are covered with applicable cost share in-network and out of network. Evaluation and treatment provided by a CARE agreement or plan approved by a court are covered with no cost share regardless of whether the service is provided by an in-network or out-of-network provider.

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**	30% per admission
	no **deductible** applies
Other inpatient services and supplies during a **hospital stay**	No charge
Outpatient office visit to a **physician** or **behavioral health provider**	$60 per visit no **deductible** applies
Physician or **behavioral health provider telemedicine** consultation	$60 per visit no **deductible** applies
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	$60 per visit no **deductible** applies

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	$0 per visit

	no **deductible** applies

Telemedicine health care provider substance related disorders consultation	Cost share based on type of service and **health care provider** from which it is received

Clinical trials

Description	In-network
Experimental or investigational therapies	Cost share based on type of service and where it is received
Routine patient costs	Cost share based on type of service and where it is received

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

Description	In-network
Diabetic services	Cost share based on type of service and where it is received
Diabetic supplies	Cost share based on type of service and where it is received
Diabetic equipment	Cost share based on type of service and where it is received
Diabetic self-care programs	Cost share based on type of service and where it is received

Durable medical equipment (DME)

Description	In-network
DME	$30 per item

	no **deductible** applies

Emergency services and care

Description	In-network
Emergency room	$150 per visit

	no **deductible** applies

Emergency services and care important note:
Out-of-network health care providers do not have a contract with us. The **health care 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 **health care provider** and the amount paid by the plan. If the **health care 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 **health care provider**. Make sure the member ID is on the bill. If you are admitted to the **hospital** as 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
Orthotic devices	$0 per item

	no **deductible** applies

Gender affirming treatment

Description	In-network
Gender affirming treatment	Cost share based on type of service and where it is received

Habilitation therapy services

Outpatient physical (PT), occupational (OT) therapies

Description	In-network
PT, OT therapies	$0 per visit no **deductible** applies

Outpatient speech therapy (ST)

Description	In-network
ST therapy	$0 per visit no **deductible** applies

Home health care

A visit is a period of 4 hours or less

Description	In-network
Home health care	$60 per visit no **deductible** applies

Visit limit per day	3 intermittent visits
Limit per year	120

Home health care important note:
Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits.

Hospice care

Description	In-network
Inpatient services - **room and board**	30% per admission
	no **deductible** applies
Other inpatient services and supplies	No charge
Outpatient services	$60 per visit
	no **deductible** applies

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 24 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 24 hours a day.

Hospital care

Description	In-network
Inpatient services – **room and board**	30% per admission
	no **deductible** applies
Other inpatient services and supplies	No charge

Infertility services

Basic infertility

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

Advanced reproductive technology (ART) for fertility preservation

Description	In-network
In vitro fertilization (IVF) for fertility preservation	Cost share based on type of service and where it is received

Jaw joint disorder

Includes TMJ

Description	In-network
Jaw joint disorder treatment	$60 per visit
	no **deductible** applies

Maternity and related newborn care

Includes complications

Description	In-network
Inpatient services – **room and board**	30% per admission
	no **deductible** applies
Other inpatient services and supplies	No charge
Services performed in **physician** or **specialist** office or a facility	$30 per visit
	no **deductible** applies
Other services and supplies	Cost share based on type of service and where it is received

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 EOC. It will give you more information about coverage for maternity care under this plan.

Nutritional support

Description	In-network
Nutritional support	$30 per item
	no **deductible** applies

Obesity (bariatric) surgery

Description	In-network
Inpatient services – **room and board**	Cost share based on type of service and where it is received

Outpatient surgery

Description	In-network
At **hospital** outpatient department	30% per visit
	no **deductible** applies
At facility that is not a **hospital**	30% per visit
	no **deductible** applies
At the **physician** office	Cost share based on type of service and where it is received

Physician and specialist services

Including surgical services

Your PCP

Description	In-network
Physician office hours (not surgical, not preventive)	$30 per visit no **deductible** applies
Immunizations that are not considered preventive care	Cost share based on type of service and where it is received.
Physician visit during inpatient **stay**	$30 per visit no **deductible** applies
Physician home visit (not preventive)	$30 per visit no **deductible** applies
Physician surgical services	$30 per visit no **deductible** applies
Physician telemedicine consultation	$30 per visit no **deductible** applies

Telemedicine health care provider consultation Basic medical services	Cost share based on type of service and **health care provider** from which it is received

Specialist

Description	In-network
Specialist office hours (not surgical, not preventive)	$60 per visit no **deductible** applies

Specialist home visit (not preventive)	$60 per visit no **deductible** applies

Specialist surgical services	$60 per visit no **deductible** applies

Specialist telemedicine consultation	$60 per visit no **deductible** applies

Telemedicine health care provider consultation **Specialist** services	Cost share based on type of service and **health care provider** from which it is received

Preventive care

Description	In-network
Preventive care services	$0 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 1 year 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: 1 year to replace an existing electric pump
Counseling for obesity, healthy diet visit limit per day	1
Counseling for obesity, healthy diet visit limit	26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection visit limit	2 visits/12 months
Counseling for tobacco cessation visit limit per day	1
Counseling for tobacco cessation visit limit	8 visits/12 months

Description	In-network
Immunizations limit	Covered persons age 0-99 Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Routine 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 of your EOC
Routine lung cancer screening limit	1 screening every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing
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 routine 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

Includes medical wigs

Description	In-network
Prosthetic devices	$0 per item

	no **deductible** applies

Reconstructive surgery and supplies

Including breast **surgery**

Description	In-network
Surgery and supplies	Cost share 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	$60 per visit no **deductible** applies

Pulmonary rehabilitation

Description	In-network
Pulmonary rehabilitation	$60 per visit no **deductible** applies

Cognitive rehabilitation

Description	In-network
Cognitive rehabilitation	Cost share based on type of service and where it is received

Physical, occupational therapies

Description	In-network
At the **physician** office	$60 per visit no **deductible** applies
At facility that is not a **hospital**	$60 per visit no **deductible** applies
At **hospital** outpatient department	$60 per visit no **deductible** applies

Speech therapy (ST)

Description	In-network
At the **physician** office	$60 per visit no **deductible** applies
At facility that is not a **hospital**	$60 per visit no **deductible** applies
At **hospital** outpatient department	$60 per visit no **deductible** applies

Spinal manipulation

Description	In-network
At the **physician** office	$15 per visit no **deductible** applies
At facility that is not a **hospital**	$15 per visit no **deductible** applies

Description	In-network
At **hospital** outpatient department	$15 per visit no **deductible** applies

Visit limit per day	1
Visit limit per year	20

Skilled nursing facility

Description	In-network
Inpatient services – **room and board**	30% per admission

	no **deductible** applies

Day limit per year	100

Other inpatient services and supplies	No charge

Tests, images and labs - outpatient

Diagnostic complex imaging services

Description	In-network
At facility that is not a **hospital**	30% per visit no **deductible** applies
At **hospital** outpatient department	30% per visit no **deductible** applies

Diagnostic lab work

Description	In-network
At facility that is not a **hospital**	$40 per visit no **deductible** applies
At **hospital** outpatient department	$40 per visit no **deductible** applies

Diagnostic x-ray and other radiological services

Description	In-network
At facility that is not a **hospital**	$40 per visit no **deductible** applies
At **hospital** outpatient department	$40 per visit no **deductible** applies

Therapies

Chemotherapy

Description	In-network
Chemotherapy services	Cost share based on type of service and where it is received

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

Description	In-network (GCIT-designated facility/health care provider)	Non-designated network facility/health care provider (Including **health care providers** who are otherwise part of Aetna's network but are not GCIT-designated facilities/**health care providers**)
Services and supplies	Cost share based on type of service and where it is received	Not covered
Gene therapy products, **prescription drugs**	$60 per visit no **deductible** applies	Not covered

Infusion therapy

Outpatient services

Description	In-network
In **physician** office	$60 per visit
	no **deductible** applies
At an infusion location	30% per visit
	no **deductible** applies
In the home	$60 per visit
	no **deductible** applies
At **hospital** outpatient department	30% per visit
	no **deductible** applies
At facility that is not a **hospital**	30% per visit
	no **deductible** applies

Radiation therapy

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

Transplant services

Description	Network (IOE facility)	Network non-IOE facility (Including **health care providers** who are otherwise part of Aetna's network but are non-IOE **health care providers**)
Inpatient services and supplies	30% per admission	Not covered

	no **deductible** applies	

Urgent care services

At a freestanding facility or **health care provider** that is not a **hospital**
A separate urgent care cost share will apply for each visit to an urgent care facility or **health care provider**

Description	In-network
Urgent care facility	$50 per visit
	no **deductible** applies
Complex imaging, lab and radiology services	No charge
Non-urgent use of an urgent care facility or **health care provider**	Not covered

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Adult vision care

Description	In-network
Adult vision exam	$0 per visit
	no **deductible** applies
Limit	Limited to covered persons age 19 and older
Visit limit	1 every 24 months

Pediatric vision care

Description	In-network
Pediatric vision exam	$0 per visit
	no **deductible** applies
Limit	Limited to covered persons through the end of the month in which the person turns 19
Visit limit	1 every 24 months

Voluntary sterilization

Description	In-network
Tubal ligation and other similar sterilization procedures	$0 no **deductible** applies
Vasectomy	$0 no **deductible** applies

Walk-in clinic

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

Description	Designated network	Non-designated network
Non-**emergency services and care**	$0 per visit	$30 per visit
	no **deductible** applies	no **deductible** applies
Telemedicine consultation for non-**emergency services and care** through a **walk-in clinic**	$0 per visit no **deductible** applies	Not covered
Preventive care immunizations	$0 per visit no **deductible** applies	$0 per visit no **deductibl**e applies
Immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Preventive screening and counseling services	$0 per visit no **deductible** applies	$0 per visit no **deductible** applies
Telemedicine consultation for preventive screening and counseling services through a **walk-in clinic**	$0 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

Important note:
Key terms
Designated network health care provider
A **network health care provider** listed in the directory under *Maximum savings* as a **health care provider** for your plan.

Non-designated network health care provider
A **health care provider** listed in the directory under *Standard savings* as a **health care provider** for your plan.
See the *Contact us* section if you have questions.

You will pay less cost share when you use a designated network **walk-in clinic health care provider**. Non-designated network **walk-in clinic health care providers** are available to you, but the cost share will be at a higher level when these **health care providers** are used.