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:

Policyholder:	Windmill Health Products, LLC
Policyholder number:	GP-0251955-H
Plan name:	Open Access Managed Choice - High Deductible Health Plan
Schedule of Benefits:	1A
Group policy effective date:	January 1, 2025
Plan effective date:	January 1, 2025
Plan issue date:	March 7, 2025

Underwritten by Aetna Life Insurance Company in the state of New Jersey

Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles**, **copayments** or **coinsurance**, 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**.
  - You will be responsible for the dollar amount for **covered services** under your medical plan.
  - For pharmacy benefits where a percentage cost share acts like a **copayment**, you will be responsible for the percentage amount.
- **Coinsurance** amounts, if any, listed in the schedule below are what you will pay for **covered services**. Sometimes for out-of-network services, your cost share shows a combination of your dollar amount **copayment** that you will be responsible for and the **coinsurance** percentage that your plan will pay.
- You are responsible to pay any **deductibles**, **copayments** and remaining **coinsurance**, if they apply and before the plan will pay for any **covered services**.
- When a **covered service** shows "no charge", this means you have no responsibility for **deductibles, copayments** or **coinsurance**.
- 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 plan

  See the schedule of benefits 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.
- Sometimes we don't show a specific cost share for a benefit. Instead we say, "Covered based on type of service and where it is received." That means your cost share will depend on the exact care you get and who provides it. For example, if you receive services for diabetes from a specialist in their office, you will pay the cost share listed in Specialist office visits. If you receive services for diabetes during a hospital stay, you will pay the cost share listed in Hospital care.

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 Calendar Year **deductible**, **maximum out-of-pocket**, limits, **copayment** or **coinsurance** unless otherwise stated in this schedule of benefits. The *Surprise bill* section in the certificate explains your protections from a surprise bill.

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 **coinsurance** you pay when you get **covered services** from an in-network or **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 **coinsurance**, 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 certificate.

Aetna Life Insurance Company's group policy provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your certificate.

Plan features

Precertification covered services reduction

This only applies to **out-of-network covered services**:
Your certificate contains a complete description of the **precertification** process. You will find details in the *How your plan works - Medical necessity and precertification requirements* section.

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

- **Covered services** reduced by the lesser of 50% of the benefit that would have been payable and $200

You may have to pay an additional portion of the **allowable amount** 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	$2,500 per year	$5,000 per year
Family	$5,000 per year	$10,000 per year

Deductible waiver

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

- Preventive care
- Family planning services – contraceptives

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%.

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.

Deductible and cost share waiver for tobacco cessation prescription and OTC drugs

The **prescription** drug **deductible** and the per **prescription** cost share will not apply to the first two, 90 day treatment programs for tobacco cessation **prescription** and OTC drugs when obtained at a network **retail pharmacy**. This means they will be paid at 100%. Your per **prescription** cost share will apply after those two programs have been exhausted.

Maximum out-of-pocket limit

Maximum out-of-pocket type	In-network	Out-of-network
Individual	$5,000 per year	$10,000 per year
Family	$7,500 per year	$20,000 per year

General coverage provisions

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

Deductible provisions

Covered services that are subject to the **deductible** include those provided under the medical plan and the **prescription** drug plan.

In-network **covered services** will apply only to the in-network **deductible**. Out-of-network **covered services** will apply only to the out-of-network **deductible**.

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

Individual deductible

You pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this individual **deductible**, this plan starts to pay for **covered services** for the rest of the year. The individual **deductible** applies to a person who is enrolled for self-only coverage with no dependent coverage.

Family deductible

You and your covered dependents 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. The family **deductible** applies to a person enrolled with one or more dependents.

Deductible credit

If you paid part or all of your **deductible** under other coverage for the year that this plan went into effect, we will deduct the amount paid under the other coverage from the **deductible** on this plan for the same year. If we ask, you must submit a detailed explanation of benefits (EOB) showing the dates and amount of the **deductible** met from the other coverage in order to receive the credit.

Copayment

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

Coinsurance

This is the percentage of **covered services** you pay after your **deductible**.

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 services**. **Covered services** that are subject to the **maximum out-of-pocket limit** include those provided under the medical plan and the outpatient **prescription** drug plan.

In-network **covered services** will apply only to the in-network **maximum out-of-pocket limit**. Out-of-network **covered services** will apply only to the out-of-network **maximum out-of-pocket limit**.

Individual maximum out-of-pocket limit
After the amount of the cost share and **deductible** paid during the year for **covered services** meets 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 you for the remainder of the year.

Family maximum out-of-pocket limit
After the amount of the cost share and **deductible** paid during the year for **covered services** meets this 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 rest of the year.

For the purposes of the **maximum out-of-pocket limit** provision:

- The individual **maximum out-of-pocket limit** applies to a person enrolled for self-only coverage with no dependent coverage
- The family **maximum out-of-pocket limit** applies to a person enrolled with one or more dependents

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 certificate and the schedule
- Charges, expenses or costs in excess of the **allowable amount**
- Costs for non-emergency use of the emergency room

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 group policy.

Prescription drug - outpatient deductible provisions
Covered services that are subject to the **deductible** include **covered services** provided under the medical plan and the **prescription** drug plan.

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

Prescription drug - outpatient maximum out-of-pocket limit provisions
Covered services that are subject to the **maximum out-of-pocket limit** include **covered services** provided under the medical plan and the **prescription** drug plan.

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **coinsurance** and **deductible**, if any, for **covered services**. This plan may have an individual and family **maximum out-of-pocket limit**.

Covered services

Abortion

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

Description	In-network	Out-of-network
Acupuncture	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**
Visit limit per year	10	10

Ambulance services

Description	In-network	Out-of-network
Emergency services	20% of the **negotiated charge** per trip after **deductible**	Paid same as in-network
Non-**emergency services**	Not covered	Not covered

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

Clinical trials

Description	In-network	Out-of-network
Experimental and 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

Dental care anesthesia

Description	In-network	Out-of-network
Hospital charges	Covered based on type of service and where it is received	Covered based on type of service and where it is received

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

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

Durable medical equipment (DME)

Description	In-network	Out-of-network
DME	50% of the **negotiated charge** per item after **deductible**	50% of the **allowable amount** per item after **deductible**

Epinephrine autoinjector device

Description	In-network	Out-of-network
Epinephrine autoinjector device per 30 day supply	$25 per supply, no **deductible** applies	$25 per supply, no **deductible** applies

Emergency services

Description	In-network	Out-of-network
Emergency room	20% of the **negotiated charge** per visit after **deductible**	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. 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.

Foot orthotic devices

Description	In-network	Out-of-network
Orthotic devices	20% of the **negotiated charge** per item after **deductible**	40% of the **allowable amount** per item after **deductible**

Habilitation therapy services

Outpatient physical therapy (PT)

Description	In-network	Out-of-network

PT	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Outpatient occupational therapy (OT)

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

Outpatient speech therapy (ST)

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

Hearing aids and cochlear implants

Description	In-network	Out-of-network
Hearing aids and cochlear implant devices	20% of the **negotiated charge** per item after **deductible**	40% of the **allowable amount** per item after **deductible**
Frequency limit	One per ear every 24 consecutive months	One per ear every 24 consecutive months

Hearing exams

Hearing exams	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Home health care

Description	In-network	Out-of-network
Home health care	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**

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.

Home hemophilia treatment

Description	In-network	Out-of-network
Home treatments	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**

Hospice care

Description	In-network	Out-of-network
Inpatient services - **room and board**	20% of the **negotiated charge** per admission after **deductible**	40% of the **allowable amount** per admission after **deductible**

Other inpatient services and supplies	20% of the **negotiated charge** per admission after **deductible**	40% of the **allowable amount** per admission after **deductible**

Description	In-network	Out-of-network
Outpatient services	20% of the **negotiated charge** per visit, after **deductible**	40% of the **allowable amount** per visit, after **deductible**

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**	20% of the **negotiated charge** per admission after **deductible**	40% of the **allowable amount** per admission after **deductible**
Other inpatient services and supplies	20% of the **negotiated charge** after **deductible**	40% of the **allowable amount** after **deductible**

Infertility services

Description	In-network	Out-of-network
Treatment of **infertility**	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

Description	In-network	Out-of-network
Inpatient services – **room and board**	20% of the **negotiated charge** per admission after **deductible**	40% of the **allowable amount** per admission after **deductible**
Other inpatient services and supplies	20% of the **negotiated charge** per admission after **deductible**	40% of the **allowable amount** per admission after **deductible**
Services performed in **physician** office or a facility	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**
Services performed in **specialist** office or a facility	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**
Other services and supplies	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 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 certificate. It will give you more information about coverage for maternity care under this plan.

Mental health conditions

Mental health conditions treatment

Coverage provided is under the **same terms and conditions** as for any other illness

Description	In-network	Out-of-network
Inpatient services - **room and board** including **residential treatment facility**	20% of the **negotiated charge** per admission after **deductible**	40% of the **allowable amount** per admission after **deductible**
Other inpatient services and supplies Other **residential treatment facility** services and supplies	20% of the **negotiated charge** per admission after **deductible**	40% of the **allowable amount** after **deductible**

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**
Physician or **behavioral health provider telemedicine** and/or **telehealth** consultation	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**
Outpatient **mental health disorders telemedicine** and/or **telehealth** cognitive therapy consultations by a **physician** or **behavioral health provider**	0% per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**

Description	In-network	Out-of-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 after you meet your **deductible**	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**

Description	In-network	Out-of-network
Telemedicine and/or	Covered based on type of service and	Not covered

telehealth provider mental health disorders consultation	where it is received.	

Autism spectrum disorder or other developmental disabilities

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
Outpatient 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

Substance use disorders treatment

Includes **detoxification**, rehabilitation and **residential treatment facility**
Coverage provided under the **same terms and conditions** as for any other condition

Description	In-network	Out-of-network
Inpatient services-**room and board** during a **hospital stay**	20% of the **negotiated charge** per admission after **deductible**	40% of the **allowable amount** per admission after **deductible**

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**
Physician or **behavioral health provider telemedicine** and/or **telehealth** consultation	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**
Outpatient **telemedicine** and/or **telehealth** cognitive therapy consultations by a **physician** or **behavioral health provider**	0% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**

Description	In-network	Out-of-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**

outpatient program The cost share doesn't apply to in-network peer counseling support services after you meet your **deductible**		

Description	In-network	Out-of-network
Telemedicine and/or **telehealth provider substance related disorders** consultation	Covered based on type of service and where it is received.	Not covered

Nutritional support

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

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	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**
At facility that is not a **hospital**	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** 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 services

Physician services-general or family practitioner

Including surgical services

Description	In-network	Out-of-network
Physician office hours (not surgical, not preventive)	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**
Physician home visit (not preventive)	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**
Physician surgical services	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**

Description	In-network	Out-of-network
Physician visit during	20% of the **negotiated charge** per visit	40% of the **allowable amount** per visit

inpatient **stay**	after **deductible**	after **deductible**

Description	In-network	Out-of-network
Physician telemedicine and/or **telehealth** consultation	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**

Description	In-network	Out-of-network
Telemedicine and/or **telehealth provider** consultation Basic medical services	Covered based on type of service and **provider** from which it is received	Not covered

Physician Services-Specialist

Description	In-network	Out-of-network
Specialist office hours (not surgical, not preventive)	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**
Specialist home visit (not preventive)	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**
Specialist surgical services	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**

Description	In-network	Out-of-network
Specialist telemedicine and/or **telehealth** consultation	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**

Description	In-network	Out-of-network
Telemedicine and/or **telehealth 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	Covered based on type of service and where it is received.	Covered based on type of service and where it is received.

Prescription drugs – outpatient

Description	In-network	Out-of-network
90 day supply at a **retail pharmacy**	20% after **deductible**	$0 then the plan pays 50% after **deductible**
90 day supply at a **mail order pharmacy**	20% after **deductible**	Not covered

Description	In-network	Out-of-network
90 day supply at a **retail pharmacy**	20% after **deductible**	$0 then the plan pays 50% after **deductible**
90 day supply at a **mail order pharmacy**	20% after **deductible**	Not covered

Asthma inhaler important note:
Your cost share will not exceed $50 per 30 day supply of a covered **prescription** asthma inhalers filled at a network pharmacy. No **deductible** applies for asthma inhalers.

Epinephrine autoinjector device important note:
Your cost share will not exceed $25 per 30 day supply of a covered **prescription** epinephrine autoinjector device filled at a network pharmacy. No **deductible** applies for epinephrine autoinjector devices.

Anti-cancer drugs taken by mouth

Description	In-network	Out-of-network
30 day supply	Paid based on the tier of drug in the schedule, above	Paid based on the tier of drug in the schedule, above
90 day supply	Paid based on the tier of drug in the schedule, above	Paid based on the tier of drug in the schedule, above

Contraceptives (birth control)

Brand-name prescription drugs and devices are covered at 100% when a generic is not available

Description	In-network	Out-of-network
30 day or 12 month supply of generic and OTC drugs and devices	$0, no **deductible** applies	Paid based on the tier of drug in the schedule, above
30 day or 12 month supply of **brand-name prescription drugs** and devices	Paid based on the tier of drug in the schedule, above	Paid based on the tier of drug in the schedule, above

Infertility drugs

Description	In-network	Out-of-network
Infertility drugs	Paid based on the tier of drug in the schedule, above	Paid based on the tier of drug in the schedule, above

Diabetic supplies and insulin

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	Paid based on the tier of drug in the schedule, above	Paid based on the tier of drug in the schedule, above
90 day supply at a **retail pharmacy**	Paid based on the tier of drug in the schedule, above	Paid based on the tier of drug in the schedule, above
30 day supply at a **mail order pharmacy**	Paid based on the tier of drug in the schedule, above	Paid based on the tier of drug in the schedule, above
90 day supply at a **mail order pharmacy**	Paid based on the tier of drug in the schedule, above	Paid based on the tier of drug in the schedule, above

Diabetic supplies, drugs, and insulin important note:
Your cost share will not exceed $35 per 30 day supply of a covered **prescription** insulin drug. No deductible applies for diabetic supplies and insulin.

Prescription drug important note:
If a **provider** prescribes a covered **brand-name prescription drug** when a **generic prescription drug** equivalent is available and specifies "Dispense As Written" (DAW), you will pay the cost share for the brand-name drug. If a **provider** does not specify DAW and you request a covered **brand-name prescription drug**, you will be responsible for the cost share that applies to the brand-name drug, plus the cost difference between the generic drug and the brand-name drug.

Preventive care drugs and supplements

Description	In-network	Out-of-network
Preventive care drugs and supplements	$0, no **deductible** applies	Paid based on the tier of drug in the schedule, above
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF). For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section.	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF). For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section.

Risk reducing breast cancer prescription drugs

Description	In-network	Out-of-network
Risk reducing breast cancer **prescription** drugs	$0, no **deductible** applies	Paid based on the tier of drug in the schedule, above
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF. For a current list of risk reducing breast cancer drugs or more information, see the *Contact us* section.	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF. For a current list of risk reducing breast cancer drugs or more information, see the *Contact us* section.

Tobacco cessation prescription and OTC drugs

Description	In-network	Out-of-network
Tobacco cessation **prescription** and OTC drugs	$0, no **deductible** applies	Paid based on the tier of drug in the schedule, above
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF. For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section.	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF. For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section.

Preventive care

Description	In-network	Out-of-network
Preventive care services	0% of the **negotiated charge** per visit, no **deductible** applies	40% of the **allowable amount** per visit after **deductible**
Breast-feeding counseling and support	0% of the **negotiated charge** per visit, no **deductible** applies	0% of the **allowable amount** per visit, no **deductible** applies
Breast pump, accessories and supplies limit	**Important note:** You are limited to 2 breast pump kits per birth • The purchase of an electric or manual breast pump, including supplies and accessories • The purchase or rental of a multi-user breast pump, including supplies and accessories	
Breast pump waiting period	Electric pump: 1 year to replace an existing electric pump	Electric pump: 1 year to replace an existing electric pump
Counseling for substance use disorder	0% of the **negotiated charge** per visit, no **deductible** applies	40% of the **allowable amount** per visit after **deductible**
Counseling for substance use disorder visit limit	5 visits/12 months	5 visits/12 months
Counseling for obesity, healthy diet	0% of the **negotiated charge** per visit, no **deductible** applies	40% of the **allowable amount** per visit after **deductible**
Counseling for obesity, healthy diet- visit limit	Age 0-22: unlimited visits. Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	Age 0-22: unlimited visits. 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	0% of the **negotiated charge** per visit, no **deductible** applies	40% of the **allowable amount** per visit after **deductible**
Counseling for sexually transmitted infection visit limit	2 visits/12 months	2 visits/12 months
Family planning services (female contraception, counseling)	0% of the **negotiated charge** per visit	40% of the **allowable amount** per visit after **deductible**
Immunizations	0% of the **negotiated charge** per visit, no **deductible** applies	40% of the **allowable amount** per visit after **deductible**
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**	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 screenings	0% of the **negotiated charge** per visit, no **deductible** applies	40% of the **allowable amount** per visit after **deductible**
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the	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	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	0% of the **negotiated charge** per visit, no **deductible** applies	40% of the **allowable amount** per visit after **deductible**
Routine lung cancer screening limit	1 screening every 12 months Screening that exceeds this limit covered as outpatient diagnostic testing	1 screening every 12 months Screening that exceeds this limit covered as outpatient diagnostic testing
Routine physical exam	0% of the **negotiated charge** per visit, no **deductible** applies	40% of the **allowable amount** per visit after **deductible**
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	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	0% of the **negotiated charge** per visit, no **deductible** applies	40% of the **allowable amount** per visit after **deductible**
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	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
Limit	1 visit	1 visit

Prosthetic devices

Description	In-network	Out-of-network
Prosthetic devices	20% of the **negotiated charge** per item after **deductible**	40% of the **allowable amount** 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 cardiac and pulmonary rehabilitation services

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

Physical, occupational and speech therapies

Description	In-network	Out-of-network
	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**

Physical, occupational and speech therapies

Description	In-network	Out-of-network
Visit limit per year (Does not apply to **Mental health conditions**)	90	90

Short-term rehabilitation services

Spinal Manipulation

Description	In-network	Out-of-network
	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**
Visit limit per year	25	25

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.

Sickle cell anemia

Description	In-network	Out-of-network
Medical expenses and **prescription** drugs for treatment	Covered based on type of service and where it is received.	Covered based on type of service and where it is received.

Skilled nursing facility

Description	In-network	Out-of-network
Inpatient services - **room and board**	20%of the **negotiated charge** per admission after **deductible**	40% of the **allowable amount** per admission after **deductible**
Other inpatient services and supplies	20%of the **negotiated charge** per admission after **deductible**	40% of the **allowable amount** per admission after **deductible**

Day limit per year (Does not apply to **Mental health conditions)**	100	100

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network	Out-of-network
	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**

Diagnostic lab work

Description	In-network	Out-of-network
	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network
	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** 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	Covered based on type of service and where it is received

Infusion therapy

Outpatient services

Description	In-network	Out-of-network
In **physician** office	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**
At an infusion location	Covered based on type of service and where it is received	Covered based on type of service and where it is received
In the home	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**
At **hospital** outpatient department	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**
At facility that is not a **hospital**	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** 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	20% of the **negotiated charge** per transplant after **deductible**	40% of the **negotiated charge** 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	20% of the **negotiated charge** per visit after **deductible**	30% of the **allowable amount** per visit after **deductible**
Non-urgent use of an urgent care facility or **provider**	20% of the **negotiated charge** per visit after **deductible**	30% of the **allowable amount** per visit after **deductible**

Virtual primary care

Telemedicine and/or **telehealth** consultation

Description	In-network	Out-of-network
Preventive care consultations	0% of the **negotiated charge** no **deductible** applies	Not covered
All other basic medical services consultations	0% of the **negotiated charge** per visit after **deductible**	Not covered
Routine physical check-up limit	1 virtual visit per year	Not covered

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Description	In-network	Out-of-network
	0% of the **negotiated charge** per visit, no **deductible** applies	40% of the **allowable amount** per visit after **deductible**

Visit limit	1 visit every 24 months	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	Designated network	Non-designated network	Out-of-network
Non-**emergency services**	0% of the **negotiated charge** per visit after **deductible**	20% of the **negotiated charge** per visit after **deductible**	40% of the **allowable amount** per visit after **deductible**
Preventive care immunizations	0% of the **negotiated charge** per visit no **deductible** applies	0% of the **negotiated charge** per visit no **deductible** applies	40% of the **allowable amount** per visit after **deductible**
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**	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% of the **negotiated charge** per visit no **deductible** applies	0% of the **negotiated charge** per visit no **deductible** applies	40% of the **allowable amount** per visit after **deductible**
Preventive screening and counseling limits	See the *Preventive care services* section of the Schedule	See the *Preventive care services* section of the Schedule	See the *Preventive care services* section of the Schedule
Important note regarding Walk-in clinics: **Designated network provider**			

A **network provider** listed in the directory under *Best Results for your plan* as a **provider** for your plan.

Non-designated network provider
A **provider** listed in the directory under the *All other results* tab as a **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 provider**. Non-designated network **walk-in clinic providers** are available to you, but the cost share will be at a higher level when these **providers** are used.