

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 Elect Choice – High Option Plan
Schedule of Benefits:	2A
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**.
- 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:
 - Based on a rolling, 12 month period starting with the date of your most recent visit under this planSee 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 **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

Deductible

You have to meet your **deductible** before this plan pays for benefits.

Deductible type	Designated provider
Individual	\$750 per year
Family	\$1,500 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	Designated provider
Individual	\$3,000 per year
Family	\$6,000 per year

General coverage provisions

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

Deductible provisions

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

Family deductible

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

Deductible 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.

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 certificate and the schedule
- Costs for non-emergency use of the emergency room

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 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	Designated provider
Abortion	Covered based on type of service and where it is received

Description	Designated provider
Acupuncture	\$20 per visit, no deductible applies

Visit limit per year	10
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Ambulance services

Description	Designated provider	Out-of-network
Emergency services	0% of the negotiated charge per trip, no deductible applies	Paid same as in-network
Non-emergency services	Not covered	Not covered

Applied behavior analysis

Description	Designated provider
Applied behavior analysis	Covered based on type of service and where it is received

Clinical trials

Description	Designated provider
Experimental and 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

Dental care anesthesia

Description	Designated provider
Hospital charges	Covered based on type of service and where it is received

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

Description	Designated provider
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	Designated provider
DME	50% of the negotiated charge per item after deductible

Epinephrine autoinjector device

Description	Designated Provider
Epinephrine autoinjector device per 30 day supply	\$25 per supply, no deductible applies

Emergency services

Description	Designated provider	Out-of-network
Emergency room	\$100 per visit, no deductible applies	Paid same as designated provider

Non-emergency care in a hospital emergency room	Not covered	Not covered
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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.

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	Designated provider
Orthotic devices	\$20 per item, no deductible applies

Habilitation therapy services

Outpatient physical therapy (PT)

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

Outpatient occupational therapy (OT)

Description	Designated provider
OT	Covered based on type of service and where it is received

Outpatient speech therapy (ST)

Description	Designated provider
ST therapy	Covered based on type of service and where it is received

Hearing aids and cochlear implants

Description	Designated provider
Hearing aids and cochlear implant devices	\$20 per item, no deductible applies
Frequency limit	One per ear every 24 consecutive months

Hearing exams

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

Description	Designated provider
Home health care	\$40 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	Designated provider
Home treatments	20% of the negotiated amount per visit after deductible

Hospice care

Description	Designated provider
Inpatient services - room and board	20% of the negotiated charge per admission after deductible

Other inpatient services and supplies	20% of the negotiated charge per admission after deductible
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Description	Designated provider
Outpatient services	20% of the negotiated charge 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	Designated provider
Inpatient services – room and board	20% of the negotiated charge per admission after deductible

Other inpatient services and supplies	20% of the negotiated charge after deductible
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Infertility services

Description	Designated provider
Treatment of infertility	Covered based on type of service and where it is received

Advanced reproductive technology (ART)

Description	Designated provider
	20% of the negotiated charge per visit after deductible

Maternity and related newborn care

Includes complications

Description	Designated provider
Inpatient services – room and board	20% of the negotiated charge per admission after deductible
Other inpatient services and supplies	20% of the negotiated charge per admission after deductible
Services performed in physician office or a facility	20% of the negotiated charge per visit after deductible
Services performed in specialist office or a facility	0% of the negotiated charge per visit after deductible
Other services and supplies	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	Designated provider
Inpatient services - room and board including residential treatment facility	20% of the negotiated charge per admission after deductible
Other inpatient services and supplies Other residential treatment facility services and supplies	20% of the negotiated charge after deductible

Description	Designated provider
Outpatient office visit to a physician or behavioral health provider	\$40 per visit, no deductible applies
Physician or behavioral health provider telemedicine and/or telehealth consultation	\$40 per visit, no deductible applies
Outpatient mental health disorders telemedicine and/or telehealth cognitive therapy consultations by a physician or behavioral health provider	0% per visit, no deductible applies

Description	Designated provider
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program	0% of the negotiated charge per visit, no deductible applies

Description	Designated provider
Telemedicine and/or telehealth provider mental health disorders consultation	Covered based on type of service and where it is received.

Autism spectrum disorder or other developmental disabilities

Description	Designated provider
Diagnosis and testing	Covered based on type of service and where it is received
Treatment	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

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	Designated provider
Inpatient services-room and board during a hospital stay	20% of the negotiated charge per admission after deductible

Description	Designated provider
Outpatient office visit to a physician or behavioral health provider	\$40 per visit, no deductible applies
Physician or behavioral health provider telemedicine and/or telehealth consultation	\$40 per visit, no deductible applies
Outpatient telemedicine and/or telehealth cognitive therapy consultations by a physician or behavioral health provider	0% per visit, no deductible applies

Description	Designated provider
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 service	0% of the negotiated charge per visit, no deductible applies

Description	In-network
Telemedicine and/or telehealth provider substance related disorders consultation	Covered based on type of service and where it is received.

Nutritional support

Description	Designated provider
Nutritional support	Covered based on type of service and where it is received

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	Designated provider
Treatment of mouth, jaws and teeth	Covered based on type of service and where it is received

Outpatient surgery

Description	Designated provider
At hospital outpatient department	20% of the negotiated charge per visit after deductible
At facility that is not a hospital	20% of the negotiated charge per visit after deductible
At the physician office	Covered based on type of service and where it is received

Physician services**Physician services-general or family practitioner**

Including surgical services

Description	Designated provider
Physician office hours (not surgical, not preventive)	\$20 per visit, no deductible applies
Physician home visit (not preventive)	0% of the negotiated charge per visit, no deductible applies
Physician surgical services	\$20 per visit, no deductible applies

Description	Designated provider
Physician visit during inpatient stay	20% of the negotiated charge per visit after deductible

Description	Designated provider
Physician telemedicine and/or telehealth consultation	\$20 per visit, no deductible applies

Description	Designated Provider
Telemedicine and/or telehealth provider consultation	Covered based on type of service and provider from which it is received
Basic medical services	

Physician Services -Specialist

Description	Designated provider
Specialist office hours (not surgical, not preventive)	\$40 per visit, no deductible applies
Specialist home visit (not preventive)	20% of the negotiated charge per visit after deductible
Specialist surgical	\$40 per visit, no deductible applies

services	
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Description	Designated provider
Specialist telemedicine and/or telehealth consultation	\$40 per visit, no deductible applies

Description	Designated Provider
Telemedicine and/or telehealth provider consultation	Covered based on type of service and provider from which it is received
Specialist services	

All other services not shown above

Description	Designated provider
All other services	Covered based on type of service and where it is received.

Prescription drugs – outpatient

Generic prescription drugs

Description	In-network
Up to a 30 day supply filled at a retail pharmacy	\$10, no deductible applies
More than a 30 day supply but less than a 61 day supply filled at a retail pharmacy	\$20, no deductible applies
More than a 60 day supply but less than a 91 day supply filled at a retail pharmacy	\$20, no deductible applies
30 day supply at a mail order pharmacy	\$10, no deductible applies
90 day supply at a mail order pharmacy	\$20, no deductible applies

Preferred prescription drugs

Description	In-network
Up to a 30 day supply filled at a retail pharmacy	\$30, no deductible applies
More than 30 day supply but less than 61 day supply at a retail pharmacy	\$60, no deductible applies
More than 60 day supply but less than 91 day supply at a retail pharmacy	\$60, no deductible applies
30 day supply at a mail order pharmacy	\$30, no deductible applies
90 day supply at a mail order pharmacy	\$60, no deductible applies

Non-preferred prescription drugs

Description	In-network
Up to a 30 day supply filled at a retail pharmacy	\$50 no deductible applies
More than 30 day supply but less than 61 day supply at a retail pharmacy	\$100 no deductible applies
More than 60 day supply but less than 91 day supply at a retail pharmacy	\$100 no deductible applies
30 day supply at a mail order pharmacy	\$50 no deductible applies
90 day supply at a mail order pharmacy	\$100 no deductible applies

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
30 day or 12 month supply of generic and OTC drugs and devices	\$0, no deductible applies
30 day or 12 month supply of brand-name prescription drugs and devices	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, 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
Preventive care drugs and supplements	\$0, no deductible applies
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 <i>Contact us</i> section.

Risk reducing breast cancer prescription drugs

Description	In-network
Risk reducing breast cancer prescription drugs	\$0, no deductible applies
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 <i>Contact us</i> section.

Tobacco cessation prescription and OTC drugs

Description	In-network
Tobacco cessation	\$0, no deductible applies

prescription and OTC drugs	
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 <i>Contact us</i> section.

Preventive care

Description	Designated provider
Preventive care services	0% of the negotiated charge per visit, no deductible applies
Breast feeding counseling and support	0% of the negotiated charge per visit, no deductible applies
Breast feeding counseling and support limit	6 visits in a group or individual setting Telemedicine and/or telehealth visits do not apply toward your visit limit. All other visits that exceed the limit are covered under the physician services office visit
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
Counseling for substance use disorder	0% of the negotiated charge per visit, no deductible applies
Counseling for substance use disorder visit limit	5 visits/12 months
Counseling for obesity, healthy diet	0% of the negotiated charge per visit, no deductible applies
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.
Counseling for sexually transmitted infection	0% of the negotiated charge per visit, no deductible applies
Counseling for sexually transmitted infection visit limit	2 visits/12 months
Family planning services (female contraception, counseling)	0% of the negotiated charge per visit
Immunizations	0% of the negotiated charge , 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
Routine cancer screenings	0% of the negotiated charge 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 <i>Contact us</i> section
Limit per screening	1 visit
Routine lung cancer screening	0% of the negotiated charge per visit, no deductible applies
Routine lung cancer screening limit	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
Routine physical exams 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	0% of the negotiated charge 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
Limit	1 visit

Prosthetic devices

Description	Designated provider
Prosthetic devices	\$20 per item, no deductible applies

Reconstructive surgery and supplies

Including breast **surgery**

Description	Designated provider
Surgery and supplies	Covered based on type of service and where it is received

Short-term cardiac and pulmonary rehabilitation services

Cardiac Rehabilitation

Description	Designated provider
Cardiac rehabilitation	Covered based on type of service and where it is received

Pulmonary Rehabilitation

Description	Designated provider
Pulmonary rehabilitation	Covered based on type of service and where it is received

Physical, Occupational and Speech Therapies

Description	Designated provider
	\$40 per visit, no deductible applies

Physical, occupational and speech therapies

Description	Designated provider
Visit limit per year (Does not apply to Mental health conditions)	90

Short-term rehabilitation services

Spinal Manipulation

Description	Designated provider
	\$40 per visit, no deductible applies
Visit limit per year	25

Cognitive rehabilitation

Description	Designated provider
Cognitive rehabilitation	Covered based on type of service and where it is received.

Sickle cell anemia

Description	Designated provider
Medical expenses and prescription drugs for treatment	Covered based on type of service and where it is received.

Skilled nursing facility

Description	Designated provider
Inpatient services - room and board	20% of the negotiated charge per admission after deductible
Other inpatient services and supplies	20% of the negotiated charge per admission after deductible

Day limit per year (Does not apply to Mental health conditions)	100
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Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	Designated provider
	20% of the negotiated charge per visit after deductible

Diagnostic lab work

Description	Designated provider
	20% of the negotiated charge per visit, no deductible applies

Diagnostic x-ray and other radiological services

Description	Designated provider
	20% of the negotiated charge per visit, no deductible applies

Therapies**Chemotherapy**

Description	Designated provider
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	Covered based on type of service and where it is received

Infusion therapy

Outpatient services

Description	Designated provider
In physician office	\$40 per visit, no deductible applies
At an infusion location	Covered based on type of service and where it is received
In the home	\$40 per visit, no deductible applies
At hospital outpatient department	20% of the negotiated charge per visit after deductible
At facility that is not a hospital	20% of the negotiated charge per visit after deductible

Radiation therapy

Description	Designated provider
Radiation therapy	Covered based on type of service and where it is received

Transplant services

Description	Designated provider (IOE facility)
Inpatient services and supplies	20% of the negotiated charge per transplant after deductible
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	Designated provider	Non-designated provider
Urgent care facility	\$50 per visit, no deductible applies	Paid same as designated provider

Non-urgent use of an urgent care facility or provider	\$50 per visit, no deductible applies	\$50 per visit, no deductible applies
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Virtual primary care

Telemedicine and/or telehealth consultation

Description	In-network
Preventive care consultations	0% of the negotiated charge no deductible applies
All other basic medical services consultations	0% of the negotiated charge per visit no deductible applies
Routine physical check-up limit	1 virtual visit per year

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Description	Designated provider
	\$30 per visit, no deductible applies

Visit limit	1 visit every 24 months
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Walk-in clinic

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

Description	Designated network	Non-designated network
Non-emergency services	0% of the negotiated charge per visit, no deductible applies	\$20 per visit, no deductible applies
Preventive care immunizations	0% of the negotiated charge per visit, no deductible applies	0% of the negotiated charge 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	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
Preventive screening and counseling limits	See the <i>Preventive care services</i> section of the Schedule	See the <i>Preventive care services</i> 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.