

PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit limitations - For any service o	or supply that is subject to a maximum vi	sit, day, or dollar limitation on a per
year basis, the benefit year begins on .	January 1st unless otherwise mandated.	Refer to your plan documents for more
information.		
Deductible (per calendar year)	\$3,500 Individual	\$5,500 Individual
,	\$7,000 Family	\$11,000 Family
All covered expenses accumulate simu	Iltaneously toward both the preferred and	
	ible must be met prior to benefits being	
	es, as indicated in the plan, are excluded	
Pharmacy expenses do not apply towa		
	Deductible for all family members. The fa	amily Deductible can be met by a
	ver, no single individual within the family	
individual Deductible amount.		
Member Coinsurance	30%	50%
Applies to all expenses unless otherwis		3070
Payment Limit (per calendar year)	\$6,000 Individual	\$10,000 Individual
dyniene Emile (per calendar year)	\$12,000 Family	\$20,000 Family
All covered expenses accumulate simu	iltaneously toward both the preferred an	
	may not apply toward the Payment Lim	
Pharmacy expenses apply towards the		it.
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Routine Mammograms	Covered 100%; deductible waived	50%; after deductible				
Women's Health	Covered 100%; deductible waived 50%; after deductible					
cludes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually						
transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for						
interpersonal and domestic violence, breastfeeding support, supplies and counseling.						
Contraceptive methods, sterilization pro	Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.					
Routine Digital Rectal Exam	Covered 100%; deductible waived	50%; after deductible				
Recommended: For covered males age	e 40 and over.					
Prostate-specific Antigen Test	Covered 100%; deductible waived 50%; after deductible					
Recommended: For covered males age	e 40 and over.					
Colorectal Cancer Screening	Covered 100%; deductible waived	Your cost sharing is based on the type of service and where it is performed				
Recommended: For all members age 4						
Routine Eye Exams	Covered 100%; deductible waived	50%; after deductible				
1 routine exam per 24 months.						
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible				
1 routine exam every 12 months						
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK				
Office Visits to non-Specialist	30%; after deductible	50%; after deductible				
	al physician, family practitioner or pediat					
Specialist Office Visits	30%; after deductible	50%; after deductible				
Walk-in Clinics	30%; after deductible	50%; after deductible				
		ternative to a physician's office visit for istration of certain immunizations. It is				
treatment of unscheduled, non-emerger not an alternative for emergency room s room, nor the outpatient department of	ncy illnesses and injuries and the admin services or the ongoing care provided by a hospital, shall be considered a Walk-ii	istration of certain immunizations. It is a physician. Neither an emergency Clinic.				
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PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
npatient Coverage	30%; after deductible	50%; after deductible
our cost sharing applies to all covered	0, 1	
npatient Maternity Coverage	30%; after deductible	50%; after deductible
includes delivery and postpartum		
care)		
Your cost sharing applies to all covered	d benefits incurred during your inpa	atient stay.
Outpatient Hospital Expenses	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered	d benefits incurred during your out	patient visit.
Outpatient Surgery - Hospital	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered	d benefits incurred during your out	
Outpatient Surgery - Freestanding	30%; after deductible	50%; after deductible
Facility		
Your cost sharing applies to all covered	d benefits incurred during your out	patient visit.
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Mental Health Inpatient	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered	d benefits incurred during your inpa	
Mental Health Office Visits	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered	d benefits incurred during your out	patient visit.
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Substance Abuse Inpatient	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered	d benefits incurred during your inpa	atient stay.
Residential Treatment Facility	30%; after deductible	50%; after deductible
Substance Abuse Rehabilitation	30%; after deductible	50%; after deductible
Visits	•	•
Your cost sharing applies to all covered	d benefits incurred during your out	patient visit.
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility	30%; after deductible	50%; after deductible
imited to 100 days per calendar year.		
Your cost sharing applies to all covered		
	d benefits incurred during your inpage 30%; after deductible	atient stay. 50%; after deductible
Your cost sharing applies to all covered Home Health Care Limited to 120 visits per calendar year.	30%; after deductible	
Home Health Care Limited to 120 visits per calendar year.	30%; after deductible	
Home Health Care Limited to 120 visits per calendar year.	30%; after deductible	50%; after deductible
Home Health Care Limited to 120 visits per calendar year. Limited to 3 intermittent visits per day b	30%; after deductible	50%; after deductible
Home Health Care Limited to 120 visits per calendar year. Limited to 3 intermittent visits per day bess.	30%; after deductible by a participating home health care 30%; after deductible	50%; after deductible agency; 1 visit equals a period of 4 hrs or 50%; after deductible
Home Health Care Limited to 120 visits per calendar year. Limited to 3 intermittent visits per day bess. Hospice Care - Inpatient	30%; after deductible by a participating home health care 30%; after deductible	50%; after deductible agency; 1 visit equals a period of 4 hrs or 50%; after deductible
Home Health Care Limited to 120 visits per calendar year. Limited to 3 intermittent visits per day bess. Hospice Care - Inpatient Your cost sharing applies to all covered	30%; after deductible by a participating home health care 30%; after deductible d benefits incurred during your input 30%; after deductible	50%; after deductible e agency; 1 visit equals a period of 4 hrs or 50%; after deductible atient stay. 50%; after deductible
Home Health Care Limited to 120 visits per calendar year. Limited to 3 intermittent visits per day bess. Hospice Care - Inpatient Your cost sharing applies to all covered Hospice Care - Outpatient	30%; after deductible by a participating home health care 30%; after deductible d benefits incurred during your input 30%; after deductible	50%; after deductible e agency; 1 visit equals a period of 4 hrs or 50%; after deductible atient stay. 50%; after deductible
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Home Health Care Limited to 120 visits per calendar year. Limited to 3 intermittent visits per day bess. Hospice Care - Inpatient Your cost sharing applies to all covered Hospice Care - Outpatient Your cost sharing applies to all covered Private Duty Nursing Outpatient Speech Therapy Outpatient Physical and	30%; after deductible by a participating home health care 30%; after deductible d benefits incurred during your input 30%; after deductible d benefits incurred during your out Not Covered 30%; after deductible	50%; after deductible e agency; 1 visit equals a period of 4 hrs or 50%; after deductible atient stay. 50%; after deductible patient visit. Not Covered 50%; after deductible
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Home Health Care Limited to 120 visits per calendar year. Limited to 3 intermittent visits per day bess. Hospice Care - Inpatient Your cost sharing applies to all covered Hospice Care - Outpatient Your cost sharing applies to all covered Private Duty Nursing Outpatient Speech Therapy Outpatient Physical and Occupational Therapy	30%; after deductible by a participating home health care 30%; after deductible d benefits incurred during your input 30%; after deductible d benefits incurred during your out Not Covered 30%; after deductible 30%; after deductible	50%; after deductible e agency; 1 visit equals a period of 4 hrs or 50%; after deductible atient stay. 50%; after deductible patient visit. Not Covered 50%; after deductible 50%; after deductible



PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Covered same as any other Outpatient Mental Health Other Services benefit Autism Physical Therapy 30%; after deductible 50%; after deductible Autism Occupational Therapy 30%; after deductible 50%; after deductible Durable Medical Equipment 30%; after deductible 50%; after deductible Orthotics 30%; after deductible 50%; after deductible Orthotics and special footwear covered for persons with foot disfigurement. Diabetic Supplies (if not covered overed for persons with foot disfigurement. Covered same as any other medical expense. Affordable Care Act mandated Women's Contraceptive drugs and devices not obtainable at a pharmacy Vision Eyewear Not Covered Transplants Augure Not Covered Not Covered Bariatric Surgery Not Covered Not Covered Not Covered Not Covered Acupuncture Limit of 20 visits per year FAMILY PLANNING Infertility Treatment Diagnosis and treatment of the underlying medical condition only. Not Covered Diagnosis and treatment of the underlying medical condition only. Comprehensive Infertility Services Artificial insemination and ovulation induction Advanced Reproductive Not Covered Advanced Reproductive Not Covered Not Covered Not Covered Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery Vasectomy 30%; after deductible 50%; after d							
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Infertility Treatment Your cost sharing is based on the type of service and where it is performed Diagnosis and treatment of the underlying medical condition only. Comprehensive Infertility Services Artificial insemination and ovulation induction Advanced Reproductive Not Covered Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery Vasectomy 30%; after deductible Tubal Ligation 100% No Deductible/No Copay applied including associated ancillary							
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PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

PHARMACY	IN-NE	ETWORK	OUT-OF-NETWORK	
Pharmacy Plan Type:	Advanced Control Pharmacy - Aetna			
Preferred Generic Drugs:				
Retail	\$10 c	copay	\$10 copay	
Mail Order	\$10 c	copay	Not Covered	
Preferred Brand Name Drugs:				
Retail	\$75 co	pay	\$75 copay	
Mail Order	\$75 co	pay	Not Covered	
Non-Preferred Generic and Brand Drugs:				
Retail	50% up	to a max of \$250	50% up to a max of \$250	
Mail Order	50% up	to a max of \$500	Not Covered	
0 1 1 1 0				
Specialty Drugs:				
Preferred Specialty	50% up	to a max of \$250	Not Covered	
Non-Preferred Specialty	50% up	to a max of \$250	Not Covered	
		Up to a 30-day supply from Aeto Percentage copays will not be compared to the		
Mail Order		A 31-90-day supply from CVS Caremark® Mail Service Pharmacy		
Specialty		Up to a 30-day supply First prescription fill at any retail	l or specialty pharmacy. Subsequent	

Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.

fills must be through our preferred specialty pharmacy network.

Advanced Control Formulary Aetna Insured List

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.

Precert for growth hormones included



PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

GENERAL PROVISIONS

Dependents Eligibility

Spouse, children from birth to age 26 regardless of student status.

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.

- For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.
- For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Navigator member site.

This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.



PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at 1-888-982-3862.

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862**.

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to www.aetna.com.

Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.
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