

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

DI AN EFATUREO	IN NETWORK	OUT OF NETWORK	
PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK	
		There might be a maximum number of	
		s on January 1 (unless otherwise noted).	
Refer to your plan documents to learn		<b>040.000</b>	
Deductible (per calendar year)	\$7,700 per Individual	\$10,000 per Individual	
	\$15,400 per Family	\$20,000 per Family	
	th your in-network and out-of-network of		
	fore the plan begins paying benefits, ur		
The amount you pay (cost sharing) for some medical services does not count toward your deductible. Prescription			
	le. Refer to your plan documents for de		
	You will meet it when the expenses of		
	have to pay more than the individual de		
Member coinsurance	Covered 100%	You pay 50%	
Applies to all expenses except as not	ed.		
Out-of-pocket limit (per calendar	\$8,150 per Individual	\$12,000 per Individual	
year)	•	•	
	\$16,300 per Family	\$24,000 per Family	
Covered expenses add up toward bo	th your in-network and out-of-network o	out-of-pocket limit at the same time.	
Some of your cost sharing may not co	ount toward the out-of-pocket limit.	·	
Your pharmacy expenses count towa			
In-network expenses include coinsura			
	nsurance and deductibles. Penalty amo	ounts do not apply.	
Your family will have one out-of-pocket limit. You will meet it when the expenses of several family members add up to			
the family out-of-pocket limit. No one person will have to pay more than the individual out-of-pocket limit amount.			
Lifetime maximum	porcorr min mare to pay more man me		
Unlimited except where otherwise ind	licated.		
Payment for out-of-network care**	Does not apply	Professional: 105% of Medicare	
- Lyman or our or norman and	- 100o. o.b.)	Facility: 140% of Medicare	
Primary care physician selection	Encouraged	Does not apply	
Precertification requirements -	Encodiagod	Dood flot apply	
	approval by us in advance (precertificati	ion) Without this approval, we reduce	
Some out-of-network services need approval by us in advance (precertification). Without this approval, we reduce benefits by \$400. Refer to your plan documents for a full list of services that need this approval.			
Referral requirement	Not required	None	
	<b>.</b>		
<b>Telehealth consultations</b> - You can access covered services for telehealth visits from different kinds of providers in your plan. Log on to <b>Aetna.com</b> to see a list of telehealth providers. You'll also find more about your options, including			
cost share amounts.	o a not of tolerically providers. Touli a	iso into more about your options, including	
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK	
	Covered 100%; no deductible		
Routine adult physical exams/	Covered 100%, no deductible	50%; after deductible	

1 exam every 12 months until age 65, then 1 exam every 12 months age 65 and older

immunizations

Routine well child Covered 100%; no deductible 50%; after deductible

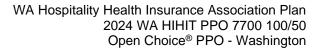
exams/immunizations

- 7 exams in the first 12 months
- 3 exams from age 13 through 24 months
- 3 exams from age 25 through 36 months
- 1 exam every 12 months from age 3 until age 22 years

Routine gynecological care exams Covered 100%; no deductible

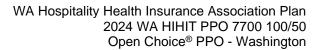
1 exam and pap smear per year, including related fees

50%; after deductible





/irtual primary care (VPC)	Covered 100%; no deductible	Not Covered
preventive care consultations	on itsee for members are 10 and older	
Routine mammogram	ervices for members age 18 and older Covered 100%; no deductible	50%; after deductible
Recommended: One per year for me		50%, after deductible
Nomen's health	Covered 100%; no deductible	50%; after deductible
	iabetes, HPV (Human- Papillomavirus) DN	
	d screening for human immunodeficiency	
	breastfeeding support, supplies and coun	
	s (ACA mandated contraceptives, including	
	edures (including tubal ligation), patient ed	
apply.	· 5 5 7/1	ů ,
Pre-natal maternity	Covered 100%; no deductible	50%; after deductible
Routine digital rectal exam	Covered 100%; no deductible	50%; after deductible
Recommended: For members age 4		
Prostate-specific antigen test	Covered 100%; no deductible	50%; after deductible
Recommended: For members age 4		,
Colorectal cancer screening	Covered 100%; no deductible	50%; after deductible
Recommended: For members age 4		
Routine eye exams	Not Covered	Not Covered
Routine hearing screening	Covered 100%; no deductible	50%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office visits to non-specialist	\$30 office visit copay; no deductible	50%; after deductible
	eral physician, family practitioner or pediat	
/irtual primary care (VPC)	Covered 100%; no deductible	Not Covered
consultations		
	ultations for members age 18 and older	
Telehealth consultation with non-	\$30 office visit copay; no deductible	50%; after deductible
specialist	<b>A.S.</b> <i>W</i>	
Specialist office visits	\$60 office visit copay; no deductible	50%; after deductible
ncludes visits to a naturopath	000 (1)	<b>-00</b> / 6/ 1 1 1 1 1 1 1
Telehealth consultation with	\$60 office visit copay; no deductible	50%; after deductible
specialist	0 14000/ 1 1 1/1	
Hearing exams	Covered 100%; no deductible	Not Covered
routine exam per 24 months.	<b>000</b>	500/ -f( l- l- //l-l-
Walk-in clinics	\$30 copay; no deductible	50%; after deductible
	Ith care facilities. Sometimes they may be	
•	ey offer some limited medical care and sel	
surgical centers, and physician office	ers, emergency rooms, the outpatient depa	irineni oi a nospilai, ambulatory
Allergy testing		Vour cost sharing amount depends
Allergy testing	Your cost sharing amount depends on the type of service and where you	Your cost sharing amount depends on the type of service and where you
	receive it.	receive it.
Allergy injections	Your cost sharing amount depends	Your cost sharing amount depends
anorgy injections	on the type of service and where you	on the type of service and where you
	receive it. Covered 100% when an	receive it.
	office visit charge is not applicable.	1000IVO IL.
	IN-NETWORK	OUT-OF-NETWORK
DIAGNOSTIC PROCEDURES		
DIAGNOSTIC PROCEDURES Diagnostic X-ray (Other than	Covered 100%; after deductible	50%; after deductible





Diagnostic laboratory	Covered 100%; after deductible	50%; after deductible		
When your physician performs and bill	s for this service at their office, you pay	y your office visit cost share amount.		
Diagnostic complex imaging	Covered 100%; after deductible	50%; after deductible		
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.				

EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent care provider	\$60 office visit copay; no deductible	50%; after deductible
Non-urgent use of urgent care provider	Not Covered	Not Covered
Emergency room	\$100 copay; after deductible	Same as in-network care
Copay waived if admitted		
Non-emergency care in an	Not Covered	Not Covered
emergency room		
Emergency use of ambulance	Covered 100%; after deductible	Same as in-network care
Non-emergency use of ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient coverage	Covered 100%; after deductible	50%; after deductible
When you're admitted into a hospital fo	or the care you need, your cost sharing a	mount counts toward all covered
benefits you receive.		
Inpatient maternity coverage	Covered 100%; after deductible	50%; after deductible
(includes delivery and postpartum		
care) When you're admitted into a hospital for	or the care you need, your cost sharing a	mount counts toward all covered
benefits you receive.	,, ,	
Outpatient hospital	Covered 100%; after deductible	50%; after deductible
•	hospital but don't stay overnight, your co	
covered benefits during your visit.	, , , , , , , , , , , , , , , , , , , ,	g and the state of
Outpatient surgery - hospital	Covered 100%; after deductible	50%; after deductible
	hospital but don't stay overnight, your co	ost sharing amount counts toward all
covered benefits during your visit.		3
Outpatient surgery - freestanding	Covered 100%; after deductible	50%; after deductible
facility		

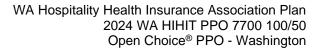
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.

MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%; after deductible	50%; after deductible
When you're admitted into a hospital	for the care you need, your cost sharing	amount counts toward all covered
benefits you receive.		
Mental health office visits	\$30 copay; no deductible	50%; after deductible
Mental health telehealth	\$30 office visit copay; no deductible	50%; after deductible
consultations		
Other mental health services	Covered 100%; after deductible	50%; after deductible
When you receive outpatient care at covered benefits during your visit.	a facility but don't stay overnight, your co	st sharing amount counts toward all
CUDETANCE ADUSE	IN NETWORK	OUT OF NETWORK

SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK	
Inpatient	Covered 100%; after deductible	50%; after deductible	
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered			
benefits you receive.			

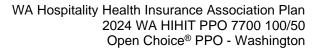
**Residential treatment facility** Covered 100%; after deductible 50%; after deductible

When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.



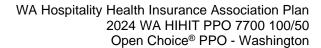


Substance abuse office visits	\$30 copay; no deductible	50%; after deductible
Substance abuse telehealth	\$30 office visit copay; no deductible	50%; after deductible
consultations	too omee their copaly, no academic	0070, 0.10. 0000010.0
Other substance abuse services	Covered 100%; after deductible	50%; after deductible
	facility but don't stay overnight, your cos	
covered benefits during your visit.	, , , , , , , , , , , , , , , , , , , ,	3
THERAPY SERVICES	IN-NETWORK	OUT-OF-NETWORK
Spinal manipulation therapy	\$60 copay; no deductible	50%; after deductible
Limited to 20 visits per year		
Outpatient short-term	\$60 copay; no deductible	50%; after deductible
rehabilitation		
Limited to 25 visits per year		
Includes speech, physical, occupational		
Habilitative physical therapy	Covered 100%; after deductible	50%; after deductible
Habilitative occupational therapy	Covered 100%; after deductible	50%; after deductible
Habilitative speech therapy	Covered 100%; after deductible	50%; after deductible
Autism related physical therapy	Covered 100%; after deductible	50%; after deductible
Autism related occupational	Covered 100%; after deductible	50%; after deductible
therapy		
Autism related speech therapy	Covered 100%; after deductible	50%; after deductible
Autism related behavioral therapy	\$30 copay; no deductible	50%; after deductible
These benefits are combined with outp		
Autism related applied behavior	Covered 100%; after deductible	50%; after deductible
analysis		
Maria Lange Conference and Conference Conference (L.		a although a sure and a sure fit
Your benefits for these services are the		
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
OTHER SERVICES Skilled nursing facility		
OTHER SERVICES Skilled nursing facility Limited to 120 days per year	IN-NETWORK Covered 100%; after deductible	OUT-OF-NETWORK 50%; after deductible
OTHER SERVICES Skilled nursing facility Limited to 120 days per year When you're admitted into a facility for	IN-NETWORK Covered 100%; after deductible	OUT-OF-NETWORK
OTHER SERVICES Skilled nursing facility Limited to 120 days per year When you're admitted into a facility for you receive.	IN-NETWORK  Covered 100%; after deductible  the care you need, your cost sharing an	OUT-OF-NETWORK 50%; after deductible nount counts toward all covered benefits
OTHER SERVICES Skilled nursing facility Limited to 120 days per year When you're admitted into a facility for you receive. Home health care	IN-NETWORK  Covered 100%; after deductible  the care you need, your cost sharing an  Covered 100%; after deductible	OUT-OF-NETWORK 50%; after deductible
OTHER SERVICES Skilled nursing facility Limited to 120 days per year When you're admitted into a facility for you receive. Home health care Home health care services include priv	IN-NETWORK  Covered 100%; after deductible  the care you need, your cost sharing an  Covered 100%; after deductible vate duty nursing	OUT-OF-NETWORK 50%; after deductible nount counts toward all covered benefits 50%; after deductible
OTHER SERVICES Skilled nursing facility Limited to 120 days per year When you're admitted into a facility for you receive. Home health care Home health care services include privalimited to three visits per day by staff for the skilled in the services include privalimited to three visits per day by staff for the skilled in the skilled	IN-NETWORK  Covered 100%; after deductible  the care you need, your cost sharing an  Covered 100%; after deductible vate duty nursing from a home health care agency. One vis	OUT-OF-NETWORK 50%; after deductible nount counts toward all covered benefits 50%; after deductible sit equals a period of four hours or less.
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Infusion therapy - outpatient	Covered 100%; after deductible	50%; after deductible
hospital/freestanding facility Transplants	Covered 100%; after deductible	50%; after deductible
Transplants	In-network coverage is only available	Out-of-network coverage applies
	at Institutes of Excellence (IOE)	when you use a non-IOE facility. You
	contracted facility.	will pay more out of pocket when
Davidata accessor	Not Occurred.	using a non-IOE facility.
Bariatric surgery	Not Covered	Not Covered
Acupuncture	\$30 copay; no deductible	50%; after deductible
Limited to 20 visits per year		
Temporomandibular joint disorder	Covered 100%; after deductible	50%; after deductible
(TMJ)		
Includes coverage for surgical and		
non-surgical TMJ treatment		
Other licensed providers (including	Your cost sharing depends on the	Your cost sharing depends on the
alternative care)	type of service and where you	type of service and where you
	receive it.	receive it.
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility treatment	Your cost sharing amount depends	Your cost sharing amount depends
	on the type of service and where you	on the type of service and where you
	receive it.	receive it.
	nd treatment of the underlying cause of i	
Comprehensive infertility services	Not Covered	Not Covered
Artificial insemination and ovulation inc		
Advanced Reproductive	Not Covered	Not Covered
Technology (ART)		
In-vitro fertilization (IVF), zygote intrafa	ıllopian transfer (ZIFT), gamete intrafallor	pian transfer (GIFT), cryopreserved
embryo transfers, intracytoplasmic spe	rm injection (ICSI), or ovum microsurger	y
Vasectomy	Covered 100%; no deductible	50%; after deductible
Tubal ligation	Covered 100%; no deductible	50%; after deductible
PHARMACY	IN-NETWORK	OUT-OF-NETWORK
The full cost of the drug is applied to the	e deductible before any benefits are con	sidered for payment under the
pharmacy plan.	·	
Pharmacy plan type	Advanced Control Plan - Aetna	
Prescription drug deductible	Prescription drug expenses apply to your medical deductible.	
No deductible for formulary generic dru	ıgs.	
Prescription drug out-of-pocket	Prescription drug expenses apply to yo	our medical out-of-pocket limit.
limit		·





Generic drugs		
Retail	\$15 copay	40% of submitted cost; after applicable in-network cost share
Mail order	\$30 copay	Not Applicable
Preferred brand-name drugs		
Retail	\$45 copay	40% of submitted cost; after applicable in-network cost share
Mail order	\$90 copay	Not Applicable
Non-preferred generic and brand-na	me drugs	
Retail	\$70 copay	40% of submitted cost; after applicable in-network cost share
Mail order	\$140 copay	Not Applicable
Specialty drugs		
Preferred specialty	30%	40% of submitted cost; after applicable in-network cost share
	Maximum \$150	• •
Non-preferred specialty	30%	40% of submitted cost; after applicable in-network cost share
	Maximum \$150	
Pharmacy day supply and requirement	ents	
Retail	You can get up to a 30-day supply from Aetna National Network	
Mail order	You can get a 31-90-day supply from CVS Caremark® Mail Service Pharmacy.1	
Specialty	You can get up to a 30-day supply of specialty drugs You may fill your first prescription at any retail or specialty pharmacy. After that, all other fills must be through our preferred specialty pharmacy network.	

#### Your prescription drug plan also includes:

- Diabetic supplies
- Insulin up to a \$35 member payment maximum per fill per 30-day supply; no deductible for insulin drugs. Cost sharing maximum reduces plan deductible

Advanced Control Formulary Aetna Insured List

• A limited list of over-the-counter medications when filled with a prescription

### Family planning

Contraceptives included up to a 12 month supply

#### The following are covered 100% in-network:

- Oral chemotherapy drugs
- Seasonal vaccinations
- Preventive vaccinations
- Affordable Care Act (ACA) eligible preventive medications and contraceptives, also includes male condoms Refer to **Aetna.com** for a complete list of eligible prescription drugs.

### Precertification requirements

Some covered prescription drugs need approval from us before we will cover the drug. If you are currently taking one of these drugs when you switch to this plan, you may get one fill of your prescription within the first 90 days of starting the plan.

Some covered prescription drugs require step therapy before we cover them. With step therapy, you must first try one or more drugs before we will pay for drugs that require step therapy. If you are currently taking one of these drugs when you switch to this plan. you may get one fill of your prescription within the first 90 days of starting this plan. To get the most up-to-date precertification requirements and a list of drugs that require step therapy, see your plan documents or go online to your member website.



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Choose generics with dispense as written (DAW) override - Sometimes your physician may say you need a brand-name prescription drug even if a generic is available. If so, you will pay the brand-name copay. If you ask for a brand-name prescription drug when a generic is available, you will pay the applicable brand-name copay plus the difference between the generic price and the brand-name price.

#### **GENERAL PROVISIONS**

# Dependents who are eligible to be on your plan

Spouse, children from birth to age 26. Student status of children does not matter.

\*\*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 innetwork. You pay your plan's copayments 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 and deductibles.

Plans are provided by: Aetna Health Inc. 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. 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.

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.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- · Custodial care.
- Dental care and dental X-rays.
- · Donor egg retrieval
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids
- Home births
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

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

Translation of this material into another language may be available. Please call Member Services at the number on the back of your ID card.

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.



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