

## MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK		
Benefit limitations - Some service or supplies have limits on them per year. There might be a maximum number of					
visits or days, or a dollar limit per year. In such cases, the benefit year begins on January 1 (unless otherwise noted).					
Refer to your plan document	s to learn more.				
Deductible (per calendar	\$3,000 per Individual	\$3,000 per Individual	\$6,000 per Individual		
year)					
	\$6,000 per Family	\$6,000 per Family	\$12,000 per Family		
Covered expenses in-networ	rk add up towards your maximu	um savings and standard savin	gs deductible at the same		
time. Covered expenses out-	of-network add up separately	towards your out-of-network de	eductible.		
You must first meet the dedu	ictible before the plan begins p	aying benefits, unless otherwis	se noted.		
The amount you pay (cost sh	naring) for some medical servic	ces does not count toward your	deductible.		
Prescription drug costs do no	ot count toward the deductible.	Refer to your plan documents	for details.		
Your family will have one dee	ductible. You will meet it when	the expenses of several family	members add up to the		
family deductible. No one pe	rson will have to pay more that	n the individual deductible.			
Member coinsurance	You pay 20%	You pay 40%	You pay 50%		
Applies to all expenses exce	pt as noted.				
Out-of-pocket limit (per	\$6,000 per Individual	\$6,000 per Individual	\$12,000 per Individual		
calendar year)					
	\$12,000 per Family	\$12,000 per Family	\$24,000 per Family		
Covered expenses in-networ	k add up towards your maximu	um savings and standard savin	gs out-of-pocket limit at the		
same time. Covered expense	es out-of-network add up sepa	rately towards your out-of-netw	ork out-of-pocket limit.		
Your pharmacy expenses co	unt toward your out-of-pocket	limit.	- -		
In-network expenses include	coinsurance/copays and dedu	ictibles.			
Out-of-network expenses inc	lude coinsurance and deductib	oles. Penalty amounts do not a	pply.		
Your family will have one out	t-of-pocket limit. You will meet	it when the expenses of severa	al family members add up to		
the family out-of-pocket limit.	No one person will have to pa	y more than the individual out-	of-pocket limit amount.		
Lifetime maximum					
Unlimited except where othe	rwise indicated.				
Payment for out-of-	Not applicable	Not applicable	Professional: 185% of		
network care**			Medicare		
			Facility: 185% of Medicare		
Primary care physician	Optional	Not applicable	Does not apply		
selection					
Precertification requirement					
	es need approval by us in adva				
benefits by \$400. Refer to ye	our plan documents for a full lis	st of services that need this ap	proval.		
Referral requirement	Not required	Not required	None		
	<ul> <li>You can access covered service</li> </ul>				
your network. Log on to Aetr	na.com to see a list of virtual c	are providers. You'll also find r	nore about your options,		
including cost share amounts.					
CVS VIRTUAL CARE	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK		
CVS Health Virtual	Covered 100%; no	Covered 100%; no	Not applicable		
Primary Care (VPC) -	deductible	deductible			
preventive care					
consultations					
	coling convision through CV/S L	loolth Virtual Brimany Caro for	momboro ago 19 and oldor:		

Includes screening and counseling services through CVS Health Virtual Primary Care for members age 18 and older; refer to Aetna.com for more information.

Primary Care (VPC) - consultations         deductible         deductible           Includes basic medical service consultations through CVS Health Virtual Primary Care for members age 18 and older; refer to Aetna.com for additional information.         Not applicable           CVS Health Virtual Care         Covered 100%; no         Not applicable           (VC) - general medicine         deductible         Covered 100%; no         Not applicable           (VC) - mental health         deductible         Covered 100%; no         StaMADR SAVINGS         OUT-OF-NETWORK           Routine adult physical         Covered 100%; no         Covered 100%; no         So%; after deductible         deductible           Ream every 12 months until age 65, then 1 exam every 12 months age 65 and older         Revented 100%; no         So%; after deductible           3 exams from age 13 months         deductible         deductible         deductible         deductible           1 exam every 12 months to 24 months         3 exams from age 25 months to 34 months         3 exams from age 26 months to 24 months         1 exam every 12 months thereafter unil age 22           Routine gynecological         Covered 100%; no         Covered 100%; no         50%; after deductible           1 exam every 12 months thereafter unil age 22         Routine mamogram         Covered 100%; no         Covered 100%; no           Routine mamogram         Covered 100	CVS Health Virtual	Covered 100%; no	Covered 100%; no	Not applicable
Includes basic medical service consultations through CVS Health Virtual Primary Care for members age 18 and older; refer to Aetna.com for additional information. CVS Health Virtual Care Covered 100%; no Covered 100%; no Not applicable (VC) - general medicine Covered 100%; no Covered 100%; no Not applicable (VC) - mental health covered 100%; no Covered 100%; no So%; after deductible PREVENTVE CARE MAXIMUM SAVINGS STANDARD SAVINGS OUT-C-NETWORK Routine adult physical Covered 100%; no Covered 100%; no 50%; after deductible exams/immunizations deductible deductible deductible exams/immunizations deductible deductible deductible 7 exams inthe first 12 months 3 exams from age 25 months to 24 months 3 exams from age 25 months to 36 months 1 exam every 12 months thereafter until age 25. Routine gynecological Covered 100%; no Covered 100%; no 50%; after deductible deductible 1 exam every 12 months thereafter until age 25. Routine gynecological Covered 100%; no Covered 100%; no 50%; after deductible deductible deductible deductible Recommended: One per year, includes related fees. Routine mammogram Covered 100%; no Covered 100%; no 50%; after deductible deductible deductible Recommended: One per year for members age 40 and over Women's health Covered 100%; no Covered 100%; no 50%; after deductible fucludes: Screening for gestational diabetes, HPV (Human-Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immundeficiency virus, screening and counseling for interpresonal and domestic violence, breastfeeding support, supplies and counseling. Limits may apply. Pre-natal maternity Covered 100%; no Covered 100%; no 50%; after deductible deductible deductible Recommended: For members age 40 and over Prostate-specific antige Recommended: For members age 40 and over Recommended: For members age 40 and over Recomm		deductible	deductible	
and older; refer to Aetna.com for additional information.       CVS Health Virtual Care       Covered 100%; no       Not applicable         (VC) - general medicine       deductible       deductible       Not applicable         (VC) - general medicine       deductible       deductible       Not applicable         (VC) - math health       deductible       deductible       OUT-OF-NETWORK         Routine adult physical       Covered 100%; no       Sow; after deductible       deductible         exams very 12 months until age 65, then 1 exam every 12 months age 65 and older       Routine adult physical       Covered 100%; no       Sow; after deductible         exams from age 13 months to 24 months       3 exams from age 13 months to 24 months       3 exams from age 13 months to 24 months       3 exams from age 13 months to 24 months         1 exam every 12 months thereafter until age 22       Routine agmecological       Covered 100%; no       Covered 100%; no       50%; after deductible         1 exam and pap smear per year, includes related fees.       Routine gynecological       Covered 100%; no       deductible         Recommended: One per year for members age 40 and over       Women's health       Covered 100%; no       Covered 100%; no       fo%; after deductible         Interpretering for gestational diabetes, HPV (Human-Papillomavirus) DNA testing, counseling for interpretering and counseling for interpretering and counseling for interpreteri				
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(VC) - general medicine       deductible       deductible         CVS Health Virtual Care       Covered 100%; no       Covered 100%; no       Not applicable         (VC) - mental health       deductible       deductible       deductible         PREVENTIVE CARE       MAXIMUM SAVINGS       STANDARD SAVINGS       OUT-OF-NETWORK         Routine adult physical       Covered 100%; no       50%; after deductible         exam every 12 months       deductible       deductible         1 exam every 12 months       deductible       deductible         - 7 exams in the first 12 months       -       -         - 3 exams from age 13 months to 24 months       -       -         - 3 exams from age 13 months to 24 months       -       -         - 1 exam every 12 months thetreafter until age 22       -       -       -         Routine agnecological       Covered 100%; no       Covered 100%; no       50%; after deductible         - 1 exam and pap smear per year, includes related fees.       -       -       -         Routine mammogram       Covered 100%; no       Covered 100%; no       50%; after deductible         deductible       -       -       -       -         Routine mamogram       Covered 100%; no       Covered 100%; no       50%; after deductib	,			Nie (Leona Paralita
CVS Health Virtual Care         Covered 100%; no         Covered 100%; no         Not applicable           V(C) - mental health         deductible         deductible         deductible           PREVENTIVE CARE         MAXIMUM SAVINGS         STANDARD SAVINGS         OUT-OF-NETWORK           Routine adult physical         Covered 100%; no         Covered 100%; no         50%; after deductible           exams immunizations         deductible         deductible         50%; after deductible           Routine well child         Covered 100%; no         Covered 100%; no         50%; after deductible           * a exams from age 13 months to 36 months         •         •         •           * a evams from age 25 months to 36 months         •         •         •           * a evams from age 25 months to 36 months         •         •         •           * a evams dap as mear per year, includes related fees.         Routine gaps mear per year, includes related fees.           Routine mammogram         Covered 100%; no         Covered 100%; no         50%; after deductible           deductible         deductible         deductible         feductible           deductible         deductible         deductible         feductible           Routine mammogram         Covered 100%; no         Covered 100%; no         50			,	Not applicable
(VC) - mental health         deductible           PREVENTIVE CARE         MAXIMUM SAVINGS         STANDARD SAVINGS         OUT-OF-NETWORK           Routine adult physical exams/immunizations         Covered 100%; no deductible         Covered 100%; no deductible         S0%; after deductible           1 exam every 12 months until age 65, then 1 exam every 12 months 3 exams from age 13 months to 24 months         -         50%; after deductible           - 7 exams in the first 12 months         64 months         -         50%; after deductible           - 3 exams from age 13 months to 24 months         -         -         50%; after deductible           - 1 exam every 12 months thereafter until age 22         -         -         -         -           Routine gynecological care exams         Covered 100%; no deductible         Covered 100%; no fourtible         50%; after deductible           1 exam every 12 months tage 40 long; no deductible         Covered 100%; no deductible         50%; after deductible           1 exam and pap smear per year, includes related fees.         -         -         -           Routine mamogram         Covered 100%; no deductible         Covered 100%; no deductible         50%; after deductible           Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Limits may apply.				Net englischie
PREVENTIVE CARE         MAXIMUM SAVINGS         STANDARD SAVINGS         OUT-OF-NETWORK           Routine adult physical exams immunizations         Govered 100%; no         50%; after deductible         6ductible         6ductible         50%; after deductible           1 exam every 12 months until age 65, then 1 exam every 12 months age 65 and older         50%; after deductible         50%; after deductible           exams inmunizations         deductible         deductible         50%; after deductible           * 7 exams in the first 12 months         3 exams from age 13 months to 24 months         5 exams from age 25 months to 36 months           * 1 exam every 12 months threafter nutil age 22         Routine gynecological         Covered 100%; no         50%; after deductible           deductible         deductible         deductible         50%; after deductible         6ductible           1 exam every 12 months threafter nutil age 22         Routine mamogram         Covered 100%; no         Covered 100%; no         50%; after deductible           deductible         deductible         deductible         deductible         deductible           Routine mamogram         Covered 100%; no         Covered 100%; no         50%; after deductible           deductible         deductible         deductible         deductible           I exam and pap smear per year includes trelated fees.				Not applicable
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exams/ immunizations         deductible         deductible           1 exam every 12 months until age 65, then 1 exam every 12 months age 65 and older         Routine well child         Covered 100%; no         Covered 100%; no         deductible           exams in the first 12 months         deductible         deductible         50%; after deductible           • 7 exams in the first 12 months         sams from age 13 months to 24 months         sams from age 25 months to 36 months           • 1 exam every 12 months thereafter until age 22         Covered 100%; no         50%; after deductible           deductible         deductible         deductible           1 exam and pap smear per year, includes related fees.         Covered 100%; no         Covered 100%; no           Recommended: One per year for members age 40 and over         Covered 100%; no         50%; after deductible           deductible         deductible         deductible         feductible           Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually         transmitted infections, counseling and screening for human immunodeficiency virus, screening and downes(vicuble           Also includes: contraceptive methods (ACA mandated contraceptives, including counseling.         Also includes: no and counseling.           Also includes: contraceptive methods (ACA mandated contraceptives, including counseling.         S0%; after deductible				
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<ul> <li>7 exams in the first 12 months</li> <li>3 exams from age 13 months to 24 months</li> <li>3 exams from age 15 months to 36 months</li> <li>1 exam every 12 months thereafter until age 22</li> <li>Routine gynecological Covered 100%; no deductible</li> <li>1 exam and pap smear per year, includes related fees.</li> <li>Routine mammogram Covered 100%; no deductible</li> <li>1 exam and pap smear per year, includes related fees.</li> <li>Routine mammogram Covered 100%; no deductible</li> <li>Recommended: One per year for members age 40 and over</li> <li>Women's health Covered 100%; no deductible</li> <li>Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling or interpersonal and domestic violence, breastfeeding support, supplies and counseling. Limits may apply.</li> <li>Pre-natal maternity Covered 100%; no Covered 100%; no 50%; after deductible deductible</li> <li>Routine digital rectal Covered 100%; no Covered 100%; no 50%; after deductible</li> <li>Routine digital rectal Covered 100%; no Covered 100%; no 50%; after deductible</li> <li>Recommended: For members age 40 and over</li> <li>Pro-natal maternity Covered 100%; no Covered 100%; no 50%; after deductible</li> <li>Recommended: For members age 40 and over</li> <li>Prostate-specific antigen Covered 100%; no Covered 100%; no 50%; after deductible</li> <li>Recommended: For members age 40 and over</li> <li>Prostate-specific antigen Covered 100%; no Covered 100%; no 50%; after deductible</li> <li>Recommended: For members age 40 and over</li> <li>Routine degital rectal Covered 100%; no Covered 100%</li></ul>				
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1 exam and pap smear per year, includes related fees.         Routine mammogram       Covered 100%; no deductible       Covered 100%; no deductible       50%; after deductible         Recommended: One per year for members age 40 and over       Women's health       Covered 100%; no deductible       50%; after deductible         Includes: 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.       Also includes: contraceptive methods (ACA mandated contraceptives, including contraceptives and devices you can't get at a pharmacy), sterilization procedures (including tubal ligation), patient education and counseling.         Pre-natal maternity       Covered 100%; no       Covered 100%; no       50%; after deductible         Routine digital rectal       Covered 100%; no       Covered 100%; no       50%; after deductible         Recommended: For members age 40 and over       Evered 100%; no       Covered 100%; no       50%; after deductible         Recommended: For members age 40 and over       Evered 100%; no       Covered 100%; no       50%; after deductible         Recommended: For members age 40 and over       Evered 100%; no       Covered 100%; no       50%; after deductible         Recommended: For members age 40 and over       Evered 100%; no       Covered 100%; no       50%; after deductib				
Routine mammogram         Covered 100%; no deductible         Covered 100%; no deductible         50%; after deductible           Recommended: One per year for members age 40 and over         Women's health         Covered 100%; no deductible         50%; after deductible           Women's health         Covered 100%; no deductible         Covered 100%; no deductible         50%; after deductible           Includes: 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.         Also includes: contraceptive methods (ACA mandated contraceptives, including contraceptives and devices you can't get at a pharmacy), sterilization procedures (including tubal ligation), patient education and counseling. Limits may apply.           Pre-natal maternity         Covered 100%; no deductible         Covered 100%; no deductible         50%; after deductible           Routine digital rectal exam         Covered 100%; no deductible         Covered 100%; no deductible         50%; after deductible           Recommended: For members age 40 and over         Covered 100%; no deductible         Covered 100%; no deductible         50%; after deductible           Recommended: For members age 40 and over         Covered 100%; no deductible         Covered 100%; no deductible         50%; after deductible           Recommended: For members age 43 and over         Covere				
deductible       deductible         Recommended: One per year for members age 40 and over			Covered 100%; no	50%; after deductible
Women's health         Covered 100%; no deductible         Covered 100%; no deductible         50%; after deductible           Includes:         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.         Also includes: contraceptive methods (ACA mandated contraceptives, including contraceptives and devices you can't get at a pharmacy), sterilization procedures (including tubal ligation), patient education and counseling. Limits may apply.           Pre-natal maternity         Covered 100%; no deductible         Covered 100%; no deductible         50%; after deductible           Routine digital rectal         Covered 100%; no deductible         Covered 100%; no deductible         50%; after deductible           Prostate-specific antigen deductible         Covered 100%; no deductible         Sow; after deductible           Recommended: For members age 40 and over         Covered 100%; no deductible         Sow; after deductible           Recommended: For members age 40 and over         Covered 100%; no deductible         Sow; after deductible           Recommended: For members age 45 and over         Covered 100%; no deductible         Sow; after deductible           Recommended: For members age 45 and over         Covered 100%; no deductible         Sow; after deductible           Routine eye exams         Covered 100%; no	U			
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Recommended: For members age 45 and over         Routine eye exams       Covered 100%; no       Covered 100%; no       50%; after deductible         1 routine exam per 12 months.       deductible       deductible       50%; after deductible         Routine hearing       Covered 100%; no       50%; after deductible         screening       Covered 100%; no       Covered 100%; no       50%; after deductible	Colorectal cancer			
Routine eye exams       Covered 100%; no deductible       Covered 100%; no deductible       50%; after deductible         1 routine exam per 12 months.	-			50%; after deductible
deductible     deductible       1 routine exam per 12 months.     6000000000000000000000000000000000000		deductible		50%; after deductible
Routine hearing screeningCovered 100%; no deductibleCovered 100%; no deductible50%; after deductible	Recommended: For membe	deductible ers age 45 and over	deductible	
screening deductible deductible	Recommended: For membe	deductible ers age 45 and over Covered 100%; no	deductible Covered 100%; no	
	Recommended: For member Routine eye exams	deductible ers age 45 and over Covered 100%; no deductible hs.	deductible Covered 100%; no	50%; after deductible
PHYSICIAN SERVICES MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK	Recommended: For member Routine eye exams	deductible ers age 45 and over Covered 100%; no deductible hs.	deductible Covered 100%; no deductible	50%; after deductible
	Recommended: For member Routine eye exams 1 routine exam per 12 mont Routine hearing screening	deductible ers age 45 and over Covered 100%; no deductible hs. Covered 100%; no deductible	deductible Covered 100%; no deductible Covered 100%; no deductible	50%; after deductible 50%; after deductible



Office visits to non- specialist	\$35 office visit copay; no deductible	\$55 office visit copay; no deductible	50%; after deductible
	nist, general physician, family		
Specialist office visits	\$45 office visit copay; no deductible	\$65 office visit copay; no deductible	50%; after deductible
Includes visits to a naturopat			
Hearing exams	Not Covered	Not Covered	Not Covered
Walk-in clinics	\$35 copay; no deductible	\$55 copay; no deductible	50%; after deductible
		etimes they may be within a p	harmacy, drug store,
		s, the outpatient department of	a hospital, ambulatory
Allergy testing	Your cost sharing amount	Your cost sharing amount	Your cost sharing amoun
Anergy testing	depends on the type of	depends on the type of	depends on the type of
	service and where you	service and where you	service and where you
	receive it.	receive it.	receive it.
Allergy injections	Your cost sharing amount	Your cost sharing amount	Your cost sharing amoun
	depends on the type of	depends on the type of	depends on the type of
	service and where you	service and where you	service and where you
	receive it.	receive it.	receive it.
DIAGNOSTIC PROCEDURES	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Diagnostic X-ray (Other	20%; after deductible	40%; after deductible	50%; after deductible
han complex imaging	,		,
services)			
When your physician perform	ns and bills for this service at t	their office, you pay your office	
Diagnostic laboratory	20%; after deductible	40%; after deductible	50%; after deductible
		their office, you pay your office	
Diagnostic complex maging	20%; after deductible	40%; after deductible	50%; after deductible
		their office, you pay your office	
EMERGENCY MEDICAL	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Jrgent care provider	\$50 office visit copay; no deductible	\$50 office visit copay; no deductible	50%; after deductible
Non-urgent use of urgent care provider	Not Covered	Not Covered	Not Covered
Emergency room	20% after \$350 copay; no	20% after \$350 copay; no	Same as in-network care
	deductible	deductible	
Copay waived if admitted	Not On and	Not On and	
Non-emergency care in an emergency room	Not Covered	Not Covered	Not Covered
Emergency use of ambulance	20%; no deductible	20%; no deductible	Same as in-network care
Non-emergency use of ambulance	Not Covered	Not Covered	Not Covered
HOSPITAL CARE	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Inpatient coverage	20%; after deductible	40%; after deductible	50%; after deductible
inpatient coverage		,	,

## MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Inpatient maternity coverage (includes delivery and postpartum	20%; after deductible	40%; after deductible	50%; after deductible
care)			
	hospital for the care you need	d your cost sharing amount co	unte toward all covered
penefits you receive.	Thospital for the care you need	a, your cost sharing amount co	unis loward an covered
Dutpatient hospital	20%; after deductible	40%; after deductible	50%; after deductible
	it care at a hospital but don't st		
covered benefits during you		ay overnight, your cost sharing	g amount counts toward an
Dutpatient surgery -	20%; after deductible	40%; after deductible	50%; after deductible
nospital			
	it care at a hospital but don't st	tay overnight, your cost sharing	a amount counts toward all
covered benefits during you		ay overnight, your cost sharing	g arrount counts toward an
Outpatient surgery -	20%; after deductible	40%; after deductible	50%; after deductible
reestanding facility			
	it care at a hospital but don't st	tay overnight, your cost sharing	a amount counts toward all
covered benefits during you	r visit		g amount counts toward an
MENTAL HEALTH	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
SERVICES			
npatient	20%; after deductible	40%; after deductible	50%; after deductible
	a hospital for the care you need		
penefits you receive.		a, your ooor onamig amount oo	
Mental health office visits	\$45 copay; no deductible	\$65 copay; no deductible	50%; after deductible
Other mental health	20%; after deductible	40%; after deductible	50%; after deductible
services			
	nt care at a facility but don't sta	v overnight, vour cost sharing	amount counts toward all
covered benefits during you		,	
SUBSTANCE ABUSE	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
npatient	20%; after deductible	40%; after deductible	50%; after deductible
•	a hospital for the care you need		
penefits you receive.	, , , , , , , , , , , , , , , , , , ,	,,	
Residential treatment	20%; after deductible	40%; after deductible	50%; after deductible
acility			
	a facility for the care you need,	your cost sharing amount cou	nts toward all covered benef
/ou receive.	, , , , , , , , , , , , , , , , , , ,	, 3	
Substance abuse office	\$45 copay; no deductible	\$65 copay; no deductible	50%; after deductible
visits			•
Other substance abuse	20%; after deductible	40%; after deductible	50%; after deductible
services	·		•
When you receive outpatien	nt care at a facility but don't sta	y overnight, your cost sharing	amount counts toward all
covered benefits during you			
THERAPY SERVICES	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Spinal manipulation	\$45 copay; no deductible	\$65 copay; no deductible	50%; after deductible
therapy			,
l imited to 12 visits per year			

Limited to 12 visits per year

# MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Outpatient short-term			
rehabilitation	\$45 copay; no deductible	\$65 copay; no deductible	50%; after deductible
Limited to 25 visits per year			
Includes physical, occupation	onal, and speech therapies.		
Habilitative physical	20%; after deductible	40%; after deductible	50%; after deductible
therapy			
Habilitative occupational	20%; after deductible	40%; after deductible	50%; after deductible
therapy			
Habilitative speech	20%; after deductible	40%; after deductible	50%; after deductible
therapy			
Autism related physical	20%; after deductible	40%; after deductible	50%; after deductible
therapy			
Autism related	20%; after deductible	40%; after deductible	50%; after deductible
occupational therapy			
Autism related speech	20%; after deductible	40%; after deductible	50%; after deductible
therapy			
Autism related behavioral	\$45 copay; no deductible	\$65 copay; no deductible	50%; after deductible
therapy			
These benefits are combine	ed with outpatient mental health	n visits	
Autism related applied	20%; after deductible	40%; after deductible	50%; after deductible
behavior analysis			
Your benefits for these serv	ices are the same as any othe	r outpatient mental health othe	r services benefit
OTHER SERVICES	MAXIMUM SAVINGS	STANDARD SAVINGS	OUT-OF-NETWORK
Skilled nursing facility	20%; after deductible	40%; after deductible	50%; after deductible
When you're admitted into a	a facility for the care you need	your cost sharing amount cou	nts toward all covered benefits
you receive.	a facility for the care you need,		
you receive. Home health care	20%; after deductible	your cost sharing amount cou 40%; after deductible	nts toward all covered benefits 50%; after deductible
you receive. <b>Home health care</b> Limited to 120 visits per yea	20%; after deductible		
you receive. <b>Home health care</b> Limited to 120 visits per yea Home health care services i	20%; after deductible ar include private duty nursing	40%; after deductible	50%; after deductible
you receive. Home health care Limited to 120 visits per yea Home health care services i Limited to three visits per da	20%; after deductible ar include private duty nursing ay by staff from a home health	40%; after deductible care agency. One visit equals	50%; after deductible
you receive. Home health care Limited to 120 visits per yea Home health care services i Limited to three visits per da	20%; after deductible ar include private duty nursing	40%; after deductible	50%; after deductible
you receive. Home health care Limited to 120 visits per yea Home health care services i Limited to three visits per da Hospice care - inpatient When you're admitted into a	20%; after deductible ar include private duty nursing ay by staff from a home health	40%; after deductible care agency. One visit equals 40%; after deductible	50%; after deductible a period of four hours or less 50%; after deductible
you receive. Home health care Limited to 120 visits per yea Home health care services i Limited to three visits per da Hospice care - inpatient When you're admitted into a you receive.	20%; after deductible ar include private duty nursing ay by staff from a home health 20%; after deductible a facility for the care you need,	40%; after deductible care agency. One visit equals 40%; after deductible your cost sharing amount cou	50%; after deductible a period of four hours or less 50%; after deductible nts toward all covered benefit
you receive. Home health care Limited to 120 visits per yea Home health care services i Limited to three visits per da Hospice care - inpatient When you're admitted into a you receive. Hospice care - outpatient	20%; after deductible ar include private duty nursing ay by staff from a home health 20%; after deductible a facility for the care you need, 20%; after deductible	40%; after deductible <u>care agency. One visit equals</u> 40%; after deductible your cost sharing amount cou 40%; after deductible	50%; after deductible <u>a period of four hours or less.</u> 50%; after deductible nts toward all covered benefit 50%; after deductible
you receive. Home health care Limited to 120 visits per yea Home health care services i Limited to three visits per da Hospice care - inpatient When you're admitted into a you receive. Hospice care - outpatient When you receive outpatient	20%; after deductible ar include private duty nursing ay by staff from a home health 20%; after deductible a facility for the care you need, 20%; after deductible nt care at a facility but don't sta	40%; after deductible <u>care agency. One visit equals</u> 40%; after deductible your cost sharing amount cou 40%; after deductible	50%; after deductible <u>a period of four hours or less.</u> 50%; after deductible nts toward all covered benefit 50%; after deductible
you receive. Home health care Limited to 120 visits per yea Home health care services i Limited to three visits per da Hospice care - inpatient When you're admitted into a you receive. Hospice care - outpatient When you receive outpatient when you receive outpatient covered benefits during you	20%; after deductible ar include private duty nursing ay by staff from a home health 20%; after deductible a facility for the care you need, 20%; after deductible at care at a facility but don't sta ir visit.	40%; after deductible care agency. One visit equals 40%; after deductible your cost sharing amount cou 40%; after deductible y overnight, your cost sharing	50%; after deductible a period of four hours or less. 50%; after deductible nts toward all covered benefit: 50%; after deductible amount counts toward all
you receive. Home health care Limited to 120 visits per yea Home health care services i Limited to three visits per da Hospice care - inpatient When you're admitted into a you receive. Hospice care - outpatient When you receive outpatient when you receive outpatient covered benefits during you	20%; after deductible ar include private duty nursing ay by staff from a home health 20%; after deductible a facility for the care you need, 20%; after deductible at care at a facility but don't sta ir visit. Covered as part of home	40%; after deductible care agency. One visit equals 40%; after deductible your cost sharing amount cou 40%; after deductible y overnight, your cost sharing Covered as part of home	50%; after deductible a period of four hours or less. 50%; after deductible nts toward all covered benefit: 50%; after deductible amount counts toward all Covered as part of home
you receive. Home health care Limited to 120 visits per yea Home health care services i Limited to three visits per da Hospice care - inpatient When you're admitted into a you receive. Hospice care - outpatient When you receive outpatient when you receive outpatient covered benefits during you Private duty nursing	20%; after deductible ar include private duty nursing ay by staff from a home health 20%; after deductible a facility for the care you need, 20%; after deductible at care at a facility but don't sta ir visit. Covered as part of home health care	40%; after deductible <u>care agency. One visit equals</u> 40%; after deductible your cost sharing amount cou 40%; after deductible y overnight, your cost sharing Covered as part of home health care	50%; after deductible a period of four hours or less. 50%; after deductible nts toward all covered benefit: 50%; after deductible amount counts toward all
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you receive. Home health care Limited to 120 visits per yea Home health care services i Limited to three visits per da Hospice care - inpatient When you're admitted into a you receive. Hospice care - outpatient When you receive outpatient When you receive outpatient covered benefits during you Private duty nursing We count each period of up Durable medical equipment Diabetic supplies	20%; after deductible ar include private duty nursing ay by staff from a home health 20%; after deductible a facility for the care you need, 20%; after deductible nt care at a facility but don't sta r visit. Covered as part of home health care to 8 hours as one private duty 20%; after deductible	40%; after deductible <u>care agency. One visit equals</u> 40%; after deductible your cost sharing amount cour 40%; after deductible y overnight, your cost sharing <u>Covered as part of home</u> health care <u>nursing shift.</u> 40%; after deductible	50%; after deductible <u>a period of four hours or less</u> 50%; after deductible nts toward all covered benefit 50%; after deductible amount counts toward all Covered as part of home health care 50%; after deductible
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you receive. Home health care Limited to 120 visits per yea Home health care services i Limited to three visits per da Hospice care - inpatient When you're admitted into a you receive. Hospice care - outpatient When you receive outpatient When you receive outpatient when you receive outpatient Covered benefits during you Private duty nursing We count each period of up Durable medical equipment Diabetic supplies • If not covered under the prescription drug benefit	20%; after deductible ar include private duty nursing ay by staff from a home health 20%; after deductible a facility for the care you need, 20%; after deductible nt care at a facility but don't sta ir visit. Covered as part of home health care to 8 hours as one private duty 20%; after deductible You pay your PCP visit cost sharing amount	40%; after deductible <u>care agency. One visit equals</u> 40%; after deductible your cost sharing amount cou 40%; after deductible y overnight, your cost sharing Covered as part of home health care nursing shift. 40%; after deductible You pay your PCP visit cost sharing amount	50%; after deductible <u>a period of four hours or less.</u> 50%; after deductible nts toward all covered benefit: 50%; after deductible amount counts toward all Covered as part of home health care 50%; after deductible You pay your PCP visit cost sharing amount
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you receive. Home health care Limited to 120 visits per yea Home health care services i Limited to three visits per da Hospice care - inpatient When you're admitted into a you receive. Hospice care - outpatient When you receive outpatient covered benefits during you Private duty nursing	20%; after deductible ar include private duty nursing ay by staff from a home health 20%; after deductible a facility for the care you need, 20%; after deductible at care at a facility but don't sta ir visit. Covered as part of home health care to 8 hours as one private duty 20%; after deductible You pay your PCP visit cost sharing amount You pay your applicable	40%; after deductible <u>care agency. One visit equals</u> 40%; after deductible your cost sharing amount cou 40%; after deductible y overnight, your cost sharing Covered as part of home health care nursing shift. 40%; after deductible You pay your PCP visit cost sharing amount You pay your applicable	50%; after deductible <u>a period of four hours or less.</u> 50%; after deductible nts toward all covered benefits 50%; after deductible amount counts toward all Covered as part of home health care 50%; after deductible You pay your PCP visit cost sharing amount You pay your applicable

Infusion therapy -			
outpatient	20%; after deductible	40%; after deductible	50%; after deductible
hospital/freestanding facility			
Gene-based, Cellular,	Your cost sharing amount	Your cost sharing amount	Not Covered
and other Innovative	depends on the type of	depends on the type of	
Therapies (GCIT™)	service and where you receive it.	service and where you receive it.	
	\$50 copay; no deductible	\$50 copay; no deductible	
	for gene therapy drugs, if	for gene therapy drugs, if	
	applicable	applicable	
	In-network coverage is	In-network coverage is	
	provided at GCIT™	provided at GCIT™	
	designated facilities only.	designated facilities only.	
learing aids	20%; no deductible	20%; no deductible	20%; no deductible
3,000 per rolling 36 month		_	
/ision eyewear	Covered 100% up to \$350		
	per year; no deductible		
Fransplants	20%; after deductible	20%; after deductible	50%; after deductible
	In-network coverage is only	In-network coverage is only	Out-of-network coverage
	available at Institutes of	available at Institutes of	applies when you use a
	Excellence (IOE)	Excellence (IOE)	non-IOE facility. You will
	contracted facility.	contracted facility.	pay more out of pocket
			when using a non-IOE
<u> </u>	Not Covered	Not Covered	facility. Not Covered
			NOI COVEIEO
Acupuncture	\$35 copay; no deductible	\$55 copay; no deductible	50%; after deductible
Acupuncture _imited to 12 visits per year	\$35 copay; no deductible	\$55 copay; no deductible	50%; after deductible
Acupuncture _imited to 12 visits per year Alaska medical travel	\$35 copay; no deductible Covered 100%; no	\$55 copay; no deductible Covered 100%; no	50%; after deductible Covered 100%; no
Acupuncture .imited to 12 visits per year Alaska medical travel eimbursement	\$35 copay; no deductible Covered 100%; no deductible	\$55 copay; no deductible Covered 100%; no deductible	50%; after deductible Covered 100%; no deductible
Acupuncture Limited to 12 visits per year Alaska medical travel reimbursement For Air Transportation to the	\$35 copay; no deductible Covered 100%; no	\$55 copay; no deductible Covered 100%; no deductible agnose and treatment of a non	50%; after deductible Covered 100%; no deductible -emergency medical
Acupuncture Limited to 12 visits per year Alaska medical travel reimbursement For Air Transportation to the condition. All non-emergen	\$35 copay; no deductible Covered 100%; no deductible e nearest facility equipped to dia	\$55 copay; no deductible Covered 100%; no deductible agnose and treatment of a non	50%; after deductible Covered 100%; no deductible -emergency medical
Acupuncture Limited to 12 visits per year Alaska medical travel reimbursement For Air Transportation to the condition. All non-emergen blan documents. Other" health care - 40%	\$35 copay; no deductible Covered 100%; no deductible e nearest facility equipped to dia	\$55 copay; no deductible Covered 100%; no deductible agnose and treatment of a non UIRE prior approval and are su	50%; after deductible Covered 100%; no deductible -emergency medical ubject to limitations; see you
Acupuncture imited to 12 visits per year Alaska medical travel eimbursement For Air Transportation to the condition. All non-emergen an documents. Other" health care - 40% network.	\$35 copay; no deductible Covered 100%; no deductible e nearest facility equipped to dia cy transportation services REQ	\$55 copay; no deductible Covered 100%; no deductible agnose and treatment of a non UIRE prior approval and are su	50%; after deductible Covered 100%; no deductible -emergency medical ubject to limitations; see you
Acupuncture Limited to 12 visits per year Alaska medical travel eimbursement For Air Transportation to the condition. All non-emergen blan documents. Other" health care - 40% network. FAMILY PLANNING	\$35 copay; no deductible Covered 100%; no deductible e nearest facility equipped to dia cy transportation services REQ member coinsurance, after dec	\$55 copay; no deductible Covered 100%; no deductible agnose and treatment of a non UIRE prior approval and are su luctible, for services that are no	50%; after deductible Covered 100%; no deductible -emergency medical ubject to limitations; see you either in-network nor out-of- OUT-OF-NETWORK
Acupuncture Limited to 12 visits per year Alaska medical travel eimbursement For Air Transportation to the condition. All non-emergen blan documents. Other" health care - 40% network. FAMILY PLANNING	\$35 copay; no deductible Covered 100%; no deductible e nearest facility equipped to dia cy transportation services REQ member coinsurance, after dec MAXIMUM SAVINGS	\$55 copay; no deductible Covered 100%; no deductible agnose and treatment of a non UIRE prior approval and are su luctible, for services that are no STANDARD SAVINGS	50%; after deductible Covered 100%; no deductible -emergency medical ubject to limitations; see you either in-network nor out-of- OUT-OF-NETWORK
Acupuncture Limited to 12 visits per year Alaska medical travel eimbursement For Air Transportation to the condition. All non-emergen blan documents. Other" health care - 40% network. FAMILY PLANNING	\$35 copay; no deductible Covered 100%; no deductible e nearest facility equipped to dia cy transportation services REQ member coinsurance, after dec MAXIMUM SAVINGS Your cost sharing amount	\$55 copay; no deductible Covered 100%; no deductible agnose and treatment of a non UIRE prior approval and are su luctible, for services that are no <b>STANDARD SAVINGS</b> Your cost sharing amount	50%; after deductible Covered 100%; no deductible -emergency medical ubject to limitations; see you either in-network nor out-of- OUT-OF-NETWORK Your cost sharing amount
Acupuncture Limited to 12 visits per year Alaska medical travel reimbursement For Air Transportation to the condition. All non-emergen blan documents. Cother" health care - 40% network. FAMILY PLANNING Infertility treatment	\$35 copay; no deductible Covered 100%; no deductible e nearest facility equipped to dia cy transportation services REQ member coinsurance, after dec <u>MAXIMUM SAVINGS</u> Your cost sharing amount depends on the type of service and where you receive it.	\$55 copay; no deductible Covered 100%; no deductible agnose and treatment of a non UIRE prior approval and are su luctible, for services that are no <b>STANDARD SAVINGS</b> Your cost sharing amount depends on the type of service and where you receive it.	50%; after deductible Covered 100%; no deductible -emergency medical ubject to limitations; see you either in-network nor out-of- OUT-OF-NETWORK Your cost sharing amount depends on the type of
Acupuncture imited to 12 visits per year Alaska medical travel reimbursement For Air Transportation to the condition. All non-emergen blan documents. Other" health care - 40% network. FAMILY PLANNING nfertility treatment You have coverage for the o	\$35 copay; no deductible Covered 100%; no deductible e nearest facility equipped to dia cy transportation services REQ member coinsurance, after dec MAXIMUM SAVINGS Your cost sharing amount depends on the type of service and where you receive it. diagnosis and treatment of the u	\$55 copay; no deductible Covered 100%; no deductible agnose and treatment of a non UIRE prior approval and are su luctible, for services that are no <b>STANDARD SAVINGS</b> Your cost sharing amount depends on the type of service and where you receive it. underlying cause of infertility.	50%; after deductible Covered 100%; no deductible -emergency medical ubject to limitations; see you either in-network nor out-of- <b>OUT-OF-NETWORK</b> Your cost sharing amount depends on the type of service and where you receive it.
Acupuncture imited to 12 visits per year Alaska medical travel reimbursement For Air Transportation to the condition. All non-emergen blan documents. Other" health care - 40% network. FAMILY PLANNING nfertility treatment You have coverage for the of You have coverage for artifi	\$35 copay; no deductible Covered 100%; no deductible e nearest facility equipped to dia cy transportation services REQ member coinsurance, after dec MAXIMUM SAVINGS Your cost sharing amount depends on the type of service and where you receive it. diagnosis and treatment of the u cial insemination and the diagno	\$55 copay; no deductible Covered 100%; no deductible agnose and treatment of a non UIRE prior approval and are su luctible, for services that are no <b>STANDARD SAVINGS</b> Your cost sharing amount depends on the type of service and where you receive it. underlying cause of infertility. osis and treatment of the unde	50%; after deductible Covered 100%; no deductible -emergency medical ubject to limitations; see you either in-network nor out-of- <b>OUT-OF-NETWORK</b> Your cost sharing amount depends on the type of service and where you receive it.
Acupuncture imited to 12 visits per year Alaska medical travel eimbursement For Air Transportation to the condition. All non-emergen blan documents. 'Other" health care - 40% network. FAMILY PLANNING Infertility treatment You have coverage for the of You have coverage for artific Advanced Reproductive	\$35 copay; no deductible Covered 100%; no deductible e nearest facility equipped to dia cy transportation services REQ member coinsurance, after dec MAXIMUM SAVINGS Your cost sharing amount depends on the type of service and where you receive it. diagnosis and treatment of the u	\$55 copay; no deductible Covered 100%; no deductible agnose and treatment of a non UIRE prior approval and are su luctible, for services that are no <b>STANDARD SAVINGS</b> Your cost sharing amount depends on the type of service and where you receive it. underlying cause of infertility.	50%; after deductible Covered 100%; no deductible -emergency medical ubject to limitations; see you either in-network nor out-of- <b>OUT-OF-NETWORK</b> Your cost sharing amount depends on the type of service and where you receive it.
Acupuncture imited to 12 visits per year Alaska medical travel eimbursement For Air Transportation to the condition. All non-emergen blan documents. Other" health care - 40% network. FAMILY PLANNING Infertility treatment You have coverage for the of Advanced Reproductive Technology (ART)	\$35 copay; no deductible Covered 100%; no deductible e nearest facility equipped to dia cy transportation services REQ member coinsurance, after dec MAXIMUM SAVINGS Your cost sharing amount depends on the type of service and where you receive it. diagnosis and treatment of the u cial insemination and the diagn Not Covered	\$55 copay; no deductible Covered 100%; no deductible agnose and treatment of a non UIRE prior approval and are su luctible, for services that are ne <b>STANDARD SAVINGS</b> Your cost sharing amount depends on the type of service and where you receive it. underlying cause of infertility. osis and treatment of the unde Not Covered	50%; after deductible Covered 100%; no deductible -emergency medical ubject to limitations; see you either in-network nor out-of- OUT-OF-NETWORK Your cost sharing amount depends on the type of service and where you receive it.
Acupuncture imited to 12 visits per year Alaska medical travel reimbursement For Air Transportation to the condition. All non-emergen blan documents. Other" health care - 40% network. FAMILY PLANNING nfertility treatment You have coverage for the of You have coverage for artific Advanced Reproductive Fechnology (ART) n-vitro fertilization (IVF), zy	\$35 copay; no deductible Covered 100%; no deductible e nearest facility equipped to dia cy transportation services REQ member coinsurance, after dec MAXIMUM SAVINGS Your cost sharing amount depends on the type of service and where you receive it. diagnosis and treatment of the u cial insemination and the diagn Not Covered gote intrafallopian transfer (ZIF	\$55 copay; no deductible Covered 100%; no deductible agnose and treatment of a non UIRE prior approval and are su luctible, for services that are ne <b>STANDARD SAVINGS</b> Your cost sharing amount depends on the type of service and where you receive it. underlying cause of infertility. osis and treatment of the unde Not Covered T), gamete intrafallopian transf	50%; after deductible Covered 100%; no deductible -emergency medical ubject to limitations; see you either in-network nor out-of- OUT-OF-NETWORK Your cost sharing amount depends on the type of service and where you receive it. Inlying cause of infertility. Not Covered er (GIFT), ovulation induction
Acupuncture imited to 12 visits per year Alaska medical travel reimbursement For Air Transportation to the condition. All non-emergen blan documents. <b>Other" health care -</b> 40% hetwork. FAMILY PLANNING Infertility treatment Advanced Reproductive Fechnology (ART) n-vitro fertilization (IVF), zy OI), cryopreserved embryo	\$35 copay; no deductible Covered 100%; no deductible e nearest facility equipped to dia cy transportation services REQ member coinsurance, after dec <b>MAXIMUM SAVINGS</b> Your cost sharing amount depends on the type of service and where you receive it. diagnosis and treatment of the u cial insemination and the diagn Not Covered gote intrafallopian transfer (ZIF transfers, intracytoplasmic spe	<ul> <li>\$55 copay; no deductible</li> <li>Covered 100%; no deductible</li> <li>agnose and treatment of a non</li> <li>UIRE prior approval and are su</li> <li>luctible, for services that are ne</li> <li>STANDARD SAVINGS</li> <li>Your cost sharing amount depends on the type of service and where you receive it.</li> <li>underlying cause of infertility.</li> <li>osis and treatment of the unde Not Covered</li> <li>T), gamete intrafallopian transf rm injection (ICSI), or ovum mi</li> </ul>	50%; after deductible Covered 100%; no deductible -emergency medical ubject to limitations; see you either in-network nor out-of- OUT-OF-NETWORK Your cost sharing amount depends on the type of service and where you receive it. Inlying cause of infertility. Not Covered er (GIFT), ovulation induction icrosurgery
Acupuncture Limited to 12 visits per year Alaska medical travel reimbursement For Air Transportation to the condition. All non-emergen plan documents. "Other" health care - 40% network. FAMILY PLANNING Infertility treatment You have coverage for the of You have coverage for artific Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zy (OI), cryopreserved embryo Fertility preservation	\$35 copay; no deductible Covered 100%; no deductible e nearest facility equipped to dia cy transportation services REQ member coinsurance, after dec MAXIMUM SAVINGS Your cost sharing amount depends on the type of service and where you receive it. diagnosis and treatment of the u cial insemination and the diagn Not Covered gote intrafallopian transfer (ZIF transfers, intracytoplasmic spe Not Covered	<ul> <li>\$55 copay; no deductible</li> <li>Covered 100%; no deductible</li> <li>agnose and treatment of a non</li> <li>UIRE prior approval and are su</li> <li>luctible, for services that are ne</li> <li>STANDARD SAVINGS</li> <li>Your cost sharing amount depends on the type of service and where you receive it.</li> <li>underlying cause of infertility.</li> <li>osis and treatment of the under Not Covered</li> <li>T), gamete intrafallopian transfirm injection (ICSI), or ovum minose</li> </ul>	50%; after deductible Covered 100%; no deductible -emergency medical ubject to limitations; see you either in-network nor out-of- OUT-OF-NETWORK Your cost sharing amount depends on the type of service and where you receive it. Inlying cause of infertility. Not Covered er (GIFT), ovulation inductio icrosurgery Not Covered
Acupuncture Limited to 12 visits per year Alaska medical travel reimbursement For Air Transportation to the condition. All non-emergen plan documents. "Other" health care - 40% network. FAMILY PLANNING Infertility treatment You have coverage for the of You have coverage for artifit Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zy (OI), cryopreserved embryo Fertility preservation Vasectomy	\$35 copay; no deductible Covered 100%; no deductible e nearest facility equipped to dia cy transportation services REQ member coinsurance, after dec MAXIMUM SAVINGS Your cost sharing amount depends on the type of service and where you receive it. diagnosis and treatment of the u cial insemination and the diagn Not Covered gote intrafallopian transfer (ZIF <sup>-</sup> transfers, intracytoplasmic spe Not Covered 20%; after deductible	\$55 copay; no deductible Covered 100%; no deductible agnose and treatment of a non UIRE prior approval and are su luctible, for services that are no <b>STANDARD SAVINGS</b> Your cost sharing amount depends on the type of service and where you receive it. underlying cause of infertility. <u>osis and treatment of the unde</u> Not Covered T), gamete intrafallopian transf rm injection (ICSI), or ovum mi Not Covered 40%; after deductible	50%; after deductible Covered 100%; no deductible -emergency medical ubject to limitations; see you either in-network nor out-of- OUT-OF-NETWORK Your cost sharing amount depends on the type of service and where you receive it. not Covered er (GIFT), ovulation induction icrosurgery Not Covered 50%; after deductible
condition. All non-emergen plan documents. <b>"Other" health care -</b> 40% network. <b>FAMILY PLANNING</b> Infertility treatment You have coverage for the of You have coverage for artifi Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zy	\$35 copay; no deductible Covered 100%; no deductible e nearest facility equipped to dia cy transportation services REQ member coinsurance, after dec MAXIMUM SAVINGS Your cost sharing amount depends on the type of service and where you receive it. diagnosis and treatment of the u cial insemination and the diagn Not Covered gote intrafallopian transfer (ZIF transfers, intracytoplasmic spe Not Covered	<ul> <li>\$55 copay; no deductible</li> <li>Covered 100%; no deductible</li> <li>agnose and treatment of a non</li> <li>UIRE prior approval and are su</li> <li>luctible, for services that are ne</li> <li>STANDARD SAVINGS</li> <li>Your cost sharing amount depends on the type of service and where you receive it.</li> <li>underlying cause of infertility.</li> <li>osis and treatment of the under Not Covered</li> <li>T), gamete intrafallopian transfirm injection (ICSI), or ovum minose</li> </ul>	50%; after deductible Covered 100%; no deductible -emergency medical ubject to limitations; see you either in-network nor out-of- OUT-OF-NETWORK Your cost sharing amount depends on the type of service and where you receive it. not Covered er (GIFT), ovulation induction icrosurgery Not Covered



In-network pharmacy expenses apply towards the Maximum Savings tier only. Out-of-network pharmacy expenses apply towards the out-of-network tier.

apply towards the out-of-netw			
Pharmacy plan type	Advanced Control Plan - Aetna		
Prescription drug out-of-	Prescription drug expenses apply to your medical out-of-pocket limit.		
pocket limit			
Preferred generic drugs			
Retail	\$15 copay	20% of allowed charges	
Mail order	\$37.50 copay	20% of allowed charges	
Preferred brand-name drug	js		
Retail	\$45 copay	20% of allowed charges	
Mail order	\$112.50 copay	20% of allowed charges	
Non-preferred generic and	brand-name drugs		
Retail	\$70 copay	20% of allowed charges	
Mail order	\$175 copay	20% of allowed charges	
Specialty drugs			
Preferred specialty	30%	20% of allowed charges	
	Maximum \$200		
Non-preferred specialty	30%	20% of allowed charges	
	Maximum \$300	-	
Pharmacy day supply and	requirements		
Retail	You can get up to a 30-day supply from Aetna National Network		
	For a 31-90 day supp	bly you will be responsible for the Mail Order Drug copay.	
Mail order	You can get a 31-90-day supply from CVS Caremark® Mail Service		
	Pharmacy.		
Specialty	You can get up to a 3	30-day supply of specialty drugs	
		ormulary Aetna Insured List	
Your prescription drug plan		•	
Diabetic supplies			
• \$25 copay maximum per fill	per 30 day supply for	formulary insulin drugs	
• A limited list of over-the-cou			
Family planning			
• Oral fertility drugs included.			
		Contraceptive copay strategy applies.	
The following are covered			
Oral chemotherapy drugs			
Seasonal vaccinations			
Preventive vaccinations			
Affordable Care Act (ACA)	eligible preventive med	lications and contraceptives	
Refer to Aetna.com for a con			
	englise pr		

### 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.

**Choose generics with dispense as written (DAW) override** - Sometimes your physician may say you need a brandname prescription drug even if a generic is available. If so, you will pay the brand-name copay. If you ask for a brandname 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<br/>eligible to be on yourSpouse, children from birth to age 26. Student status of children does not<br/>matter.planmatter.

\*\*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. 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.

# MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

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.

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

\*\*\*This plan document provides you with an overview of some of your benefits and your cost share obligations. This information is for illustrative purposes ONLY. This document is not an official document and may differ from your Certificate of Coverage (COC), which is your official document. Refer to your COC for your coverage and services and any obligations on your part. © 2021 Aetna Inc.