

including cost share amounts.

The Alaska Support Industry Alliance Association Proposed Effective Date: 01-01-2025 Open Choice® PPO - Alaska AK24 PPO Plus 1500 80/60/50 RX4

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

| PLAN FEATURES | MAXIMUM SAVINGS | STANDARD SAVINGS | OUT-OF-NETWORK |
|------------------------------|--------------------------------|--|------------------------------------|
| | | s on them per year. There mig | |
| | | | ry 1 (unless otherwise noted). |
| Refer to your plan documen | ts to learn more. | | , |
| Deductible (per calendar | \$1,500 per Individual | \$1,500 per Individual | \$3,000 per Individual |
| year) | | | • |
| | \$3,000 per Family | \$3,000 per Family | \$6,000 per Family |
| | | mum savings and standard sa | |
| | | y towards your out-of-network | |
| | | s paying benefits, unless other | |
| | | vices does not count toward ye | |
| | | our plan documents for details | |
| | | en the expenses of several fan | nily members add up to the |
| | erson will have to pay more th | | |
| Member coinsurance | You pay 20% | You pay 40% | You pay 50% |
| Applies to all expenses exce | | ** | 440.000 |
| Out-of-pocket limit (per | \$6,000 per Individual | \$6,000 per Individual | \$10,000 per Individual |
| calendar year) | # 40.000 F 'I | #40.000 | #00.000 as a Face! |
| 0 | \$12,000 per Family | \$12,000 per Family | \$20,000 per Family |
| | | | vings out-of-pocket limit at the |
| | | parately towards your out-of-ne | etwork out-oi-pocket ilmit. |
| | nay not count toward the out- | | |
| | ount toward your out-of-pocke | | |
| | e coinsurance/copays and de | นนะแมเยร. tibles. Penalty amounts do no | t apply |
| | | | eral family members add up to |
| | | pay more than the individual o | |
| Lifetime maximum | i. No one person will have to | pay more man me mulvidual o | ut-or-pocket iiriit amount. |
| Unlimited except where other | arwise indicated | | |
| Payment for out-of- | Not applicable | Not applicable | Professional: 80th |
| network care** | Not applicable | Not applicable | percentile of Fair Health |
| network care | | | Facility: Facility Fee |
| | | | Schedule |
| Primary care physician | Optional | Not applicable | Does not apply |
| selection | Optional | Not applicable | Does not apply |
| Precertification requireme | ents - | | |
| | | vance (precertification). Withou | ut this approval, we reduce |
| | | list of services that need this | |
| Referral requirement | Not required | Not required | None |
| | | | om different kinds of providers in |
| | | care providers. You'll also fin | |
| including cost share amount | | | J |



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

| 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 | | | |
| ncludes screening and cou | nseling services through CVS | S Health Virtual Primary Care for | or members age 18 and older; |
| efer to Aetna.com for more | | | |
| CVS Health Virtual | Covered 100%; no | Covered 100%; no | Not applicable |
| Primary Care (VPC) - | deductible | deductible | |
| consultations | | | |
| ncludes basic medical se | ervice consultations throug | ıh CVS Health Virtual Primaı | ry Care for members age 18 |
| and older; refer to Aetna. | com for additional informa | tion. | |
| CVS Health Virtual Care | Covered 100%; no | Covered 100%; no | Not applicable |
| (VC) - general medicine | deductible | deductible | • • |
| CVS Health Virtual Care | Covered 100%; no | Covered 100%; no | Not applicable |
| (VC) - mental health | 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 | |
| I exam every 12 months un | | y 12 months age 65 and older | |
| Routine well child | Covered 100%; no | Covered 100%; no | 50%; after deductible |
| exams/immunizations | deductible | deductible | |
| 7 exams in the first 12 mor | | | |
| 3 exams from age 13 mon | | | |
| 3 exams from age 25 mon | | | |
| 1 exam every 12 months t | | | |
| Routine gynecological | Covered 100%; no | Covered 100%; no | 50%; after deductible |
| care exams | deductible | deductible | |
| exam and pap smear per | | | |
| Routine mammogram | Covered 100%; no | Covered 100%; no | 50%; after deductible |
| | deductible | deductible | |
| | ar for members age 40 and o | | |
| Women's health | Covered 100%; no | Covered 100%; no | 50%; after deductible |
| | deductible | deductible | |
| | | an- Papillomavirus) DNA testin | |
| | | nan immunodeficiency virus, sc | reening and counseling for |
| • | | ort, supplies and counseling. | andina and dariana mana |
| | | ontraceptives, including contract | |
| | tion procedures (including tu | bal ligation), patient education | and counseling. Limits may |
| apply. | Covered 1000/ : == | Covered 100%: | EOO/, often dedetible |
| Pre-natal maternity | Covered 100%; no | Covered 100%; no | 50%; after deductible |
| Douting digital rootal | deductible | deductible | EOO/: ofter deductible |
| Routine digital rectal | Covered 100%; no | Covered 100%; no | 50%; after deductible |
| exam Pagammandad: Far mamba | deductible | deductible | |
| Recommended: For membe Prostate-specific antigen | | Covered 100%: 55 | EOO/: ofter deductible |
| riostate-specific antiden | Covered 100%; no | Covered 100%; no deductible | 50%; after deductible |
| | | GEGUCHOIE | |
| test | deductible | acachore | |
| t est Recommended: For membe | ers age 40 and over | | E00/: ofter deductible |
| test Recommended: For membe Colorectal cancer screening | | Covered 100%; no deductible | 50%; after deductible |



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

| Routine eye exams Covered 100%; no deductible department of a hospital, ambulatory depends on the type of service and where you receive it. depends on the type of service and where you receive it. depends on the type of service and where you receive it. depends on the type of service and where you receive it. depends on the type of service and where you receive it. depends on the type of service and | Recommended: For member | rs age 45 and over | | |
|---|--------------------------------|---|----------------------------------|--------------------------|
| Routine hearing Covered 100%; no deductible Screening deductible deductible Screening Screening deductible deductible deductible Screening Maximum Savings STANDARD SAVINGS OUT-OF-NETWORK Office visit to non-specialist on non-specialist office visit copay; no deductible deductible includes services of an internist, general physician, family practitioner or pediatrician. Specialist office visits \$40 office visit copay; no deductible deductible deductible includes visits to a naturopath Maximum Savings Maximum Savings Soperal Sovered Maximum Savings Soperal Sovered Maximum Soperal Sovered Sovered Maximum Soperal Sovered Sovered Sovered Maximum Soperal Sovered Sove | Routine eye exams | | • | 50%; after deductible |
| Routine hearing Covered 100%; no deductible deductible deductible PHYSICIAN SERVICES MAXIMUM SAVINGS STANDARD SAVINGS Office visits to non-specialist of deductible deductible deductible deductible deductible includes services of an internist, general physician, family practitioner or pediatrician. Specialist office visits S40 office visit copay; no deductible deductible deductible deductible Includes visits to a naturopath Not Covered Not Covered Not Covered Not Covered Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services. Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices. Allergy testing Your cost sharing amount depends on the type of service and where you receive it. Allergy injections Your cost sharing amount depends on the type of service and where you receive it. Your cost sharing amount depends on the type of service and where you receive it. PROCEDURES DIAGNOSTIC MAXIMUM SAVINGS STANDARD SAVINGS Your cost sharing amount depends on the type of service and where you receive it. PROCEDURES DIAGNOSTIC MAXIMUM SAVINGS STANDARD SAVINGS OVAL Covered Walk-in clinics was free-standing mount depends on the type of service and where you receive it. PROCEDURES Diagnostic X-ray (Other than complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic laboratory 20%; after deductible When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic complex 20%; after deductible When your physician performs and bills for this service at their office, you pay your office visit cost share amount. EMERGENCY MEDICAL MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK All office visit copay; | | | deductible | |
| Description | | | | |
| PHYSICIÁN SERVICES MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK Office visit to non- \$30 office visit copay; no deductible deductible deductible includes services of an internist, general physician, family practitioner or pediatrician. Specialist S40 office visit copay; no deductible floctudes visits to a naturopath Hearing exams Not Covered Walk-in clinics \$30 copay; no deductible Walk-in clinics \$30 copay; no deductible Walk-in clinics \$30 copay; no deductible Walk-in clinics sare free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services. Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices. Allergy testing Your cost sharing amount depends on the type of service and where you receive it. Allergy injections Your cost sharing amount depends on the type of service and where you receive it. POCEDURES Diagnostic X-ray (Other than complex imaging services) Diagnostic Laboratory 20%; after deductible 40%; after deductible 50%; 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. Diagnostic complex 20%; after deductible 40%; 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. Diagnostic complex 20%; after deductible 40%; 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. Diagnostic complex 20%; after deductible 40%; after deductible 50%; after deductible When your physician performs and bills for this service at their office, you pay your office visit cost s | | | | 50%; after deductible |
| Office visits to non- specialist Includes services of an intermist, general physician, family practitioner or pediatrician. Specialist office visits \$40 office visit copay; no deductible Includes visits to a naturopath Hearing exams Not Covered Walk-in clinics \$30 copay; no deductible Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services. Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices. Allergy testing Your cost sharing amount depends on the type of service and where you receive it. Allergy injections Your cost sharing amount depends on the type of service and where you receive it. Proceeve it. Allergy injections Walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices. Your cost sharing amount depends on the type of service and where you receive it. Your cost sharing amount depends on the type of service and where you receive it. Procedence of the proceeding of the type of service and where you receive it. DIAGNOSTIC MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK DIAGNOSTIC MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK Diagnostic Laboratory Vow; after deductible 40%; 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. Diagnostic complex 20%; after deductible When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic complex Your cost sharing amount depends on the type of service and where you receive it. Your cost sharing amount depends on the type of service and where you receive it. Your cost sharing amount depends on the type of service and where you receive it. Your c | | | | OUT OF NETWORK |
| Specialist deductible deductible Includes services of an internist, general physician, family practitioner or pediatrician. | | | | |
| Includes services of an internist, general physician, family practitioner or pediatrician. Specialist office visits \$40 office visit copay; no deductible odeductible includes visits to a naturopath Hearing exams Not Covered Not Covered \$500 office visit copay; no deductible \$400 copay; no deductible \$500 office visit copay; no | | | | 50%; after deductible |
| Specialist office visits \$40 office visit copay; no deductible Includes visits to a naturopath Hearing exams Not Covered Not Covered Successive in the property of the prope | | | | |
| deductible Includes visits to a naturopath Hearing exams Not Covered Walk-in clinics \$30 copay; no deductible Valk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services. Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices. Allergy testing Your cost sharing amount depends on the type of service and where you receive it. Allergy injections Your cost sharing amount depends on the type of service and where you receive it. Your cost sharing amount depends on the type of service and where you receive it. POCEDURES Diagnostic X-ray (Other than complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic laboratory When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic complex 20%; after deductible Waximum savings STANDARD Savings OUT-OF-NETWORK Diagnostic laboratory When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic complex 20%; after deductible When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic complex 20%; after deductible Waximum savings STANDARD Savings OUT-OF-NETWORK Diagnostic visit cost share amount. Diagnostic aboratory When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic aboratory When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic visit open yen of the deductible Weath of the deductible of the deduc | | | | EOO/ Laftar daductible |
| Includes visits to a naturopath Hearing exams Not Covered Not Covered Sal Copay; no deductible \$40 copay; no deductible \$40 copay; no deductible \$40 copay; no deductible \$60%; after deductible \$60%; af | Specialist office visits | | | 50%, after deductible |
| Hearing exams Not Covered Not Covered Walk-in clinics \$30 copay; no deductible \$40 copay; no deductible 50%; after deductible \$00%; after deductible \$50%; after deductible \$50% | Includes visits to a naturonat | | deddclible | |
| Walk-in clinics \$30 copay; no deductible \$40 copay; no deductible 50%; after deductible Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services. Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices. Allergy testing Your cost sharing amount depends on the type of service and where you receive it. Allergy injections Your cost sharing amount depends on the type of service and where you receive it. Allergy injections Your cost sharing amount depends on the type of service and where you receive it. Allergy injections Your cost sharing amount depends on the type of service and where you receive it. Allergy injections Your cost sharing amount depends on the type of service and where you receive it. Allergy injections Your cost sharing amount depends on the type of service and where you receive it. Allergy injections Your cost sharing amount depends on the type of service and where you receive it. DIAGNOSTIC MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK PROCEDURES Diagnostic X-ray (Other than complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic laboratory 20%; after deductible 40%; 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. Diagnostic complex 20%; after deductible 40%; after deductible 50%; after deductible imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount. EMERGENCY MEDICAL MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK CARE Urgent care provider \$50 office visit copay; no deductible deductible \$00%; after deductible deductible \$00%; after deductible deductible \$00%; after deduc | | | Not Covered | Not Covered |
| Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services. Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices. Allergy testing Your cost sharing amount depends on the type of service and where you receive it. Allergy injections Your cost sharing amount depends on the type of service and where you receive it. Your cost sharing amount depends on the type of service and where you receive it. Allergy injections Your cost sharing amount depends on the type of service and where you receive it. Your cost sharing amount depends on the type of service and where you receive it. Porcepture it. Procedures Diagnostic Aray (Other than complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic laboratory 20%; after deductible When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic complex 20%; after deductible 40%; after deductible 40%; 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. Diagnostic complex 20%; after deductible 40%; 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. Diagnostic complex 20%; after deductible 40%; after deductible 50%; after deductible 40%; after deductible 50%; | | | | |
| supermarket, or other retail store. They offer some limited medical care and services. Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices. Allergy testing Your cost sharing amount depends on the type of service and where you receive it. Allergy injections Your cost sharing amount depends on the type of service and where you receive it. Your cost sharing amount depends on the type of service and where you receive it. Your cost sharing amount depends on the type of service and where you receive it. DIAGNOSTIC MAXIMUM SAVINGS Diagnostic X-ray (Other 20%; after deductible than complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic complex 20%; after deductible 40%; 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. Diagnostic complex 20%; after deductible 40%; after deductible 50%; after deductible imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount. EMERGENCY MEDICAL MAXIMUM SAVINGS Not Covered MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK OUT-OF-NETWORK PROCEDURES Diagnostic complex 20%; after deductible 40%; after deductible 50%; after deductible imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount. EMERGENCY MEDICAL MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK OUT-OF-NETWORK CARE Urgent care provider \$50 office visit copay; no deductible deductible Not Covered | | | | |
| Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices. Allergy testing Your cost sharing amount depends on the type of service and where you receive it. Allergy injections Your cost sharing amount depends on the type of service and where you receive it. Allergy injections Your cost sharing amount depends on the type of service and where you receive it. Procedure and where you receive it. DIAGNOSTIC MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK PROCEDURES Diagnostic X-ray (Other 20%; after deductible 40%; after deductible 50%; after deductible than complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic laboratory 20%; after deductible 40%; 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. Diagnostic complex 20%; after deductible 40%; 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. Diagnostic complex 20%; after deductible 40%; 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. Diagnostic complex 20%; after deductible 50%; after deductible 50%; after deductible formal performs and bills for this service at their office, you pay your office visit cost share amount. EMERGENCY MEDICAL MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK CARE Urgent care provider From the five of the proper formal performs and bills for this service at their office, you pay your office visit cost share amount. EMERGENCY MEDICAL MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK CARE Urgent care provider Emergency room 20% after \$250 copay; no deductible Non-emergency care in Not Covered Not Covered Not Covered | | | | namasy, arag store, |
| Allergy testing Your cost sharing amount depends on the type of service and where you receive it. Allergy injections Your cost sharing amount depends on the type of service and where you receive it. Allergy injections Your cost sharing amount depends on the type of service and where you receive it. Allergy injections Your cost sharing amount depends on the type of service and where you receive it. Procedures DIAGNOSTIC MAXIMUM SAVINGS Diagnostic X-ray (Other than complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic laboratory 20%; after deductible 40%; after deductible 40%; 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. Diagnostic complex 20%; after deductible 40%; after deductible 40%; 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. Diagnostic laboratory 20%; after deductible 40%; after deductible 40%; after deductible 50%; after ded | | | | a hospital, ambulatory |
| Allergy testing Your cost sharing amount depends on the type of service and where you receive it. Allergy injections Your cost sharing amount depends on the type of service and where you receive it. Allergy injections Your cost sharing amount depends on the type of service and where you receive it. Allergy injections Your cost sharing amount depends on the type of service and where you receive it. Allergy injections Your cost sharing amount depends on the type of service and where you receive it. Pour cost sharing amount depends on the type of service and where you receive it. DIAGNOSTIC PROCEDURES Diagnostic X-ray (Other than complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic laboratory When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic complex imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic complex imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount. EMERGENCY MEDICAL CARE Urgent care provider So office visit copay; no deductible Non-urgent use of urgent care provider Emergency room 20% after \$250 copay; no deductible Not Covered | | | , | , |
| depends on the type of service and where you receive it. Allergy injections Your cost sharing amount depends on the type of service and where you receive it. Your cost sharing amount depends on the type of service and where you receive it. Your cost sharing amount depends on the type of service and where you receive it. DIAGNOSTIC PROCEDURES Diagnostic X-ray (Other tana complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic laboratory When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic complex imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic laboratory 20%; after deductible 40%; 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. Diagnostic complex imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount. EMERGENCY MEDICAL CARE Urgent care provider \$50 office visit copay; no deductible Not Covered | | | Your cost sharing amount | Your cost sharing amount |
| Allergy injections Your cost sharing amount depends on the type of service and where you receive it. DIAGNOSTIC MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK PROCEDURES Diagnostic X-ray (Other than complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic complex imaging Service and bills for this service at their office, you pay your office visit cost share amount. Diagnostic complex imaging Service at their office, you pay your office visit cost share amount. Diagnostic laboratory 20%; after deductible 40%; 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. Diagnostic complex and bills for this service at their office, you pay your office visit cost share amount. Diagnostic complex and bills for this service at their office, you pay your office visit cost share amount. Diagnostic complex and bills for this service at their office, you pay your office visit cost share amount. EMERGENCY MEDICAL MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK CARE Urgent care provider \$50 office visit copay; no deductible deductible Not Covered Not Covered | | | | |
| Allergy injections Your cost sharing amount depends on the type of service and where you receive it. DIAGNOSTIC PROCEDURES Diagnostic X-ray (Other 20%; after deductible 40%; 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. Diagnostic laboratory 20%; after deductible 40%; 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. Diagnostic laboratory 20%; after deductible 40%; 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. Diagnostic complex 20%; after deductible 40%; 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. Diagnostic complex 20%; after deductible 40%; after deductible 50%; after deductible imaging when your physician performs and bills for this service at their office, you pay your office visit cost share amount. EMERGENCY MEDICAL MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK CARE Urgent care provider \$50 office visit copay; no deductible deductible Non-urgent use of urgent care provider 20% after \$250 copay; no deductible Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered | | service and where you | service and where you | service and where you |
| depends on the type of service and where you receive it. DIAGNOSTIC MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK PROCEDURES Diagnostic X-ray (Other than complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic laboratory 20%; after deductible 40%; 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. Diagnostic laboratory 20%; after deductible 40%; 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. Diagnostic complex 20%; after deductible 40%; after deductible 50%; after deductible imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount. EMERGENCY MEDICAL MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK CARE Urgent care provider \$50 office visit copay; no deductible deductible Non-urgent use of urgent care provider 20% after \$250 copay; no deductible Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered | | receive it. | receive it. | receive it. |
| service and where you receive it. DIAGNOSTIC MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK PROCEDURES Diagnostic X-ray (Other than complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic laboratory 20%; after deductible 40%; 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. Diagnostic laboratory 20%; after deductible 40%; 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. Diagnostic complex 20%; after deductible 40%; after deductible 50%; after deductible imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount. EMERGENCY MEDICAL MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK CARE Urgent care provider \$50 office visit copay; no deductible deductible Non-urgent use of urgent care provider S50 office visit copay; no deductible deductible Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered | Allergy injections | Your cost sharing amount | Your cost sharing amount | Your cost sharing amount |
| receive it. receive it. receive it. DIAGNOSTIC MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK PROCEDURES Diagnostic X-ray (Other 20%; after deductible 40%; after deductible 50%; after deductible than complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic laboratory 20%; after deductible 40%; 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. Diagnostic complex 20%; after deductible 40%; after deductible 50%; after deductible imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount. EMERGENCY MEDICAL MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK CARE Urgent care provider \$50 office visit copay; no deductible deductible deductible Non-urgent use of urgent care provider Emergency room 20% after \$250 copay; no deductible deductib | | | | |
| DIAGNOSTIC MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK PROCEDURES Diagnostic X-ray (Other 20%; after deductible 40%; after deductible 50%; after deductible services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic laboratory 20%; after deductible 40%; 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. Diagnostic complex 20%; after deductible 40%; after deductible 50%; after deductible imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount. EMERGENCY MEDICAL MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK CARE Urgent care provider \$50 office visit copay; no deductible deductible Non-urgent use of urgent Not Covered Not Covered Not Covered Care provider Emergency room 20% after \$250 copay; no deductible Copay waived if admitted Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered | | service and where you | service and where you | service and where you |
| Diagnostic X-ray (Other 20%; after deductible 40%; after deductible 50%; after deductible than complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic laboratory 20%; after deductible 40%; 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. Diagnostic complex 20%; after deductible 40%; after deductible 50%; after deductible imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount. EMERGENCY MEDICAL MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK CARE Urgent care provider \$50 office visit copay; no \$50 office visit copay; no 50%; after deductible deductible Mon-urgent use of urgent care provider \$50 office visit copay; no 20% after \$250 copay; no 30%; after \$250 copay; no 30% after \$ | | | | |
| than complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic laboratory 20%; after deductible 40%; 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. Diagnostic complex 20%; after deductible 40%; after deductible 50%; after deductible imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount. EMERGENCY MEDICAL MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK CARE Urgent care provider \$50 office visit copay; no deductible deductible deductible Non-urgent use of urgent Not Covered Not Covered Not Covered Emergency room 20% after \$250 copay; no deductible deductible deductible deductible Copay waived if admitted Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered | PROCEDURES | MAXIMUM SAVINGS | STANDARD SAVINGS | |
| When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic laboratory 20%; after deductible 40%; 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. Diagnostic complex 20%; after deductible 40%; after deductible 50%; after deductible imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount. EMERGENCY MEDICAL MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK CARE Urgent care provider \$50 office visit copay; no deductible deductible deductible deductible deductible Non-urgent use of urgent Not Covered Not Covered Not Covered Emergency room 20% after \$250 copay; no deductible deductible deductible deductible deductible deductible deductible deductible Non-emergency room 20% after \$250 copay; no deductible Non-emergency care in Not Covered Not Cover | | 20%; after deductible | 40%; 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. Diagnostic laboratory 20%; after deductible 40%; 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. Diagnostic complex 20%; after deductible 40%; after deductible 50%; after deductible imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount. EMERGENCY MEDICAL MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK CARE Urgent care provider \$50 office visit copay; no deductible deductible deductible Non-urgent use of urgent Not Covered Not Covered Not Covered Not Covered Same as in-network care deductible deductible Copay waived if admitted Non-emergency care in Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered | | | | |
| Diagnostic laboratory When your physician performs and bills for this service at their office, you pay your office visit cost share amount.Diagnostic complex imaging20%; after deductible40%; after deductible50%; after deductibleWhen your physician performs and bills for this service at their office, you pay your office visit cost share amount.EMERGENCY MEDICAL CAREMAXIMUM SAVINGS Urgent care providerSTANDARD SAVINGS STANDARD SAVINGSOUT-OF-NETWORK OUT-OF-NETWORKUrgent care provider Care provider\$50 office visit copay; no deductible\$50 office visit copay; no deductible\$50 office visit copay; no deductibleNon-urgent use of urgent care providerNot CoveredNot CoveredNot CoveredEmergency room deductible20% after \$250 copay; no deductible20% after \$250 copay; no deductibleSame as in-network care deductibleCopay waived if admittedNot CoveredNot CoveredNon-emergency care inNot CoveredNot Covered | | | | |
| When your physician performs and bills for this service at their office, you pay your office visit cost share amount. Diagnostic complex 20%; after deductible 40%; after deductible 50%; after deductible imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount. EMERGENCY MEDICAL MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK CARE Urgent care provider \$50 office visit copay; no deductible deductible deductible Non-urgent use of urgent Not Covered Not Covered Not Covered care provider Emergency room 20% after \$250 copay; no deductible deductible deductible deductible deductible deductible Non-emergency care in Not Covered Not Covered Not Covered Not Covered Non-emergency care in Not Covered No | | | | |
| Diagnostic complex imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount. EMERGENCY MEDICAL MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK CARE Urgent care provider \$50 office visit copay; no deductible deductible Non-urgent use of urgent care provider Emergency room 20% after \$250 copay; no deductible Copay waived if admitted Not Covered Not Covered Non-emergency care in Not Covered Not Covered Not Covered | | | | |
| When your physician performs and bills for this service at their office, you pay your office visit cost share amount. EMERGENCY MEDICAL MAXIMUM SAVINGS STANDARD SAVINGS OUT-OF-NETWORK CARE Urgent care provider \$50 office visit copay; no deductible deductible Non-urgent use of urgent care provider Emergency room 20% after \$250 copay; no deductible Copay waived if admitted Not Covered Not Covered Not Covered Not Covered Moductible Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered | | | heir office, you pay your office | |
| When your physician performs and bills for this service at their office, you pay your office visit cost share amount. EMERGENCY MEDICAL CARE Urgent care provider \$50 office visit copay; no deductible \$50 office visit copay; no \$5 | | 20%; after deductible | 40%; after deductible | 50%; after deductible |
| EMERGENCY MEDICAL CAREMAXIMUM SAVINGSSTANDARD SAVINGSOUT-OF-NETWORKUrgent care provider\$50 office visit copay; no deductible\$50 office visit copay; no deductible50%; after deductibleNon-urgent use of urgent care providerNot CoveredNot CoveredNot CoveredEmergency room Copay waived if admitted20% after \$250 copay; no deductible20% after \$250 copay; no deductibleSame as in-network careNon-emergency care inNot CoveredNot Covered | | and the time from the transition of the | hala afficia | Note and all and and and |
| Urgent care provider \$50 office visit copay; no deductible \$50 office | | | | |
| Urgent care provider\$50 office visit copay; no deductible\$50 office visit copay; no deductible\$50 office visit copay; no deductibleNon-urgent use of urgent care providerNot CoveredNot CoveredNot CoveredEmergency room20% after \$250 copay; no deductible20% after \$250 copay; no deductibleSame as in-network care deductibleCopay waived if admittedNot CoveredNot CoveredNot Covered | | MAXIMUM SAVINGS | STANDARD SAVINGS | OUT-OF-NETWORK |
| deductible deductible Non-urgent use of urgent care provider Emergency room 20% after \$250 copay; no deductible Copay waived if admitted Not Covered Not Covered Not Covered Same as in-network care deductible Non-emergency care in Not Covered Not Covered Not Covered Not Covered | | \$50 office visit copav: no | \$50 office visit copay: no | FO9/: after deductible |
| Non-urgent use of urgent care provider Emergency room Copay waived if admitted Not Covered | orgenit care provider | | | 50%, after deductible |
| care provider Emergency room 20% after \$250 copay; no deductible 20% after \$250 copay; no deductible Same as in-network care deductible Copay waived if admitted Not Covered Not Covered | Non-urgent use of urgent | | | Not Covered |
| Emergency room 20% after \$250 copay; no deductible 20% after \$250 | | 1101 0000100 | 1101 0010100 | 1101 0070100 |
| deductible deductible Copay waived if admitted Non-emergency care in Not Covered Not Covered Not Covered | | 20% after \$250 copay; no | 20% after \$250 copay; no | Same as in-network care |
| Non-emergency care in Not Covered Not Covered Not Covered | | | | |
| Non-emergency care in Not Covered Not Covered Not Covered | Copay waived if admitted | | | |
| an emergency room | | Not Covered | Not Covered | Not Covered |
| | an emergency room | | | |



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

| Emergency use of ambulance | 20%; no deductible | 20%; no deductible | Same as in-network care |
|--|--|---|---|
| Non-emergency use of | Not Covered | Not Covered | Not Covered |
| ambulance | | | |
| HOSPITAL CARE | MAXIMUM SAVINGS | STANDARD SAVINGS | OUT-OF-NETWORK |
| Inpatient coverage | 20%; after deductible | 40%; after deductible | 50%; after deductible |
| | hospital for the care you need | d, your cost sharing amount co | unts toward all covered |
| benefits you receive. | | | |
| Inpatient maternity | 20%; after deductible | 40%; after deductible | 50%; after deductible |
| coverage (includes | | | |
| delivery and postpartum | | | |
| care) | | | |
| = | hospital for the care you need | d, your cost sharing amount co | unts toward all covered |
| benefits you receive. | 000/ 6 1 1 (1) | 400/ 6/ 1 1 1/11 | 500/ 6/ 1 1 4/11 |
| Outpatient hospital | 20%; after deductible | 40%; after deductible | 50%; after deductible |
| | t care at a hospital but don't st | ay overnight, your cost sharing | g amount counts toward all |
| Covered benefits during you | | 400/ Lofton do diretible | EOO/ Lofton do diretible |
| Outpatient surgery - | 20%; after deductible | 40%; after deductible | 50%; after deductible |
| hospital | t care at a bospital but don't at | ov overnight your cost sharing | a amount counts toward all |
| covered benefits during you | t care at a hospital but don't st | ay overnight, your cost sharing | g amount counts toward all |
| Outpatient surgery - | 20%; after deductible | 40%; after deductible | 50%; after deductible |
| freestanding facility | 20%, arter deductible | 40 %, after deductible | 50%, after deductible |
| | t care at a hospital but don't st | av overnight, vour cost sharing | n amount counts toward all |
| covered benefits during you | | ay overnight, your cost sharing | g amount counts toward an |
| | | | |
| | | STANDARD SAVINGS | OUT-OF-NETWORK |
| MENTAL HEALTH | MAXIMUM SAVINGS | STANDARD SAVINGS | OUT-OF-NETWORK |
| | | STANDARD SAVINGS 40%; after deductible | OUT-OF-NETWORK 50%; after deductible |
| MENTAL HEALTH SERVICES Inpatient | MAXIMUM SAVINGS | 40%; after deductible | 50%; after deductible |
| MENTAL HEALTH SERVICES Inpatient | MAXIMUM SAVINGS 20%; after deductible | 40%; after deductible | 50%; after deductible |
| MENTAL HEALTH SERVICES Inpatient When you're admitted into a | MAXIMUM SAVINGS 20%; after deductible | 40%; after deductible | 50%; after deductible |
| MENTAL HEALTH SERVICES Inpatient When you're admitted into a benefits you receive. | MAXIMUM SAVINGS 20%; after deductible hospital for the care you need | 40%; after deductible d, your cost sharing amount co | 50%; after deductible bunts toward all covered |
| MENTAL HEALTH SERVICES Inpatient When you're admitted into a benefits you receive. Mental health office visits | MAXIMUM SAVINGS 20%; after deductible hospital for the care you need \$40 copay; no deductible | 40%; after deductible d, your cost sharing amount co \$60 copay; no deductible | 50%; after deductible bunts toward all covered 50%; after deductible |
| MENTAL HEALTH SERVICES Inpatient When you're admitted into a benefits you receive. Mental health office visits Other mental health services When you receive outpatien | MAXIMUM SAVINGS 20%; after deductible hospital for the care you need \$40 copay; no deductible 20%; after deductible t care at a facility but don't sta | 40%; after deductible d, your cost sharing amount co \$60 copay; no deductible 40%; after deductible | 50%; after deductible bunts toward all covered 50%; after deductible 50%; after deductible |
| MENTAL HEALTH SERVICES Inpatient When you're admitted into a benefits you receive. Mental health office visits Other mental health services When you receive outpatien covered benefits during you | MAXIMUM SAVINGS 20%; after deductible hospital for the care you need \$40 copay; no deductible 20%; after deductible t care at a facility but don't start visit. | 40%; after deductible d, your cost sharing amount co \$60 copay; no deductible 40%; after deductible y overnight, your cost sharing | 50%; after deductible bunts toward all covered 50%; after deductible 50%; after deductible amount counts toward all |
| MENTAL HEALTH SERVICES Inpatient When you're admitted into a benefits you receive. Mental health office visits Other mental health services When you receive outpatien covered benefits during your | MAXIMUM SAVINGS 20%; after deductible hospital for the care you need \$40 copay; no deductible 20%; after deductible t care at a facility but don't starvisit. MAXIMUM SAVINGS | 40%; after deductible d, your cost sharing amount co \$60 copay; no deductible 40%; after deductible y overnight, your cost sharing STANDARD SAVINGS | 50%; after deductible funts toward all covered 50%; after deductible 50%; after deductible amount counts toward all |
| MENTAL HEALTH SERVICES Inpatient When you're admitted into a benefits you receive. Mental health office visits Other mental health services When you receive outpatien covered benefits during your SUBSTANCE ABUSE Inpatient | MAXIMUM SAVINGS 20%; after deductible hospital for the care you need \$40 copay; no deductible 20%; after deductible t care at a facility but don't starvisit. MAXIMUM SAVINGS 20%; after deductible | 40%; after deductible d, your cost sharing amount co \$60 copay; no deductible 40%; after deductible y overnight, your cost sharing STANDARD SAVINGS 40%; after deductible | 50%; after deductible funts toward all covered 50%; after deductible 50%; after deductible amount counts toward all OUT-OF-NETWORK 50%; after deductible |
| MENTAL HEALTH SERVICES Inpatient When you're admitted into a benefits you receive. Mental health office visits Other mental health services When you receive outpatien covered benefits during your SUBSTANCE ABUSE Inpatient When you're admitted into a | MAXIMUM SAVINGS 20%; after deductible hospital for the care you need \$40 copay; no deductible 20%; after deductible t care at a facility but don't starvisit. MAXIMUM SAVINGS | 40%; after deductible d, your cost sharing amount co \$60 copay; no deductible 40%; after deductible y overnight, your cost sharing STANDARD SAVINGS 40%; after deductible | 50%; after deductible funts toward all covered 50%; after deductible 50%; after deductible amount counts toward all OUT-OF-NETWORK 50%; after deductible |
| MENTAL HEALTH SERVICES Inpatient When you're admitted into a benefits you receive. Mental health office visits Other mental health services When you receive outpatien covered benefits during your SUBSTANCE ABUSE Inpatient When you're admitted into a benefits you receive. | MAXIMUM SAVINGS 20%; after deductible hospital for the care you need \$40 copay; no deductible 20%; after deductible t care at a facility but don't star visit. MAXIMUM SAVINGS 20%; after deductible hospital for the care you need | 40%; after deductible d, your cost sharing amount co \$60 copay; no deductible 40%; after deductible y overnight, your cost sharing STANDARD SAVINGS 40%; after deductible d, your cost sharing amount co | 50%; after deductible bunts toward all covered 50%; after deductible 50%; after deductible amount counts toward all OUT-OF-NETWORK 50%; after deductible bunts toward all covered |
| MENTAL HEALTH SERVICES Inpatient When you're admitted into a benefits you receive. Mental health office visits Other mental health services When you receive outpatien covered benefits during your SUBSTANCE ABUSE Inpatient When you're admitted into a benefits you receive. Residential treatment | MAXIMUM SAVINGS 20%; after deductible hospital for the care you need \$40 copay; no deductible 20%; after deductible t care at a facility but don't starvisit. MAXIMUM SAVINGS 20%; after deductible | 40%; after deductible d, your cost sharing amount co \$60 copay; no deductible 40%; after deductible y overnight, your cost sharing STANDARD SAVINGS 40%; after deductible | 50%; after deductible funts toward all covered 50%; after deductible 50%; after deductible amount counts toward all OUT-OF-NETWORK 50%; after deductible |
| MENTAL HEALTH SERVICES Inpatient When you're admitted into a benefits you receive. Mental health office visits Other mental health services When you receive outpatien covered benefits during your SUBSTANCE ABUSE Inpatient When you're admitted into a benefits you receive. Residential treatment facility | MAXIMUM SAVINGS 20%; after deductible hospital for the care you need \$40 copay; no deductible 20%; after deductible t care at a facility but don't star visit. MAXIMUM SAVINGS 20%; after deductible hospital for the care you need 20%; after deductible | 40%; after deductible d, your cost sharing amount co \$60 copay; no deductible 40%; after deductible y overnight, your cost sharing STANDARD SAVINGS 40%; after deductible d, your cost sharing amount co 40%; after deductible | 50%; after deductible bunts toward all covered 50%; after deductible 50%; after deductible amount counts toward all OUT-OF-NETWORK 50%; after deductible bunts toward all covered 50%; after deductible |
| MENTAL HEALTH SERVICES Inpatient When you're admitted into a benefits you receive. Mental health office visits Other mental health services When you receive outpatien covered benefits during your SUBSTANCE ABUSE Inpatient When you're admitted into a benefits you receive. Residential treatment facility When you're admitted into a | MAXIMUM SAVINGS 20%; after deductible hospital for the care you need \$40 copay; no deductible 20%; after deductible t care at a facility but don't star visit. MAXIMUM SAVINGS 20%; after deductible hospital for the care you need 20%; after deductible | 40%; after deductible d, your cost sharing amount co \$60 copay; no deductible 40%; after deductible y overnight, your cost sharing STANDARD SAVINGS 40%; after deductible d, your cost sharing amount co 40%; after deductible | 50%; after deductible bunts toward all covered 50%; after deductible 50%; after deductible amount counts toward all OUT-OF-NETWORK 50%; after deductible bunts toward all covered |
| MENTAL HEALTH SERVICES Inpatient When you're admitted into a benefits you receive. Mental health office visits Other mental health services When you receive outpatien covered benefits during your SUBSTANCE ABUSE Inpatient When you're admitted into a benefits you receive. Residential treatment facility When you're admitted into a you receive. | MAXIMUM SAVINGS 20%; after deductible hospital for the care you need \$40 copay; no deductible 20%; after deductible t care at a facility but don't stary visit. MAXIMUM SAVINGS 20%; after deductible hospital for the care you need 20%; after deductible facility for the care you need, | 40%; after deductible d, your cost sharing amount co \$60 copay; no deductible 40%; after deductible y overnight, your cost sharing STANDARD SAVINGS 40%; after deductible d, your cost sharing amount co 40%; after deductible your cost sharing amount cou | 50%; after deductible funts toward all covered 50%; after deductible 50%; after deductible amount counts toward all OUT-OF-NETWORK 50%; after deductible funts toward all covered 50%; after deductible funts toward all covered benefits |
| MENTAL HEALTH SERVICES Inpatient When you're admitted into a benefits you receive. Mental health office visits Other mental health services When you receive outpatien covered benefits during your SUBSTANCE ABUSE Inpatient When you're admitted into a benefits you receive. Residential treatment facility When you're admitted into a you receive. Substance abuse office | MAXIMUM SAVINGS 20%; after deductible hospital for the care you need \$40 copay; no deductible 20%; after deductible t care at a facility but don't star visit. MAXIMUM SAVINGS 20%; after deductible hospital for the care you need 20%; after deductible | 40%; after deductible d, your cost sharing amount co \$60 copay; no deductible 40%; after deductible y overnight, your cost sharing STANDARD SAVINGS 40%; after deductible d, your cost sharing amount co 40%; after deductible | 50%; after deductible bunts toward all covered 50%; after deductible 50%; after deductible amount counts toward all OUT-OF-NETWORK 50%; after deductible bunts toward all covered 50%; after deductible |
| MENTAL HEALTH SERVICES Inpatient When you're admitted into a benefits you receive. Mental health office visits Other mental health services When you receive outpatien covered benefits during your SUBSTANCE ABUSE Inpatient When you're admitted into a benefits you receive. Residential treatment facility When you're admitted into a you receive. Substance abuse office visits | MAXIMUM SAVINGS 20%; after deductible hospital for the care you need \$40 copay; no deductible 20%; after deductible t care at a facility but don't star visit. MAXIMUM SAVINGS 20%; after deductible hospital for the care you need 20%; after deductible facility for the care you need, \$40 copay; no deductible | 40%; after deductible d, your cost sharing amount co \$60 copay; no deductible 40%; after deductible y overnight, your cost sharing STANDARD SAVINGS 40%; after deductible d, your cost sharing amount co 40%; after deductible your cost sharing amount cou \$60 copay; no deductible | 50%; after deductible bunts toward all covered 50%; after deductible 50%; after deductible amount counts toward all OUT-OF-NETWORK 50%; after deductible bunts toward all covered 50%; after deductible bunts toward all covered benefits 50%; after deductible bunts toward all covered benefits |
| MENTAL HEALTH SERVICES Inpatient When you're admitted into a benefits you receive. Mental health office visits Other mental health services When you receive outpatien covered benefits during your SUBSTANCE ABUSE Inpatient When you're admitted into a benefits you receive. Residential treatment facility When you're admitted into a you receive. Substance abuse office visits Other substance abuse | MAXIMUM SAVINGS 20%; after deductible hospital for the care you need \$40 copay; no deductible 20%; after deductible t care at a facility but don't stary visit. MAXIMUM SAVINGS 20%; after deductible hospital for the care you need 20%; after deductible facility for the care you need, | 40%; after deductible d, your cost sharing amount co \$60 copay; no deductible 40%; after deductible y overnight, your cost sharing STANDARD SAVINGS 40%; after deductible d, your cost sharing amount co 40%; after deductible your cost sharing amount cou | 50%; after deductible funts toward all covered 50%; after deductible 50%; after deductible amount counts toward all OUT-OF-NETWORK 50%; after deductible funts toward all covered 50%; after deductible funts toward all covered benefits |
| MENTAL HEALTH SERVICES Inpatient When you're admitted into a benefits you receive. Mental health office visits Other mental health services When you receive outpatien covered benefits during your SUBSTANCE ABUSE Inpatient When you're admitted into a benefits you receive. Residential treatment facility When you're admitted into a you receive. Substance abuse office visits Other substance abuse services | MAXIMUM SAVINGS 20%; after deductible hospital for the care you need \$40 copay; no deductible 20%; after deductible t care at a facility but don't star visit. MAXIMUM SAVINGS 20%; after deductible hospital for the care you need 20%; after deductible facility for the care you need, \$40 copay; no deductible | 40%; after deductible d, your cost sharing amount co \$60 copay; no deductible 40%; after deductible y overnight, your cost sharing STANDARD SAVINGS 40%; after deductible d, your cost sharing amount co 40%; after deductible your cost sharing amount cou \$60 copay; no deductible 40%; after deductible | 50%; after deductible bunts toward all covered 50%; after deductible 50%; after deductible amount counts toward all OUT-OF-NETWORK 50%; after deductible bunts toward all covered 50%; after deductible ants toward all covered benefits 50%; after deductible 50%; after deductible |

Prepared: 11/01/2024 11:48 AM

covered benefits during your visit.



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

| THERAPY SERVICES | MAXIMUM SAVINGS | STANDARD SAVINGS | OUT-OF-NETWORK |
|--|---|-------------------------------------|-------------------------------------|
| Spinal manipulation | \$40 copay; no deductible | \$60 copay; no deductible | 50%; after deductible |
| therapy | | | |
| Limited to 12 visits per year | | | |
| Outpatient short-term | \$40 copay; no deductible | \$60 copay; no deductible | 50%; after deductible |
| rehabilitation | | | |
| Limited to 25 visits per year | | | |
| Includes physical, occupation | nai, and speech therapies. 20%; after deductible | 400/ cofton do desatible | FOO() often dedicatible |
| Habilitative physical | 20%; after deductible | 40%; after deductible | 50%; after deductible |
| therapy Habilitative occupational | 20%; after deductible | 40%; after deductible | 50%; after deductible |
| therapy | 20%, after deductible | 40 %, after deductible | 50 %, arter deductible |
| Habilitative speech | 20%; after deductible | 40%; after deductible | 50%; after deductible |
| therapy | 2070, artor addadation | 1070, and addadable | 5070, and adaddible |
| 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 | \$40 copay; no deductible | \$60 copay; no deductible | 50%; after deductible |
| therapy | | | |
| | d with outpatient mental health | | |
| Autism related applied | 20%; after deductible | 40%; after deductible | 50%; after deductible |
| behavior analysis | | and the Control of the Alberta | nam tanakan Ci |
| | ces are the same as any other | | |
| OTHER SERVICES | MAXIMUM SAVINGS | STANDARD SAVINGS | OUT-OF-NETWORK |
| Skilled nursing facility Limited to 60 days per year | 20%; after deductible | 40%; after deductible | 50%; after deductible |
| | facility for the care you need | your cost sharing amount cou | nts toward all covered benefits |
| you receive. | facility for the care you need, | your cost snaring amount cou | ilis toward all covered benefits |
| Home health care | 20%; after deductible | 40%; after deductible | 50%; after deductible |
| Limited to 120 visits per year | | 4070, arter deductible | 5070, arter deddotible |
| Home health care services in | | | |
| | | care agency. One visit equals | a period of four hours or less. |
| Hospice care - inpatient | 20%; after deductible | 40%; after deductible | 50%; after deductible |
| | | | nts toward all covered benefits |
| you receive. | - | - | |
| Hospice care - outpatient | 20%; after deductible | 40%; after deductible | 50%; after deductible |
| | t care at a facility but don't stay | y overnight, your cost sharing | amount counts toward all |
| covered benefits during your | | | |
| Private duty nursing | Covered as part of home health care | Covered as part of home health care | Covered as part of home health care |
| We count each period of up | to 8 hours as one private duty | | data dare |
| Durable medical | 20%; after deductible | 40%; after deductible | 50%; after deductible |
| equipment | | | 1170, 3.13. 333331010 |
| 1 | | | |



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

| Diabetic supplies (if not | Covered same as any | Covered same as any | Covered same as any |
|--|--|--------------------------------------|---------------------------------|
| covered under the | other medical expense. | other medical expense. | other medical expense. |
| prescription drug benefit) | | | |
| | You pay your prescription | You pay your prescription | You pay your prescription |
| | drug cost sharing amount if | drug cost sharing amount if | drug cost sharing amount if |
| | you have prescription drug | you have prescription drug | you have prescription drug |
| | coverage. If not, you pay | coverage. If not, you pay | coverage. If not, you pay |
| | your PCP visit cost sharing | your PCP visit cost sharing | your PCP visit cost sharing |
| | amount. | amount. | amount. |
| Infusion therapy - | \$40 copay; no deductible | \$60 copay; no deductible | 50%; after deductible |
| home/office | | | |
| Infusion therapy - | 20%; after deductible | 40%; after deductible | 50%; after deductible |
| outpatient | | | |
| hospital/freestanding | | | |
| facility | Variable de la companya de la compan | Manager of the state of the state of | Nation |
| 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 | service and where you | |
| | receive it. | 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™ | |
| Llooring oids | designated facilities only. | designated facilities only. | 200/ upo dodustiblo |
| Hearing aids \$3,000 per rolling 36 month | 20%; no deductible | 20%; no deductible | 20%; no deductible |
| Vision eyewear | Covered 100% up to \$350 | = | |
| vision eyewear | per year; no deductible | | |
| Transplants | 20%; after deductible | 20%; after deductible | 50%; after deductible |
| Tanopianto | 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 |
| | contracted racinty. | contracted racinty. | when using a non-IOE |
| | | | facility. |
| Bariatric surgery | Not Covered | Not Covered | Not Covered |
| Acupuncture | \$30 copay; no deductible | \$40 copay; no deductible | 50%; after deductible |
| Limited to 12 visits per year | | | |
| Alaska medical travel | Covered 100%; no | Covered 100%; no | Covered 100%; no |
| reimbursement | deductible | deductible | deductible |
| | nearest facility equipped to dia | | |
| | cy transportation services REQ | UIRE prior approval and are su | ubject to limitations; see your |
| plan documents. | | | |
| | member coinsurance, after dec | luctible, for services that are no | either in-network nor out-of- |
| network. | | | |
| FAMILY PLANNING | MAXIMUM SAVINGS | STANDARD SAVINGS | OUT-OF-NETWORK |



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

| Infertility treatment | Your cost sharing amount | Your cost sharing amount | Your cost sharing amount |
|---|--|---|---|
| | 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. |
| | iagnosis and treatment of the | | N. (O |
| Advanced Reproductive | Not Covered | Not Covered | Not Covered |
| Technology (ART) | | T) was at a interest libraries to a second | for (OIFT) and define in denting |
| | | T), gamete intrafallopian trans | |
| Comprehensive infertility | Not Covered | erm injection (ICSI), or ovum m Not Covered | Not Covered |
| services | Not Covered | Not Covered | Not Covered |
| Artificial insemination and ov | ulation induction | | |
| Vasectomy | 20%; after deductible | 40%; after deductible | 50%; after deductible |
| Tubal ligation | Covered 100%; no | Covered 100%; no | 50%; after deductible |
| i abai ngation | deductible | deductible | 5070, after academole |
| PHARMACY | IN-NETWORK | OUT-OF-NETWORK | |
| | | m Savings tier only. Out-of-ne | etwork pharmacy expenses |
| apply towards the out-of-net | | , | , , , |
| Pharmacy plan type | Advanced Control Plan - Ae | tna | |
| Prescription Drug | \$300 per Individual | \$300 per Individual | |
| | • | • | |
| Deductible (per calendar | | | |
| | | | |
| year) | \$600 per Family | \$600 per Family | |
| | xpenses add up toward both y | \$600 per Family our in-network and out-of-netw | ork prescription drug |
| year) Covered prescription drug exdeductible at the same time. | xpenses add up toward both y | our in-network and out-of-netw | |
| year) Covered prescription drug exdeductible at the same time. You must first meet the pres | xpenses add up toward both y | | |
| year) Covered prescription drug exdeductible at the same time. You must first meet the presotherwise noted. | xpenses add up toward both y cription drug deductible before | our in-network and out-of-netweethe plan begins paying prescr | ription drug benefits, unless |
| year) Covered prescription drug exdeductible at the same time. You must first meet the presotherwise noted. Your family will have one prescription | xpenses add up toward both y cription drug deductible before escription drug deductible. You | our in-network and out-of-netweethe plan begins paying presculus will meet it when the expense | ription drug benefits, unless |
| year) Covered prescription drug extended deductible at the same time. You must first meet the presotherwise noted. Your family will have one preadd up to the family prescrip | xpenses add up toward both y cription drug deductible before escription drug deductible. You | our in-network and out-of-netweethe plan begins paying prescr | ription drug benefits, unless |
| year) Covered prescription drug exdeductible at the same time. You must first meet the presotherwise noted. Your family will have one preadd up to the family prescrip drug deductible. | expenses add up toward both your cription drug deductible before escription drug deductible. You tion drug deductible. No one p | our in-network and out-of-netweethe plan begins paying presculus will meet it when the expense | ription drug benefits, unless |
| year) Covered prescription drug exideductible at the same time. You must first meet the presotherwise noted. Your family will have one preadd up to the family prescrip drug deductible. No deductible for generic drug | expenses add up toward both your cription drug deductible before escription drug deductible. You tion drug deductible. No one pugs | our in-network and out-of-netweethe the plan begins paying presculus will meet it when the expense person will have to pay more the | ription drug benefits, unless es of several family members an the individual prescription |
| year) Covered prescription drug exdeductible at the same time. You must first meet the presotherwise noted. Your family will have one preadd up to the family prescripdrug deductible. No deductible for generic drug prescription drug out-of- | expenses add up toward both your cription drug deductible before escription drug deductible. You tion drug deductible. No one pugs | our in-network and out-of-netweethe plan begins paying presculus will meet it when the expense | ription drug benefits, unless es of several family members an the individual prescription |
| Covered prescription drug exdeductible at the same time. You must first meet the presotherwise noted. Your family will have one preadd up to the family prescripdrug deductible. No deductible for generic drug procket limit | cription drug deductible before escription drug deductible. You tion drug deductible. No one pugs Prescription drug expenses | e the plan begins paying prescr will meet it when the expense person will have to pay more the | ription drug benefits, unless es of several family members ean the individual prescription ocket limit. |
| Covered prescription drug exdeductible at the same time. You must first meet the presotherwise noted. Your family will have one preadd up to the family prescrip drug deductible. No deductible for generic drup prescription drug out-of-pocket limit. | cription drug deductible before escription drug deductible. You tion drug deductible. No one pugs Prescription drug expenses expenses add up toward both you | our in-network and out-of-netweethe the plan begins paying presculus will meet it when the expense person will have to pay more the | ription drug benefits, unless es of several family members ean the individual prescription ocket limit. |
| Covered prescription drug exdeductible at the same time. You must first meet the presotherwise noted. Your family will have one preadd up to the family prescripdrug deductible. No deductible for generic drug Prescription drug out-of-pocket limit Covered prescription drug expocket limit at the same time | cription drug deductible before escription drug deductible. You tion drug deductible. No one pugs Prescription drug expenses expenses add up toward both you | e the plan begins paying prescr will meet it when the expense person will have to pay more the | ription drug benefits, unless es of several family members ean the individual prescription ocket limit. |
| Covered prescription drug exdeductible at the same time. You must first meet the presotherwise noted. Your family will have one preadd up to the family prescripdrug deductible. No deductible for generic drug Prescription drug out-of-pocket limit Covered prescription drug expocket limit at the same time Preferred generic drugs | cription drug deductible before escription drug deductible. You tion drug deductible. No one pugs Prescription drug expenses expenses add up toward both you. | e the plan begins paying prescue the plan begins paying prescue will meet it when the expense person will have to pay more the apply to your medical out-of-poour in-network and out-of-network | ription drug benefits, unless es of several family members ean the individual prescription ocket limit. |
| Covered prescription drug ex deductible at the same time. You must first meet the pres otherwise noted. Your family will have one preadd up to the family prescrip drug deductible. No deductible for generic drug Prescription drug out-of-pocket limit Covered prescription drug expocket limit at the same time Preferred generic drugs Retail | cription drug deductible before escription drug deductible. You tion drug deductible. No one pugs Prescription drug expenses expenses add up toward both you. | the plan begins paying prescription will meet it when the expense person will have to pay more the apply to your medical out-of-pour in-network and out-of-network of allowed charges | ription drug benefits, unless es of several family members ean the individual prescription ocket limit. |
| Covered prescription drug ex deductible at the same time. You must first meet the pres otherwise noted. Your family will have one preadd up to the family prescrip drug deductible. No deductible for generic drug Prescription drug out-of-pocket limit Covered prescription drug expocket limit at the same time Preferred generic drugs Retail Mail order | cription drug deductible before escription drug deductible. You tion drug deductible. No one pugs Prescription drug expenses expenses add up toward both you. \$15 copay \$37.50 copay | e the plan begins paying prescue the plan begins paying prescue will meet it when the expense person will have to pay more the apply to your medical out-of-poour in-network and out-of-network | ription drug benefits, unless es of several family members ean the individual prescription ocket limit. |
| Covered prescription drug ex deductible at the same time. You must first meet the pres otherwise noted. Your family will have one present add up to the family prescrip drug deductible. No deductible for generic drug Prescription drug out-ofpocket limit Covered prescription drug expocket limit at the same time Preferred generic drugs Retail Mail order Preferred brand-name drug | cription drug deductible before escription drug deductible. You tion drug deductible. No one pugs Prescription drug expenses expenses add up toward both you. \$15 copay \$37.50 copay | the plan begins paying prescription will meet it when the expense person will have to pay more the apply to your medical out-of-pour in-network and out-of-network and out-of-network of allowed charges 20% of allowed charges | ription drug benefits, unless es of several family members ean the individual prescription ocket limit. |
| Covered prescription drug extended deductible at the same time. You must first meet the prescription drug extended dup to the family prescription drug deductible. No deductible for generic drug drug drug drug drug drug drug drug | cription drug deductible before escription drug deductible. You tion drug deductible. No one pugs Prescription drug expenses expenses add up toward both you. \$15 copay \$37.50 copay gs \$55 copay | e the plan begins paying prescue the plan begins paying prescue will meet it when the expense person will have to pay more the apply to your medical out-of-pour in-network and out-of-network and out-of-network and charges 20% of allowed charges | ription drug benefits, unless es of several family members ean the individual prescription ocket limit. |
| Covered prescription drug extended deductible at the same time. You must first meet the prescription drug extended dup to the family prescription drug deductible. No deductible for generic drug Prescription drug out-of-pocket limit Covered prescription drug expocket limit at the same time Preferred generic drugs Retail Mail order Preferred brand-name drug Retail Mail order | cription drug deductible before escription drug deductible. You tion drug deductible. No one pugs Prescription drug expenses expenses add up toward both you. \$15 copay \$37.50 copay \$55 copay \$137.50 copay | the plan begins paying prescription will meet it when the expense person will have to pay more the apply to your medical out-of-pour in-network and out-of-network and out-of-network of allowed charges 20% of allowed charges | ription drug benefits, unless es of several family members ean the individual prescription ocket limit. |
| Covered prescription drug extended deductible at the same time. You must first meet the prescription drug extended dup to the family prescription drug deductible. No deductible for generic drug drug drug drug drug drug drug drug | cription drug deductible before escription drug deductible. You tion drug deductible. No one pugs Prescription drug expenses expenses add up toward both yes. \$15 copay \$37.50 copay \$55 copay \$137.50 copay brand-name drugs | the plan begins paying prescription will meet it when the expense terson will have to pay more the apply to your medical out-of-pour in-network and out-of-network and out-of-network of allowed charges 20% of allowed charges 20% of allowed charges 20% of allowed charges | ription drug benefits, unless es of several family members ean the individual prescription ocket limit. |
| Covered prescription drug extended deductible at the same time. You must first meet the prescription drug extended dup to the family prescription drug deductible. No deductible for generic drug Prescription drug out-of-pocket limit Covered prescription drug expocket limit at the same time Preferred generic drugs Retail Mail order Preferred brand-name drug Retail Mail order Non-preferred generic and | cription drug deductible before escription drug deductible. You tion drug deductible. No one pugs Prescription drug expenses expenses add up toward both you. \$15 copay \$37.50 copay \$55 copay \$137.50 copay | e the plan begins paying prescue the plan begins paying prescue will meet it when the expense person will have to pay more the apply to your medical out-of-pour in-network and out-of-network and out-of-network and charges 20% of allowed charges | ription drug benefits, unless es of several family members ean the individual prescription ocket limit. |
| Covered prescription drug extended deductible at the same time. You must first meet the prescription drug extended dup to the family prescripting deductible. No deductible for generic drug deductible for generic drug Prescription drug out-of-pocket limit Covered prescription drug expocket limit at the same time Preferred generic drugs Retail Mail order Preferred brand-name drug Retail Mail order Non-preferred generic and Retail | cription drug deductible before escription drug deductible. You tion drug deductible. No one pugs Prescription drug expenses expenses add up toward both you. \$15 copay \$37.50 copay \$55 copay \$137.50 copay brand-name drugs \$95 copay | the plan begins paying prescription will meet it when the expense person will have to pay more the apply to your medical out-of-pour in-network and out-of-network and out-of-network and charges 20% of allowed charges | ription drug benefits, unless es of several family members ean the individual prescription ocket limit. |
| Covered prescription drug extended deductible at the same time. You must first meet the prescription drug extended dup to the family prescripting deductible. No deductible for generic drug deductible for generic drug prescription drug out-of-pocket limit Covered prescription drug expocket limit at the same time. Preferred generic drugs Retail Mail order Non-preferred generic and Retail Mail order | cription drug deductible before escription drug deductible. You tion drug deductible. No one pugs Prescription drug expenses expenses add up toward both you. \$15 copay \$37.50 copay \$55 copay \$137.50 copay brand-name drugs \$95 copay | the plan begins paying prescription will meet it when the expense person will have to pay more the apply to your medical out-of-pour in-network and out-of-network and out-of-network and charges 20% of allowed charges | ription drug benefits, unless es of several family members ean the individual prescription ocket limit. |
| Covered prescription drug ex deductible at the same time. You must first meet the pres otherwise noted. Your family will have one present add up to the family prescrip drug deductible. No deductible for generic drug deductible for generic drug Prescription drug out-of-pocket limit Covered prescription drug expocket limit at the same time Preferred generic drugs Retail Mail order Preferred brand-name drug Retail Mail order Non-preferred generic and Retail Mail order Specialty drugs Preferred specialty | cription drug deductible before escription drug deductible. You tion drug deductible. No one pugs Prescription drug expenses expenses add up toward both you start to be seen to | the plan begins paying prescription will meet it when the expense person will have to pay more the apply to your medical out-of-pour in-network and out-of-network and out-of-network and charges 20% of allowed charges | ription drug benefits, unless es of several family members ean the individual prescription ocket limit. |
| Covered prescription drug ex deductible at the same time. You must first meet the pres otherwise noted. Your family will have one preadd up to the family prescrip drug deductible. No deductible for generic drug Prescription drug out-of-pocket limit Covered prescription drug expocket limit at the same time Preferred generic drugs Retail Mail order Preferred brand-name drug Retail Mail order Non-preferred generic and Retail Mail order Specialty drugs | cription drug deductible before escription drug deductible. You tion drug deductible. No one pugs Prescription drug expenses expenses add up toward both you start to be seen to | the plan begins paying prescription will meet it when the expense person will have to pay more the apply to your medical out-of-pour in-network and out-of-network and out-of-network and charges 20% of allowed charges | ription drug benefits, unless es of several family members ean the individual prescription ocket limit. |



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

Pharmacy day supply and requirements

Retail 1x retail copay for 30 day supply, 2x retail copay for 31-60 day supply, and 3x

retail copay for 61-90 day supply from Aetna National Network.

Mail order You can get a 31-90-day supply from CVS Caremark® Mail Service

Pharmacy.

Advanced Control Formulary Aetna Insured List

Your prescription drug plan also includes:

· Diabetic supplies

- \$25 copay maximum per fill per 30 day supply for formulary insulin drugs; no deductible for formulary insulin drugs
- A limited list of over-the-counter medications when filled with a prescription

Family planning

• Contraceptives covered up to a 12-month supply. Contraceptive copay strategy applies.

The following are covered 100% in-network:

- Oral chemotherapy drugs
- Seasonal vaccinations
- Preventive vaccinations
- Affordable Care Act (ACA) eligible preventive medications and contraceptives

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.

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.

This amount is based on the out-of-network plan you or your employer picks.

• For doctors and other professionals the amount is based on the "prevailing" charges. We get this data from an external database.



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

• 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.

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.



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

- 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 MinuteClinic-branded walk-in clinics) are both within the CVS Health family. © 2021 Aetna Inc.