

penalty amounts) may be used to satisfy the out-of-pocket maximum. No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, all family members will be considered as having met their out-of-maximum for the remainder of the year. Payment for Out-of-Network Care* Not applicable Professional: 105% of Medicare Precertification Requirements Some out-of-network services need approval by us in advance (precertification). Without this approval, a benefit reduction per occurrence applies separately to each type of covered service. Refer to your plan documents for a full list of services this approval. Referral Requirement Not Required Not Required Not applicable PHYSICIAN SERVICES NETWORK CARE OUT-OF-NETWORK C Office Visits to Non-Specialist Some out-of-network services and internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illne injury. Telemedicine Consultations with Non-Specialist Virtual Primary Care Telemedicine Provider Consultations Includes basic medical and preventive health care services for persons 18 years of age or older. Telemedicine preventive screening and counseling services are subject to the preventive care benefit. Non-Specialist Telemedicine Provider Consultations Specialist Office Visits S75 copayment after deductible Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Specialist Office Visits	PLAN FEATURES	NETWORK CARE	OUT-OF-NETWORK CARE
Unless otherwise indicated, the deductible must be met before benefits can be paid. All covered expenses accumulate separately toward the network and out-of-network Deductible. As indicated in the plan, member cost sharing for certain services are excluded from the charges to meet the deductible. No one family member may contribute more than the individual deductible amount to the family deductible. Once the family deductible is met, all framily members will be considered as having met their deductible for the remainder of the year. Member Coinsurance (applies to all expenses unless otherwise stated) Out-of-Pocket (OOP) Maximum (per calendar year, includes deductible) \$15,000 Family \$20,000 Individual (per calendar year, includes deductible) \$15,000 Family \$60,000 Fami	ary Care Physician Selection N	Not required	Not required
All covered expenses accumulate separately toward the network and out-of-network Deductible. As indicated in the plan, member cost sharing for certain services are excluded from the charges to meet the deductible. No one family member may contribute more than the individual deductible amount to the family deductible. Once the famil deductible is met, all family members will be considered as having met their deductible for the remainder of the year. Member Coinsurance (applies to all expenses unless otherwise stated) Out-of-Pocket (OOP) Maximum (\$7,500 Individual \$15,000 Family) All covered expenses accumulate separately toward the network and out-of-network Out of Pocket Limit. Pharmacy expenses apply towards the Out-of-Pocket Maximum. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and copays (excensive maximum). No one family member may contribute more than the individual out-of-pocket maximum. Once the family out-of-pocket maximum is met, all family members will be considered as having met their out-omaximum for the remainder of the year. Payment for Out-of-Network Care* Not applicable Precertification Requirements Some out-of-network services need approval by us in advance (precertification). Without this approval, a benefit reduction per occurrence applies separately to each type of covered service. Refer to your plan documents for a full list of services this approval. Referral Requirement Not Required Not Required Not applicable Net WORK CARE OUT-OF-NETWORK C Office Visits to Non-Specialist Virtual Primary Care Telemedicine Provider Consultations Covered in full after deductible Not Covered Not Covered Not Covered Not Specialist Telemedicine Provider Consultations Specialist Telemedicine Provider Consultations Specialist Office Visits			
As indicated in the plan, member cost sharing for certain services are excluded from the charges to meet the deductible. No one family member may contribute more than the individual deductible amount to the family deductible. Once the famil deductible is met, all family members will be considered as having met their deductible for the remainder of the year. Member Coinsurance (applies to all expenses unless otherwise stated) 50% 50% Out-of-Pocket (OOP) Maximum \$7,500 Individual \$20,000 Individual \$20,000 Family All covered expenses accumulate separately toward the network and out-of-network Out of Pocket Limit. Pharmacy expenses apply towards the Out-of-Pocket Maximum. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and copays (expenalty amounts) may be used to satisfy the out-of-pocket maximum. No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, all family members will be considered as having met their out-omaximum for the remainder of the year. Payment for Out-of-Network Care* Not applicable Professional: 105% of Medicare Precertification Requirements Some out-of-network services need approval by us in advance (precertification). Without this approval, a benefit reduction per occurrence applies separately to each type of covered service. Refer to your plan documents for a full list of services this approval. Referral Requirement Not Required Not applicable Soft Medicare PHYSICIAN SERVICES NETWORK CARE OUT-OF-NETWORK C Office Visits to Non-Specialist \$35 copayment after deductible 50% after deductible Virtual Primary Care Telemedicine Provider Consultations Includes basic medical and preventive health care services for persons 18 years of age or older. Telemedicine preventive screening and counseling services are subject to the preventive care benefit. Non-Specialist Telemedicine Provider Consultations Specialist Of	ss otherwise indicated, the deductible must be met be	pefore benefits can be paid.	
No one family member may contribute more than the individual deductible amount to the family deductible. Once the famil deductible is met, all family members will be considered as having met their deductible for the remainder of the year. Member Coinsurance (applies to all expenses unless otherwise stated) Out-of-Pocket (OP) Maximum (per calendar year, includes deductible) All covered expenses accumulate separately toward the network and out-of-network Out of Pocket Limit. Pharmacy expenses apply towards the Out-of-Pocket Maximum. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and copays (expenally amounts) may be used to satisfy the out-of-pocket maximum. No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum. None the family out-of-pocket maximum is met, all family members will be considered as having met their out-of-maximum for the remainder of the year. Payment for Out-of-Network Care* Not applicable Professional: 105% of Medicare Precertification Requirements Some out-of-network services need approval by us in advance (precertification). Without this approval, a benefit reduction per occurrence applies separately to each type of covered service. Refer to your plan documents for services this approval. Referral Requirement Not Required Not Required Not applicable PHYSICIAN SERVICES Office Visits to Non-Specialist \$35 copayment after deductible 50% after deductible Virtual Primary Care Telemedicine Provider Consultations Includes basic medical and preventive health care services for persons 18 years of age or oder. Telemedicine preventive screening and counseling services are subject to the preventive health care services are subject to the preventive health care services are subject to the preventive care benefit. Non-Specialist Telemedicine Provider Consultations Specialist Office Visits	overed expenses accumulate separately toward the n	network and out-of-network Deductib	le.
deductible is met, all family members will be considered as having met their deductible for the remainder of the year.	dicated in the plan, member cost sharing for certain s	services are excluded from the charge	ges to meet the deductible.
Capplies to all expenses unless otherwise stated)	ne family member may contribute more than the indivictible is met, all family members will be considered as	vidual deductible amount to the familias having met their deductible for the	y deductible. Once the family remainder of the year.
Second Services Second Seco		50%	50%
Pharmacy expenses apply towards the Out-of-Pocket Maximum. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and copays (excepnally amounts) may be used to satisfy the out-of-pocket maximum. No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum for the remainder of the year. Payment for Out-of-Network Care* Not applicable Professional: 105% of Medifacility: 140% of Medicare Precertification Requirements Some out-of-network services need approval by us in advance (precertification). Without this approval, a benefit reduction per occurrence applies separately to each type of covered service. Refer to your plan documents for a full list of services this approval. Referral Requirement Not Required Not Required Not Required Not applicable PHYSICIAN SERVICES NETWORK CARE OUT-OF-NETWORK C Office Visits to Non-Specialist Non-Specialist Virtual Primary Care Telemedicine Provider Consultations Includes basic medical and preventive health care services for persons 18 years of age or older. Telemedicine preventive screening and counseling services are subject to the preventive care benefit. Non-Specialist Telemedicine Provider Consultations Specialist Office Visits Specialist Office Visits Specialist Office Visits Specialist Office Visits Not Covered Specialist Office Visits Some out-of-pocket maximum amount to the family out-of-pocket maximum is met, all family members will be considered as having met their out-of-pocket maximum amount to the family out-of-pocket maximum amount to the famil			
Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and copays (excepenalty amounts) may be used to satisfy the out-of-pocket maximum. No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, all family members will be considered as having met their out-of-maximum for the remainder of the year. Payment for Out-of-Network Care* Not applicable Professional: 105% of Medicare Precertification Requirements Some out-of-network services need approval by us in advance (precertification). Without this approval, a benefit reduction per occurrence applies separately to each type of covered service. Refer to your plan documents for a full list of services this approval. Referral Requirement Not Required Not Required Not applicable PHYSICIAN SERVICES NETWORK CARE OUT-OF-NETWORK C Office Visits to Non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illneinjury. Telemedicine Consultations with Non-Specialist Virtual Primary Care Telemedicine Provider Consultations Includes basic medical and preventive health care services for persons 18 years of age or older. Telemedicine preventive screening and counseling services are subject to the preventive care benefit. Non-Specialist Telemedicine Provider Consultations Specialist Office Visits Specialist Office Visits Specialist Office Visits Sout-off-pocket maximum amount to the family out-of-pocket maximum amount to the family out-of-pocket maximum benefits and rout-of-pocket maximum benefits and value for feature in the family percentive deductible Not Covered Not Covered Not Covered Specialist Office Visits	overed expenses accumulate separately toward the n	network and out-of-network Out of Po	ocket Limit.
maximum. Once the family out-of-pocket maximum is met, all family members will be considered as having met their out-of-maximum for the remainder of the year. Payment for Out-of-Network Care* Not applicable Professional: 105% of Medicare Precertification Requirements Some out-of-network services need approval by us in advance (precertification). Without this approval, a benefit reduction per occurrence applies separately to each type of covered service. Refer to your plan documents for a full list of services this approval. Referral Requirement Not Required Not applicable PHYSICIAN SERVICES NETWORK CARE OUT-OF-NETWORK C Office Visits to Non-Specialist \$35 copayment after deductible Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illne injury. Telemedicine Consultations with Non-Specialist \$35 copayment after deductible Virtual Primary Care Telemedicine Provider Consultations Includes basic medical and preventive health care services for persons 18 years of age or older. Telemedicine preventive screening and counseling services are subject to the preventive care benefit. Non-Specialist Telemedicine Provider Consultations Specialist Office Visits \$75 copayment after deductible 50% after deductible	Pharmacy expenses apply towards the Out-of-Pocket Maximum. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and copays (except any penalty amounts) may be used to satisfy the out-of-pocket maximum.		
Precertification Requirements Some out-of-network services need approval by us in advance (precertification). Without this approval, a benefit reduction per occurrence applies separately to each type of covered service. Refer to your plan documents for a full list of services this approval. Referral Requirement Not Required Not applicable PHYSICIAN SERVICES NETWORK CARE OUT-OF-NETWORK COME Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illustringury. Telemedicine Consultations with Non-Specialist Virtual Primary Care Telemedicine Provider Consultations Includes basic medical and preventive health care services for persons 18 years of age or older. Telemedicine preventive screening and counseling services are subject to the preventive care benefit. Non-Specialist Telemedicine Provider Consultations Specialist Office Visits \$75 copayment after deductible 50% after deductible Not Covered Not Covered Specialist Office Visits	mum. Once the family out-of-pocket maximum is met	et, all family members will be consider	red as having met their out-of-pocket
Some out-of-network services need approval by us in advance (precertification). Without this approval, a benefit reduction per occurrence applies separately to each type of covered service. Refer to your plan documents for a full list of services to this approval. Referral Requirement Not Required Not Required Not applicable PHYSICIAN SERVICES NETWORK CARE OUT-OF-NETWORK C Office Visits to Non-Specialist \$35 copayment after deductible Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illneinjury. Telemedicine Consultations with Non-Specialist \$35 copayment after deductible 50% after deductible Virtual Primary Care Telemedicine Provider Consultations Includes basic medical and preventive health care services for persons 18 years of age or older. Telemedicine preventive screening and counseling services for persons 18 years of age or older. Telemedicine preventive screening and counseling services are subject to the preventive care benefit. Non-Specialist Telemedicine Provider Consultations Specialist Office Visits \$75 copayment after deductible 50% after deductible	nent for Out-of-Network Care*	Not applicable	Professional: 105% of Medicare Facility: 140% of Medicare
per occurrence applies separately to each type of covered service. Refer to your plan documents for a full list of services this approval. Referral Requirement PHYSICIAN SERVICES Office Visits to Non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illustriquiry. Telemedicine Consultations with Non-Specialist Virtual Primary Care Telemedicine Provider Consultations Includes basic medical and preventive health care services for persons 18 years of age or older. Telemedicine proventive screening and counseling services are subject to the preventive care benefit. Non-Specialist Telemedicine Provider Consultations Specialist Office Visits \$75 copayment after deductible Not Covered Not Covered Not Covered Not Covered Not Covered S75 copayment after deductible S0% after deductible	Precertification Requirements		
PHYSICIAN SERVICES STOPAYMENT CARE OUT-OF-NETWORK COMMENT COMM	occurrence applies separately to each type of covered	vance (precertification). Without this a discribination and service. Refer to your plan docume	approval, a benefit reduction of \$400 ents for a full list of services that need
Sast copayment after deductible So% after deductible	rral Paguirament	Mat Danishad	Martin and Production
Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illnoinjury. Telemedicine Consultations with Non-Specialist Virtual Primary Care Telemedicine Provider Consultations Includes basic medical and preventive health care services for persons 18 years of age or older. Telemedicine preventive screening and counseling services are subject to the preventive care benefit. Non-Specialist Telemedicine Provider Consultations Specialist Office Visits \$75 copayment after deductible 50% after deductible Not Covered Not Covered Not Covered S75 copayment after deductible 50% after deductible	nai Kequirement	Not Required	Not applicable
Telemedicine Consultations with Non-Specialist Some after deductible Virtual Primary Care Telemedicine Provider Consultations Includes basic medical and preventive health care services for persons 18 years of age or older. Telemedicine preventive screening and counseling services are subject to the preventive care benefit. Non-Specialist Telemedicine Provider Consultations Specialist Office Visits \$35 copayment after deductible Covered in full after deductible Not Covered Not Covered Not Covered Some after deductible Not Covered Some after deductible			OUT-OF-NETWORK CARE
Virtual Primary Care Telemedicine Provider Consultations Includes basic medical and preventive health care services for persons 18 years of age or older. Telemedicine preventive screening and counseling services are subject to the preventive care benefit. Non-Specialist Telemedicine Provider Consultations Covered in full after deductible Not Covered Not Covered Not Covered Not Covered State of the preventive care benefit. Not Covered Not Covered Not Covered State of the preventive care benefit.	PHYSICIAN SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Includes basic medical and preventive health care services for persons 18 years of age or older. Telemedicine preventive screening and counseling services are subject to the preventive care benefit. Non-Specialist Telemedicine Provider Consultations Covered in full after deductible Not Covered Specialist Office Visits \$75 copayment after deductible	PHYSICIAN SERVICES te Visits to Non-Specialist des services of an internist, general physician, family	NETWORK CARE \$35 copayment after deductible	OUT-OF-NETWORK CARE 50% after deductible
Consultations \$75 copayment after deductible 50% after deductible	PHYSICIAN SERVICES se Visits to Non-Specialist des services of an internist, general physician, family //	NETWORK CARE \$35 copayment after deductible y practitioner or pediatrician for diagn	OUT-OF-NETWORK CARE 50% after deductible osis and treatment of an illness or
	PHYSICIAN SERVICES the Visits to Non-Specialist des services of an internist, general physician, family y. medicine Consultations with Non-Specialist tal Primary Care Telemedicine Provider sultations des basic medical and preventive health care ces for persons 18 years of age or older. medicine preventive screening and counseling	NETWORK CARE \$35 copayment after deductible y practitioner or pediatrician for diagn \$35 copayment after deductible	OUT-OF-NETWORK CARE 50% after deductible osis and treatment of an illness or 50% after deductible
Telemedicine Consultations with Specialist \$75 copayment after deductible 50% after deductible	physician services te Visits to Non-Specialist des services of an internist, general physician, family medicine Consultations with Non-Specialist sal Primary Care Telemedicine Provider sultations des basic medical and preventive health care ces for persons 18 years of age or older. medicine preventive screening and counseling ces are subject to the preventive care benefit. Specialist Telemedicine Provider \$ 5	NETWORK CARE \$35 copayment after deductible y practitioner or pediatrician for diagn \$35 copayment after deductible Covered in full after deductible	OUT-OF-NETWORK CARE 50% after deductible cosis and treatment of an illness or 50% after deductible Not Covered
The soperation of the sound of	physician services the Visits to Non-Specialist des services of an internist, general physician, family medicine Consultations with Non-Specialist sal Primary Care Telemedicine Provider sultations des basic medical and preventive health care ces for persons 18 years of age or older. medicine preventive screening and counseling ces are subject to the preventive care benefit. Specialist Telemedicine Provider sultations Care	NETWORK CARE \$35 copayment after deductible y practitioner or pediatrician for diagn \$35 copayment after deductible Covered in full after deductible Covered in full after deductible	OUT-OF-NETWORK CARE 50% after deductible cosis and treatment of an illness or 50% after deductible Not Covered
Specialist Telemedicine Provider Consultations Covered in full after deductible Not Covered	PHYSICIAN SERVICES the Visits to Non-Specialist des services of an internist, general physician, family of the medicine Consultations with Non-Specialist all Primary Care Telemedicine Provider sultations des basic medical and preventive health care ces for persons 18 years of age or older. medicine preventive screening and counseling ces are subject to the preventive care benefit. Specialist Telemedicine Provider sultations cialist Office Visits \$ 3.	NETWORK CARE \$35 copayment after deductible y practitioner or pediatrician for diagn \$35 copayment after deductible Covered in full after deductible Covered in full after deductible	OUT-OF-NETWORK CARE 50% after deductible cosis and treatment of an illness or 50% after deductible Not Covered
Non-Specialist and Specialist Surgical Services 50% after deductible 50% after deductible	PHYSICIAN SERVICES the Visits to Non-Specialist des services of an internist, general physician, family of the provider of the preventive health care can be preventive screening and counseling can be are subject to the preventive care benefit. Specialist Telemedicine Provider of the preventive care benefit. Specialist Telemedicine Provider of the preventive care benefit. Specialist Telemedicine Provider of the preventive care benefit. Specialist Office Visits of the preventive care benefit.	NETWORK CARE \$35 copayment after deductible y practitioner or pediatrician for diagn \$35 copayment after deductible Covered in full after deductible \$75 copayment after deductible \$75 copayment after deductible	OUT-OF-NETWORK CARE 50% after deductible cosis and treatment of an illness or 50% after deductible Not Covered Not Covered 50% after deductible 50% after deductible
Walk-in Clinics Designated Walk-in Clinics: Covered in full after deductible All Other Network Providers: \$35 copayment after deductible	PHYSICIAN SERVICES the Visits to Non-Specialist des services of an internist, general physician, family //. medicine Consultations with Non-Specialist sultations des basic medical and preventive health care ces for persons 18 years of age or older. medicine preventive screening and counseling ces are subject to the preventive care benefit. Specialist Telemedicine Provider sultations cialist Office Visits stalist Telemedicine Provider Consultations Cialist Telemedicine Provider Consultations Cialist Telemedicine Provider Consultations Cialist Telemedicine Provider Consultations Cialist Telemedicine Provider Consultations Consultations Consultations Consultations Consultations Consultations Consultations Consultations	NETWORK CARE \$35 copayment after deductible y practitioner or pediatrician for diagn \$35 copayment after deductible Covered in full after deductible \$75 copayment after deductible \$75 copayment after deductible Covered in full after deductible \$75 copayment after deductible Covered in full after deductible	OUT-OF-NETWORK CARE 50% after deductible cosis and treatment of an illness or 50% after deductible Not Covered Not Covered 50% after deductible 50% after deductible Not Covered



Walk-in clinics are freestanding health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be walk-in clinics.

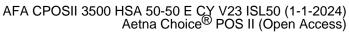
to be wark-in clinics.		
Telemedicine Consultations for Non-Emergency Services through a Walk-in Clinic If telemedicine preventive screening and counseling services are provided through a walk-in clinic, these services are paid under the preventive care benefit.	Cost-sharing is based on type of service and where it is received.	50% after deductible
Maternity - Delivery and Post-Partum Care	50% after deductible	50% after deductible
Allergy Testing	Cost-sharing is based on type of service and where it is received.	50% after deductible
Allergy Injections	50% after deductible	50% after deductible
PREVENTIVE CARE	NETWORK CARE	OUT-OF-NETWORK CARE
Preventive care services are covered in accordance wit	h Health Care Reform.	
Routine Adult Physical Exams and Immunizations Limited to 1 exam every 12 months.	Covered in full	50% after deductible
Well Child Exams and Immunizations Provides coverage for 7 exams in the first year of life; 3 exams in the second year; 3 exams in the third year; and 1 exam per 12 months from age 3 to age 22.	Covered in full	50% after deductible
Routine Gynecological Exams Includes routine tests and related lab fees. Limited to 1 exam every 12 months.	Covered in full	50% after deductible
Routine Mammograms	Covered in full	50% after deductible
Women's Health Includes: Screening for gestational diabetes, HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for Human Immunodeficiency Virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies, and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	Covered in full	50% after deductible
Prenatal Maternity	Covered in full	50% after deductible
Routine Digital Rectal Exam / Prostate-Specific Antigen Test Recommended: For covered males age 40 and over.	Covered in full	50% after deductible
Colorectal Cancer Screening Recommended: For all members age 45 and over.	Covered in full	50% after deductible
Routine Eye and Hearing Screenings	Paid as part of routine physical exam.	Paid as part of routine physical exam.
HEARING SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Hearing Exam (by Specialist)	Not covered	Not covered
Hearing Aid	Not covered	Not covered
VISION SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Adult Routine Eye Exams (Refraction) Coverage is limited to 1 exam every 12 months.	Covered in full	50% after deductible
Pediatric Routine Eye Exams (Refraction) Coverage is limited to 1 exam every 12 months.	Covered in full	50% after deductible
Adult Vision Hardware	Not Covered	Not Covered
Pediatric Vision Hardware	Not Covered	Not Covered
DIAGNOSTIC PROCEDURES	NETWORK CARE	OUT-OF-NETWORK CARE



Diagnostic Laboratory	50% after deductible	50% after deductible
Diagnostic X-ray (except for Complex Imaging Services)	50% after deductible	50% after deductible
Diagnostic X-ray for Complex Imaging Services (Including, but not limited to, MRI, MRA, PET and CT Scans)	50% after deductible	50% after deductible
EMERGENCY MEDICAL CARE	NETWORK CARE	OUT-OF-NETWORK CARE
Urgent Care Provider	50% after deductible	50% after deductible
Non-Urgent Use of Urgent Care Provider	Not covered	Not covered
Emergency Room	50% after deductible	Paid as in-network
Non-Emergency Care in an Emergency Room	Not covered	Not covered
Emergency Use of Ambulance	50% after deductible	Paid as in-network
Non-Emergency Use of Ambulance	50% after deductible	Paid as in-network
HOSPITAL CARE	NETWORK CARE	OUT-OF-NETWORK CARE
Inpatient Coverage Including maternity (delivery and postpartum care). The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	50% after deductible	50% after deductible
Outpatient Surgery Provided in an outpatient hospital department or freestanding surgical facility.	50% after deductible	50% after deductible
Colonoscopy (non-preventive)	Cost-sharing is based on type of service and where it is received.	Cost-sharing is based on type of service and where it is received.
Transplants Coverage is limited to IOE facilities only.	50% after deductible	Not covered
BEHAVIORAL HEALTH SERVICES (MENTAL HEALTH and SUBSTANCE RELATED DISORDERS)	NETWORK CARE	OUT-OF-NETWORK CARE
Inpatient Services (including inpatient residential treatment facility) The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	50% after deductible	50% after deductible
Outpatient Office Visits The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered in full after deductible	50% after deductible
Physician or Behavioral Health Provider Telemedicine Consultations	Covered in full after deductible	50% after deductible
Telemedicine Provider Consultations	Covered in full after deductible	Not Covered
Other Outpatient Services (Includes partial hospitalization treatment, intensive outpatient program.)	50% after deductible	50% after deductible
THERAPY SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Outpatient Chiropractic/Spinal Manipulation Therapy Coverage is limited to 60 visits per year PT/OT/ST/Chiro combined.	\$75 copayment after deductible	50% after deductible



Outpatient Short-Term Rehabilitation - Physical Therapy Coverage is limited to 60 visits per year PT/OT/ST/Chiro combined.	\$75 copayment after deductible	50% after deductible
Outpatient Short-Term Rehabilitation - Occupational Therapy Coverage is limited to 60 visits per year PT/OT/ST/Chiro combined.	\$75 copayment after deductible	50% after deductible
Outpatient Short-Term Rehabilitation - Speech Therapy Coverage is limited to 60 visits per year PT/OT/ST/Chiro combined.	\$75 copayment after deductible	50% after deductible
Habilitative Physical, Occupational and Speech Therapy	50% after deductible	50% after deductible
Autism Physical, Occupational and Speech Therapy	50% after deductible	50% after deductible
Autism Behavioral Therapy	Covered in full after deductible	50% after deductible
Autism Applied Behavior Analysis	50% after deductible	50% after deductible
OTHER SERVICES	NETWORK CARE	OUT-OF-NETWORK CARE
Skilled Nursing Facility Coverage is limited to 60 days per year.	50% after deductible	50% after deductible
The member cost sharing applies to all covered benefits incurring during a member's inpatient stay.		
Home Health Care Coverage is limited to 60 visits per year.	50% after deductible	50% after deductible
Infusion Therapy Provided in the home or physician's office.	50% after deductible	50% after deductible
Infusion Therapy Provided in the outpatient hospital department of freestanding facility.	50% after deductible	50% after deductible
Gene-Based, Cellular and Other Innovative Therapies (GCIT) Coverage is limited to GCIT-designated facilities only.	Cost-sharing is based on type of service and where it is received.	Not Covered
Inpatient Hospice Care The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	50% after deductible	50% after deductible
Outpatient Hospice Care The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	50% after deductible	50% after deductible
Private Duty Nursing - Outpatient	Not covered	Not covered
Acupuncture Coverage is limited to 10 visits per year.	\$35 copayment after deductible	Not covered
Durable Medical Equipment	50% after deductible	50% after deductible
Prosthetics	50% after deductible	50% after deductible
Diabetic Supplies not obtainable at a pharmacy	Covered same as any other medical expense.	Covered same as any other medical expense.
Mouth, Jaws and Teeth Coverage for medical in nature oral surgery only. No coverage for dental in nature oral surgery or for removal of impacted teeth.	Cost-sharing is based on type of service and where it is received.	50% after deductible
Bariatric Surgery	Not Covered	Not Covered
FAMILY PLANNING	NETWORK CARE	OUT-OF-NETWORK CARE



50% after deductible



Infortility Treatment

PLAN DESIGN & BENEFITS ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

Cost-sharing is based on type of

Infertility Treatment Covered only for the diagnosis and treatment of the underlying medical condition.	Cost-sharing is based on type of service and where it is received.	50% after deductible
Comprehensive Infertility Services Artificial insemination or ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered	Not Covered
Vasectomy	Cost-sharing is based on type of service and where it is received.	50% after deductible
Tubal Ligation	Covered in full	50% after deductible
PHARMACY DEDUCTIBLE	NETWORK CARE	OUT-OF-NETWORK CARE
Prescription drug calendar year deductible	Prescription drugs purchased at a network pharmacy are subject to the in-network medical deductible which must be satisfied before any prescription drug benefits are paid.	Prescription drugs purchased at an out-of-network pharmacy are subject to the out-of-network medical deductible which must be satisfied before any prescription drug benefits are paid.
PHARMACY - PRESCRIPTION DRUG BENEFITS	NETWORK CARE	OUT-OF-NETWORK CARE
Generic Drugs		
Retail	Generic - T1A: \$3 copayment after deductible Generic - T1: \$10 copayment after deductible	50% after deductible
Mail Order	Generic - T1A: \$6 copayment after deductible Generic - T1: \$20 copayment after deductible	Not covered
Preferred Brand Drugs		
Retail	\$50 copayment after deductible	50% after deductible
Mail Order	\$100 copayment after deductible	Not covered
Non-Preferred Generic and Brand Drugs		
Retail	\$100 copayment after deductible	50% after deductible
Mail Order	\$200 copayment after deductible	Not covered
Specialty Drugs		
Preferred Specialty	50% up to \$250 after deductible	Not covered
Non-Preferred Specialty	50% up to \$500 after deductible	Not covered
Pharmacy Day Supply and Requirements		
Retail Up to 30 day supply from the Aetna National Pharmacy	Network	
Mail Order 31-90 day supply from a participating mail service pharr	macy or at selected participating retail	providers
Maintananca Chaica® with Ont Out - After two retail		•

Maintenance Choice® with Opt Out - After two retail fills, members must choose to fill a 90-day supply of their maintenance drugs at a participating mail service pharmacy or at selected participating retail providers. If the member wants to continue to fill their 30-day supply at any other network pharmacy, they simply need to call us at the number on their member ID card. If they do not notify us that they want to opt out of the 90-day supply at a participating mail service pharmacy or at selected participating retail providers, they'll be responsible for 100 percent of their medication cost. The member may call us any time, even from the pharmacy, to let us know that they intend to opt out of the benefit.

Specialty- Up to a 30 day supply. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Network.

True Accumulation - Some specialty prescription drugs may qualify for third-party copay assistance programs, like a manufacturer coupon or a rebate. These could lower out-of-pocket costs. Any amount received through one of these programs will not apply towards the Deductible or Out-of-Pocket Maximum.

Choose Generics with Dispense as Written (DAW) override - The member pays the applicable cost-sharing only if the



physician requires brand. If the member requests brand when a generic is available, the member pays the applicable cost-sharing plus the cost difference between the generic and brand does not count toward the Deductible or Out-of-Pocket Maximum.

Precertification - Included. See formulary for details.

Step Therapy - Included. See formulary for details.

Preventive Medications - Deductible is waived for certain preventive medications.

Pharmacy Plan includes:

Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs, Diabetic supplies.

Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

Preventive and seasonal vaccinations covered 100% in-network.

Cost-share is \$0 copay, deductible waived, for preferred generic and brand diabetic supplies and preferred generic and brand insulin.

Performance Enhancing Drugs - Coverage is excluded for lifestyle/performance drugs.

Not all drugs are covered. It is important to look at the Drug List (Advanced Control Plan - Aetna Formulary) to understand which drugs are covered.

*How out-of-network care is reimbursed:

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

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

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

The members' doctor sets his or her own rate to charge members. These rates may be higher -- sometimes much higher -- than what the members' Aetna plan "recognizes." Members' doctors may bill them for the dollar amount that their plan doesn't "recognize." Members must also pay any copayments, coinsurance and deductibles under their plan. No dollar amount above the "recognized charge" counts toward their deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit **Aetna.com**. Type "how Aetna pays" in the search box.

Members can avoid these extra costs by getting their care from Aetna's network of health care providers. Go to **www.aetna.com** and click on "Find a Doctor" on the left side of the page. Members can sign on to the Aetna member site.

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

What's Not Covered

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; Cosmetic surgery; Custodial care; Dental services; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, 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;

Nonmedically necessary services or supplies; Orthotics, except diabetic orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. 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.



AFA CPOSII 3500 HSA 50-50 E CY V23 ISL50 (1-1-2024) Aetna Choice[®] POS II (Open Access)

PLAN DESIGN & BENEFITS ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract.

Not all services are covered. See plan documents for a complete description of benefits, exclusions and limitations 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.

Medications on the Aetna Drug Guide, precertification, step-therapy and quantity limits lists are subject to change.

Aetna, CVS Pharmacy® and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are part of the CVS Health® family of companies.CVS Caremark® Mail Service Pharmacy and Aetna are part of the CVS Health® family of companies.

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

While this information is believed to be accurate as of the print date, it is subject to change. For more information about Aetna plans, refer to **Aetna.com**.

Aetna Funding AdvantageSM plans are self-funded, meaning the benefits coverage is provided by the employer. Plans are administered by Aetna Life Insurance Company.