

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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK

**Benefit limitations** - Some service or supplies have limits on them per year. There might be a maximum number of visits or days, or a dollar limit per year. In such cases, the benefit year begins on January 1 (unless otherwise noted). Refer to your plan documents to learn more.

Relei to your plan documents to learn more

**Deductible** (per calendar year) \$250 per Individual \$500 per Individual

\$500 per Family \$1,000 per Family

Covered expenses in-network add up towards your in-network deductible. Covered expenses out-of-network add up towards your out-of-network deductible.

You must first meet the deductible before the plan begins paying benefits, unless otherwise noted.

The amount you pay (cost sharing) for some medical services does not count toward your deductible. Prescription drug costs do not count toward the deductible. Refer to your plan documents for details.

Your family will have one deductible. You will meet it when the expenses of several family members add up to the family deductible. No one person will have to pay more than the individual deductible.

Member coinsurance Covered 100% You pay 20%
Applies to all expenses except as noted.

Out-of-pocket limit (per calendar \$2,000 per Individual \$3,000 per Individual

year)

\$4,000 per Family

\$6,000 per Family

Covered expenses in-network add up towards your in-network out-of-pocket limit. Covered expenses out-of-network add up towards your out-of-network out-of-pocket limit.

Some of your cost sharing may not count toward the out-of-pocket limit.

Your pharmacy expenses count toward your out-of-pocket limit.

In-network expenses include coinsurance/copays and deductibles.

Out-of-network expenses include coinsurance and deductibles. Penalty amounts do not apply.

Your family will have one out-of-pocket limit. You will meet it when the expenses of several family members add up to the family out-of-pocket limit. No one person will have to pay more than the individual out-of-pocket limit amount.

#### Lifetime maximum

Unlimited except where otherwise indicated.

Payment for out-of-network care**	Does not apply	Professional: 150% of Medicare Facility: Facility Fee Schedule
Primary care physician selection	Does not apply	Does not apply

#### Precertification requirements -

Some out-of-network services need approval by us in advance (precertification). Without this approval, we reduce benefits by \$500. Refer to your plan documents for a full list of services that need this approval.

Referral requirement Not required None

**Telehealth consultations** - You can access covered services for telehealth visits from different kinds of providers in your plan. Log on to **Aetna.com** to see a list of telehealth providers. You'll also find more about your options, including cost share amounts.

PREVENTIVE CARE
IN-NETWORK
OUT-OF-NETWORK
Routine adult physical exams/
immunizations
OUT-OF-NETWORK
20%; after deductible

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

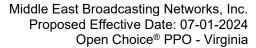
Routine well child Covered 100%; no deductible 20%; after deductible

### exams/immunizations

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

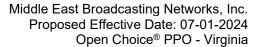
Routine gynecological care exams Covered 100%; no deductible 20%; after deductible

1 exam and pap smear per year, includes related fees.



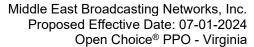


Virtual primary care (VPC)	Covered 100%; no deductible	Not Covered
preventive care consultations	2010104 10070, 110 4044011D10	Hot Govereu
Includes screening and counseling ser	vices for members age 18 and older	
Routine mammogram	Covered 100%; no deductible	20%; after deductible
Recommended: One per year for mem		•
Women's health	Covered 100%; no deductible	20%; after deductible
Includes: Screening for gestational dia	betes, HPV (Human- Papillomavirus) DN	IA testing, counseling for sexually
transmitted infections, counseling and	screening for human immunodeficiency v	virus, screening and counseling for
interpersonal and domestic violence, b	reastfeeding support, supplies and coun-	seling.
	ACA mandated contraceptives, including	
	lures (including tubal ligation), patient ed	ucation and counseling. Limits may
apply.		
Pre-natal maternity	Covered 100%; no deductible	20%; after deductible
Routine digital rectal exam	Covered 100%; no deductible	20%; after deductible
Recommended: For members age 40 a		
Prostate-specific antigen test	Covered 100%; no deductible	20%; after deductible
Recommended: For members age 40		
Colorectal cancer screening	Covered 100%; no deductible	20%; after deductible
Recommended: For members age 45		
Routine eye exams	Not Covered	Not Covered
Routine hearing screening	Covered 100%; no deductible	20%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office visits to non-specialist	\$10 office visit copay; no deductible	20%; after deductible
	al physician, family practitioner or pediat	
Virtual primary care (VPC)	Covered 100%; no deductible	Not Covered
consultations		
for VPC vendor information	ations through a VPC vendor for membe	rs age 18 and older; refer to Aetha.com
Telehealth consultation with non-	\$10 office visit copay; no deductible	20%; after deductible
specialist		·
Specialist office visits	\$20 office visit copay; no deductible	20%; after deductible
Telehealth consultation with	\$20 office visit copay; no deductible	20%; after deductible
specialist	• •	
Hearing exams	Not Covered	Not Covered
Walk-in clinics	\$10 copay; no deductible	20%; after deductible
	Designated Walk-in clinics	
	Covered 100%; no deductible	
	care facilities. Sometimes they may be	
•	offer some limited medical care and ser	
<del>_</del>	s, emergency rooms, the outpatient depa	ırtment of a hospital, ambulatory
surgical centers, and physician offices.		
Allergy testing	Your cost sharing amount depends	Your cost sharing amount depends
	on the type of service and where you	on the type of service and where you
	receive it.	receive it.
Allergy injections	Your cost sharing amount depends	Your cost sharing amount depends
	on the type of service and where you	on the type of service and where you
	receive it. Covered 100% when an	receive it.
	office visit charge is not applicable.	



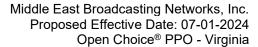


DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray (Other than	Covered 100%; no deductible	20%; after deductible
complex imaging services)		
	s for this service at their office, you pay y	
Diagnostic laboratory	Covered 100%; no deductible	20%; after deductible
	s for this service at their office, you pay y	
Diagnostic complex imaging	Covered 100%; after deductible	20%; after deductible
	s for this service at their office, you pay y	
EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent care provider	\$25 office visit copay; no deductible	20%; after deductible
Non-urgent use of urgent care provider	Not Covered	Not Covered
Emergency room	\$150 copay; no deductible	Same as in-network care
Copay waived if admitted		Same as in-network care
Non-emergency care in an emergency room	\$150 copay; no deductible	\$150 per visit deductible; no deductible
Emergency use of ambulance	\$150 copay; no deductible	Same as in-network care
Non-emergency use of ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient coverage	Covered 100%; after deductible	20%; after deductible
	r the care you need, your cost sharing a	
benefits you receive.		iniount counts toward all covered
	Covered 100%; after deductible r the care you need, your cost sharing a	20%; after deductible  mount counts toward all covered
benefits you receive.	Covered 100%; after deductible	20%; after deductible
Outpatient hospital		
covered benefits during your visit.	hospital but don't stay overnight, your co	ost snaring amount counts toward an
Outpatient surgery - hospital	Covered 100%; after deductible	20%; after deductible
When you receive outpatient care at a covered benefits during your visit.	hospital but don't stay overnight, your co	ost sharing amount counts toward all
Outpatient surgery - freestanding facility	Covered 100%; after deductible	20%; after deductible
	hospital but don't stay overnight, your co	ost sharing amount counts toward all
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%; after deductible	20%; after deductible
When you're admitted into a hospital fo	r the care you need, your cost sharing a	
benefits you receive.  Mental health office visits	\$20 consy; no doductible	20%: after deductible
	\$20 copay; no deductible	20%; after deductible
Mental health telehealth consultations	\$20 office visit copay; no deductible	20%; after deductible
Other mental health services	Covered 100%; no deductible	20%; after deductible
When you receive outpatient care at a covered benefits during your visit.	facility but don't stay overnight, your cos	t sharing amount counts toward all
Covered benefits duffing your visit.		



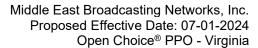


SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%; after deductible	20%; after deductible
When you're admitted into a hospital for	or the care you need, your cost sharing a	mount counts toward all covered
benefits you receive.		
Residential treatment facility	Covered 100%; after deductible	20%; after deductible
	the care you need, your cost sharing am	ount counts toward all covered benefits
you receive.	COO consulare de divetible	200/ . often deducatible
Substance abuse office visits	\$20 copay; no deductible	20%; after deductible
Substance abuse telehealth consultations	\$20 office visit copay; no deductible	20%; after deductible
Other substance abuse services	Covered 100%; no deductible	20%; after deductible
	facility but don't stay overnight, your cos	· · · · · · · · · · · · · · · · · · ·
covered benefits during your visit.	,,g, ,	
THERAPY SERVICES	IN-NETWORK	OUT-OF-NETWORK
Spinal manipulation therapy	\$20 copay; no deductible	20%; after deductible
Limited to 20 visits per year	1 37	- ,
Outpatient short-term	\$20 copay; no deductible	20%; after deductible
rehabilitation	1 37	- ,
Limited to 90 visits per year		
Includes physical, occupational, and sp	peech therapies.	
Habilitative physical therapy	Covered 100%; no deductible	20%; after deductible
Habilitative occupational therapy	Covered 100%; no deductible	20%; after deductible
Habilitative speech therapy	Covered 100%; no deductible	20%; after deductible
Autism related physical therapy	Covered 100%; no deductible	20%; after deductible
Autism related occupational	Covered 100%; no deductible	20%; after deductible
therapy	<u> </u>	
Autism related speech therapy	Covered 100%; no deductible	20%; after deductible
Autism related behavioral therapy	\$20 copay; no deductible	20%; after deductible
These benefits are combined with outp		,
Autism related applied behavior	Covered 100%; no deductible	20%; after deductible
analysis		
	e same as any other outpatient mental he	ealth other services benefit
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled nursing facility	Covered 100%; after deductible	20%; after deductible
When you're admitted into a facility for	the care you need, your cost sharing am	ount counts toward all covered benefits
you receive.		
Home health care	Covered 100%; after deductible	20%; after deductible
Home health care services include private	ate duty nursing	
Limited to three visits per day by staff f	rom a home health care agency. One vis	sit equals a period of four hours or less.
Hospice care - inpatient	Covered 100%; after deductible	20%; after deductible
When you're admitted into a facility for	the care you need, your cost sharing am	ount counts toward all covered benefits
you receive.		
Hospice care - outpatient	Covered 100%; after deductible	20%; after deductible
	facility but don't stay overnight, your cos	t sharing amount counts toward all
covered benefits during your visit.		
Private duty nursing	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 nursing shift.	
Durable medical equipment	Covered 100%; after deductible	20%; after deductible
Prosthetics	Covered 100%; after deductible	20%; after deductible





Diabetic supplies (if not covered	Covered same as any other medical	Covered same as any other medical
under the prescription drug benefit)	expense.	expense.
	You pay your prescription drug cost	You pay your prescription drug cost
	sharing amount if you have	sharing amount if you have
	prescription drug coverage. If not,	prescription drug coverage. If not,
	you pay your PCP visit cost sharing	you pay your PCP visit cost sharing
	amount.	amount.
Infusion therapy - home/office	\$20 copay; no deductible	20%; after deductible
Infusion therapy - outpatient	Your cost sharing amount depends	Your cost sharing amount depends
hospital/freestanding facility	on the type of service and where you	on the type of service and where you
	receive it.	receive it.
Hearing aids	Covered 100%; no deductible	Covered 100%; no deductible
1 hearing aid per ear to \$1,500 maxim	ium per ear per 24 months to age 18 yea	
Transplants	Covered 100%; after deductible	20%; after deductible
	In-network coverage is only available	Out-of-network coverage applies
	at Institutes of Excellence (IOE)	when you use a non-IOE facility. Yo
	contracted facility.	will pay more out of pocket when
	-	using a non-IOE facility.
Bariatric surgery	Covered 100%; after deductible	20%; after deductible
	or the care you need, your cost sharing a	mount counts toward all covered
benefits you receive.		
Acupuncture	\$10 copay; no deductible	20%; after deductible
Limited to 10 visits per year		
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility treatment	Your cost sharing amount depends	Your cost sharing amount depends
-	on the type of service and where you	on the type of service and where yo
	receive it.	receive it.
You have coverage for the diagnosis a	and treatment of the underlying cause of i	nfertility.
Comprehensive infertility services	Not Covered	Not Covered
Artificial insemination and ovulation in	duction	
Advanced Reproductive	Not Covered	Not Covered
Technology (ART)		
	allopian transfer (ZIFT), gamete intrafallo	pian transfer (GIFT), cryopreserved
	erm injection (ICSI), or ovum microsurger	
Vasectomy	Covered 100%; after deductible	20%; after deductible
Tubal ligation	Covered 100%; no deductible	20%; after deductible
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PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy plan type	Advanced Control Plan - Aetna	
Prescription drug out-of-pocket limit	Prescription drug expenses apply to y	our medical out-of-pocket limit.
Preferred generic drugs		
Retail	Covered 100%	50% of submitted cost; after applicable in-network cost share
Mail order	Covered 100%	50% of submitted cost; after applicable in-network cost share
Preferred brand-name drugs		• •
Retail	\$15 copay	50% of submitted cost; after applicable in-network cost share
Mail order	\$15 copay	50% of submitted cost; after applicable in-network cost share
Non-preferred generic and brand-na	me drugs	
Retail	\$30 copay	50% of submitted cost; after applicable in-network cost share
Mail order	\$30 copay	50% of submitted cost; after applicable in-network cost share
Specialty drugs		
Preferred specialty	50% Maximum \$75	Not Covered
Non-preferred specialty	50% Maximum \$100	Not Covered
Pharmacy day supply and requirement	ents	
Retail	You can get up to a 30-day supply from Aetna National Network For a 31-90 day supply you will be responsible for the Mail Order Drug copay.	
Mail order	You can get a 31-90-day supply from CVS Caremark® Mail Service Pharmacy.	
Specialty	·	
	network. Advanced Control Formulary Aetna In	sured List
Your prescription drug plan also inc		

#### Your prescription drug plan also includes:

- Diabetic supplies
- \$25 copay maximum per fill per 30 day supply for formulary insulin drugs and \$50 copay maximum per fill per 30 day supply for non-formulary insulin drugs; no deductible for insulin drugs
- Sexual dysfunction drugs, including daily dose, additional 6 tablets a month for erectile dysfunction
- 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.



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#### **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** - Sometimes you or your provider may ask for a brand-name prescription drug when a generic is available. If so, you will pay the brand-name copay plus the difference between the generic price and the brand-name price.

#### **GENERAL PROVISIONS**

Dependents who are eligible to be on your plan

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

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

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

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

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



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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.



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

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

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

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

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

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

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

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

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

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