



PLAN DESIGN & BENEFITS  
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

| PLAN FEATURES                                                                                                                                                                                                                                                                                                                                                                                                            | NETWORK CARE                                                                                                       | OUT-OF-NETWORK CARE                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| <b>Primary Care Physician Selection</b>                                                                                                                                                                                                                                                                                                                                                                                  | Not required                                                                                                       | Not required                                                 |
| <b>Deductible</b> (per calendar year)                                                                                                                                                                                                                                                                                                                                                                                    | \$0 Individual<br>\$0 Family                                                                                       | \$5,000 Individual<br>\$15,000 Family                        |
| Unless otherwise indicated, the deductible must be met before benefits can be paid.                                                                                                                                                                                                                                                                                                                                      |                                                                                                                    |                                                              |
| 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.                                                                                                                                                                                                                                                                                                                 |                                                                                                                    |                                                              |
| <b>Member Coinsurance</b><br>(applies to all expenses unless otherwise stated)                                                                                                                                                                                                                                                                                                                                           | 0%                                                                                                                 | 50%                                                          |
| <b>Out-of-Pocket (OOP) Maximum</b><br>(per calendar year, includes deductible)                                                                                                                                                                                                                                                                                                                                           | \$6,000 Individual<br>\$12,000 Family                                                                              | \$10,000 Individual<br>\$30,000 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 Limit.<br>Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and copays 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.                                                                                                                                                                                                                                                                                           |                                                                                                                    |                                                              |
| <b>Payment for Out-of-Network Care*</b>                                                                                                                                                                                                                                                                                                                                                                                  | Not applicable                                                                                                     | Professional: 105% of Medicare<br>Facility: 140% of Medicare |
| <b>Certification Requirements</b>                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                    |                                                              |
| Certification for certain types of out-of-network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care and Hospice Care is required - excluded amount applied separately to each type of expense is \$400 per occurrence                                                  |                                                                                                                    |                                                              |
| <b>Referral Requirement</b>                                                                                                                                                                                                                                                                                                                                                                                              | Not Required                                                                                                       | Not applicable                                               |
| PHYSICIAN SERVICES                                                                                                                                                                                                                                                                                                                                                                                                       | NETWORK CARE                                                                                                       | OUT-OF-NETWORK CARE                                          |
| <b>Office Visits to Non-Specialist</b>                                                                                                                                                                                                                                                                                                                                                                                   | \$40 copayment                                                                                                     | 50% after deductible                                         |
| Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illness or injury.                                                                                                                                                                                                                                                                           |                                                                                                                    |                                                              |
| <b>Specialist Office Visits</b>                                                                                                                                                                                                                                                                                                                                                                                          | \$75 copayment                                                                                                     | 50% after deductible                                         |
| <b>Walk-in Clinics</b>                                                                                                                                                                                                                                                                                                                                                                                                   | <b>Designated Walk-in Clinics:</b><br>Covered in full<br><br><b>All Other Network Providers:</b><br>\$40 copayment | 50% after deductible                                         |
| 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. |                                                                                                                    |                                                              |
| <b>Prenatal Maternity</b>                                                                                                                                                                                                                                                                                                                                                                                                | Covered in full                                                                                                    | 50% after deductible                                         |
| <b>Maternity - Delivery and Post-Partum Care</b>                                                                                                                                                                                                                                                                                                                                                                         | Covered in full                                                                                                    | 50% after deductible                                         |
| <b>Allergy Testing</b> (given by a physician)                                                                                                                                                                                                                                                                                                                                                                            | Member cost sharing is based on the type of service performed and the place rendered.                              | 50% after deductible                                         |
| <b>Allergy Injections</b> (not given by a physician)                                                                                                                                                                                                                                                                                                                                                                     | Covered in full                                                                                                    | 50% after deductible                                         |
| PREVENTIVE CARE                                                                                                                                                                                                                                                                                                                                                                                                          | NETWORK CARE                                                                                                       | OUT-OF-NETWORK CARE                                          |
| Preventive care services are covered in accordance with Health Care Reform.                                                                                                                                                                                                                                                                                                                                              |                                                                                                                    |                                                              |
| <b>Routine Adult Physical Exams and Immunizations</b><br>Limited to 1 exam every 12 months.                                                                                                                                                                                                                                                                                                                              | Covered in full                                                                                                    | 50% after deductible                                         |
| <b>Well Child Exams and Immunizations</b><br>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                                         |

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| <b>Routine Gynecological Exams</b><br>Includes routine tests and related lab fees. Limited to 1 exam every 12 months.                                                                                                                                                                                                                                                                                                                                  | Covered in full               | 50% after deductible |
| <b>Routine Mammograms</b><br>For covered females age 40 and over.                                                                                                                                                                                                                                                                                                                                                                                      | Covered in full               | 50% after deductible |
| <b>Women's Health</b><br>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 |
| <b>Routine Digital Rectal Exam / Prostate-Specific Antigen Test</b><br>For covered males age 40 and over.                                                                                                                                                                                                                                                                                                                                              | Covered in full               | 50% after deductible |
| <b>Colorectal Cancer Screening</b><br>For all members age 45 and over.                                                                                                                                                                                                                                                                                                                                                                                 | Covered in full               | 50% after deductible |
| <b>VISION SERVICES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |                               |                      |
| <b>Routine Eye Exams (Refraction)</b><br>Coverage is limited to 1 exam every 12 months.                                                                                                                                                                                                                                                                                                                                                                | Covered in full               | 50% after deductible |
| <b>DIAGNOSTIC PROCEDURES</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |                               |                      |
| <b>Outpatient Diagnostic Laboratory</b>                                                                                                                                                                                                                                                                                                                                                                                                                | \$15 copayment                | 50% after deductible |
| <b>Outpatient Diagnostic X-ray (except for Complex Imaging Services)</b>                                                                                                                                                                                                                                                                                                                                                                               | \$75 copayment                | 50% after deductible |
| <b>Outpatient Diagnostic X-ray for Complex Imaging Services</b><br>(Including, but not limited to, MRI, MRA, PET and CT Scans)                                                                                                                                                                                                                                                                                                                         | \$350 copayment               | 50% after deductible |
| <b>EMERGENCY MEDICAL CARE</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |                               |                      |
| <b>Urgent Care Provider</b><br>(Benefit Availability may vary by location.)                                                                                                                                                                                                                                                                                                                                                                            | \$100 copayment               | 50% after deductible |
| <b>Non-Urgent Use of Urgent Care Provider</b>                                                                                                                                                                                                                                                                                                                                                                                                          | Not covered                   | Not covered          |
| <b>Emergency Room</b><br>Copay waived if admitted.                                                                                                                                                                                                                                                                                                                                                                                                     | \$500 copayment               | Paid as in-network   |
| <b>Non-Emergency care in an Emergency Room</b>                                                                                                                                                                                                                                                                                                                                                                                                         | Not covered                   | Not covered          |
| <b>Emergency Use of Ambulance</b>                                                                                                                                                                                                                                                                                                                                                                                                                      | \$500 copayment               | Paid as in-network   |
| <b>Non-Emergency Use of Ambulance</b>                                                                                                                                                                                                                                                                                                                                                                                                                  | \$500 copayment               | Paid as in-network   |
| <b>HOSPITAL CARE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |                               |                      |
| <b>Inpatient Coverage</b><br>Including maternity (delivery and postpartum care). The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.                                                                                                                                                                                                                                                                    | \$750 copayment per admission | 50% after deductible |
| <b>Outpatient Surgery</b><br>Provided in an outpatient hospital department or freestanding surgical facility.                                                                                                                                                                                                                                                                                                                                          | \$750 copayment               | 50% after deductible |

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| <b>Transplants</b><br>Coverage at the in-network cost share is limited to IOE only. Non-IOE par facilities and out-of-network facilities are covered at out-of-network cost sharing.                                       | \$750 copayment per admission | 50% after deductible |
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| MENTAL HEALTH and ALCOHOL/DRUG ABUSE SERVICES                                                                                                                                                                              | NETWORK CARE                  | OUT-OF-NETWORK CARE  |
| <b>Inpatient Mental Health</b><br>The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.                                                                                       | \$750 copayment per admission | 50% after deductible |
| <b>Outpatient Mental Health</b><br>The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.                                                                                    | \$75 copayment                | 50% after deductible |
| <b>Inpatient Detoxification</b><br>The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.                                                                                      | \$750 copayment per admission | 50% after deductible |
| <b>Outpatient Detoxification</b><br>The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.                                                                                   | \$75 copayment                | 50% after deductible |
| <b>Inpatient Rehabilitation</b><br>The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.                                                                                      | \$750 copayment per admission | 50% after deductible |
| <b>Outpatient Rehabilitation</b><br>The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.                                                                                   | \$75 copayment                | 50% after deductible |
| <b>All Other Outpatient Services</b><br>Includes Mental Health, Substance Abuse and Behavioral Therapies.                                                                                                                  | \$75 copayment                | 50% after deductible |
| OTHER SERVICES AND PLAN DETAILS                                                                                                                                                                                            | NETWORK CARE                  | OUT-OF-NETWORK CARE  |
| <b>Skilled Nursing Facility</b><br>Coverage is limited to 60 days per year.<br><br>The member cost sharing applies to all covered benefits incurring during a member's inpatient stay Network and Out-of-Network combined. | \$750 copayment per admission | 50% after deductible |
| <b>Home Health Care</b><br>Coverage is limited to 60 visits per year. Network and Out-of-Network combined; 1 visit equals a period of 4 hours or less. Network and Out-of-Network combined.                                | Covered in full               | 50% after deductible |
| <b>Infusion Therapy</b><br>Provided in the home or physician's office.                                                                                                                                                     | \$75 copayment                | 50% after deductible |
| <b>Infusion Therapy</b><br>Provided in the outpatient hospital department of freestanding facility.                                                                                                                        | \$750 copayment               | 50% after deductible |
| <b>Inpatient Hospice Care</b><br>The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.                                                                                        | \$750 copayment per admission | 50% after deductible |
| <b>Outpatient Hospice Care</b><br>The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.                                                                                     | Covered in full               | 50% after deductible |
| <b>Outpatient Short-Term Rehabilitation - Physical Therapy</b><br>Coverage is limited to 60 visits per year PT/OT/ST/Chiro combined.<br><br>Network and Out-of-Network combined.                                           | \$75 copayment                | 50% after deductible |



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| <b>Outpatient Short-Term Rehabilitation - Occupational Therapy</b><br>Coverage is limited to 60 visits per year<br>PT/OT/ST/Chiro combined.<br><br>Network and Out-of-Network combined. | \$75 copayment                                                                                               | 50% after deductible                                                   |
| <b>Outpatient Short-Term Rehabilitation - Speech Therapy</b><br>Coverage is limited to 60 visits per year<br>PT/OT/ST/Chiro combined.<br><br>Network and Out-of-Network combined.       | \$75 copayment                                                                                               | 50% after deductible                                                   |
| <b>Outpatient Chiropractic</b><br>Coverage is limited to 60 visits per year<br>PT/OT/ST/Chiro combined.<br><br>Network and Out-of-Network combined.                                     | \$75 copayment                                                                                               | 50% after deductible                                                   |
| <b>Habilitative Physical, Occupational and Speech Therapy</b>                                                                                                                           | \$75 copayment                                                                                               | 50% after deductible                                                   |
| <b>Autism Behavioral Therapy</b>                                                                                                                                                        | \$75 copayment                                                                                               | 50% after deductible                                                   |
| <b>Autism Applied Behavior Analysis</b>                                                                                                                                                 | Not covered                                                                                                  | Not covered                                                            |
| <b>Autism Physical, Occupational and Speech Therapy</b>                                                                                                                                 | \$75 copayment                                                                                               | 50% after deductible                                                   |
| <b>Durable Medical Equipment</b>                                                                                                                                                        | 50%                                                                                                          | 50% after deductible                                                   |
| <b>Diabetic Supplies not obtainable at a pharmacy</b>                                                                                                                                   | Covered same as any other medical expense.                                                                   | Covered same as any other medical expense.                             |
| <b>Mouth, Jaws and Teeth</b><br>(oral surgery procedures, medical in nature)                                                                                                            | Member cost sharing is based on the type of service performed and the place of service where it is rendered. | 50% after deductible                                                   |
| <b>FAMILY PLANNING</b>                                                                                                                                                                  |                                                                                                              |                                                                        |
| <b>Infertility Treatment - Diagnostic only</b><br>Covered only for the diagnosis and treatment of the underlying medical condition.                                                     | Member cost sharing is based on the type of service performed and the place rendered.                        | 50% after deductible                                                   |
| <b>Voluntary Sterilization - Vasectomy</b>                                                                                                                                              | Member cost sharing is based on the type of service performed and the place rendered.                        | 50% after deductible                                                   |
| <b>Voluntary Sterilization - Tubal Ligation</b>                                                                                                                                         | Covered in full                                                                                              | 50% after deductible                                                   |
| <b>PHARMACY DEDUCTIBLE</b>                                                                                                                                                              |                                                                                                              |                                                                        |
| <b>Prescription drug calendar year deductible</b>                                                                                                                                       | Not Applicable under both the network care and out-of-network columns.                                       | Not Applicable under both the network care and out-of-network columns. |
| <b>PHARMACY - PRESCRIPTION DRUG BENEFITS</b>                                                                                                                                            |                                                                                                              |                                                                        |
| <b>Retail</b><br>Up to a 30-day supply                                                                                                                                                  |                                                                                                              |                                                                        |
| <b>Generic Drugs</b>                                                                                                                                                                    | Generic - T1A: \$3 copayment<br>Generic - T1: \$10 copayment                                                 | 50%                                                                    |
| <b>Preferred Brand Drugs</b>                                                                                                                                                            | \$45 copayment                                                                                               | 50%                                                                    |
| <b>Non-Preferred Generic and Brand Drugs</b>                                                                                                                                            | \$75 copayment                                                                                               | 50%                                                                    |
| <b>Specialty Drugs</b><br>Includes self-injectable, infused and oral specialty drugs, excludes insulin (Up to a 30-day supply)                                                          | Specialty Preferred: 20% up to \$250<br>Specialty Nonpreferred: 40% up to \$500                              | Not covered                                                            |
| <b>Mail Order Delivery</b><br>31-90 days – excludes specialty drugs                                                                                                                     |                                                                                                              |                                                                        |
| <b>Generic Drugs</b>                                                                                                                                                                    | Generic - T1A: \$6 copayment<br>Generic - T1: \$20 copayment                                                 | Not covered                                                            |



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| <b>Preferred Brand Drugs</b>                 | \$90 copayment  | Not covered |
| <b>Non-Preferred Generic and Brand Drugs</b> | \$150 copayment | Not covered |

**Specialty-**

First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.

**Choose Generics with Dispense as Written (DAW) override** - Included. See Aetna Formulary for details.

The cost difference between the generic and brand does not count toward the Deductible or Out-of-Pocket Maximum.

**Precertification** - Included. See Aetna Formulary for details.

**Step Therapy** - Included. See Aetna Formulary for details.

**Mandatory Maintenance Choice** - Members can choose the most convenient place to fill 90-day supplies of their maintenance drugs – from CVS Caremark® Mail Service Pharmacy or CVS pharmacy retail locations. A 90-day supply of maintenance drugs is required to be filled at CVS Caremark® Mail Service Pharmacy or CVS pharmacy retail locations after two retail fills. Otherwise, the member will be responsible for 100 percent of the cost-share

**Pharmacy Plan includes:**

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

Formulary generic FDA-approved Womens Contraceptives covered 100% in network.

Preventive and seasonal vaccinations covered 100% in-network.

Not all drugs are covered. It is important to look at the Drug List (Small Group Value Plus 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.



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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, including breast reduction; Custodial care; Dental care and X-rays; 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; 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.

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. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan.

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. Aetna is not responsible or liable in any manner for services received at CVS MinuteClinic locations. CVS Caremark® Mail Service Pharmacy and Aetna are part of the CVS Health family of companies. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are available under plans with an open formulary.

They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are administered by Aetna Life Insurance Company.