AETNA MEDICAL PLANS COMPARISON CHART

	SELECT OPEN ACCESS	CHOICE POS II	
BENEFIT	**IN-NETWORK ONLY**	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
Service Areas/Networks	Any provider in the Aetna Select Open Access national network	Any provider in the Choice POS II Network (national network)	Any Provider
Health Reimbursement Account (HRA) —Individual/Family HRA funds can only be used for medical plan and prescrip-tion drug expenses.	N/A	N/A	N/A
Deductibles—Individual/Family	N/A	$500 individual; $1,000 family (combined in– and out-of-network)	
Medical Out-of-Pocket Maximum—Includes medical deductible, coinsurance, and/or co-pays	$5,000 individual; $10,000 family	$5,000 individual; $10,000 family (combined in– and out-of-network)	
Rx Out-of-Pocket Maximum—Includes Rx co-pays and deductible	$2,000 individual; $4,000 family	$2,000 individual; $4,000 family (combined in– and out-of-network)	
Lifetime Maximum	Unlimited	Unlimited	
PHYSICIAN OFFICE VISITS	**YOU PAY**	**YOU PAY**	**YOU PAY**
Primary Care Physician (PCP)	$35 co-pay	20% after deductible	40% after deductible
Specialist (SPC)	$60 co-pay	20% after deductible	40% after deductible
Teladoc: Doctor	$25 co-pay	$25 co-pay	N/A
Teladoc: Behavioral Health	$25 co-pay	20% after deductible	N/A
Preventative Adult Physical Exams	No co-pay	0%	40% after deductible
Preventative GYN Care (including Pap test) (direct access to participating providers)	No co-pay	0%	40% after deductible
Mammography Preventive Screening	No co-pay	0%	40% after deductible
Immunizations	No co-pay	0%	40% after deductible
Allergy Injections	Co-pay waived for allergy injections billed separately	20% after deductible	40% after deductible
Allergy Tests **Lab** **X-Ray Outpatient** **Advanced Outpatient Radiology Services (MRI, CAT scan, PET scan, etc.)**	$50 co-pay $25 co-pay $50 co-pay $250 co-pay	20% after deductible	40% after deductible
Colonoscopy Screenings—Preventive and Diagnostic	No co-pay	0%	40% after deductible
Chiropractic Services (limits apply) (direct access to participating providers)	$60 co-pay, 20 visits per calendar year	20% after deductible	40% after deductible
		20 visits per calendar year combined in– or out-of-network	
Hearing Exam	$25 co-pay	20% after deductible	40% after deductible

	CDHP + HRA	BASIC ESSENTIAL
BENEFIT	**IN-NETWORK ONLY**	**IN-NETWORK ONLY**
Service Areas/Networks	Any provider in the Aetna Select Open Access national net-work	Any provider in the Aetna Select Open Access National Network
Health Reimbursement Account (HRA) —Individual/Family HRA funds can only be used for medical plan and prescription drug expenses.	$500 individual $750 employee + child(ren) $750 employee + spouse $1,000 family HRA contributions are prorated based on your date of hire	N/A
Deductibles—Individual/Family	$1,500 individual; $3,000 family	$2,300 individual, $6,900 family
Medical Out-of-Pocket Maximum—Includes medical deductible, coinsurance, and/or co-pays	$5,000 individual; $10,000 family	$8,550 individual; $17,100 family
Rx Out-of-Pocket Maximum—Includes Rx co-pays and deductible	$2,000 individual; $4,000 family	Combined with medical
Lifetime Maximum	Unlimited	Unlimited
PHYSICIAN OFFICE VISITS	**YOU PAY**	**YOU PAY**
Primary Care Physician (PCP)	20% after deductible	$50 co-pay
Specialist (SPC)	20% after deductible	30% after deductible
Teladoc: Doctor	$25 co-pay	$40 co-pay
Teladoc: Behavioral Health	20% after deductible	0% no deductible
Preventative Adult Physical Exams	0%, no deductible	0%, no deductible
Preventative GYN Care (including Pap test) (direct access to participating providers)	0%, no deductible	0%, no deductible
Mammography Preventive Screening	0%, no deductible	0%, no deductible
Immunizations	0%, no deductible	0%, no deductible
Allergy Injections	20% after deductible	30% after deductible
Allergy Tests **Lab** **X-Ray Outpatient** **Advanced Outpatient Radiology Ser-vices (MRI, CAT scan, PET scan, etc.)**	20% after deductible	30% after deductible
Colonoscopy Screenings—Preventive and Diagnostic	0%, no deductible	0%, no deductible
Chiropractic Services (limits apply) (direct access to participating provid-ers)	20% after deductible; 20 visits per calendar year	30% after deductible; 20 visits per calendar year
Hearing Exam	20% after deductible	30% after deductible

Understanding How Much You Have to Pay

Health Reimbursement Account (HRA) (CDHP only). Use your HRA to pay your deductible, coinsurance, and Rx co-pays, reducing your out-of-pocket costs. The amount deposited in your HRA is prorated based on your benefits effective date. Note the IRS requires that 100% of disbursements made from your HRA be substantiated or verified.

Medical Plan Deductible (Choice POS II, CDHP + HRA, Basic Essential). The amount you pay for medical expenses before the plan begins paying benefits.

Coinsurance (Choice POS II, CDHP + HRA, Basic Essential). The percentage of eligible medical expenses you pay after paying the deductible for most services.

Co-pays. The fixed amount you pay for medical care and prescriptions.

Aetna Prescription Drug Program. You pay co-pays for generic and preferred brand drugs. For non-preferred brand drugs, you pay the Rx deductible before you pay co-pays. In the Basic Essential plan, the deductible does not apply to the non-preferred brand drugs. More information can be found on page 17.

This chart provides a brief outline of the medical coverage options available to you through Aetna. Complete details are in the official plan documents. In any conflict between the plan documents and this basic comparison chart, the plan documents will control.

Please note: The dollar amounts are co-pays, deductibles, and maximums, which you pay; the percentages are coinsurance amounts, which you pay after you meet applicable deductibles. The amount the plan pays may be based on usual, reasonable, and customary (URC) fees for out-of-network services only.

1 Usual, customary, reasonable (UCR) fees. Out-of-network charges that exceed UCR fees may be billed to the member.

AETNA MEDICAL PLANS COMPARISON CHART

	SELECT OPEN ACCESS	CHOICE POS II	
HOSPITAL	**IN-NETWORK ONLY**	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
Inpatient (Includes maternity and newborn services)	$500 co-pay per day; up to 5-day maximum	$500 co-pay per day; up to 5-day maximum	40% after deductible
Outpatient Surgery (including facility charges)	$500 co-pay	20% after deductible	40% after deductible
Emergency Room Services	$500 co-pay	20% after deductible	20% after deductible
Ambulance	No co-pay	20% after deductible	20% after deductible
Urgent Care Facility	$50 co-pay	20% after deductible	40% after deductible
Maternity Care/OB Visits	$50 co-pay for initial visit only	20% after deductible	40% after deductible
MENTAL HEALTH SERVICES			
Outpatient Mental Health Services	$25 co-pay	20% after deductible	40% after deductible
Inpatient Mental Health Services	$500 co-pay per day; up to 5-day maximum	$500 co-pay per day; up to 5-day maximum	40% after deductible
MISCELLANEOUS			
Home Health Care (limits apply)	$25 co-pay	20% after deductible	40% after deductible
Hospice—Inpatient (limits apply)	$500 co-pay per day; up to 5-day maximum[2]	$500 co-pay per day; up to 5-day maximum[2]	40% after deductible; 30-day lifetime maximum
Skilled Nursing Facility (limits apply)	$500 co-pay per day; up to 5-day maximum; up to 120-visit limit per calendar year	$500 co-pay per day; up to 120-visit per calendar year	40% after deductible, 120-visit limit per calendar year
Short-Term Rehabilitation/Outpatient Therapy (speech, physical, occupational)	$25 co-pay per visit, 60-visit limit per calendar year for all therapies combined	20% after deductible; 60-visit limit per calendar year for all therapies combined	40% after deductible, 60-visit per calendar year for all therapies combined
Diabetic Supplies (syringes, test strips)	See prescription drugs below	See prescription drugs below	See prescription drugs below
Durable Medical Equipment (DME)	$50 co-pay	20% after deductible	40% after deductible
AETNA PRESCRIPTION DRUG PROGRAM—SOME DRUGS MAY BE SUBJECT TO STEP-THERAPY OR PRECERTIFICATION[3]			
Up to 30-day supply:	*Mandatory Generics Unless Dispensed As Written*	*Mandatory Generics Unless Dispensed As Written*	*Mandatory Generics Unless Dispensed As Written*
Generic	$15 co-pay, no Rx deductible	$15 co-pay, no Rx deductible	
Preferred Brand	$60 co-pay, no Rx deductible	$60 co-pay, no Rx deductible	
Non-Preferred Brand	$90 co-pay, after Rx deductible	$90 co-pay, after Rx deductible	NOT COVERED
Specialty—PrudentRx*	30% coinsurance, $0 if enrolled	30% coinsurance, $0 if enrolled	
90-day Supply (maintenance medications) at CVS retail or mail order (mail order must be through CVS Caremark mail order delivery.)	*Mandatory Generics Unless Dispensed As Written*	*Mandatory Generics Unless Dispensed As Written*	*Mandatory Generics Unless Dispensed As Written*
Generic	$30 co-pay, no Rx deductible	$30 co-pay, no Rx deductible	
Preferred Brand	$120 co-pay, no Rx deductible	$120 co-pay, no Rx deductible	
Non-Preferred Brand	$180 co-pay, after Rx deductible	$180 co-pay, after Rx deductible	NOT COVERED
Specialty—PrudentRx*	N/A	N/A	

	CDHP + HRA	BASIC ESSENTIAL
HOSPITAL	**IN-NETWORK ONLY**	**IN-NETWORK ONLY**
Inpatient (Includes maternity and newborn services)	20% after deductible	30% after deductible
Outpatient Surgery (including facility charges)	20% after deductible	30% after deductible
Emergency Room Services	20% after deductible	30% after deductible
Ambulance	20% after deductible	30% after deductible
Urgent Care Facility	20% after deductible	30% after deductible
Maternity Care/OB Visits	20% after deductible	30% after deductible
MENTAL HEALTH SERVICES	**YOU PAY**	**YOU PAY**
Outpatient Mental Health Services	20% after deductible	0% no deductible
Inpatient Mental Health Services	20% after deductible	30% after deductible
MISCELLANEOUS		
Home Health Care (limits apply)	20% after deductible; 120-visit limit per calendar year	30% after deductible; 120-visit limit per calendar year
Hospice—Inpatient (limits apply)	20% after deductible	30% after deductible
Skilled Nursing Facility (limits apply)	20% after deductible; 120-visit limit per calendar year	30% after deductible; 120-visit limit per calendar year
Short-Term Rehabilitation/Outpatient Therapy (speech, physical, occupational)	20% after deductible; 60-visit limit per calendar year for all therapies combined	30% after deductible; 60-visit limit per calendar year for all therapies combined
Diabetic Supplies (syringes, test strips)	See prescription drugs below	N/A
Durable Medical Equipment (DME)	20% after deductible	30% after deductible
AETNA PRESCRIPTION DRUG PROGRAM—SOME DRUGS MAY BE SUBJECT TO STEP-THERAPY OR PRECERTIFICATION[3]		
Up to 30-day supply:	*Mandatory Generics Unless Dispensed As Written*	*Mandatory Generics Unless Dispensed As Written*
Generic	$15 co-pay, no Rx deductible	$25 co-pay, no Rx deductible
Preferred Brand	$60 co-pay, no Rx deductible	$60 co-pay, no Rx deductible
Non-Preferred Brand	$90 co-pay, after Rx deductible	$90 co-pay, no Rx deductible
Specialty—PrudentRx*	30% coinsurance, $0 if enrolled	30% coinsurance, $0 if enrolled
90-day Supply (maintenance medications) at CVS retail or mail order (mail order must be through CVS Caremark mail order delivery.)	*Mandatory Generics Unless Dispensed As Written*	*Mandatory Generics Unless Dispensed As Written*
Generic	$30 co-pay, no Rx deductible	$30 co-pay, no Rx deductible
Preferred Brand	$120 co-pay, no Rx deductible	$120 co-pay, no Rx deductible
Non-Preferred Brand	$180 co-pay, after Rx deductible	$180 co-pay, after Rx deductible
Specialty—PrudentRx*	N/A	N/A

Aetna Concierge
(Group #109718)
Customer Service
866-253-0599

Please note: The dollar amounts are co-pays, deductibles, and maximums, which you pay; the percentages are coinsurance amounts, which you pay after you meet applicable deductibles. The amount the plan pays may be based on usual, reasonable, and customary (URC) fees for out-of-network services only.

This chart provides a brief outline of the medical coverage options available to you through Aetna. Complete details are in the official plan documents. In any conflict between the plan documents and this basic comparison chart, the plan documents will control.

See the Diabetes CARE Program information for details about free diabetic testing supplies.

1 Usual, customary, reasonable (UCR) fees. Out-of-network charges that exceed UCR fees may be billed to the member.

2 Waived if transferred from hospital

3 See page 17 for Aetna Prescription Drug Program and step-therapy information.

***** May be eligible for $0 co-pay under PrudentRx program, see page 18 for details. Some exclusions apply. Any specialty prescriptions not eligible under PrudentRx will fall to applicable tier for that drug.