AETNA MEDICAL .PtANS COMPARIS,O N CHART

	SEIJECT OPEN ACCESS	CHOICE POS II	
BENEFIT	**IN-NETWORK ONLY**	**IN-NETWORK**	**OUT-OF-NEIWORK [1]**
Service Areas/Networks	AA] provider in the Aetna Select Open kces<s national network	Any provider in the Choice POS II NetvfOfk (national network)	Any Provider
Health Reimbursement Account (HRA) - Individual/Family HRS funds ran only be used for medical plan and prescription drug expenses.	NIA	NIA	NIA
Deductibles—IndividuaVFamjly	NIA	£500 in1fvidual; S1,000fami (combined in- and out-of-neh\'Orl)	
Medical Ol!lt*of-Pmket Maximum-Indud.es Rx co-pays and deductible	$5,000 indlvidual; $10,000 family	SS,000 ind'.1idual; Sl0,000 fami(combined in- and out-of-network}	
Rx out-of..:Pocket Maximum-Indudes Rx co-pays and deductible	$2,000 indiYidual; $4,ooo family	s2,ooo ind''idual; S4,000 family(combined in- and out-of-networl}	
LHetime Maximum	Unli,iited	Unlimited	
PHYSICIAN OFFICE VISITS	**YOU PAY**	**YOU PAY**	**YOU PAY**
Primary care Physidan (PCP)	$35co-pay	2OUafter deduch'ble	40% afteJ deducifble
Specialist (SP()	$60co-pay	2OUafter deductl'be	40% after deductible
Teladoc: Doctor	S25co-pay	$25 co-pay	N/A
leladoc: Behavioral Health.	$25 co-pay	2OUafter dedudible	NIA
Preventative, Adult Physical .Exams	No co-pay	O6	40% after deduciible
Preventative GYN Care {rncluding Pap test) (direct access to parfcipating provi rs)	NCO01) ay	OD	40% after deduciible
Mammography Preventive Screening	No co-pay	OU	40% afte.rdeductihie
Immunizations	No co-pay	0%	40% after deducible
Allergy Injections	Co-pay waived for allergy injections billed separately	2OUafter deductible	40% after deductible
Allergy Tests lab x.:Ray Out.patient Advanced Outpatient Radiology Se-rvices (MRI, CAT scan PET .scan, etc.)	S50co-pay S25 co-pay S50 co-pay S250 co-pay	20UJ after deductible	40% after deducible
Colonoscopy Screenings-Preventive and Diagnostic	No co-pay	0%	4afteJdeductlhie
Chiropradi'c Services (limits apply) (dirc t access to participating providers)	S60 co-pay, 20 visits per calendar year	20UJ after deductible 20 visits per calendar year combinedin- orout-of-networt	40% afteJ deductible
Hearing Exam	$25co-pay	2Oafter deductible	4D% after deductible

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PfNse notr.: The dollar c1mconBare co-pa deductibles,aoo lMlimums, whidayoo pa: the perrent11gesc1recoin9.Jraocec1mou1MEwhich you pay after)tiu meet appirable deductibles._The c1mconthe plan pays SW be ba5ed co usua reasonable,c11bbustomary(U&C) fires for oot-of-neiWcd sel'Niresonly_

1 Usual, wstoma,y, reasonable (UCR) fee>_ Out-0f-nfM'<Jrkcharges that meed UGRees may be biled to tile member.

AETNA MED;ICAL PIANS COMPARISON CHART

	CDHP t HRA	BASIC ESSENTIAL
BENEFIT	**IN-NETWORK ONLY**	**IN-NEIWORK ONIY**
Service Areas/Networks	Any provider in the Aftna Select Open Access national network	Any provider in the Choice POS II Network (national network)
Uealth Reimbursem.ent Account (HRA) -Individual/family HRS funds can only be used for medical plan andl prescription d expenses.	$500 individual $750 employee + child(ren) $750 employee + spouse $1,000 famfly HRA contributions are prorated based on your oote of hire	NIA
Deductibles-Individ11al/Family	S1,SOO individual; 53,000 family	S2,300 individual, S6,900 family
Medical Out-of-Pocket Maxdmum—Indudes Rx co-pays and deductible	$5,000 individual; $10,000 family	$8,5.50 individual; $17,100 family
Rx Out-of-'Pocket Maximum-Includes Rx co-pays and dedu:dible	$2,000 indivictual; $4,0DOfamily	Combined \Ilih medical
Lifetime Maximum	Unlimited	Unlimited
PHYSICIAN OFFICE VISITS	**YOU PAY**	**YOU PAY**
Primary Care Physician (PCP)	20'lliafter deductible	s50copay
Specialist (SPC)	20% after deductible	30% afterdeductible
leladoc: Doctor	i25 co-pay	S40copay
Teladoc: Behavioral HM-lth	20'lli after deductible	G no deductible
Prevenrative Adult Physical Exams.	O%, no deductible	OUb, no deductible
Preventative GYN re (including Pap test) (direct access to participating provide-rs)	O%, no dedu:ible	OUi, no deductible
Mammography Preventive Screening	0%, no deductible	0%, no deductible
Immunizations	0%, no deductible	0%, no deductible
Allergy Injections	20!!J after deductible	30% after deductibl,e
AUergy Tests lab X-sRay Outpatient Advanced Outpatient Radiology Services (MRI, CAT scan_ PET scan, etc.)	20!!J after deductible	30% after dedudfble
Cofonoscopy Screenings-Preventive and Diagnostic	o%, nodeductible	0%
Chiropractic Services (limits apply)t (direct access to part'cipati provide.rs)	20% after deductible; 20 visits per calendar year	30% after d:ductible; 20 visits per calendar year
Uearing Exam	20!!J after deductible	30% afterdedudfble

Understanding How Much You Have to Pay

Health Reimbursement Account .(HRA) (CDHP only)_ Use your HR/Ho pay your deductible, coinsurance, and Rx co-pays, reducing your out-0f-podet costs. The amount deited in your HRA is prorated based on your benefis effedJive date_ Note the IRS rfGuires lhat 100% of disbursements made rrom your HRI\ be sub51anliated or 't'aified.

Medical Plan Deductible (Choice POS II, CDHp + HRA, B:lsic Essmtial)_ The amount you pay for medical expenses be!ore the plan begins paying benefits.

Coinsura11ce (Choice POS H, CDHP 4 HRA, llasic Essootial)_ The percentage of eligible medical expenses you pa}r after paying lhe deductible for most services..

(pays. The moo amount you payfor medical care and presaiptions.

Aetna Pescription Drug Program. You pay co-pays for generic and preferred brand drugs_ fi>r noll-preferred brand aoo specialty drugs, yoo pay the Rx dedudl1Jle before yo11 pay co-pays. In the Basic Es.5fftial plan, the decmctible does not apply to the non-preferred brand drug,. More information can found on page 17_

AETNA MEDICAL PLANS COMPARISON CHART

	SELECT OPEN ACCESS	CHOICE POS II	
HOSPITAL	**IN-NETWORK ONLY**	**IN-NETWORK**	**OUT-OF-NETWORK'**
Inpatient (Includes maternity and newbom services)	S500 co-pay per day; up to s-day maximum	$500 co-pay per day; up to 5-day maximum	40% after deductible
Outpatient surgery {induding facility charges)	5500 co-pey	20% after deductible	40% after deductible
Emergency Room Services	ssoo co-pay	20% after deductible	20% after deductible
Ambulance	Noco 1ay	20% after deductible	20% afterdedudible
Urgent (a:re Facil1ty	$60 co-pay	20% after deductible	40% after deductible
Maternity Care/OB Visits	S50 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 dedudfble
Inpatient Mental Health Services	S500 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
Uospice-l111patient (limits apply)	S500 co-pay per day; up to 5-day maximum[2]	$500 co-pay per day after deductible; up to S-day maximum2	40% after deductible; 30-day lifetime maximum
Skilled Nursing fanlity (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 after deductible; up to 120-visit percalendar year	40% after deductible, 120-visit limit per calendar year
Short-Term Rehabilitation/Outpatient Therapy (speech, physical, occupational)	525 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 Preferred Brand Non-Preferred Brand Specialty-PrudentRx*	$15 co-pay, no Rx deductible $60 co-pay, no Rx deductible $90 co-pay, after Rx deductible 30% coinsurance, $0 if enrolled	$15 co-pay, no Rx deductible $60 co-pay, no Rx deductible $90 co-pay, after Rx deductible 30% coinsurance, so if enrolled	NOT COVERED
90 day supply (maintenance medications) at CVS retail or mail order (mail order must be through CVS Caremark mail order delivery.) Generic Preferred Brand Non.Preferred Brand Specialty-PrudentRx*	Mandatory Generics Unless Dispensed As Written $30 co-pay, no Rx deductible $120 co-pay, no Rx deductible $100 co-pay, after Rx deductible 30% coinsurance, $0 if enrolled	Mandatory Generics Unless Dispensed As Written $30 co-pay, no Rx deductible S120 co-pay, no Rx dedudible $180 co-pay, after Rx deductible 30% coinsurance, so if enrolled	Mandatory Generics Unless Dispensed As Written NOT COVERED

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.

AETNA MEDICAL PLANS COMPARISON CHART

	CDHP + HRA	BASIC ESSENTIAL
HOSPITAL	**IN-NETWORK ONLY**	**IN-NETWORK ONLY**
Inpatient (Includes maternity and newborn services)	2l1ó after deduruble	30% after deductible
Outpatient surgery (indudmg facility charges)	2l1ó ater 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	(q6 no deductible
Inpatient Mental Health Services	20% after deductible	30% after dedudfble
MISCELLANEOUS		
Home Health care (limits applly)	20% after doouctible; 120-visit limit per calendar year	30% after deductible; 120-visit limit per calendar year
H'ospice-Inpatient (limits apply)	20% after deductible	30% after deductible
Skilled. Nursing Facility (limlts apply)	20% after deductible; 120-visit limit per calendar year	30% after deductible; 120-visit limit per calendar year
Short.Tenn Rehabilitation/Outpatient Therapy (speech, physical, occupational)	20% after deductible; 60-visit limit per calendar year for all therapies combined	30% after deductible
Diabetic Supplie-s (syringes, test strips)	See prescription drugs below	N/A
Durable Medical Equipment (DME)	2l1ó after deduruble	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 Preferred Brand Non-Preferred Brand Specialty-PrudentRx*	$15 co-pey, no Rx deductible S60 co-pay, no Rx deductible S90 co-pay, after Rx deductible 30% coinsurance, $0 if enrolled	$25 co-pay, no Rx deductible $60 co-pay, no Rx deductible $90 co-pay, no Rx deductible 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.) Generic Preferred Brand Non-Preferred Brand Specialty-PrndentRx*	Mandatory Generics Unless Dispensed As Written $30 co-pey, no Rx deductible $110 co-pay, no Rx deductible $100 co-pey, after Rx deductible 30% minsurance, $0 if enrolled	Mandatory Generics Unless Dispensed As Written $50 co-pay, no Rx deductible $120 co-pay, no Rx deductible $180 co-pay, no Rx dedudfble 30% coinsurance, $0 if enrolled

Aetna Concierge (Group 109718)
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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 available to you through Aetna. Complete details are in the 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.

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.