AETNA MEDICAL PLANS
Comparison Chart

The amount the plan pays may be based on usual, reasonable, customary (URC) fees.

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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.

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. See page 28-29. Note the IRS requires that 100% of disbursements made from your HRA be substantiated or verified. See page 29 for the HRA rollover maximum, effective January 1, 2023.
- Medical Plan Deductible (Choice POS II, CDHP + HRA and Basic Essential). The amount you pay for medical expenses before the plan begins paying benefits.
- Coinsurance (Choice POS II, CDHP + HRA and 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 (all plans). You pay co-pays for generic and preferred brand drugs. For non-preferred brand and specialty 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.

Aetna Concierge (Group #109718) Customer Service 866-253-0599 Benefit	Select Open Access In-Network Only	Choice POS II In-Network	Choice POS II Out-of-Network[1]	CDHP + HRA In-Network Only	Basic Essential In-Network Only
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	Any provider in the Aetna Select Open Access national network	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.	N/A	N/A	N/A	$500 Individual; $750 Employee + Child(ren) or Employee + Spouse; $1,000 Family. HRA contributions are prorated based on your date of hire.	N/A
Deductibles—Individual/Family	N/A	$500 Individual; $1,000 Family (combined in- and out-of-network)		$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	$5,000 Individual; $10,000 Family (combined in- and out-of-network)		$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	$2,000 Individual; $4,000 Family (combined in- and out-of-network)		$2,000 Individual; $4,000 Family	Combined with medical
Lifetime Maximum	Unlimited	Unlimited		Unlimited	Unlimited
Physician Office Visits	**You Pay:**	**You Pay:**	**You Pay:**	**You Pay:**	**You Pay:**
Primary Care Physician (PCP)	$35 co-pay	20% after deductible	40% after deductible	20% after deductible	$50 co-pay
Specialist (SPC)	$60 co-pay	20% after deductible	40% after deductible	20% after deductible	30% after deductible
Teladoc: Doctor	$25 co-pay	$25 co-pay	N/A	$25 co-pay	$40 co-pay
Teladoc: Behavioral Health	$25 co-pay / $60 Specialist	20% after deductible	N/A	20% after deductible	0% no deductible
Preventive Adult Physical Exams	No co-pay	0%	40% after deductible	0% no deductible	0% no deductible
Preventive GYN Care (including Pap test) (direct access to participating providers)	No co-pay	0%	40% after deductible	0% no deductible	0% no deductible
Mammography Preventive Screening	No co-pay	0%	40% after deductible	0% no deductible	0% no deductible
Immunizations	No co-pay	0%	40% after deductible	0% no deductible	0% no deductible
Allergy Injections	Co-pay waived for allergy injections billed separately	20% after deductible	40% after deductible	20% after deductible	30% 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 20% after deductible 20% after deductible 20% after deductible	40% after deductible 40% after deductible 40% after deductible 40% after deductible	20% after deductible 20% after deductible 20% after deductible 20% after deductible	30% after deductible 30% after deductible 30% after deductible 30% after deductible
Colonoscopy Screenings—Preventive and Diagnostic	No co-pay	0%	40% after deductible	0% no deductible	0% no deductible
Chiropractic Services (limits apply) (direct access to participating providers)	$60 co-pay 20 visits per calendar year	20% after deductible 20 visits per calendar year combined in- or out-of-network	40% after deductible	20% after deductible 20 visits per calendar year	30% after deductible 20 visits per calendar year
Hearing Exam	$25 co-pay	20% after deductible	40% after deductible	20% after deductible	30% after deductible

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.

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

Continued on next page

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Diabetes CARE

See the online BENEFlex Guide for details about the Diabetes CARE Program and free diabetic testing supplies.

Important Rx Information

Maintenance Choice Program

Pay two co-pays for a 90-day supply only when you fill your maintenance prescriptions through CVS Caremark mail order delivery or at a CVS Pharmacy retail location.

Rx Deductible May Apply

For non-preferred brand and specialty drugs, you must pay the $250 per person or $500 per family Rx deductible before you begin paying co-pays.

Aetna Concierge (Group #109718) Customer Service 866-253-0599 Benefit	Select Open Access In-Network Only	Choice POS II In-Network	Choice POS II Out-of-Network[1]	CDHP + HRA In-Network Only	Basic Essential In-Network Only
Hospital					
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	20% after deductible	30% after deductible
Outpatient Surgery (including facility charges)	$500 co-pay	20% after deductible	40% after deductible	20% after deductible	30% after deductible
Emergency Room Services	$500 co-pay	20% after deductible	20% after deductible	20% after deductible	30% after deductible
Ambulance	No co-pay	20% after deductible	20% after deductible	20% after deductible	30% after deductible
Urgent Care Facility	$60 co-pay	20% after deductible	40% after deductible	20% after deductible	30% after deductible
Maternity Care/OB Visits	$50 co-pay for initial visit only	20% after deductible	40% after deductible	20% after deductible	30% after deductible
Mental Health Services					
Outpatient Mental Health Services	$25 co-pay	20% after deductible	40% after deductible	20% after deductible	0% no deductible
Inpatient Mental Health Services	$500 co-pay per day; up to 5-day maximum	$500 co-pay per day after deductible; up to 5-day maximum	40% after deductible	20% after deductible	30% after deductible
Miscellaneous					
Home Health Care (limits apply)	$25 co-pay	20% after deductible	40% after deductible	20% after deductible; 120-visit limit per calendar year	30% after deductible; 120-visit limit per calendar year
Hospice—Inpatient (limits apply)	$500 co-pay per day; up to 5-day maximum[2]	$500 co-pay per day after deductible; up to 5-day maximum[2]	40% after deductible; 30-day lifetime maximum	20% after deductible	30% after deductible
Skilled Nursing Facility (limits apply)	$500 co-pay per day; up to 5-day maximum[2] up to 120-visit limit per calendar year	$500 co-pay per day after deductible; up to 120-visit limit per calendar year	40% after deductible	20% after deductible up to 120-visit limit per calendar year	30% after deductible up to 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	20% after deductible 60-visit limit per calendar year for all therapies combined	30% after deductible
Diabetic Supplies (syringes, test strips)	See prescription drugs below	See prescription drugs below	See prescription drugs below	See prescription drugs below	N/A
Durable Medical Equipment (DME)	$50 co-pay	20% after deductible	40% after deductible	20% after deductible	30% after deductible
Aetna Prescription Drug Program	*Mandatory Generics Unless Dispensed As Written*	*Mandatory Generics Unless Dispense As Written*		*Mandatory Generics Unless Dispense As Written*	*Mandatory Generics Unless Dispense As Written*
Up to 30-day supply: **Generic**	$15 co-pay, no Rx deductible	$15 co-pay, no Rx deductible	NOT COVERED	$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		$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		$90 co-pay, after Rx deductible	$90 co-pay, no Rx deductible
Specialty—PrudentRx*	30% coinsurance, $0 if enrolled	30% coinsurance, $0 if enrolled		30% coinsurance, $0 if enrolled	30% coinsurance, $0 if enrolled
90-day Supply (maintenance medica-tions) 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 Dispense As Written*		*Mandatory Generics Unless Dispense As Written*	*Mandatory Generics Unless Dispense As Written*
Preferred Brand	$30 co-pay, no Rx deductible	$30 co-pay; no Rx deductible	NOT COVERED	$30 co-pay, no Rx deductible	$50 co-pay, no Rx deductible
Non-Preferred Brand Specialty—PrudentRx*	$120 co-pay, no Rx deductible	$120 co-pay; no Rx deductible		$120 co-pay, no Rx deductible	$120 co-pay, no Rx deductible
Some drugs may be subject to step-therapy or precertification	$180 co-pay, after Rx deductible N/A	$180 co-pay; after Rx deductible N/A		$180 co-pay, after Rx deductible N/A	$180 co-pay, no Rx deductible N/A

[1] *Subject to usual, customary, reasonable (UCR) fees*

[2] *Waived if transferred from hospital*

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