AETNA MEDICAL PLANS
COMPARISON CHART

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

Please note: The dollar amounts are copays, 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 copays, reducing your out-of-pocket costs. The amount deposited in your HRA is prorated based on your benefits effective date. See pages 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, 2024.
- **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.
- **Copays** The fixed amount you pay for medical care and prescriptions.
- **Aetna Prescription Drug Program** (all plans). You pay copays for generic and preferred brand drugs. For non-preferred brand and specialty drugs, you pay the Rx deductible before you pay copays. 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 copays	$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 copays 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 copay	20% after deductible	40% after deductible	20% after deductible	$50 copay
Specialist (SPC)	$60 copay	20% after deductible	40% after deductible	20% after deductible	30% after deductible
Teladoc: Doctor	$25 copay	$25 copay	N/A	$25 copay	$40 copay
Teladoc: Behavioral Health	$25 copay / $60 Specialist	20% after deductible	N/A	20% after deductible	0% no deductible
Preventive Adult Physical Exams	No copay	0%	40% after deductible	0% no deductible	0% no deductible
Preventive GYN Care (including Pap test) (direct access to participating providers)	No copay	0%	40% after deductible	0% no deductible	0% no deductible
Mammography Preventive Screening	No copay	0%	40% after deductible	0% no deductible	0% no deductible
Immunizations	No copay	0%	40% after deductible	0% no deductible	0% no deductible
Allergy Injections	Copay 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 copay $25 copay $50 copay $250 copay	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 copay	0%	40% after deductible	0% no deductible	0% no deductible
Chiropractic Services (limits apply) (direct access to participating providers)	$60 copay 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 copay	20% after deductible	40% after deductible	20% after deductible	30% after deductible

AETNA MEDICAL PLANS
COMPARISON CHART

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 supercede.
**Some drugs may be subject to step-therapy or precertification.*
***Not all specialty prescriptions offer assistance. Eligibility for third-party copay assistance program is dependent on the applicable terms and conditions required by that particular program and are subject to change.*
[1] Subject to usual, customary, reasonable (UCR) fees [2] Waived if transferred from hospital

Please note: The dollar amounts are copays, 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.

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 copay per day; up to 5-day maximum	$500 copay per day; up to 5-day maximum	40% after deductible	20% after deductible	30% after deductible
Outpatient Surgery (including facility charges)	$500 copay	20% after deductible	40% after deductible	20% after deductible	30% after deductible
Emergency Room Services	$500 copay	20% after deductible	20% after deductible	20% after deductible	30% after deductible
Ambulance	No copay	20% after deductible	20% after deductible	20% after deductible	30% after deductible
Urgent Care Facility	$60 copay	20% after deductible	40% after deductible	20% after deductible	30% after deductible
Maternity Care/OB Visits	$50 copay for initial visit only	20% after deductible	40% after deductible	20% after deductible	30% after deductible
Mental Health Services Outpatient Mental Health Services	$25 copay	20% after deductible	40% after deductible	20% after deductible	0% no deductible
Inpatient Mental Health Services	$500 copay per day; up to 5-day maximum	$500 copay 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 copay	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 copay per day; up to 5-day maximum[2]				
Skilled Nursing Facility (limits apply)	$500 copay per day; up to 5-day maximum[2] up to 120-visit limit per calendar year	$500 copay per day after deductible; up to 5-day maximum[2] $500 copay per day after deductible; up to	40% after deductible; 30-day lifetime maximum 40% after deductible	20% after deductible 20% after deductible up to 120-visit limit per calendar year	30% after deductible 30% after deductible up to 120-visit limit per calendar year
Short-Term Rehabilitation/Outpatient Therapy (speech, physical, occupational)	$25 copay per visit 60-visit limit per calendar year for all therapies combined	120-visit limit per calendar year		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	20% after deductible	40% after deductible	See prescription drugs below	N/A
Durable Medical Equipment (DME)	$50 copay	60-visit limit per calendar year for all therapies combined		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 copay, no Rx deductible	$15 copay, no Rx deductible	Not covered	$15 copay, no Rx deductible	$25 copay, no Rx deductible
Preferred Brand	$60 copay, no Rx deductible	$60 copay, no Rx deductible		$60 copay, no Rx deductible	$60 copay, no Rx deductible
Non-Preferred Brand	$90 copay, after Rx deductible	$90 copay, after Rx deductible		$90 copay, after Rx deductible	$90 copay, 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 copay, no Rx deductible	$30 copay, no Rx deductible	Not covered	$30 copay, no Rx deductible	$50 copay, no Rx deductible
Non-Preferred Brand Specialty—PrudentRx*	$120 copay, no Rx deductible	$120 copay, no Rx deductible		$120 copay, no Rx deductible	$120 copay, no Rx deductible
	$180 copay, after Rx deductible	$180 copay, after Rx deductible		$180 copay, after Rx deductible	$180 copay, no Rx deductible
	N/A	N/A		N/A	N/A

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 copays 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 copays.