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 page 47 in the 2025 Employee Benefits & Wellness Guide. Note the IRS requires that 100% of disbursements made from your HRA be substantiated or verified. See page 48 in the 2025 Employee Benefits & Wellness Guide for the HRA rollover maximum, effective January 1, 2025.

- **Medical Plan Deductible** (Choice Share Plan, CDHP + HRA and Basic Essential). The amount you pay for medical expenses before the plan begins paying benefits.
- **Coinsurance** (Choice Share Plan, 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 866-253-0599 **Benefit**	Select Open Access **In-Network Only**	Choice Share Plan **In-Network Only**	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 Aetna Select Open Access national network	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	$500 Individual; $750 Employee + Child(ren) or Employee + Spouse; $1,000 Family. HRA contributions are prorated based on your effective date.	N/A
Deductibles—Individual/Family	N/A	$500 Individual; $1,500 Family	$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	$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	$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:**
Primary Care Physician (PCP)	$35 copay	20% after deductible	20% after deductible	$50 copay
Specialist (SPC)	$60 copay	20% after deductible	20% after deductible	30% after deductible
CVS Virtual Primary Care	$35 copay	20% after deductible	20% after deductible	$50 copay
CVS Virtual On-Demand Care	$25 copay / $60 Specialist	20% after deductible	20% after deductible	0% no deductible
Preventive Adult Physical Exams	No copay	0%	0% no deductible	0% no deductible
Preventive GYN Care (including Pap test) (direct access to participating providers)	No copay	0%	0% no deductible	0% no deductible
Mammography Preventive Screening	No copay	0%	0% no deductible	0% no deductible
Immunizations	No copay	0%	0% no deductible	0% no deductible
Allergy Injections	$15 copay	20% 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	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%	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	20% after deductible 20 visits per calendar year	30% after deductible 20 visits per calendar year
Hearing Exam	$25 copay	20% after deductible	20% after deductible	30% after deductible

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** 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.*

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.

Important Rx Information

Maintenance Choice Program

Pay 2 copays for a 90-day supply only when you fill your maintenance prescriptions through CVS Caremark mail order delivery or at a CVS and Costco 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.

Weight Loss GLP1 (NEW)

25% co-insurance (all plans the same) Criteria applies. Does not apply to out-of-pocket max.

Diabetes Care

See **page 71** the 2025 Employee Benefits & Wellness Guide for details about the Diabetes CARE Program and free diabetic testing supplies.

Aetna Concierge Group #109718 866-253-0599 **Benefit**	Select Open Access **In-Network Only**	Choice Share Plan **In-Network Only**	CDHP + HRA **In-Network Only**	Basic Essential **In-Network Only**
Hospital Inpatient (includes maternity and newborn services)	$600 copay per day; up to 6-day maximum	$600 copay per day; up to 6-day maximum	20% after deductible	30% after deductible
Outpatient Surgery (including facility charges) **Hospital** **Non-Hospital** **Provider Office**	 $600 copay $500 copay $250 copay	20% after deductible	20% after deductible	30% after deductible
Emergency Room Services	$500 copay	20% after deductible	20% after deductible	30% after deductible
Ambulance	$100	20% after deductible	20% after deductible	30% after deductible
Urgent Care Facility	$60 copay	20% after deductible	20% after deductible	30% after deductible
Maternity Care/OB Visits	$50 copay for initial visit only	20% after deductible	20% after deductible	30% after deductible
Mental Health Services Outpatient Mental Health Services	 $25 copay	20% after deductible	20% after deductible	0% no deductible
Inpatient Mental Health Services	$600 copay per day; up to 6-day maximum	$600 copay per day; up to 6-day maximum	20% after deductible	30% after deductible
Miscellaneous Home Health Care (limits apply)	 $25 copay; 90-visit limit per calendar year	20% after deductible; 90-visit limit per calendar year	20% after deductible; 90-visit limit per calendar year	30% after deductible; 90-visit limit per calendar year
Hospice—Inpatient (limits apply)	$600 copay per day; up to 6-day maximum[2]	$600 copay per day; up to 6-day maximum[2]	20% after deductible	30% after deductible
Skilled Nursing Facility (limits apply)	$600 copay per day; up to 6-day maximum[2] up to 120-visit limit per calendar year	$600 copay per day; up to 6-day maximum[2] 120-visit limit per calendar year	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 copay 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	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	N/A
Durable Medical Equipment (DME)	$50 copay	20% 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 copay, no Rx deductible	$15 copay, no Rx deductible	$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
Weight Loss GLP1	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
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 and Costco or mail order (mail order must be through CVS Caremark mail order delivery.)	*Mandatory Generics Unless Dispensed As Written* $30 copay, no Rx deductible	*Mandatory Generics Unless Dispense As Written* $30 copay; no Rx deductible	*Mandatory Generics Unless Dispense As Written* $30 copay, no Rx deductible	*Mandatory Generics Unless Dispense As Written* $50 copay, no Rx deductible
Preferred Brand	$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
Non-Preferred Brand Specialty—PrudentRx*	N/A	N/A	N/A	N/A