

SECTION VIII

EXPOSURE, LOSS DATA AND CONTRACT PROVISIONS

SOURCE OF INFORMATION

The School District of Hendry County, and current vendors and carriers supplied all data and statistical information. In some instances, data was retyped for clarity. If there are omissions, additional data is not readily available.

Exhibit 1 –Plan Information and Medical Rates and Monthly Contributions for 2019 - 2022

- Exhibit 2 Medical and Prescription Experience Reports
- Exhibit 3 Benefits Match-Up a,b,c (In Word format)
- Exhibit 4 Most Utilized Provider Comparison Match-Up (In Excel format)
- Exhibit 5 Wellness Information

Exhibit 6 – Medical Census (In Excel format)

A request for any documents in Word or Excel may be made to:

Theresa Conley Siver Insurance Consultants tconley@siver.com

EXHIBIT 1

Plan Information and Medical Rates and Monthly Contributions for 2019 - 2022

School Board of Hendry County Medical Historical Cost Review

Plan and Tier	2022	<u>2021</u>	<u>2020</u>	<u>2019</u>	2018	2017	2016
	Aetna	Aetna	Aetna	Aetna	Florida Blue	Florida Blue	UHC
	Open Access MC 1	BlueOptions 03564	BlueOptions 03564	AHLV-M			
Employee Only	\$791.32	\$744.92	\$702.75	\$684.94	\$761.04	\$601.43	\$703.43
Emp + Spouse	\$1,740.91	\$1,638.83	\$1,546.07	\$1,506.89	\$1,674.32	\$1,323.16	\$1,547.55
Emp + Child(ren)	\$1,582.64	\$1,489.84	\$1,405.51	\$1,369.89	\$1,522.10	\$1,202.86	\$1,406.85
Family	\$2,215.69	\$2,085.77	\$1,967.71	\$1,917.85	\$2,130.94	\$1,684.01	\$1,969.60
	Open Access MC 2	BlueOptions 05302	BlueOptions 05302	AHMK			
Employee Only	\$636.90	\$599.57	\$565.63	\$551.30	\$612.55	\$484.08	\$566.18
Emp + Spouse	\$1,401.26	\$1,319.10	\$1,244.43	\$1,212.89	\$1,347.65	\$1,065.00	\$1,245.61
Emp + Child(ren)	\$1,273.86	\$1,199.17	\$1,131.29	\$1,102.62	\$1,225.13	\$968.11	\$1,132.38
Family	\$1,783.40	\$1,678.83	\$1,583.80	\$1,543.66	\$1,715.18	\$1,358.45	\$1,585.32
	Open Access MC 5000 HSA	BlueOptions 05903/05173 (HSA)	BlueOptions 05903/05173 (HSA)	AHI4 MOD (HSA)			
Employee Only	\$530.24	\$499.16	\$470.91	\$458.98	\$509.98	\$403.02	\$471.37
Emp + Spouse	\$1,166.57	\$1,098.17	\$1,036.01	\$1,009.76	\$1,121.95	\$886.64	\$1,037.01
Emp + Child(ren)	\$1,060.51	\$998.33	\$941.82	\$917.95	\$1,019.94	\$806.03	\$942.73
Family	\$1,484.72	\$1,397.67	\$1,318.56	\$1,285.15	\$1,427.94	\$1,128.45	\$1,319.83

*all % changes are based on current enrollment for that year

2019 Plan Documents

HENDRY DISTRICT SCHOOL BOARD Aetna and Other Benefit Rates Calendar Year 2019 Aetna PREMIUMS

(For Period January 1 through December 31, 2019)

Employees	Aenta	Aetna	Aetna
	CY 2019	CY 2019	CY 2019
	24 PAY	21 PAY	Annual
FAMILY HEALTH INSURANCE COVERAGE	Per Pay	Per Pay	Cost
		×	
Open Access MC 1			
Employee	\$0	\$0	\$0
Employee-Spouse	\$404	\$462	\$9,695
Employee-Children	\$335	\$383	\$8,051
Family	\$609	\$696	\$14,626
Both spouses work for District (Family)	\$260	\$297	\$6,238
Open Access MC 2			
Employee	\$0	\$0	\$0
Employee-Spouse	\$257	\$294	\$6,167
Employee-Children	\$202	\$231	\$4,843
Family	\$422	\$483	\$10,136
Both spouses work for District (Family)	\$73	\$83	\$1,748
Open Access MC3 HRA/HSA			
Employee (HRA)	\$0	\$0	\$0
Employee (Health Savings Plan)	\$155	\$178	\$3,720
Employee-Children (Health Savings Plan	\$109	\$125	\$2,627
Family (Health Savings Plan)	\$293	\$335	\$7,034
Both spouses work for District (Family) (Health Savings Plan)	\$0	\$0	\$0
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DENTAL, LIFE INSURANCE, DISABILITY			
Employee	\$0	\$0	\$0
Employee-Family	\$9	\$10	\$216
EMPLOYEE LIFE INSURANCE	\$0	\$0	\$0

Employees may purchase family dental insurance, spouse or children life insurance, additional life insurance on themselves, or additional disability insurance at their own expense.

\$9,000 Board Benefit Contribution Maximum Per Employee Benefit for dental and life insurance is \$612 Per Employee

Aetna Retiree Premium Rates RATE FOR CALENDAR YEAR 2019 (For Period January 1 through December 31, 2019)

If retiree chooses to remain on one of the District's Aetna Health Care Plans the retiree pays the FULL cost.

A descision to elect retiree benefits must be made within 30 working days prior to retirement. Failure to respond to enrollment indicates a refusal of coverage. Once a benefit is refused or not elected it cannot be reinstated at a later date. Upon retirement you cannot change or switch medical plan coverage. You are given the oportunity to change plan coverage during the District's annual Open Enrollment period

Retirees

FAMILY HEALTH INSURANCE COVERAGE	2019	2019
	Per Month	Annual
		1
Open Access Plan 1		
Retiree	\$684.94	\$8,219.28
Retiree-Spouse	\$1,506.89	\$18,082.68
Retiree-Children	\$1,369.89	\$16,438.68
Family	\$1,917.85	\$23,014.20
Open Access Plan 2		
Retiree	\$551.30	\$6,615.60
Retiree-Spouse	\$1,212.89	\$14,554.68
Retiree-Children	\$1,102.62	\$13,231.44
Family	\$1,543.66	\$18,523.92
Open Acces Plan 3 HRA/HSA		
Retiree	\$458.98	\$5,507.76
Retiree-Spouse	\$1,009.76	\$12,117.12
Retiree-Children	\$917.95	\$11,015.40
Family	\$1,285.15	\$15,421.80
DENTAL		
Employee	\$7	\$84
Employee-Family	\$27	\$324
RETIREE LIFE INSURANCE		
Can be purchased at the age based negotiated rate for retirees. Retiree pays full	Age Based	Age Based

Can be purchased at the age based negotiated rate for retirees. Retiree pays full cost for life insurance.

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plan 1

School District of Hendry County Effective Date: 01-01-2019 OAMC 2000 Plan MCI

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PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	\$2,000 Individual	\$4,000 Individual
	\$4,000 Family	\$8,000 Family
	parately toward the preferred or non-pref	
Unless otherwise indicated, the dedu	ctible must be met prior to benefits being	j payable.
	ices, as indicated in the plan, are exclude	ed from charges to meet the Deductible.
Pharmacy expenses do not apply tov		
	e Deductible for all family members. The	
	ever, no single individual within the famil	y will be subject to more than the
individual Deductible amount.		
Member Coinsurance	Covered 100%	20%
Applies to all expenses unless otherw		
Payment Limit (per calendar year)	\$4,000 Individual	\$9,000 Individual
	\$8,000 Family	\$18,000 Family
	parately toward the preferred or non-pref	
Certain member cost sharing elemen	ts may not apply toward the Payment Lir	nit.
Pharmacy expenses apply towards the		
	esulting from the application of coinsuran	ce percentage, copays, and deductibles
(except any penalty amounts) may be	e used to satisfy the Payment Limit.	
The family Payment Limit is a cumula	ative Payment Limit for all family member	rs. The family Payment Limit can be met
	however, no single individual within the	family will be subject to more than the
individual Payment Limit amount.		
Lifetime Maximum		
Unlimited except where otherwise inc		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare
		Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -		
Certification for certain types of Non-	Preferred care must be obtained to avoid	a reduction in benefits paid for that
	sions, Treatment Facility Admissions, Co	
	ate Duty Nursing is required - excluded a	mount applied separately to each type of
expense is \$400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/	Covered 100%; deductible waived	20%; after deductible
Immunizations	10.00 K 20.00 K	
	rs age 22 to age 65; 1 exam every 12 mo	onths for adults age 65 and older.
Routine Well Child	Covered 100%; deductible waived	20%; deductible waived
Exams/Immunizations		
		e, 3 exams in the third 12 months of life, 1
exam per 12 months thereafter to ag		
Routine Gynecological Care	Covered 100%; deductible waived	20%; after deductible
Exams		
1 obgyn exam and pap smear per ca	lendar year	



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Deviding Manual a surrows	Covered 1000/ deductible waived	Covered 100% deductible waived
Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived 20%; after deductible
Nomen's Health	Covered 100%; deductible waived	
ncludes: Screening for gestational dia	abetes, HPV (Human- Papillomavirus) DI	NA testing, courseling for sexually
	screening for human immunodeficiency	
	breastfeeding support, supplies and cour	
	rocedures, patient education and counse	eling. Limitations may apply.
Routine Digital Rectal Exam	Covered 100%; deductible waived	20%; after deductible
Recommended: For covered males ac		
Prostate-specific Antigen Test	Covered 100%; deductible waived	20%; after deductible
Recommended: For covered males ag		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age		
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	20%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to PCP	\$25 copay; deductible waived	20%; after deductible
	ral physician, family practitioner or pedia	itrician.
Specialist Office Visits	\$50 copay, deductible waived	20%; after deductible
Hearing Exams	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
Pre-Natal Maternity	Covered 100%; deductible waived	20%; after deductible
Walk-in Clinics	\$25 copay; deductible waived	20%; after deductible
	ding health care facilities. They are an a	
treatment of unscheduled non-emerg	ency illnesses and injuries and the admi	nistration of certain immunizations. It is
not an alternative for emergency room	n services or the ongoing care provided b	ov a physician. Neither an emergency
room nor the outnatient department c	of a hospital, shall be considered a Walk-	in Clinic
Allergy Testing	Your cost sharing is based on the	Your cost sharing is based on the
Anergy rearing		four boot onlanning to buood on the
	type of service and where it is	type of service and where it is
	type of service and where it is performed	type of service and where it is performed
Alleray Injections	performed	performed
Allergy Injections		performed Your cost sharing is based on the
Allergy Injections	performed	performed Your cost sharing is based on the type of service and where it is
	performed \$10 copay; deductible waived	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	performed \$10 copay; deductible waived IN-NETWORK	performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK
DIAGNOSTIC PROCEDURES Diagnostic X-ray	performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived	performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 20%; after deductible
DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician o	performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived office visit and billed by the physician, exp	performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 20%; after deductible
DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit mem	performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived office visit and billed by the physician, exp aber cost sharing.	performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 20%; after deductible penses are covered subject to the
DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit mem Diagnostic Laboratory	performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived office visit and billed by the physician, exp ber cost sharing. Covered 100%; deductible waived	performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 20%; after deductible penses are covered subject to the 20%; after deductible
DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit mem Diagnostic Laboratory If performed as a part of a physician of	performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived office visit and billed by the physician, exp ber cost sharing. Covered 100%; deductible waived office visit and billed by the physician, exp	performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 20%; after deductible penses are covered subject to the 20%; after deductible
DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit mem Diagnostic Laboratory If performed as a part of a physician of applicable physician's office visit mem	performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived office visit and billed by the physician, exp ber cost sharing. Covered 100%; deductible waived office visit and billed by the physician, exp ber cost sharing.	performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 20%; after deductible penses are covered subject to the 20%; after deductible penses are covered subject to the
DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit mem Diagnostic Laboratory If performed as a part of a physician of applicable physician's office visit mem Diagnostic Outpatient Complex	performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived office visit and billed by the physician, exp ber cost sharing. Covered 100%; deductible waived office visit and billed by the physician, exp	performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 20%; after deductible penses are covered subject to the 20%; after deductible
DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit mem Diagnostic Laboratory If performed as a part of a physician of applicable physician's office visit mem Diagnostic Outpatient Complex Imaging	performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived office visit and billed by the physician, explore cost sharing. Covered 100%; deductible waived office visit and billed by the physician, explore cost sharing. Covered 100%; deductible waived office visit and billed by the physician, explore cost sharing. Covered 100%; after deductible	performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 20%; after deductible penses are covered subject to the 20%; after deductible penses are covered subject to the 20%; after deductible
DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit mem Diagnostic Laboratory If performed as a part of a physician of applicable physician's office visit mem Diagnostic Outpatient Complex Imaging EMERGENCY MEDICAL CARE	performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived office visit and billed by the physician, explore cost sharing. Covered 100%; deductible waived office visit and billed by the physician, explore cost sharing. Covered 100%; deductible waived office visit and billed by the physician, explore cost sharing. Covered 100%; after deductible IN-NETWORK	performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 20%; after deductible penses are covered subject to the 20%; after deductible penses are covered subject to the 20%; after deductible OUT-OF-NETWORK
Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit mem Diagnostic Laboratory If performed as a part of a physician of applicable physician's office visit mem Diagnostic Outpatient Complex Imaging	performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived office visit and billed by the physician, explore cost sharing. Covered 100%; deductible waived office visit and billed by the physician, explore cost sharing. Covered 100%; deductible waived office visit and billed by the physician, explore cost sharing. Covered 100%; after deductible	performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 20%; after deductible penses are covered subject to the 20%; after deductible penses are covered subject to the 20%; after deductible



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Emergency Room	\$125 copay; deductible waived	Same as in-network care
Copay waived if admitted		
Non-Emergency Care in an	Not Covered	Not Covered
Emergency Room		
Emergency Use of Ambulance	Covered 100%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered		stay.
Inpatient Maternity Coverage	Covered 100%; after deductible	20%; after deductible
(includes delivery and postpartum		
care)		
	I benefits incurred during your inpatient	
Outpatient Hospital Expenses	Covered 100%; after deductible	20%; after deductible
	I benefits incurred during your outpatier	nt visit.
Outpatient Surgery - Hospital	Covered 100%; after deductible	20%; after deductible
	I benefits incurred during your outpatier	
Outpatient Surgery - Freestanding	Covered 100%; after deductible	20%; after deductible
Facility		
	benefits incurred during your outpatier	nt visit.
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
npatient	Covered 100%; deductible waived	20%; deductible waived
	benefits incurred during your inpatient	
Mental Health Office Visits	Covered 100%; deductible waived	20%; deductible waived
	benefits incurred during your outpatier	nt visit.
Other Mental Health Services	Covered 100%; deductible waived	20%; deductible waived
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%; deductible waived	20%; deductible waived
	benefits incurred during your inpatient	
Residential Treatment Facility	Covered 100%; deductible waived	20%; deductible waived
Substance Abuse Office Visits	Covered 100%; deductible waived	20%; deductible waived
	benefits incurred during your outpatier	
Other Substance Abuse Services	Covered 100%; deductible waived	20%: doductible waived
		20%; deductible waived
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
OTHER SERVICES Skilled Nursing Facility		
OTHER SERVICES Skilled Nursing Facility Limited to 60 days per calendar year.	IN-NETWORK Covered 100%; after deductible	OUT-OF-NETWORK 20%; after deductible
OTHER SERVICES Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered	IN-NETWORK Covered 100%; after deductible I benefits incurred during your inpatient	OUT-OF-NETWORK 20%; after deductible stay.
OTHER SERVICES Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered Home Health Care	IN-NETWORK Covered 100%; after deductible	OUT-OF-NETWORK 20%; after deductible
OTHER SERVICES Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered Home Health Care Limited to 60 visits per calendar year.	IN-NETWORK Covered 100%; after deductible benefits incurred during your inpatient Covered 100%; after deductible	OUT-OF-NETWORK 20%; after deductible stay. 20%; after deductible
OTHER SERVICES Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered Home Health Care Limited to 60 visits per calendar year. Coverage includes nutritional counselir	IN-NETWORK Covered 100%; after deductible benefits incurred during your inpatient Covered 100%; after deductible ag and services of a medical social work	OUT-OF-NETWORK 20%; after deductible stay. 20%; after deductible ker.
OTHER SERVICES Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered Home Health Care Limited to 60 visits per calendar year. Coverage includes nutritional counselir Each visit by a nurse or therapist is one	IN-NETWORK Covered 100%; after deductible benefits incurred during your inpatient Covered 100%; after deductible ag and services of a medical social work e visit. Each visit up to 4 hours by a hon	OUT-OF-NETWORK 20%; after deductible stay. 20%; after deductible ker. he health care aide is one visit.
OTHER SERVICES Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered Home Health Care Limited to 60 visits per calendar year. Coverage includes nutritional counselir Each visit by a nurse or therapist is one	IN-NETWORK Covered 100%; after deductible benefits incurred during your inpatient Covered 100%; after deductible ag and services of a medical social work	OUT-OF-NETWORK 20%; after deductible stay. 20%; after deductible ker.
OTHER SERVICES Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered Home Health Care Limited to 60 visits per calendar year. Coverage includes nutritional counselir Each visit by a nurse or therapist is one Hospice Care - Inpatient Your cost sharing applies to all covered	IN-NETWORK Covered 100%; after deductible benefits incurred during your inpatient Covered 100%; after deductible og and services of a medical social work visit. Each visit up to 4 hours by a hon Covered 100%; after deductible benefits incurred during your inpatient	OUT-OF-NETWORK 20%; after deductible stay. 20%; after deductible ker. he health care aide is one visit. 20%; after deductible stay.
OTHER SERVICES Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered Home Health Care Limited to 60 visits per calendar year. Coverage includes nutritional counselir Each visit by a nurse or therapist is one Hospice Care - Inpatient	IN-NETWORK Covered 100%; after deductible benefits incurred during your inpatient Covered 100%; after deductible og and services of a medical social work visit. Each visit up to 4 hours by a hon Covered 100%; after deductible benefits incurred during your inpatient Covered 100%; after deductible	OUT-OF-NETWORK 20%; after deductible stay. 20%; after deductible ker. he health care aide is one visit. 20%; after deductible stay. 20%; after deductible 20%; after deductible stay. 20%; after deductible



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School District of Hendry County Effective Date: 01-01-2019 OAMC 2000 & Retirees Only – Florida

PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	\$25 copay; deductible waived	20%; after deductible
Limited to 20 visits per calendar year.		Residue de la constancia de la constanci
Outpatient Short-Term	\$25 copay; deductible waived	20%; after deductible
Rehabilitation	antista interativenti interativativa interativativativativativativativativativativ	
Includes Speech, Physical, and Occupa	ational Therapy, limited to 20 visits per t	herapy per calendar year.
Autism Behavioral Therapy	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
	Health	Health
Covered same as any other Outpatient	Mental Health benefit	ē
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
	Health Other Services	Health Other Services
Covered same as any other Outpatient	Mental Health Other Services benefit	
Autism Physical Therapy	\$25 copay; deductible waived	20%; after deductible
Autism Occupational Therapy	\$25 copay; deductible waived	20%; after deductible
Autism Speech Therapy	\$25 copay; deductible waived	20%; after deductible
Durable Medical Equipment	Covered 100%; after deductible	20%; after deductible
Diabetic Supplies (if not covered	Covered same as any other medical	Covered same as any other medical
under Pharmacy benefit)	expense.	expense.
Women's Contraceptive drugs and	Covered 100%; deductible waived	Covered same as any other expense
devices not obtainable at a		
pharmacy		
Affordable Care Act mandated	Covered 100%; deductible waived	Covered same as any other expense
Women's Contraceptives		
Infusion Therapy	Your cost sharing is based on the	Your cost sharing is based on the
Administered in the home or	type of service and where it is	type of service and where it is
physician's office	performed	performed
Infusion Therapy	Your cost sharing is based on the	Your cost sharing is based on the
Administered in an outpatient hospital	type of service and where it is	type of service and where it is
department or freestanding facility	performed	performed
Vision Eyewear	Not Covered	Not Covered
Transplants	Covered 100%; after deductible	20%; after deductible
	Preferred coverage is provided at an	Non-Preferred coverage is provided
6-	IOE contracted facility only.	at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents		d benefit level of the plan if in-network
	provider is not available.	
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed

Diagnosis and treatment of the underlying medical condition only.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation indu	uction	
Advanced Reproductive	Not Covered	Not Covered
Technology (ART)		
n-vitro fertilization (IVF), zygote intrafall		
embryo transfers, intracytoplasmic sper		
Vasectomy	Covered 100%; after deductible	20%; after deductible
Tubal Ligation	Covered 100%; deductible waived	20%; after deductible
PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	\$10 copay	\$10 copay
90 Day Retail	\$30 copay	Not Covered
Mail Order	\$20 copay	Not Covered
Preferred Brand-Name Drugs		
Retail	\$30 copay	\$30 copay
90 Day Retail	\$90 copay	Not Covered
Mail Order	\$60 copay	Not Covered
Non-Preferred Generic and Brand-Na		
Retail	\$50 copay	\$50 copay
90 Day Retail	\$150 copay	Not Covered
Mail Order	\$100 copay	Not Covered
Pharmacy Day Supply and Requirem		
Retail	Up to a 30 day supply from Aetna Star	
Mail Order	Up to a 31-90 day supply from Aetna I	
Value Plus Specialty	Up to a 30 day supply from Aetna Spe	
		ecialty pharmacy. Subsequent fills must
	be through our preferred specialty pha	
Choose Generics - If the member or th		
applicable copay plus the difference bet		
Plan Includes: Diabetic supplies and C		
A limited list of over-the-counter medica		escription.
Oral chemotherapy drugs covered 100%	6	
Value Plus Pre-certification included		
Value Plus Step Therapy included		
Seasonal Vaccinations covered 100% ir		
Preventive Vaccinations covered 100%		
One transition fill allowed within 90 days		
Affordable Care Act mandated female c	ontraceptives and preventive medication	ons covered 100% in-network.
GENERAL PROVISIONS Dependents Eligibility	Spouse, children from birth to age 26	

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.

- · Cosmetic surgery, including breast reduction.
- · Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

Home births

· Immunizations for travel or work, except where medically necessary or indicated.

· Implantable drugs and certain injectable drugs including injectable infertility drugs.

• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.

· Long-term rehabilitation therapy.

· Non-medically necessary services or supplies.

• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.

· Radial keratotomy or related procedures.

Reversal of sterilization.

• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.

Special duty nursing.

· Therapy or rehabilitation other than those listed as covered.

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

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plan 2

School District of Hendry County Effective Date: 01-01-2019 OAMC 6000

PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK			
Deductible (per calendar year)	\$6,000 Individual	\$8,000 Individual			
	\$12,000 Family	\$16,000 Family			
All covered expenses accumulate sepa	All covered expenses accumulate separately toward the preferred or non-preferred Deductible.				
Unless otherwise indicated, the deduct	ible must be met prior to benefits being	payable.			
Member cost sharing for certain service	es, as indicated in the plan, are excluded	from charges to meet the Deductible.			
Pharmacy expenses do not apply towa	rds the Deductible.				
The family Deductible is a cumulative I	Deductible for all family members. The fa	amily Deductible can be met by a			
combination of family members: howey	ver, no single individual within the family	will be subject to more than the			
individual Deductible amount.		Balancianas program. A sensitiva matrixada e concerta			
Member Coinsurance	40%	50%			
Applies to all expenses unless otherwise					
Payment Limit (per calendar year)	\$6,250 Individual	\$10,000 Individual			
raymont anna (por ouronaur your)	\$12,500 Family	\$20,000 Family			
All covered expenses accumulate sepa	arately toward the preferred or non-prefe	rred Payment Limit.			
Certain member cost sharing elements	may not apply toward the Payment Lim	it.			
Pharmacy expenses apply towards the					
Only those out-of-pocket expenses res	ulting from the application of coinsurance	e percentage, copays, and deductibles			
(except any penalty amounts) may be	used to satisfy the Payment Limit.	3, 1, 3,			
The family Payment Limit is a cumulati	ve Payment Limit for all family members	. The family Payment Limit can be met			
by a combination of family members: h	owever, no single individual within the fa	amily will be subject to more than the			
individual Payment Limit amount.	•	,			
Lifetime Maximum					
Unlimited except where otherwise indic	cated.				
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare			
, ajment let ment i element elle		Facility: 140% of Medicare			
Primary Care Physician Selection	Optional	Not Applicable			
Certification Requirements -					
Certification for certain types of Non-P	referred care must be obtained to avoid	a reduction in benefits paid for that			
care, Certification for Hospital Admissi	ons, Treatment Facility Admissions, Cor	valescent Facility Admissions, Home			
Health Care, Hospice Care and Private	e Duty Nursing is required - excluded an	nount applied separately to each type of			
expense is \$400 per occurrence.	, , ,				
Referral Requirement	None	None			
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK			
Routine Adult Physical Exams/	Covered 100%; deductible waived	50%; after deductible			
Immunizations	,				
	age 22 to age 65; 1 exam every 12 mor	ths for adults age 65 and older.			
Routine Well Child	Covered 100%; deductible waived	50%; deductible waived			
Exams/Immunizations					
	exams in the second 12 months of life,	3 exams in the third 12 months of life, 1			
exam per 12 months thereafter to age	22.				
Routine Gynecological Care	Covered 100%; deductible waived	50%; after deductible			
Exams		e kalanut - Australia			
1 obgyn exam and pap smear per cale	endar vear				
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PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

Routine Mammograms Women's Health Includes: Screening for gestational dia transmitted infections, courseling and	Covered 100%; deductible waived	Covered 100%; deductible waived
Includes: Screening for gestational dia		
Includes: Screening for gestational dia transmitted infections, counseling and	Covered 100%; deductible waived	50%; after deductible
transmitted infections counseling and	abetes, HPV (Human- Papillomavirus) Dl	NA testing, counseling for sexually
individual infootions, councoung and	screening for human immunodeficiency	virus, screening and counseling for
	breastfeeding support, supplies and cour	
Contraceptive methods, sterilization p	rocedures, patient education and counse	eling. Limitations may apply.
Routine Digital Rectal Exam	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males a	ge 40 and over.	
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males a	ge 40 and over.	
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age		ordan manualabaria anto da - alasti contraventa •) - transfer - antonesi et antones e
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to PCP	\$40 copay; deductible waived	50%; after deductible
	eral physician, family practitioner or pedia	
Specialist Office Visits	\$80 copay; deductible waived	50%; after deductible
Hearing Exams	Your cost sharing is based on the	Your cost sharing is based on the
hearing Exams	type of service and where it is	type of service and where it is
	performed	performed
Due Netel Meternity	Covered 100%; deductible waived	50%; after deductible
Pre-Natal Maternity		50%; after deductible
Walk-in Clinics	\$40 copay; deductible waived	
Walk-in Clinics are network, free-stan	ding health care facilities. They are an a	niemative to a physician's office visit ic
treatment of unscheduled, non-emerg	ency illnesses and injuries and the admi	nistration of certain immunizations. It is
not an alternative for emergency roon	n services or the ongoing care provided k	by a physician. Neither an emergency
	of a hospital, shall be considered a Walk-	in Clinic.
Allergy Testing	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
	\$10 copay; deductible waived	Your cost sharing is based on the
Allergy Injections		
Allergy Injections		type of service and where it is
Allergy Injections		type of service and where it is performed
	IN-NETWORK	performed OUT-OF-NETWORK
DIAGNOSTIC PROCEDURES		performed
DIAGNOSTIC PROCEDURES	Covered 100%; deductible waived	performed OUT-OF-NETWORK 50%; after deductible
DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician of	Covered 100%; deductible waived office visit and billed by the physician, ex	performed OUT-OF-NETWORK 50%; after deductible
DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit men	Covered 100%; deductible waived office visit and billed by the physician, ex ober cost sharing.	performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the
DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit men Diagnostic Laboratory	Covered 100%; deductible waived office visit and billed by the physician, ex ober cost sharing. Covered 100%; deductible waived	performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible
DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit men Diagnostic Laboratory If performed as a part of a physician of	Covered 100%; deductible waived office visit and billed by the physician, ex ober cost sharing. Covered 100%; deductible waived office visit and billed by the physician, ex	performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible
DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit men Diagnostic Laboratory If performed as a part of a physician of applicable physician's office visit men	Covered 100%; deductible waived office visit and billed by the physician, explored cost sharing. Covered 100%; deductible waived office visit and billed by the physician, explore cost sharing.	performed OUT-OF-NETWORK 50%; after deductible benses are covered subject to the 50%; after deductible penses are covered subject to the
DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit men Diagnostic Laboratory If performed as a part of a physician of applicable physician's office visit men Diagnostic Outpatient Complex	Covered 100%; deductible waived office visit and billed by the physician, ex ober cost sharing. Covered 100%; deductible waived office visit and billed by the physician, ex	performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible
DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit men Diagnostic Laboratory If performed as a part of a physician of applicable physician's office visit men Diagnostic Outpatient Complex Imaging	Covered 100%; deductible waived office visit and billed by the physician, explored cost sharing. Covered 100%; deductible waived office visit and billed by the physician, explored cost sharing. %300 copay; deductible waived	performed OUT-OF-NETWORK 50%; after deductible benses are covered subject to the 50%; after deductible penses are covered subject to the 50%; after deductible 50%; after deductible
DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit men Diagnostic Laboratory If performed as a part of a physician of applicable physician's office visit men Diagnostic Outpatient Complex Imaging EMERGENCY MEDICAL CARE	Covered 100%; deductible waived office visit and billed by the physician, explored cost sharing. Covered 100%; deductible waived office visit and billed by the physician, explored cost sharing. \$300 copay; deductible waived IN-NETWORK	performed OUT-OF-NETWORK 50%; after deductible benses are covered subject to the 50%; after deductible penses are covered subject to the 50%; after deductible 50%; after deductible 0UT-OF-NETWORK
applicable physician's office visit men Diagnostic Laboratory	Covered 100%; deductible waived office visit and billed by the physician, explored cost sharing. Covered 100%; deductible waived office visit and billed by the physician, explored cost sharing. %300 copay; deductible waived	performed OUT-OF-NETWORK 50%; after deductible benses are covered subject to the 50%; after deductible penses are covered subject to the 50%; after deductible 50%; after deductible

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Emergency Room	\$300 copay; deductible waived	Same as in-network care
Copay waived if admitted	toob topay, deddolible walved	
Non-Emergency Care in an	Not Covered	Not Covered
Emergency Room		Regelation of the Schwarzon
Emergency Use of Ambulance	40%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	40%; after \$500 copay; after	50%; after \$500 copay; after
	deductible	deductible
	d benefits incurred during your inpatient :	
Inpatient Maternity Coverage	40%; after \$500 copay; after	50%; after \$500 copay; after
(includes delivery and postpartum care)	deductible	deductible
	d benefits incurred during your inpatient	stav
Outpatient Hospital Expenses	40%; after deductible	50%; after deductible
	d benefits incurred during your outpatien	
Outpatient Surgery - Hospital	40%; after \$250 copay; after	50%; after \$250 copay; after
outhanom on 30.)brun	deductible	deductible
Your cost sharing applies to all covered	d benefits incurred during your outpatien	
Outpatient Surgery - Freestanding	40%; after deductible	50%; after deductible
Facility		
	d benefits incurred during your outpatien	
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%; deductible waived	50%; deductible waived
	d benefits incurred during your inpatient	
Mental Health Office Visits	\$80 copay; deductible waived	50%; deductible waived
	d benefits incurred during your outpatien	
Other Mental Health Services	Covered 100%; deductible waived	50%; deductible waived
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%; deductible waived	50%; deductible waived
Residential Treatment Facility	d benefits incurred during your inpatient Covered 100%; deductible waived	50%; deductible waived
Substance Abuse Office Visits	\$80 copay; deductible waived	50%; deductible waived
	d benefits incurred during your outpatien	
Other Substance Abuse Services	Covered 100%; deductible waived	50%; deductible waived
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility	40%; after deductible	50%; after deductible
Limited to 60 days per calendar year.		
	d benefits incurred during your inpatient	stay.
Home Health Care	40%; after deductible	50%; after deductible
Limited to 60 visits per calendar year.		
Coverage includes nutritional counseling	ng and services of a medical social work	
	e visit. Each visit up to 4 hours by a hom	
Hospice Care - Inpatient	40%; after deductible	50%; after deductible
	d benefits incurred during your inpatient	
Hospice Care - Outpatient	40%; after deductible d benefits incurred during your outpatien	50%; after deductible



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School District of Hendry County Effective Date: 01-01-2019 OAMC 6000 – Florida

PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	\$40 copay; deductible waived	50%; after deductible
Limited to 20 visits per calendar year.		
Outpatient Short-Term	\$40 copay; deductible waived	50%; after deductible
Rehabilitation		
Includes Speech, Physical, and Occupa	ational Therapy, limited to 20 visits per t	
Autism Behavioral Therapy	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
	Health	Health
Covered same as any other Outpatient		
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
	Health Other Services	Health Other Services
Covered same as any other Outpatient	Mental Health Other Services benefit	
Autism Physical Therapy	\$40 copay; deductible waived	50%; after deductible
Autism Occupational Therapy	\$40 copay; deductible waived	50%; after deductible
Autism Speech Therapy	\$40 copay; deductible waived	50%; after deductible
Durable Medical Equipment	40%; after deductible	50%; after deductible
Diabetic Supplies (if not covered	Covered same as any other medical	Covered same as any other medical
under Pharmacy benefit)	expense.	expense.
Women's Contraceptive drugs and	Covered 100%; deductible waived	Covered same as any other expense
devices not obtainable at a		
pharmacy		
Affordable Care Act mandated	Covered 100%; deductible waived	Covered same as any other expense
Women's Contraceptives		
Infusion Therapy	Your cost sharing is based on the	Your cost sharing is based on the
Administered in the home or	type of service and where it is	type of service and where it is
physician's office	performed	performed
Infusion Therapy	Your cost sharing is based on the	Your cost sharing is based on the
Administered in an outpatient hospital	type of service and where it is	type of service and where it is
department or freestanding facility	performed	performed
Vision Eyewear	Not Covered	Not Covered
Transplants	40%; after \$500 copay; after	50%; after deductible
	deductible	
	Preferred coverage is provided at an	Non-Preferred coverage is provided
	IOE contracted facility only.	at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferre	ed benefit level of the plan if in-network
	provider is not available.	
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
Diagnosis and treatment of the underly		

Diagnosis and treatment of the underlying medical condition only.



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Comprehensive Infertility Services Artificial insemination and ovulation indu	Not Covered	Not Covered
Advanced Reproductive	Not Covered	Not Covered
Technology (ART)	Not Covered	Not Covered
In-vitro fertilization (IVF), zygote intrafal	llonian transfer (ZIET), gamete intrafall	onian transfer (GIFT) cryopreserved
embryo transfers, intracytoplasmic sper		
Vasectomy	Covered 100%; after deductible	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	Aetna Value Plus Open Formulary	OUT-OF-NETWORK
Preferred Generic Drugs	Aetha value Plus Open Formulary	
	¢10 copou	20% of submitted cost; after
Retail	\$10 copay	applicable copay
00 Day Batail	\$20 appart	Not Covered
90 Day Retail	\$30 copay	
Mail Order	\$20 copay	Not Applicable
Preferred Brand-Name Drugs	* 10	
Retail	\$40 copay	20% of submitted cost; after
		applicable copay
90 Day Retail	\$120 copay	Not Covered
Mail Order	\$80 copay	Not Applicable
Non-Preferred Generic and Brand-Na		
Retail	\$80 copay	20% of submitted cost; after
		applicable copay
90 Day Retail	\$240 copay	Not Covered
Mail Order	\$160 copay	Not Applicable
Pharmacy Day Supply and Requirem	ients	
Retail	Up to a 30 day supply from Aetna Sta	ndard National Network
Mail Order	Up to a 31-90 day supply from Aetna	Rx Home Delivery®.
Value Plus Specialty	Up to a 30 day supply from Aetna Spe	
	First prescription fill at any retail or sp	ecialty pharmacy. Subsequent fills must
	be through our preferred specialty ph	armacy network.
Choose Generics - If the member or th	ne physician requests brand when gene	eric is available, the member pays the
applicable copay plus the difference be	tween the generic price and the brand	price.
Plan Includes: Diabetic supplies and C	Contraceptive drugs and devices obtain	able from a pharmacy.
A limited list of over-the-counter medica	ations are covered when filled with a pr	escription.
Oral chemotherapy drugs covered 1009	%	
Value Plus Pre-certification included		
Value Plus Step Therapy included		
Seasonal Vaccinations covered 100% i	n-network	
Preventive Vaccinations covered 100%		
One transition fill allowed within 90 day		
	contraceptives and preventive medicati	ons covered 100% in-network.
GENERAL PROVISIONS		



School District of Hendry County Effective Date: 01-01-2019 OAMC 6000 – Florida

PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

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If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.



School District of Hendry County Effective Date: 01-01-2019 OAMC 6000 – Florida

PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.

- · Cosmetic surgery, including breast reduction.
- · Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

Home births

· Immunizations for travel or work, except where medically necessary or indicated.

• Implantable drugs and certain injectable drugs including injectable infertility drugs.

• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.

- · Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.

• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.

- Radial keratotomy or related procedures.
- Reversal of sterilization.

 Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.

- · Special duty nursing.
- · Therapy or rehabilitation other than those listed as covered.

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

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In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at 1-888-982-3862.

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

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School District of Hendry County Effective Date: 01-01-2019 OAMC 6000 – Florida

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School District of Hendry County Effective Date: 01-01-2019 Aetna HealthFund OAMC HRA - Florida

FUND FEATURES		card
HealthFund Amount	\$1,500 Employee	No for family coverage only single cover
Amount contributed to the Fund by the		No for tanding coverage and cover
Fund amount reflected is on a per cale	andar year basis. The fund re	eceived may be prorated based on your effective
	enuar year basis. The fund fe	ceived may be protated based on your enective
date of coverage.	a to all family mombars com	bined. There is no Individual HealthFund limit
within the Family HealthFund amount.		
Fund Coinsurance	100%	
Percentage at which the Fund will rein		Contraction of the United States in the States of the Stat
Fund Administration		bay for your member responsibility, including your
		e. Once the deductible is met, the underlying
		erage and if a Fund balance still exists, the Fund
		oonsibility (i.e. your share of coinsurance) until the
		as been reached or the Fund has been exhausted,
	whichever comes first. Sei	rvices covered at 100% with no deductible will be
	paid by the plan and not b	y the Fund.
Employee Termination from Your	Any remaining HealthFund	d benefit amount is forfeited (or terminated) when
HealthFund	the employee's HealthFun	d coverage terminates.
Fund Rollover		d benefit amount at end of the plan year is rolled
	over into next year's Healt	
Eligible Fund Expenses		ses as the medical plan. Expenses above the
		limit, any plan limits, and any non covered
		for reimbursement under the Fund.
Fund Payment/Assignment	Network Providers: Auton	natic Assignment to provider.
and Tayment/Assignment		Member may assign payment to provider.
Pro-ration for New Employees	Monthly	nember may addigit payment to provider.
Pro-ration for Family Status		new tier based on new employee status.
Change	No pro-ration. Onlarge to	new tier based on new employee statue.
Prescription Drug Plan	Properties Drug expense	es are integrated with the medical plan (i.e., subject
Prescription Drug Plan	to modical Doductible and	applied towards the medical Out-of-Pocket Limit)
		gible for reimbursement from the Fund).
PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK \$15,000 Individual
Deductible (per calendar year)	\$5,000 Individual	
	\$10,000 Family	\$30,000 Family
All covered expenses accumulate sep		
Unless otherwise indicated, the deduc	tible must be met prior to be	nefits being payable.
Member cost sharing for certain service	ces, as indicated in the plan,	are excluded from charges to meet the Deductible.
Pharmacy expenses apply towards th	e Deductible.	
The family Deductible is a cumulative	Deductible for all family men	nbers. The family Deductible can be met by a
combination of family members; howe	ver, no single individual with	in the family will be subject to more than the
individual Deductible amount.	2	
Member Coinsurance	50%	50%
Applies to all expenses unless otherw		
Payment Limit (per calendar year)	\$6,250 Individual	\$20,000 Individual
(por balondar you)	\$12,500 Family	\$40,000 Family
All covered expenses accumulate sep	arately toward the preferred	
All covered expenses accumulate set	aratory toward the preferred	or non-protonou i dynone enne.



Professional: 105% of Medicare

PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Certain member cost sharing elements may not apply toward the Payment Limit.

Pharmacy expenses apply towards the Payment Limit.

Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit.

The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.

Lifetime Maximum

Unlimited except where otherwise indicated.

Not Applicable Payment for Non-Preferred Care**

Facility: 140% of Medicare Not Applicable Primary Care Physician Selection Optional

Certification Requirements -

Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is \$400 per occurrence.

Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/	Covered 100%; deductible waived	50%; after deductible
Immunizations		
1 exam every 12 months for member	rs age 22 to age 65; 1 exam every 12 mo	nths for adults age 65 and older.
Routine Well Child	Covered 100%; deductible waived	50%; deductible waived
Exams/Immunizations		
	, 3 exams in the second 12 months of life,	3 exams in the third 12 months of life, 7
exam per 12 months thereafter to ag		
Routine Gynecological Care	Covered 100%; deductible waived	50%; after deductible
Exams		
1 obgyn exam and pap smear per ca	llendar year	
Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	50%; after deductible
Includes: Screening for gestational d	iabetes, HPV (Human- Papillomavirus) D	NA testing, counseling for sexually
transmitted infections, counseling an	d screening for human immunodeficiency	virus, screening and counseling for
interpersonal and domestic violence,	, breastfeeding support, supplies and cou	nseling.
	procedures, patient education and counse	eling. Limitations may apply.
Routine Digital Rectal Exam	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males a		
Prostate-specific Antigen Test		50%; after deductible
Recommended: For covered males a		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age	e 50 and over.	
Routine Eye Exams	Covered 100%; deductible waived	50%; after deductible
1 routine exam per 24 months.		
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to PCP	50%; after deductible	50%; after deductible
Includes services of an internist den	eral physician, family practitioner or pedia	atrician.

Includes services of an internist, general physician, family practitioner or pediatrician.



PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Specialist Office Visits	50%; after deductible	50%; after deductible
Hearing Exams	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	50%; after deductible	50%; after deductible
	ding health care facilities. They are an a	
reatment of unscheduled, non-emerge	ency illnesses and injuries and the adm	inistration of certain immunizations. It is
not an alternative for emergency room	services or the ongoing care provided	by a physician. Neither an emergency
	f a hospital, shall be considered a Walk	
Allergy Testing	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
Allergy Injections	Your cost sharing is based on the	Your cost sharing is based on the
anorgy injocations	type of service and where it is	type of service and where it is
	performed	performed
DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray	50%; after deductible	50%; after deductible
	ffice visit and billed by the physician, ex	
applicable physician's office visit mem	ber cost sharing.	
Diagnostic Laboratory	50%; after deductible	50%; after deductible
	ffice visit and billed by the physician, ex	
applicable physician's office visit mem		
Diagnostic Outpatient Complex	50%; after deductible	50%; after deductible
maging		
EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Jrgent Care Provider	50%; after deductible	50%; after deductible
Non-Urgent Use of Urgent Care	Not Covered	Not Covered
Provider		
Emergency Room	50%; after deductible	Same as in-network care
Non-Emergency Care in an	Not Covered	Not Covered
Emergency Room		
Emergency Use of Ambulance	50%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
npatient Coverage	50%; after \$500 copay per	50%; after \$500 copay per
	admission; after deductible	admission; after deductible
Vous cost charing applica to all covers	States of the Active Sector S Sector Sector Sec	
	d benefits incurred during your inpatien	$\frac{50\%}{50\%}$, ofter 6500 concurrent
Inpatient Maternity Coverage	50%; after \$500 copay per	50%; after \$500 copay per
includes delivery and postpartum care)	admission; after deductible	admission; after deductible
	ed benefits incurred during your inpatien	
Outpatient Hospital Expenses	50%; after \$250 copay; after deductible	50%; after \$250 copay; after deductible
	ed benefits incurred during your outpatie	nt visit.
Outpatient Surgery - Hospital	50%; after \$250 copay; after deductible	50%; after \$250 copay; after deductible
Your cost sharing applies to all covere	ed benefits incurred during your outpatie	
i our obstanding applies to all covert	a sensito mounda duning your outputte	Bag

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PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Outpatient Surgery - Freestanding	50%; after deductible	50%; after deductible
Facility		
Your cost sharing applies to all covered	d benefits incurred during your outpa	atient visit.
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
npatient	50%; after \$500 copay per	50%; after \$500 copay per
	admission; after deductible	admission; after deductible
our cost sharing applies to all covered	benefits incurred during your inpat	ient stay.
lental Health Office Visits	50%; after deductible	50%; after deductible
our cost sharing applies to all covered	benefits incurred during your outpat	atient visit.
Other Mental Health Services	50%; after deductible	50%; after deductible
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
npatient	50%; after \$500 copay per	50%; after \$500 copay per
	admission; after deductible	admission; after deductible
our cost sharing applies to all covered	d benefits incurred during your inpat	ient stay.
Residential Treatment Facility	50%; after \$500 copay per	50%; after \$500 copay per
	admission; after deductible	admission; after deductible
Substance Abuse Office Visits	50%; after deductible	50%; after deductible
our cost sharing applies to all covered		atient visit.
Other Substance Abuse Services	50%; after deductible	50%; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
killed Nursing Facility	50%; after deductible	50%; after deductible
imited to 60 days per calendar year.		
our cost sharing applies to all covered	d benefits incurred during your inpat	ient stay.
Iome Health Care	50%; after deductible	50%; after deductible
imited to 60 visits per calendar year.		
Coverage includes nutritional counselir		
ach visit by a nurse or therapist is one		
lospice Care - Inpatient	50%; after deductible	50%; after deductible
our cost sharing applies to all covered		ient stay.
lospice Care - Outpatient	50%; after deductible	50%; after deductible
our cost sharing applies to all covered		
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	50%; after deductible	50%; after deductible
imited to 20 visits per calendar year.		
Outpatient Short-Term	50%; after deductible	50%; after deductible
Rehabilitation		
L. L. L. Ownersky Discribed and Ocean	ational Thomas limited to 20 visite	nor thorony nor colondor your

Includes Speech, Physical, and Occupational Therapy, limited to 20 visits per therapy per calendar year.



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Autism Behavioral Therapy	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
	Health	Health
Covered same as any other Outpatient	Mental Health benefit	
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health Other Services	Refer to MBH Outpatient Mental Health Other Services
Covered same as any other Outpatient		
Autism Physical Therapy	50%; after deductible	50%; after deductible
Autism Occupational Therapy	50%; after deductible	50%; after deductible
Autism Speech Therapy	50%; after deductible	50%; after deductible
Durable Medical Equipment	50%; after deductible	50%; after deductible
Diabetic Supplies (if not covered	Covered same as any other medical	Covered same as any other medical
under Pharmacy benefit)	expense.	expense.
Women's Contraceptive drugs and	Covered 100%; deductible waived	Covered same as any other expense.
devices not obtainable at a		
pharmacy		
Affordable Care Act mandated	Covered 100%; deductible waived	Covered same as any other expense.
Women's Contraceptives		
Infusion Therapy	50%; after deductible	50%; after deductible
Administered in the home or		
physician's office		
Infusion Therapy	50%; after deductible	50%; after deductible
Administered in an outpatient hospital		
department or freestanding facility		
Vision Eyewear	Not Covered	Not Covered
Transplants	50%; after deductible	50%; after deductible
	Preferred coverage is provided at an	Non-Preferred coverage is provided
	IOE contracted facility only.	at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferre provider is not available.	d benefit level of the plan if in-network
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Your cost sharing is based on the type of service and where it is	Your cost sharing is based on the type of service and where it is
	performed	performed
Diagnosis and treatment of the underly		Not Coursed
Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation inc		Not Covered
Advanced Reproductive	Not Covered	Not Covered
Technology (ART)	llenien transfor (ZIET) - severete interfelle	nion transfor (CIET) an insurance is d
In-vitro tertilization (IVF), zygote intrafa	allopian transfer (ZIFT), gamete intrafallo	pian transfer (GFT), cryopreserved
	erm injection (ICSI), or ovum microsurger	y E00/1 ofter deductible
Vasectomy	Your cost sharing is based on the	50%; after deductible
	type of service and where it is	
The literation	performed	E00/ , ofter deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible



PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

PHARMACY	IN-NETWORK	OUT-OF-NETWORK
	e deductible before any be	nefits are considered for payment under the
pharmacy plan.		
Pharmacy Plan Type	Aetna Value Plus Open F	ormulary
Preferred Generic Drugs		
Retail	\$10 copay	\$10 copay
90 Day Retail	\$30 copay	Not Covered
Mail Order	\$25 copay	Not Covered
Preferred Brand-Name Drugs		
Retail	\$30 copay	\$30 copay
90 Day Retail	\$90 copay	Not Covered
Mail Order	\$75 copay	Not Covered
Non-Preferred Generic and Brand-Na		
Retail	\$50 copay	\$50 copay
90 Day Retail	\$150 copay	Not Covered
Mail Order	\$125 copay	Not Covered
Pharmacy Day Supply and Requirem		
Retail		m Aetna Standard National Network
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network.	
	First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.	
Choose Generics - If the member or th	ne physician requests bran	d when generic is available, the member pays the
applicable copay plus the difference be	tween the generic price an	d the brand price.
Plan Includes: Diabetic supplies and C		
A limited list of over-the-counter medica		ed with a prescription.
Oral chemotherapy drugs covered 100°	%	
Value Plus Pre-certification included		
Value Plus Step Therapy included		
Seasonal Vaccinations covered 100% i		
Preventive Vaccinations covered 100%		
One transition fill allowed within 90 day		
	contraceptives and prevent	ive medications covered 100% in-network.
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from bir	th to age 26 regardless of student status.

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.



PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

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PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.

· Cosmetic surgery, including breast reduction.

Custodial care.

• Dental care and dental X-rays.

Donor egg retrieval

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

Home births

· Immunizations for travel or work, except where medically necessary or indicated.

· Implantable drugs and certain injectable drugs including injectable infertility drugs.

• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.

Long-term rehabilitation therapy.

• Non-medically necessary services or supplies.

• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.

· Radial keratotomy or related procedures.

• Reversal of sterilization.

• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.

· Special duty nursing.

· Therapy or rehabilitation other than those listed as covered.

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at 1-888-982-3862.

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

Plan features and availability may vary by location and group size. For more information about Aetna plans, refer to **www.aetna.com**. © 2014 Aetna Inc.



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School District of Hendry County Effective Date: 01-01-2019 Open Access® Managed Choice® POS - Florida OAMC HSA Qualified High Deductible Health Plan

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PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	\$5,000 Individual	\$15,000 Individual
	\$10,000 Family	\$30,000 Family
All covered expenses accumulate sep	arately toward the preferred or non-prefe	erred Deductible.
Unless otherwise indicated, the deduc	tible must be met prior to benefits being	payable.
Member cost sharing for certain service	es, as indicated in the plan, are exclude	d from charges to meet the Deductible.
Pharmacy expenses apply towards the	e Deductible.	
The family Deductible is a cumulative	Deductible for all family members. The fa	amily Deductible can be met by a
combination of family members; howe	ver, no single individual within the family	will be subject to more than the
individual Deductible amount.		2
Member Coinsurance	50%	50%
Applies to all expenses unless otherw	ise stated.	
Payment Limit (per calendar year)	\$6,250 Individual	\$20,000 Individual
	\$12,500 Family	\$40,000 Family
All covered expenses accumulate sep	arately toward the preferred or non-prefe	erred Payment Limit.
Certain member cost sharing element	s may not apply toward the Payment Lim	iit.
Pharmacy expenses apply towards the	e Payment Limit.	
Only those out-of-pocket expenses re-	sulting from the application of coinsurance	ce percentage, copays, and deductibles
(except any penalty amounts) may be	used to satisfy the Payment Limit.	
The family Payment Limit is a cumulat	tive Payment Limit for all family members	s. The family Payment Limit can be met
by a combination of family members; I	nowever, no single individual within the f	amily will be subject to more than the
individual Payment Limit amount.		
Lifetime Maximum		
Unlimited except where otherwise indi	cated.	
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare
		Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -		
Certification for certain types of Non-F	Preferred care must be obtained to avoid	a reduction in benefits paid for that
care. Certification for Hospital Admiss	ions, Treatment Facility Admissions, Cor	hvalescent Facility Admissions, Home
	e Duty Nursing is required - excluded an	nount applied separately to each type of
expense is \$400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/	Covered 100%; deductible waived	50%; after deductible
Immunizations	aa	u c lu u c CE and aldan
	age 22 to age 65; 1 exam every 12 mo	nths for adults age 65 and older.
Routine Well Child	Covered 100%; deductible waived	50%; deductible waived
Exams/Immunizations		O survey in the third 40 months of life 4
	3 exams in the second 12 months of life,	3 exams in the third 12 months of life, 1
exam per 12 months thereafter to age	22.	COV a then do dootle be
Routine Gynecological Care	Covered 100%; deductible waived	50%; after deductible
Routine Gynecological Care Exams 1 obgyn exam and pap smear per cal		



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Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	50%; after deductible
Includes: Screening for gestational dia	betes, HPV (Human- Papillomavirus) D	NA testing, counseling for sexually
transmitted infections, counseling and	screening for human immunodeficiency	virus, screening and counseling for
interpersonal and domestic violence, b	preastfeeding support, supplies and cour	nseling.
	ocedures, patient education and counse	eling. Limitations may apply.
Routine Digital Rectal Exam	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males ag		
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males ag		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age	50 and over.	
Routine Eye Exams	Covered 100%; deductible waived	50%; after deductible
1 routine exam per 24 months.		
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to PCP	50%; after deductible	50%; after deductible
	ral physician, family practitioner or pedia	
Specialist Office Visits	50%; after deductible	50%; after deductible
Hearing Exams	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
1	performed	performed
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	50%; after deductible	50%; after deductible
Walk-in Clinics are network, free-stand	ling health care facilities. They are an a	Iternative to a physician's office visit for
treatment of unscheduled, non-emerge	ency illnesses and injuries and the admi	nistration of certain immunizations. It is
not an alternative for emergency room	services or the ongoing care provided b	by a physician. Neither an emergency
	f a hospital, shall be considered a Walk-	
Allergy Testing	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
Allergy Injections	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray	50%; after deductible	50%; after deductible
	ffice visit and billed by the physician, ex	penses are covered subject to the
applicable physician's office visit mem		COV, often deductible
Diagnostic Laboratory	50%; after deductible	50%; after deductible
	ffice visit and billed by the physician, ex	penses are covered subject to the
applicable physician's office visit mem		
Diagnostic Outpatient Complex	50%; after deductible	50%; after deductible
Imaging		
EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Provider	50%; after deductible	50%; after deductible
Non-Urgent Use of Urgent Care	Not Covered	Not Covered
Provider		



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Emergency Room	50%; after deductible	Same as in-network care
Non-Emergency Care in an	Not Covered	Not Covered
Emergency Room		
Emergency Use of Ambulance	50%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	50%; after \$500 copay per	50%; after \$500 copay per
	admission; after deductible	admission; after deductible
Your cost sharing applies to all covered		
npatient Maternity Coverage	50%; after \$500 copay per	50%; after \$500 copay per
includes delivery and postpartum	admission; after deductible	admission; after deductible
care)		
Your cost sharing applies to all covered	benefits incurred during your inpatier	t stay.
Outpatient Hospital Expenses	50%; after \$250 copay; after	50%; after \$250 copay; after
	deductible	deductible
Your cost sharing applies to all covered		
Outpatient Surgery - Hospital	50%; after \$250 copay; after	50%; after \$250 copay; after
	deductible	deductible
Your cost sharing applies to all covered		
Dutpatient Surgery - Freestanding	50%; after deductible	50%; after deductible
Facility		
Your cost sharing applies to all covered		
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
npatient	50%; after \$500 copay per	50%; after \$500 copay per
	admission; after deductible	admission; after deductible
Your cost sharing applies to all covered	benefits incurred during your inpatier	
Mental Health Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered		
Other Mental Health Services	50%; after deductible	50%; after deductible
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
npatient	50%; after \$500 copay per	50%; after \$500 copay per
	admission; after deductible	admission; after deductible
Your cost sharing applies to all covered	benefits incurred during your inpatier	it stay.
Residential Treatment Facility	50%; after \$500 copay per	50%; after \$500 copay per
-	admission; after deductible	admission; after deductible
Substance Abuse Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered		
Other Substance Abuse Services	50%; after deductible	50%; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility	50%; after deductible	50%; after deductible
Limited to 60 days per calendar year.		
Your cost sharing applies to all covered	d benefits incurred during your inpatier	nt stav.
Home Health Care	50%; after deductible	50%; after deductible
Limited to 60 visits per calendar year.		
Coverage includes nutritional counselir	ng and services of a medical social wo	rker.
Each visit by a nurse or therapist is one		
		Dema



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PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

Hospice Care - Inpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered	benefits incurred during your inpatient s	stay.
Hospice Care - Outpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered	benefits incurred during your outpatient	visit.
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	50%; after deductible	50%; after deductible
Limited to 20 visits per calendar year.		
Outpatient Short-Term	50%; after deductible	50%; after deductible
Rehabilitation		
Includes Speech, Physical, and Occupa	ational Therapy, limited to 20 visits per th	nerapy per calendar year.
Autism Behavioral Therapy	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
	Health	Health
Covered same as any other Outpatient	Mental Health benefit	
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
	Health Other Services	Health Other Services
Covered same as any other Outpatient		
Autism Physical Therapy	50%; after deductible	50%; after deductible
Autism Occupational Therapy	50%; after deductible	50%; after deductible
Autism Speech Therapy	50%; after deductible	50%; after deductible
Durable Medical Equipment	50%; after deductible	50%; after deductible
Diabetic Supplies (if not covered	Covered same as any other medical	Covered same as any other medical
under Pharmacy benefit)	expense.	expense.
Women's Contraceptive drugs and	Covered 100%; deductible waived	Covered same as any other expense
devices not obtainable at a		
pharmacy		
Affordable Care Act mandated	Covered 100%; deductible waived	Covered same as any other expense
Women's Contraceptives		, ,
Infusion Therapy	50%; after deductible	50%; after deductible
Administered in the home or		
physician's office		
Infusion Therapy	50%; after deductible	50%; after deductible
Administered in an outpatient hospital		
department or freestanding facility		
Vision Eyewear	Not Covered	Not Covered
Transplants	50%; after deductible	50%; after deductible
Talloplanto	Preferred coverage is provided at an	Non-Preferred coverage is provided
	IOE contracted facility only.	at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferre	
out of Alea Dependents	provider is not available.	
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Your cost sharing is based on the	Your cost sharing is based on the
internity freatment	Tour cost sharing is based of the	
		type of service and where it is
	type of service and where it is performed	type of service and where it is performed

Diagnosis and treatment of the underlying medical condition only.



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Comprehensive Infertility Services Artificial insemination and ovulation inc	Not Covered	Not Covered
Advanced Reproductive	Not Covered	Not Covered
Technology (ART)	Not Obvered	Not Covored
	llopian transfer (ZIFT), gamete intrafallo	ppian transfer (GIET), cryopreserved
	rm injection (ICSI), or ovum microsurge	
Vasectomy	Your cost sharing is based on the	50%; after deductible
lacounty	type of service and where it is	
	performed	
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	IN-NETWORK	OUT-OF-NETWORK
	e deductible before any benefits are co	nsidered for payment under the
pharmacy plan.		1,2
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	\$10 copay	\$10 copay
90 Day Retail	\$30 copay	Not Covered
Mail Order	\$25 copay	Not Covered
Preferred Brand-Name Drugs		
Retail	\$30 copay	\$30 copay
90 Day Retail	\$90 copay	Not Covered
Mail Order	\$75 copay	Not Covered
Non-Preferred Generic and Brand-N		
Retail	\$50 copay	\$50 copay
90 Day Retail	\$150 copay	Not Covered
Mail Order	\$125 copay	Not Covered
Pharmacy Day Supply and Requiren		
Retail	Up to a 30 day supply from Aetna Sta	ndard National Network
Mail Order	Up to a 31-90 day supply from Aetna	
Value Plus Specialty	Up to a 30 day supply from Aetna Spe	
		ecialty pharmacy. Subsequent fills must
	be through our preferred specialty pha	armacy network.
Choose Generics - If the member or t	he physician requests brand when gene	eric is available, the member pays the
	etween the generic price and the brand	
	Contraceptive drugs and devices obtain	
	ations are covered when filled with a pr	escription.
Oral chemotherapy drugs covered 100	%	
Value Plus Pre-certification included		
Value Plus Step Therapy included		
Seasonal Vaccinations covered 100%		
Preventive Vaccinations covered 100%		
One transition fill allowed within 90 day		
	contraceptives and preventive medicati	ons covered 100% in-network.
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26	regardless of student status.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.



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• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.

- · Cosmetic surgery, including breast reduction.
- Custodial care.
- · Dental care and dental X-rays.
- Donor egg retrieval

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

Home births

· Immunizations for travel or work, except where medically necessary or indicated.

• Implantable drugs and certain injectable drugs including injectable infertility drugs.

• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.

· Long-term rehabilitation therapy.

• Non-medically necessary services or supplies.

• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.

· Radial keratotomy or related procedures.

· Reversal of sterilization.

• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.

· Special duty nursing.

· Therapy or rehabilitation other than those listed as covered.

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at 1-888-982-3862.

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to www.aetna.com.

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PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

\$2,000 Individual \$4,000 Family parately toward the preferred or non-prefectible must be met prior to benefits being ces, as indicated in the plan, are exclude	j payable.
parately toward the preferred or non-pref ctible must be met prior to benefits being ces, as indicated in the plan, are exclude	erred Deductible. payable.
ctible must be met prior to benefits being ces, as indicated in the plan, are exclude	j payable.
ces, as indicated in the plan, are exclude	
ces, as indicated in the plan, are exclude	
	ed from charges to meet the Deductible.
ards the Deductible.	5
Deductible for all family members. The f	family Deductible can be met by a
ever, no single individual within the family	
	•
Covered 100%	20%
vise stated.	
	\$9,000 Individual
	\$18,000 Family
	ce percentage copays and deductibles
	oe percentage, copays, and deductiones
	s The family Payment I imit can be met
licated	
	Professional: 105% of Medicare
	Facility: 140% of Medicare
Ontional	Not Applicable
Optional	
Preferred care must be obtained to avoid	a reduction in benefits naid for that
te Duty Nursing is required - excluded al	nount applied separately to each type of
None	None
	OUT-OF-NETWORK
	20%; after deductible
Covered 100%, deductible walved	
a ago 22 to ago 65: 1 ayom ayony 12 ma	othe for adulte and 65 and older
Covered 100%, deductible walved	20%; deductible waived
O evenue in the energy of 40 merstary of 10	O evene in the third 40 months of 10 - 4
	, 3 exams in the third 12 months of life, 1
<u>, </u>	
e 22.	
e 22. Covered 100%; deductible waived	20%; after deductible
	Covered 100% vise stated. \$4,000 Individual \$8,000 Family parately toward the preferred or non-prefits may not apply toward the Payment Limit re Payment Limit. esulting from the application of coinsurant a used to satisfy the Payment Limit. tive Payment Limit for all family member however, no single individual within the formal icated. Not Applicable Optional Preferred care must be obtained to avoid sions, Treatment Facility Admissions, Co te Duty Nursing is required - excluded ar None IN-NETWORK Covered 100%; deductible waived S age 22 to age 65; 1 exam every 12 mo Covered 100%; deductible waived 3 exams in the second 12 months of life

1 obgyn exam and pap smear per calendar year



Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	20%; after deductible
	abetes, HPV (Human- Papillomavirus) D	
	d screening for human immunodeficiency	
	breastfeeding support, supplies and cou	
	procedures, patient education and course	
Routine Digital Rectal Exam	Covered 100%; deductible waived	20%; after deductible
Recommended: For covered males a		
Prostate-specific Antigen Test	Covered 100%; deductible waived	20%; after deductible
Recommended: For covered males a		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
		Covered 100%, deductible walved
Recommended: For all members age		Net Covered
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	20%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to PCP	\$25 copay; deductible waived	20%; after deductible
	eral physician, family practitioner or pedia	
Specialist Office Visits	\$50 copay; deductible waived	20%; after deductible
Hearing Exams	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
	Covered 100%; deductible waived	20%; after deductible
Walk-in Clinics	Covered 100%; deductible waived	20%; after deductible 20%; after deductible
Walk-in Clinics Walk-in Clinics are network, free-stan	Covered 100%; deductible waived \$25 copay; deductible waived	20%; after deductible 20%; after deductible alternative to a physician's office visit for
Walk-in Clinics Walk-in Clinics are network, free-stan treatment of unscheduled, non-emerg	Covered 100%; deductible waived \$25 copay; deductible waived ading health care facilities. They are an a	20%; after deductible 20%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is
Walk-in Clinics Walk-in Clinics are network, free-stan treatment of unscheduled, non-emergency room	Covered 100%; deductible waived \$25 copay; deductible waived iding health care facilities. They are an a gency illnesses and injuries and the admi n services or the ongoing care provided b	20%; after deductible 20%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency
Walk-in Clinics Walk-in Clinics are network, free-stan treatment of unscheduled, non-emergency not an alternative for emergency room room, nor the outpatient department of	Covered 100%; deductible waived \$25 copay; deductible waived iding health care facilities. They are an a gency illnesses and injuries and the admi n services or the ongoing care provided b of a hospital, shall be considered a Walk-	20%; after deductible 20%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency -in Clinic.
Walk-in Clinics Walk-in Clinics are network, free-stan treatment of unscheduled, non-emergen not an alternative for emergency room room, nor the outpatient department of	Covered 100%; deductible waived \$25 copay; deductible waived iding health care facilities. They are an a gency illnesses and injuries and the admin n services or the ongoing care provided to of a hospital, shall be considered a Walk- Your cost sharing is based on the	20%; after deductible 20%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the
Walk-in Clinics Walk-in Clinics are network, free-stan treatment of unscheduled, non-emergen not an alternative for emergency room room, nor the outpatient department of	Covered 100%; deductible waived \$25 copay; deductible waived ading health care facilities. They are an a gency illnesses and injuries and the admin n services or the ongoing care provided to of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is	20%; after deductible 20%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency -in Clinic. Your cost sharing is based on the type of service and where it is
Walk-in Clinics Walk-in Clinics are network, free-stan treatment of unscheduled, non-emerg not an alternative for emergency roon room, nor the outpatient department of Allergy Testing	Covered 100%; deductible waived \$25 copay; deductible waived ading health care facilities. They are an a gency illnesses and injuries and the admin n services or the ongoing care provided l of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed	20%; after deductible 20%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency -in Clinic. Your cost sharing is based on the type of service and where it is performed
Walk-in Clinics Walk-in Clinics are network, free-stan treatment of unscheduled, non-emerg not an alternative for emergency roon room, nor the outpatient department of Allergy Testing	Covered 100%; deductible waived \$25 copay; deductible waived ading health care facilities. They are an a gency illnesses and injuries and the admin n services or the ongoing care provided to of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is	20%; after deductible 20%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency -in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the
Walk-in Clinics Walk-in Clinics are network, free-stan treatment of unscheduled, non-emerg not an alternative for emergency roon room, nor the outpatient department of Allergy Testing	Covered 100%; deductible waived \$25 copay; deductible waived ading health care facilities. They are an a gency illnesses and injuries and the admin n services or the ongoing care provided l of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed	20%; after deductible 20%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency -in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is
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Walk-in Clinics Walk-in Clinics are network, free-stan treatment of unscheduled, non-emergency room not an alternative for emergency room room, nor the outpatient department of Allergy Testing Allergy Injections	Covered 100%; deductible waived \$25 copay; deductible waived ding health care facilities. They are an a gency illnesses and injuries and the admin n services or the ongoing care provided by of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived IN-NETWORK	20%; after deductible 20%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency -in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK
Walk-in Clinics Walk-in Clinics are network, free-stan treatment of unscheduled, non-emergency room not an alternative for emergency room room, nor the outpatient department of Allergy Testing DIAGNOSTIC PROCEDURES Diagnostic X-ray	Covered 100%; deductible waived \$25 copay; deductible waived iding health care facilities. They are an a gency illnesses and injuries and the admin n services or the ongoing care provided b of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived	20%; after deductible 20%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency -in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 20%; after deductible
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Walk-in Clinics Walk-in Clinics are network, free-stan treatment of unscheduled, non-emergency room not an alternative for emergency room room, nor the outpatient department of Allergy Testing Allergy Injections Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit men Diagnostic Laboratory If performed as a part of a physician of applicable physician's office visit men Diagnostic Cutpatient Complex Imaging EMERGENCY MEDICAL CARE	Covered 100%; deductible waived \$25 copay; deductible waived ading health care facilities. They are an a gency illnesses and injuries and the admin n services or the ongoing care provided health of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived office visit and billed by the physician, ex nber cost sharing. Covered 100%; deductible waived office visit and billed by the physician, ex nber cost sharing. Covered 100%; after deductible IN-NETWORK	20%; after deductible 20%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency -in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 20%; after deductible penses are covered subject to the 20%; after deductible penses are covered subject to the 20%; after deductible
treatment of unscheduled, non-emergenot an alternative for emergency room room, nor the outpatient department of Allergy Testing Allergy Injections DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit men Diagnostic Laboratory	Covered 100%; deductible waived \$25 copay; deductible waived ading health care facilities. They are an a gency illnesses and injuries and the admin n services or the ongoing care provided by of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived office visit and billed by the physician, ex nber cost sharing. Covered 100%; deductible waived office visit and billed by the physician, ex nber cost sharing. Covered 100%; after deductible	20%; after deductible 20%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency -in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 20%; after deductible penses are covered subject to the 20%; after deductible penses are covered subject to the



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Emergency Room	\$125 copay; deductible waived	Same as in-network care
Copay waived if admitted Non-Emergency Care in an	Not Covered	Not Covered
Emergency Room	NOT OVERED	
Emergency Use of Ambulance	Covered 100%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	Covered 100%; after deductible	20%; after deductible
	benefits incurred during your inpatient	
Inpatient Maternity Coverage	Covered 100%; after deductible	20%; after deductible
(includes delivery and postpartum		
care)		
Your cost sharing applies to all covered	benefits incurred during your inpatient	stay.
Outpatient Hospital Expenses	Covered 100%; after deductible	20%; after deductible
	benefits incurred during your outpatien	
Outpatient Surgery - Hospital	Covered 100%; after deductible	20%; after deductible
	benefits incurred during your outpatien	
Outpatient Surgery - Freestanding Facility	Covered 100%; after deductible	20%; after deductible
	benefits incurred during your outpatien	it visit.
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%; deductible waived	20%; deductible waived
Your cost sharing applies to all covered	benefits incurred during your inpatient	stay.
Mental Health Office Visits	Covered 100%; deductible waived	20%; deductible waived
Your cost sharing applies to all covered	benefits incurred during your outpatien	it visit.
Other Mental Health Services	Covered 100%; deductible waived	20%; deductible waived
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%; deductible waived	20%; after deductible
	benefits incurred during your inpatient	
Residential Treatment Facility	Covered 100%; deductible waived	20%; after deductible
Substance Abuse Office Visits	Covered 100%; deductible waived	20%; after deductible
	benefits incurred during your outpatien	
Other Substance Abuse Services	Covered 100%; deductible waived	20%; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility	Covered 100%; after deductible	20%; after deductible
Limited to 60 days per calendar year.		
	benefits incurred during your inpatient	
Home Health Care	Covered 100%; after deductible	20%; after deductible
Limited to 60 visits per calendar year.		
	ng and services of a medical social work	
	e visit. Each visit up to 4 hours by a hom	
Hospice Care - Inpatient	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered	benefits incurred during your inpatient	stay.
Hospice Care - Outpatient	Covered 100%; after deductible benefits incurred during your outpatien	20%; after deductible



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Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	\$25 copay; deductible waived	20%; after deductible
Limited to 20 visits per calendar year.		
Outpatient Short-Term	\$25 copay; deductible waived	20%; after deductible
Rehabilitation		
	ational Therapy, limited to 20 visits per t	
Autism Behavioral Therapy	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
	Health	Health
Covered same as any other Outpatient	Mental Health benefit	
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
	Health Other Services	Health Other Services
Covered same as any other Outpatient		
Autism Physical Therapy	\$25 copay; deductible waived	20%; after deductible
Autism Occupational Therapy	\$25 copay; deductible waived	20%; after deductible
Autism Speech Therapy	\$25 copay; deductible waived	20%; after deductible
Durable Medical Equipment	Covered 100%; after deductible	20%; after deductible
Diabetic Supplies (if not covered	Covered same as any other medical	Covered same as any other medical
under Pharmacy benefit)	expense.	expense.
Women's Contraceptive drugs and	Covered 100%; deductible waived	Covered same as any other expense
devices not obtainable at a		
pharmacy		
Affordable Care Act mandated	Covered 100%; deductible waived	Covered same as any other expense
Women's Contraceptives		
Infusion Therapy	Your cost sharing is based on the	Your cost sharing is based on the
Administered in the home or	type of service and where it is	type of service and where it is
physician's office	performed	performed
Infusion Therapy	Your cost sharing is based on the	Your cost sharing is based on the
Administered in an outpatient hospital	type of service and where it is	type of service and where it is
department or freestanding facility	performed	performed
Vision Eyewear	Not Covered	Not Covered
Transplants	Covered 100%; after deductible	20%; after deductible
	Preferred coverage is provided at an	Non-Preferred coverage is provided
	IOE contracted facility only.	at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferre	d benefit level of the plan if in-network
-	provider is not available.	
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Your cost sharing is based on the	Your cost sharing is based on the
-	type of service and where it is	type of service and where it is
	performed	performed
Diagnosis and treatment of the underly	•	•

Diagnosis and treatment of the underlying medical condition only.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

Comprehensive Infertility Services	Not Covered	Not Covered	
Artificial insemination and ovulation ind			
Advanced Reproductive	Not Covered	Not Covered	
Technology (ART)			
	llopian transfer (ZIFT), gamete intrafallo	pian transfer (GIFT), cryopreserved	
	rm injection (ICSI), or ovum microsurger		
Vasectomy	Covered 100%; after deductible	20%; after deductible	
Tubal Ligation	Covered 100%; deductible waived	20%; after deductible	
PHARMACY	IN-NETWORK	OUT-OF-NETWORK	
Pharmacy Plan Type	Aetna Value Plus Open Formulary		
Preferred Generic Drugs			
Retail	\$10 copay	\$10 copay	
90 Day Retail	\$30 copay		
Mail Order	\$20 copay	Not Covered	
Preferred Brand-Name Drugs			
Retail	\$30 copay	\$30 copay	
90 Day Retail	\$90 copay		
Mail Order	\$60 copay	Not Covered	
Non-Preferred Generic and Brand-Na			
Retail	\$50 copay	\$50 copay	
90 Day Retail	\$150 copay		
Mail Order	\$100 copay	Not Covered	
Pharmacy Day Supply and Requirem			
Retail	Up to a 30 day supply from Aetna Star		
Mail Order			
Value Plus Specialty	Up to a 30 day supply from Aetna Spe		
		ecialty pharmacy. Subsequent fills must	
	be through our preferred specialty pha		
	he physician requests brand when gene		
	tween the generic price and the brand p		
	Contraceptive drugs and devices obtaina		
	ations are covered when filled with a pre	escription.	
	Oral chemotherapy drugs covered 100%		
Value Plus Pre-certification included			
Value Plus Step Therapy included			
Seasonal Vaccinations covered 100%			
Preventive Vaccinations covered 100%			
One transition fill allowed within 90 day			
	contraceptives and preventive medication	ons covered 100% in-network.	
GENERAL PROVISIONS			
Dependents Eligibility	Spouse, children from birth to age 26 i	regardless of student status.	

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.

- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

• Home births

• Immunizations for travel or work, except where medically necessary or indicated.

• Implantable drugs and certain injectable drugs including injectable infertility drugs.

• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.

- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.

• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.

- Radial keratotomy or related procedures.
- Reversal of sterilization.

• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.

- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862**.

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

Plan features and availability may vary by location and group size. For more information about Aetna plans, refer to **www.aetna.com**. © 2014 Aetna Inc.





PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	\$6,000 Individual	\$8,000 Individual
	\$12,000 Family	\$16,000 Family
All covered expenses accumulate sepa	arately toward the preferred or non-pref	erred Deductible.
Unless otherwise indicated, the deduc	tible must be met prior to benefits being	payable.
Member cost sharing for certain servic	es, as indicated in the plan, are exclude	ed from charges to meet the Deductible.
Pharmacy expenses do not apply towa	ards the Deductible.	-
The family Deductible is a cumulative	Deductible for all family members. The	family Deductible can be met by a
combination of family members; howe	ver, no single individual within the family	/ will be subject to more than the
individual Deductible amount.	-	-
Member Coinsurance	40%	50%
Applies to all expenses unless otherwi	se stated.	
Payment Limit (per calendar year)	\$6,250 Individual	\$10,000 Individual
	\$12,500 Family	\$20,000 Family
All covered expenses accumulate sepa	arately toward the preferred or non-pref	erred Payment Limit.
Certain member cost sharing elements	s may not apply toward the Payment Lir	nit.
Pharmacy expenses apply towards the	e Payment Limit.	
Only those out-of-pocket expenses res	sulting from the application of coinsuran	ce percentage, copays, and deductibles
(except any penalty amounts) may be	used to satisfy the Payment Limit.	
The family Payment Limit is a cumulat	ive Payment Limit for all family member	s. The family Payment Limit can be met
by a combination of family members; h	nowever, no single individual within the	family will be subject to more than the
individual Payment Limit amount.		
Lifetime Maximum		
Unlimited except where otherwise indi		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare
		Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -		
	referred care must be obtained to avoid	
	ons, Treatment Facility Admissions, Co	
	e Duty Nursing is required - excluded ar	mount applied separately to each type o
expense is \$400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/	Covered 100%; deductible waived	50%; after deductible
Immunizations		
	age 22 to age 65; 1 exam every 12 mo	
Routine Well Child	Covered 100%; deductible waived	50%; deductible waived
Exams/Immunizations		
		, 3 exams in the third 12 months of life,
exam per 12 months thereafter to age		
Routine Gynecological Care	Covered 100%; deductible waived	50%; after deductible
Exams		
1 obovn exam and pap smear per cale	endar vear	

1 obgyn exam and pap smear per calendar year



Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	50%; after deductible
	abetes, HPV (Human- Papillomavirus) D	
	d screening for human immunodeficiency	
	breastfeeding support, supplies and cou	
	procedures, patient education and course	
	Covered 100%; deductible waived	50%; after deductible
Routine Digital Rectal Exam		
Recommended: For covered males a		CO0/, ofter deductible
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males a		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age		
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to PCP	\$40 copay; deductible waived	50%; after deductible
	eral physician, family practitioner or pedia	
Specialist Office Visits	\$80 copay; deductible waived	50%; after deductible
Hearing Exams	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	\$40 copay; deductible waived	50%; after deductible
Walk-in Clinics are network, free-stan	\$40 copay; deductible waived iding health care facilities. They are an a gency illnesses and injuries and the admi	alternative to a physician's office visit for
Walk-in Clinics are network, free-stan treatment of unscheduled, non-emerged	nding health care facilities. They are an a gency illnesses and injuries and the admi	alternative to a physician's office visit for instration of certain immunizations. It is
Walk-in Clinics are network, free-stan treatment of unscheduled, non-emerg not an alternative for emergency roor	nding health care facilities. They are an a gency illnesses and injuries and the admi n services or the ongoing care provided b	alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency
Walk-in Clinics are network, free-stan treatment of unscheduled, non-emerg not an alternative for emergency roor room, nor the outpatient department of	nding health care facilities. They are an a gency illnesses and injuries and the admi n services or the ongoing care provided b of a hospital, shall be considered a Walk-	alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic.
Walk-in Clinics are network, free-stan treatment of unscheduled, non-emerg not an alternative for emergency roor room, nor the outpatient department of	nding health care facilities. They are an a gency illnesses and injuries and the admi n services or the ongoing care provided b of a hospital, shall be considered a Walk- Your cost sharing is based on the	alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the
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Walk-in Clinics are network, free-star treatment of unscheduled, non-emerg not an alternative for emergency roor room, nor the outpatient department of Allergy Testing	nding health care facilities. They are an a gency illnesses and injuries and the admin in services or the ongoing care provided b of a hospital, shall be considered a Walk Your cost sharing is based on the type of service and where it is performed	alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency -in Clinic. Your cost sharing is based on the type of service and where it is performed
Walk-in Clinics are network, free-star treatment of unscheduled, non-emerg not an alternative for emergency roor room, nor the outpatient department of Allergy Testing	nding health care facilities. They are an a gency illnesses and injuries and the admi n services or the ongoing care provided l of a hospital, shall be considered a Walk Your cost sharing is based on the type of service and where it is	alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency -in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the
Walk-in Clinics are network, free-star treatment of unscheduled, non-emerg not an alternative for emergency roor room, nor the outpatient department of Allergy Testing	nding health care facilities. They are an a gency illnesses and injuries and the admin in services or the ongoing care provided b of a hospital, shall be considered a Walk Your cost sharing is based on the type of service and where it is performed	Alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency -in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is
Walk-in Clinics are network, free-star treatment of unscheduled, non-emerg not an alternative for emergency roor room, nor the outpatient department of Allergy Testing Allergy Injections	ading health care facilities. They are an a gency illnesses and injuries and the admin n services or the ongoing care provided to of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived	alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed
Walk-in Clinics are network, free-star treatment of unscheduled, non-emerg not an alternative for emergency roor room, nor the outpatient department of Allergy Testing Allergy Injections	ading health care facilities. They are an a gency illnesses and injuries and the admin in services or the ongoing care provided to of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived IN-NETWORK	alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK
Walk-in Clinics are network, free-star treatment of unscheduled, non-emerg not an alternative for emergency roor room, nor the outpatient department of Allergy Testing Allergy Injections DIAGNOSTIC PROCEDURES Diagnostic X-ray	Ading health care facilities. They are an a gency illnesses and injuries and the admin in services or the ongoing care provided b of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived	alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 50%; after deductible
Walk-in Clinics are network, free-star treatment of unscheduled, non-emerg not an alternative for emergency roor room, nor the outpatient department of Allergy Testing Allergy Injections DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician of	Ading health care facilities. They are an a gency illnesses and injuries and the admin in services or the ongoing care provided b of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived office visit and billed by the physician, ex	alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 50%; after deductible
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Walk-in Clinics are network, free-star treatment of unscheduled, non-emerg not an alternative for emergency roor room, nor the outpatient department of Allergy Testing Allergy Injections DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit men Diagnostic Laboratory If performed as a part of a physician of applicable physician's office visit men Diagnostic Outpatient Complex Imaging	Ading health care facilities. They are an a gency illnesses and injuries and the admin in services or the ongoing care provided b of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived office visit and billed by the physician, ex nber cost sharing. Covered 100%; deductible waived office visit and billed by the physician, ex nber cost sharing. \$300 copay; deductible waived	alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible penses are covered subject to the
Walk-in Clinics are network, free-star treatment of unscheduled, non-emerg not an alternative for emergency roor room, nor the outpatient department of Allergy Testing Allergy Injections DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit men Diagnostic Laboratory If performed as a part of a physician of applicable physician's office visit men Diagnostic Outpatient Complex Imaging EMERGENCY MEDICAL CARE	Ading health care facilities. They are an a gency illnesses and injuries and the admin in services or the ongoing care provided b of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived office visit and billed by the physician, ex nber cost sharing. Covered 100%; deductible waived office visit and billed by the physician, ex nber cost sharing. \$300 copay; deductible waived IN-NETWORK	Alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible penses are covered subject to the 50%; after deductible DUT-OF-NETWORK
treatment of unscheduled, non-emergenot an alternative for emergency roor room, nor the outpatient department of Allergy Testing Allergy Injections DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit men Diagnostic Laboratory If performed as a part of a physician of applicable physician's office visit men Diagnostic Outpatient Complex Imaging EMERGENCY MEDICAL CARE Urgent Care Provider	Ading health care facilities. They are an a gency illnesses and injuries and the admin in services or the ongoing care provided b of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived office visit and billed by the physician, ex nber cost sharing. Covered 100%; deductible waived office visit and billed by the physician, ex nber cost sharing. Covered 100%; deductible waived office visit and billed by the physician, ex nber cost sharing. \$300 copay; deductible waived IN-NETWORK \$100 copay; deductible waived	alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible penses are covered subject to the 50%; after deductible DUT-OF-NETWORK 50%; after deductible
Walk-in Clinics are network, free-star treatment of unscheduled, non-emerg not an alternative for emergency roor room, nor the outpatient department of Allergy Testing Allergy Injections Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit men Diagnostic Laboratory If performed as a part of a physician of applicable physician's office visit men Diagnostic Outpatient Complex Imaging EMERGENCY MEDICAL CARE	Ading health care facilities. They are an a gency illnesses and injuries and the admin in services or the ongoing care provided b of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived office visit and billed by the physician, ex nber cost sharing. Covered 100%; deductible waived office visit and billed by the physician, ex nber cost sharing. \$300 copay; deductible waived IN-NETWORK	Alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible penses are covered subject to the 50%; after deductible OUT-OF-NETWORK



Emergency Room Copay waived if admitted	\$300 copay; deductible waived	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	40%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	40%; after \$500 copay; after deductible	50%; after \$500 copay; after deductible
	benefits incurred during your inpatient s	
Inpatient Maternity Coverage (includes delivery and postpartum care)	40%; after \$500 copay; after deductible	50%; after \$500 copay; after deductible
Your cost sharing applies to all covered	benefits incurred during your inpatient s	stay.
Outpatient Hospital Expenses	40%; after deductible	50%; after deductible
	benefits incurred during your outpatient	visit.
Outpatient Surgery - Hospital	40%; after \$250 copay; after deductible	50%; after \$250 copay; after deductible
	benefits incurred during your outpatient	
Outpatient Surgery - Freestanding Facility	40%; after deductible	50%; after deductible
	benefits incurred during your outpatient	
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%; deductible waived	50%; deductible waived
Your cost sharing applies to all covered	benefits incurred during your inpatient s	
Mental Health Office Visits	\$80 copay; deductible waived	50%; deductible waived
	benefits incurred during your outpatient	
Other Mental Health Services	Covered 100%; deductible waived	50%; deductible waived
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%; deductible waived	50%; deductible waived
	benefits incurred during your inpatient s	
Residential Treatment Facility	Covered 100%; deductible waived	50%; deductible waived
Substance Abuse Office Visits	\$80 copay; deductible waived	50%; deductible waived
	benefits incurred during your outpatient Covered 100%; deductible waived	50%; deductible waived
		PUM, ADDICTIDID WAIVAD
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
OTHER SERVICES Skilled Nursing Facility		
OTHER SERVICES Skilled Nursing Facility Limited to 60 days per calendar year.	IN-NETWORK 40%; after deductible	OUT-OF-NETWORK 50%; after deductible
OTHER SERVICES Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered	IN-NETWORK 40%; after deductible benefits incurred during your inpatient s	OUT-OF-NETWORK 50%; after deductible stay.
OTHER SERVICES Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered Home Health Care Limited to 60 visits per calendar year.	IN-NETWORK 40%; after deductible benefits incurred during your inpatient s 40%; after deductible	OUT-OF-NETWORK 50%; after deductible stay. 50%; after deductible
Home Health Care Limited to 60 visits per calendar year. Coverage includes nutritional counselin	IN-NETWORK 40%; after deductible benefits incurred during your inpatient s 40%; after deductible g and services of a medical social worke	OUT-OF-NETWORK 50%; after deductible 50%; after deductible er.
OTHER SERVICES Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered Home Health Care Limited to 60 visits per calendar year. Coverage includes nutritional counselin Each visit by a nurse or therapist is one	IN-NETWORK 40%; after deductible benefits incurred during your inpatient s 40%; after deductible g and services of a medical social worke visit. Each visit up to 4 hours by a home	OUT-OF-NETWORK 50%; after deductible stay. 50%; after deductible er. e health care aide is one visit.
OTHER SERVICES Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered Home Health Care Limited to 60 visits per calendar year. Coverage includes nutritional counselin Each visit by a nurse or therapist is one Hospice Care - Inpatient	IN-NETWORK 40%; after deductible benefits incurred during your inpatient s 40%; after deductible g and services of a medical social worke visit. Each visit up to 4 hours by a home 40%; after deductible	OUT-OF-NETWORK 50%; after deductible stay. 50%; after deductible er. a health care aide is one visit. 50%; after deductible
OTHER SERVICES Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered Home Health Care Limited to 60 visits per calendar year. Coverage includes nutritional counselin Each visit by a nurse or therapist is one Hospice Care - Inpatient	IN-NETWORK 40%; after deductible benefits incurred during your inpatient s 40%; after deductible g and services of a medical social worke visit. Each visit up to 4 hours by a home	OUT-OF-NETWORK 50%; after deductible stay. 50%; after deductible er. a health care aide is one visit. 50%; after deductible



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	\$40 copay; deductible waived	50%; after deductible
Limited to 20 visits per calendar year.		
Outpatient Short-Term	\$40 copay; deductible waived	50%; after deductible
Rehabilitation		
Includes Speech, Physical, and Occupa	ational Therapy, limited to 20 visits per th	nerapy per calendar year.
Autism Behavioral Therapy	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
	Health	Health
Covered same as any other Outpatient	Mental Health benefit	
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
	Health Other Services	Health Other Services
Covered same as any other Outpatient	Mental Health Other Services benefit	
Autism Physical Therapy	\$40 copay; deductible waived	50%; after deductible
Autism Occupational Therapy	\$40 copay; deductible waived	50%; after deductible
Autism Speech Therapy	\$40 copay; deductible waived	50%; after deductible
Durable Medical Equipment	40%; after deductible	50%; after deductible
Diabetic Supplies (if not covered	Covered same as any other medical	Covered same as any other medical
under Pharmacy benefit)	expense.	expense.
Women's Contraceptive drugs and	Covered 100%; deductible waived	Covered same as any other expense
devices not obtainable at a		
pharmacy		
Affordable Care Act mandated	Covered 100%; deductible waived	Covered same as any other expense
Women's Contraceptives		
Infusion Therapy	Your cost sharing is based on the	Your cost sharing is based on the
Administered in the home or	type of service and where it is	type of service and where it is
physician's office	performed	performed
Infusion Therapy	Your cost sharing is based on the	Your cost sharing is based on the
Administered in an outpatient hospital	type of service and where it is	type of service and where it is
department or freestanding facility	performed	performed
Vision Eyewear	Not Covered	Not Covered
Transplants	40%; after \$500 copay; after	50%; after deductible
-	deductible	
	Preferred coverage is provided at an	Non-Preferred coverage is provided
		Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Preferred coverage is provided at an	
Bariatric Surgery Out of Area Dependents	Preferred coverage is provided at an IOE contracted facility only.	at a Non-IOE facility. Not Covered
	Preferred coverage is provided at an IOE contracted facility only. Not Covered	at a Non-IOE facility. Not Covered
Out of Area Dependents	Preferred coverage is provided at an IOE contracted facility only. Not Covered Coverage provided at the non-preferred provider is not available.	at a Non-IOE facility. Not Covered
	Preferred coverage is provided at an IOE contracted facility only. Not Covered Coverage provided at the non-preferred provider is not available. IN-NETWORK	at a Non-IOE facility. Not Covered d benefit level of the plan if in-network
Out of Area Dependents FAMILY PLANNING	Preferred coverage is provided at an IOE contracted facility only. Not Covered Coverage provided at the non-preferred provider is not available.	at a Non-IOE facility. Not Covered d benefit level of the plan if in-network OUT-OF-NETWORK

Diagnosis and treatment of the underlying medical condition only.



Comprehensive Infertility Services Artificial insemination and ovulation ind	Not Covered uction	Not Covered
Advanced Reproductive	Not Covered	Not Covered
Technology (ART)		
In-vitro fertilization (IVF), zygote intrafal	llopian transfer (ZIFT), gamete intrafallo	ppian transfer (GIFT), cryopreserved
embryo transfers, intracytoplasmic sper		
Vasectomy	Covered 100%; after deductible	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	\$10 copay	20% of submitted cost; after
	+ - y	applicable copay
90 Day Retail	\$30 copay	
Mail Order	\$20 copay	Not Applicable
Preferred Brand-Name Drugs	· · · · ·	
Retail	\$40 copay	20% of submitted cost; after
		applicable copay
90 Day Retail	\$120 copay	
Mail Order	\$80 copay	Not Applicable
Non-Preferred Generic and Brand-Na		
Retail	\$80 copay	20% of submitted cost; after
		applicable copay
90 Day Retail	\$240 copay	
Mail Order	\$160 copay	Not Applicable
Pharmacy Day Supply and Requirem		
Retail	Up to a 30 day supply from Aetna Sta	ndard National Network
Mail Order	Up to a 31-90 day supply from Aetna	
Value Plus Specialty	Up to a 30 day supply from Aetna Spe	
		ecialty pharmacy. Subsequent fills must
	be through our preferred specialty pha	armacy network.
Choose Generics - If the member or th	ne physician requests brand when gene	eric is available, the member pays the
applicable copay plus the difference be	tween the generic price and the brand	price.
Plan Includes: Diabetic supplies and C	Contraceptive drugs and devices obtain	able from a pharmacy.
A limited list of over-the-counter medica	ations are covered when filled with a pr	escription.
Oral chemotherapy drugs covered 1009	%	
Value Plus Pre-certification included		
Value Plus Step Therapy included		
Seasonal Vaccinations covered 100% i	n-network	
Preventive Vaccinations covered 100%	in-network	
One transition fill allowed within 90 days	s of member's effective date	
Affordable Care Act mandated female of		ons covered 100% in-network.
	· ·	
GENERAL PROVISIONS		



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.

- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

• Home births

• Immunizations for travel or work, except where medically necessary or indicated.

• Implantable drugs and certain injectable drugs including injectable infertility drugs.

• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.

- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.

• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.

- Radial keratotomy or related procedures.
- Reversal of sterilization.

• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.

- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862**.

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

Plan features and availability may vary by location and group size. For more information about Aetna plans, refer to **www.aetna.com**. © 2014 Aetna Inc.





FUND FEATURES

School District of Hendry County Effective Date: 01-01-2019 Aetna HealthFund[™] Open Access[®] Managed Choice[®] POS - Florida

PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

HealthFund Amount\$1,500 Employee

Amount contributed to the Fund by the employer

Fund amount reflected is on a per calendar year basis. The fund received may be prorated based on your effective date of coverage.

The Family HealthFund amount applies to all family members combined. There is no Individual HealthFund limit within the Family HealthFund amount.

Fund Coinsurance	100%	
Percentage at which the Fund will rein	nburse	
Fund Administration	The Fund will be used to pay for your member responsibility, including your deductible and coinsurance. Once the deductible is met, the underlying medical plan provides coverage and if a Fund balance still exists, the Fund will pay your member responsibility (i.e. your share of coinsurance) until Out of Pocket Maximum has been reached or the Fund has been exhaus whichever comes first. Services covered at 100% with no deductible will paid by the plan and not by the Fund.	nd the sted,
Employee Termination from Your	Any remaining HealthFund benefit amount is forfeited (or terminated) wh	on
HealthFund	the employee's HealthFund coverage terminates.	CII
Fund Rollover	Any remaining HealthFund benefit amount at end of the plan year is rolle over into next year's HealthFund benefit amount.	d
Eligible Fund Expenses	Fund covers same expenses as the medical plan. Expenses above the Reasonable & Customary limit, any plan limits, and any non covered expenses are not eligible for reimbursement under the Fund.	
Fund Payment/Assignment	Network Providers: Automatic Assignment to provider. Non-Network Providers: Member may assign payment to provider.	
Pro-ration for New Employees	Monthly	-
Pro-ration for Family Status Change	No pro-ration. Change to new tier based on new employee status.	
Prescription Drug Plan	Prescription Drug expenses are integrated with the medical plan (i.e., subject to medical Deductible and applied towards the medical Out-of-Pocket Limit) and with the Fund (i.e., eligible for reimbursement from the Fund).	
PLAN FEATURES	IN-NETWORK OUT-OF-NETWORK	
Deductible (per calendar year)	\$5,000 Individual \$15,000 Individual \$10,000 Family \$30,000 Family	
	parately toward the preferred or non-preferred Deductible. Cible must be met prior to benefits being payable.	
Pharmacy expenses apply towards the		ible.
	Deductible for all family members. The family Deductible can be met by a ever, no single individual within the family will be subject to more than the	
Mombor Coincurance	E09/ E09/	

Member Coinsurance	50%	50%		
Applies to all expenses unless otherwise stated.				
Payment Limit (per calendar year)	\$6,250 Individual	\$20,000 Individual		
	\$12,500 Family	\$40,000 Family		
All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit.				

Page 1



PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Certain member cost sharing elements may not apply toward the Payment Limit.

Pharmacy expenses apply towards the Payment Limit.

Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit.

The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.

Individual Payment Limit amount.		
Lifetime Maximum		
Unlimited except where otherwise indi	cated.	
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare
		Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -		
Certification for certain types of Non-P	referred care must be obtained to avoid	a reduction in benefits paid for that
care. Certification for Hospital Admissi	ons, Treatment Facility Admissions, Co	nvalescent Facility Admissions, Home
Health Care, Hospice Care and Privat	e Duty Nursing is required - excluded ar	mount applied separately to each type of
expense is \$400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/	Covered 100%; deductible waived	50%; after deductible
Immunizations		
1 exam every 12 months for members	age 22 to age 65; 1 exam every 12 mo	nths for adults age 65 and older.
Routine Well Child	Covered 100%; deductible waived	50%; deductible waived
Exams/Immunizations		
7 exams in the first 12 months of life, 3	3 exams in the second 12 months of life	, 3 exams in the third 12 months of life,
exam per 12 months thereafter to age	22.	
Routine Gynecological Care	Covered 100%; deductible waived	50%; after deductible
Exams		
1 obgyn exam and pap smear per cale	endar year	
Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Nomen's Health	Covered 100%; deductible waived	50%; after deductible
	betes, HPV (Human- Papillomavirus) D	
transmitted infections, counseling and	screening for human immunodeficiency	virus, screening and counseling for
	preastfeeding support, supplies and cou	
	ocedures, patient education and couns	
Routine Digital Rectal Exam	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males ag		
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males ag		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age		
Routine Eye Exams	Covered 100%; deductible waived	50%; after deductible
1 routine exam per 24 months.		
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to PCP	50%; after deductible	50%; after deductible
Includes a subset of an interview of the second	al a brack the state of the second state of th	a dulta ta u

Includes services of an internist, general physician, family practitioner or pediatrician.



Specialist Office Visits	50%; after deductible	50%; after deductible
Hearing Exams	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	50%; after deductible	50%; after deductible
	ding health care facilities. They are an a	
	ency illnesses and injuries and the admi	
	services or the ongoing care provided I	
	f a hospital, shall be considered a Walk-	
Allergy Testing	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
Allergy Injections	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray	50%; after deductible	50%; after deductible
	ffice visit and billed by the physician, ex	penses are covered subject to the
applicable physician's office visit mem		
Diagnostic Laboratory	50%; after deductible	50%; after deductible
	ffice visit and billed by the physician, ex	penses are covered subject to the
applicable physician's office visit mem		
Diagnostic Outpatient Complex	50%; after deductible	50%; after deductible
Imaging	-	
Imaging EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Imaging EMERGENCY MEDICAL CARE Urgent Care Provider	IN-NETWORK 50%; after deductible	OUT-OF-NETWORK 50%; after deductible
Imaging EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care	IN-NETWORK	OUT-OF-NETWORK
Imaging EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider	IN-NETWORK 50%; after deductible	OUT-OF-NETWORK 50%; after deductible
Imaging EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider Emergency Room	IN-NETWORK 50%; after deductible Not Covered	OUT-OF-NETWORK 50%; after deductible Not Covered
Imaging EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider Emergency Room Non-Emergency Care in an	IN-NETWORK 50%; after deductible Not Covered 50%; after deductible	OUT-OF-NETWORK 50%; after deductible Not Covered Same as in-network care
Imaging EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider Emergency Room Non-Emergency Care in an Emergency Room	IN-NETWORK 50%; after deductible Not Covered 50%; after deductible	OUT-OF-NETWORK 50%; after deductible Not Covered Same as in-network care
Imaging EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider Emergency Room Non-Emergency Care in an Emergency Room Emergency Use of Ambulance	IN-NETWORK 50%; after deductible Not Covered 50%; after deductible Not Covered 50%; after deductible	OUT-OF-NETWORK 50%; after deductible Not Covered Same as in-network care Not Covered
Imaging EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider Emergency Room Non-Emergency Care in an Emergency Room Emergency Use of Ambulance Non-Emergency Use of Ambulance	IN-NETWORK 50%; after deductible Not Covered 50%; after deductible Not Covered 50%; after deductible	OUT-OF-NETWORK 50%; after deductible Not Covered Same as in-network care Not Covered Same as in-network care Same as in-network care
Imaging EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider Emergency Room Non-Emergency Care in an Emergency Room Emergency Use of Ambulance Non-Emergency Use of Ambulance HOSPITAL CARE	IN-NETWORK50%; after deductibleNot Covered50%; after deductibleNot Covered50%; after deductibleNot Covered	OUT-OF-NETWORK 50%; after deductible Not Covered Same as in-network care Not Covered Same as in-network care Not Covered OUT-OF-NETWORK
Imaging EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider Emergency Room Non-Emergency Care in an Emergency Room Emergency Use of Ambulance Non-Emergency Use of Ambulance HOSPITAL CARE	IN-NETWORK50%; after deductibleNot Covered50%; after deductibleNot Covered50%; after deductibleNot CoveredIN-NETWORK50%; after \$500 copay per	OUT-OF-NETWORK 50%; after deductible Not Covered Same as in-network care Not Covered Same as in-network care Not Covered OUT-OF-NETWORK 50%; after \$500 copay per
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PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Outpatient Surgery - Freestanding Facility	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered	bonofite incurred during your out	patiant visit
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	50%; after \$500 copay per	50%; after \$500 copay per
inpatient		
	admission; after deductible	admission; after deductible
Your cost sharing applies to all covered		
Mental Health Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered		
Other Mental Health Services	50%; after deductible	50%; after deductible
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	50%; after \$500 copay per	50%; after \$500 copay per
	admission; after deductible	admission; after deductible
Your cost sharing applies to all covered	benefits incurred during your inpa	atient stay.
Residential Treatment Facility	50%; after \$500 copay per	50%; after \$500 copay per
-	admission; after deductible	admission; after deductible
Substance Abuse Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered		
Other Substance Abuse Services	50%; after deductible	50%; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility	50%; after deductible	50%; after deductible
Limited to 60 days per calendar year.		,
Your cost sharing applies to all covered	I benefits incurred during your inpa	atient stay.
Home Health Care	50%; after deductible	50%; after deductible
Limited to 60 visits per calendar year.		
Coverage includes nutritional counselin	g and services of a medical socia	l worker.
Each visit by a nurse or therapist is one		
Hospice Care - Inpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered	benefits incurred during your inpa	atient stay.
Hospice Care - Outpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered		
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	50%; after deductible	50%; after deductible
Limited to 20 visits per calendar year.		
Outpatient Short-Term	50%; after deductible	50%; after deductible

Includes Speech, Physical, and Occupational Therapy, limited to 20 visits per therapy per calendar year.

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Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Covered same as any other Outpatien		
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health Other Services	Refer to MBH Outpatient Mental Health Other Services
Covered same as any other Outpatien		
Autism Physical Therapy	50%; after deductible	50%; after deductible
Autism Occupational Therapy	50%; after deductible	50%; after deductible
Autism Speech Therapy	50%; after deductible	50%; after deductible
Durable Medical Equipment	50%; after deductible	50%; after deductible
Diabetic Supplies (if not covered	Covered same as any other medical	Covered same as any other medical
under Pharmacy benefit)	expense.	expense.
Women's Contraceptive drugs and	Covered 100%; deductible waived	Covered same as any other expense
devices not obtainable at a		
pharmacy Affordable Care Act mandated	Covered 100%; deductible waived	Covered same as any other expense
Women's Contraceptives	Covered 100%, deductible walved	Covered same as any other expense
Infusion Therapy	50%; after deductible	50%; after deductible
Administered in the home or		
physician's office		
Infusion Therapy	50%; after deductible	50%; after deductible
Administered in an outpatient hospital		
department or freestanding facility		
Vision Eyewear	Not Covered	Not Covered
Transplants	50%; after deductible	50%; after deductible
-	Preferred coverage is provided at an	Non-Preferred coverage is provided
	IOE contracted facility only.	at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferre provider is not available.	d benefit level of the plan if in-network
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
Diagnosis and treatment of the underly	ving medical condition only.	
Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation inc	duction	
Advanced Reproductive	Not Covered	Not Covered
Technology (ART)		
	allopian transfer (ZIFT), gamete intrafallo	pian transfer (GIFT), cryopreserved
	erm injection (ICSI), or ovum microsurger	
Vasectomy	Your cost sharing is based on the	50%; after deductible
-	type of service and where it is	
	performed	
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible



PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

PHARMACY	IN-NETWORK	OUT-OF-NETWORK
The full cost of the drug is applied to th	e deductible before any benefits a	are considered for payment under the
pharmacy plan.		
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	\$10 copay	\$10 copay
90 Day Retail	\$30 copay	
Mail Order	\$25 copay	Not Covered
Preferred Brand-Name Drugs		
Retail	\$30 copay	\$30 copay
90 Day Retail	\$90 copay	
Mail Order	\$75 copay	Not Covered
Non-Preferred Generic and Brand-Na	-	
Retail	\$50 copay	\$50 copay
90 Day Retail	\$150 copay	
Mail Order	\$125 copay	Not Covered
Pharmacy Day Supply and Requiren		• · · · · · · · · · · ·
Retail		
Mail Order		
Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network.	
	First prescription fill at any retail or specialty pharmacy. Subsequent fills must	
	be through our preferred specialty pharmacy network.	
		n generic is available, the member pays the
applicable copay plus the difference be		
Plan Includes: Diabetic supplies and (
A limited list of over-the-counter medica		n a prescription.
Oral chemotherapy drugs covered 100	%	
Value Plus Pre-certification included		
Value Plus Step Therapy included	in an atoma da	
Seasonal Vaccinations covered 100%		
Preventive Vaccinations covered 100%		
One transition fill allowed within 90 day		diactions asvarad 100% is notwork
Affordable Care Act mandated female	contraceptives and preventive me	
GENERAL PROVISIONS	One was abildren from birth to a	
Dependents Eligibility	Spouse, children from birth to a	ge 26 regardless of student status.

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.



PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.



PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.

- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

- Home births
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT,
- ICSI and other related services, unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.

• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.

- Radial keratotomy or related procedures.
- Reversal of sterilization.

• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.

- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at 1-888-982-3862.

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

Plan features and availability may vary by location and group size. For more information about Aetna plans, refer to **www.aetna.com**. © 2014 Aetna Inc.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	\$5,000 Individual	\$15,000 Individual
	\$10,000 Family	\$30,000 Family
All covered expenses accumulate sep	arately toward the preferred or non-pref	erred Deductible.
Unless otherwise indicated, the deduc	tible must be met prior to benefits being	payable.
Member cost sharing for certain servic	es, as indicated in the plan, are exclude	ed from charges to meet the Deductible.
Pharmacy expenses apply towards the	e Deductible.	-
The family Deductible is a cumulative	Deductible for all family members. The	family Deductible can be met by a
combination of family members; howe	ver, no single individual within the family	y will be subject to more than the
individual Deductible amount.	-	-
Member Coinsurance	50%	50%
Applies to all expenses unless otherwi	se stated.	
Payment Limit (per calendar year)	\$6,250 Individual	\$20,000 Individual
	\$12,500 Family	\$40,000 Family
All covered expenses accumulate sep	arately toward the preferred or non-pref	erred Payment Limit.
	s may not apply toward the Payment Lir	
Pharmacy expenses apply towards the	e Payment Limit.	
Only those out-of-pocket expenses rea	sulting from the application of coinsuran	ce percentage, copays, and deductibles
(except any penalty amounts) may be		
The family Payment Limit is a cumulat	ive Payment Limit for all family member	s. The family Payment Limit can be met
by a combination of family members; I	nowever, no single individual within the f	family will be subject to more than the
individual Payment Limit amount.		
Lifetime Maximum		
Unlimited except where otherwise indi	cated.	
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare
-		Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -		
Certification for certain types of Non-P	referred care must be obtained to avoid	a reduction in benefits paid for that
care. Certification for Hospital Admissi	ons, Treatment Facility Admissions, Co	nvalescent Facility Admissions, Home
Health Care, Hospice Care and Privat	e Duty Nursing is required - excluded ar	mount applied separately to each type of
expense is \$400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/	Covered 100%; deductible waived	50%; after deductible
Immunizations		
1 exam every 12 months for members	age 22 to age 65; 1 exam every 12 mo	nths for adults age 65 and older.
Routine Well Child	Covered 100%; deductible waived	50%; deductible waived
Exams/Immunizations		
7 exams in the first 12 months of life, 3	3 exams in the second 12 months of life	, 3 exams in the third 12 months of life, 7
exam per 12 months thereafter to age		
Routine Gynecological Care	Covered 100%; deductible waived	50%; after deductible
Exams	· · · · · ·	
1 obgyn exam and pap smear per cale	ndar vear	

1 obgyn exam and pap smear per calendar year



Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Nomen's Health	Covered 100%; deductible waived	50%; after deductible
	abetes, HPV (Human- Papillomavirus) D	
	screening for human immunodeficiency	
	preastfeeding support, supplies and cou	
	rocedures, patient education and counse	
Routine Digital Rectal Exam	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males ag		,
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males ag		,
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age		
Routine Eye Exams	Covered 100%; deductible waived	50%; after deductible
I routine exam per 24 months.		
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to PCP	50%; after deductible	50%; after deductible
	ral physician, family practitioner or pedia	
Specialist Office Visits	50%; after deductible	50%; after deductible
Hearing Exams	Your cost sharing is based on the	Your cost sharing is based on the
······································	type of service and where it is	type of service and where it is
	·/	
	performed	performed
Pre-Natal Maternity	performed Covered 100%: deductible waived	performed 50%: after deductible
Pre-Natal Maternity Nalk-in Clinics	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	Covered 100%; deductible waived 50%; after deductible	50%; after deductible 50%; after deductible
Walk-in Clinics Walk-in Clinics are network, free-stand	Covered 100%; deductible waived 50%; after deductible ding health care facilities. They are an a	50%; after deductible 50%; after deductible alternative to a physician's office visit for
Walk-in Clinics Walk-in Clinics are network, free-stand reatment of unscheduled, non-emerge	Covered 100%; deductible waived 50%; after deductible ding health care facilities. They are an a ency illnesses and injuries and the admi	50%; after deductible 50%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is
Walk-in Clinics Walk-in Clinics are network, free-stand reatment of unscheduled, non-emergenot not an alternative for emergency room	Covered 100%; deductible waived 50%; after deductible ding health care facilities. They are an a ency illnesses and injuries and the admi o services or the ongoing care provided b	50%; after deductible 50%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency
Walk-in Clinics Walk-in Clinics are network, free-stand reatment of unscheduled, non-emerge not an alternative for emergency room oom, nor the outpatient department o	Covered 100%; deductible waived 50%; after deductible ding health care facilities. They are an a ency illnesses and injuries and the admi o services or the ongoing care provided b f a hospital, shall be considered a Walk-	50%; after deductible 50%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency -in Clinic.
Walk-in Clinics Walk-in Clinics are network, free-stand reatment of unscheduled, non-emergenot not an alternative for emergency room	Covered 100%; deductible waived 50%; after deductible ding health care facilities. They are an a ency illnesses and injuries and the admi n services or the ongoing care provided I f a hospital, shall be considered a Walk- Your cost sharing is based on the	50%; after deductible 50%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the
Walk-in Clinics Walk-in Clinics are network, free-stand reatment of unscheduled, non-emerge not an alternative for emergency room oom, nor the outpatient department o	Covered 100%; deductible waived 50%; after deductible ding health care facilities. They are an a ency illnesses and injuries and the admi in services or the ongoing care provided l f a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is	50%; after deductible 50%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency -in Clinic. Your cost sharing is based on the type of service and where it is
Walk-in Clinics Walk-in Clinics are network, free-stand reatment of unscheduled, non-emerge not an alternative for emergency room oom, nor the outpatient department of Allergy Testing	Covered 100%; deductible waived 50%; after deductible ding health care facilities. They are an a ency illnesses and injuries and the admi is services or the ongoing care provided l f a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed	50%; after deductible 50%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed
Walk-in Clinics Walk-in Clinics are network, free-stand reatment of unscheduled, non-emerge not an alternative for emergency room oom, nor the outpatient department o	Covered 100%; deductible waived 50%; after deductible ding health care facilities. They are an a ency illnesses and injuries and the admin services or the ongoing care provided l f a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the	50%; after deductible 50%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the
Walk-in Clinics Walk-in Clinics are network, free-stand reatment of unscheduled, non-emerge not an alternative for emergency room oom, nor the outpatient department of Allergy Testing	Covered 100%; deductible waived 50%; after deductible ding health care facilities. They are an a ency illnesses and injuries and the admi is services or the ongoing care provided l f a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed	50%; after deductible 50%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed
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Emergency Room	50%; after deductible	Same as in-network care
Non-Emergency Care in an	Not Covered	Not Covered
Emergency Room		
Emergency Use of Ambulance	50%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	50%; after \$500 copay per	50%; after \$500 copay per
	admission; after deductible	admission; after deductible
Your cost sharing applies to all covered	d benefits incurred during your inpatier	nt stay.
Inpatient Maternity Coverage	50%; after \$500 copay per	50%; after \$500 copay per
(includes delivery and postpartum	admission; after deductible	admission; after deductible
care)		
Your cost sharing applies to all covere		
Outpatient Hospital Expenses	50%; after \$250 copay; after	50%; after \$250 copay; after
	deductible	deductible
Your cost sharing applies to all covered		
Outpatient Surgery - Hospital	50%; after \$250 copay; after	50%; after \$250 copay; after
	deductible	deductible
Your cost sharing applies to all covered		
Outpatient Surgery - Freestanding	50%; after deductible	50%; after deductible
Facility		
Your cost sharing applies to all covered		
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	50%; after \$500 copay per	50%; after \$500 copay per
	admission; after deductible	admission; after deductible
Your cost sharing applies to all covered		
Mental Health Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered		
Other Mental Health Services	50%; after deductible	50%; after deductible
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	50%; after \$500 copay per	50%; after \$500 copay per
	admission; after deductible	admission; after deductible
Your cost sharing applies to all covered	d benefits incurred during your inpatier	nt stay.
Residential Treatment Facility	50%; after \$500 copay per	50%; after \$500 copay per
-	admission; after deductible	admission; after deductible
Substance Abuse Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered		,
Other Substance Abuse Services	50%; after deductible	50%; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility	50%; after deductible	50%; after deductible
Limited to 60 days per calendar year.	,	
Your cost sharing applies to all covere	d benefits incurred during vour inpatier	nt stay.
Home Health Care	50%; after deductible	50%; after deductible
Limited to 60 visits per calendar year.	,	
Coverage includes nutritional counseli	ng and services of a medical social wo	rker.
Each visit by a nurse or therapist is on		



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

Hospice Care - Inpatient	50%; after deductible	50%; after deductible
	d benefits incurred during your inpatient s	
Hospice Care - Outpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered	benefits incurred during your outpatient	t visit.
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	50%; after deductible	50%; after deductible
Limited to 20 visits per calendar year.		
Outpatient Short-Term	50%; after deductible	50%; after deductible
Rehabilitation		
Includes Speech, Physical, and Occupa	ational Therapy, limited to 20 visits per th	nerapy per calendar year.
Autism Behavioral Therapy	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
	Health	Health
Covered same as any other Outpatient	Mental Health benefit	
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
	Health Other Services	Health Other Services
Covered same as any other Outpatient		
Autism Physical Therapy	50%; after deductible	50%; after deductible
Autism Occupational Therapy	50%; after deductible	50%; after deductible
Autism Speech Therapy	50%; after deductible	50%; after deductible
Durable Medical Equipment	50%; after deductible	50%; after deductible
Diabetic Supplies (if not covered	Covered same as any other medical	Covered same as any other medical
under Pharmacy benefit)	expense.	expense.
Women's Contraceptive drugs and	Covered 100%; deductible waived	Covered same as any other expense
devices not obtainable at a		
pharmacy		
Affordable Care Act mandated	Covered 100%; deductible waived	Covered same as any other expense
Women's Contraceptives		
Infusion Therapy	50%; after deductible	50%; after deductible
Administered in the home or		
physician's office		
Infusion Therapy	50%; after deductible	50%; after deductible
Administered in an outpatient hospital		
department or freestanding facility		
Vision Eyewear	Not Covered	Not Covered
Transplants	50%; after deductible	50%; after deductible
	Preferred coverage is provided at an	Non-Preferred coverage is provided
	IOE contracted facility only.	at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferred	
eat of Alou Dependents	provider is not available.	
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Your cost sharing is based on the	Your cost sharing is based on the
moning meanneilt	type of service and where it is	type of service and where it is
	performed	performed
	ing medical condition only.	penonneu

Diagnosis and treatment of the underlying medical condition only.



Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation inc		
Advanced Reproductive	Not Covered	Not Covered
Technology (ART)		
	Ilopian transfer (ZIFT), gamete intrafallo	
	rm injection (ICSI), or ovum microsurge	
Vasectomy	Your cost sharing is based on the	50%; after deductible
	type of service and where it is	
	performed	
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	IN-NETWORK	OUT-OF-NETWORK
The full cost of the drug is applied to th pharmacy plan.	e deductible before any benefits are cor	nsidered for payment under the
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	\$10 copay	\$10 copay
90 Day Retail	\$30 copay	
Mail Order	\$25 copay	Not Covered
Preferred Brand-Name Drugs	· · ·	
Retail	\$30 copay	\$30 copay
90 Day Retail	\$90 copay	
Mail Order	\$75 copay	Not Covered
Non-Preferred Generic and Brand-Na	ame Drugs	
Retail	\$50 copay	\$50 copay
90 Day Retail	\$150 copay	
Mail Order	\$125 copay	Not Covered
Pharmacy Day Supply and Requiren		
Retail	Up to a 30 day supply from Aetna Star	
Mail Order	Up to a 31-90 day supply from Aetna I	
Value Plus Specialty	Up to a 30 day supply from Aetna Spe	
		ecialty pharmacy. Subsequent fills must
	be through our preferred specialty pha	
	he physician requests brand when gene	
	etween the generic price and the brand p	
	Contraceptive drugs and devices obtaina	
	ations are covered when filled with a pre	escription.
Oral chemotherapy drugs covered 100	%	
Value Plus Pre-certification included		
Value Plus Step Therapy included Seasonal Vaccinations covered 100%	in-network	
Preventive Vaccinations covered 100%		
One transition fill allowed within 90 day		
	contraceptives and preventive medication	ons covered 100% in-network
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26	regardless of student status
	opouse, ormaren nom birtir to age 20	iogardiess of student status.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.

- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

• Home births

• Immunizations for travel or work, except where medically necessary or indicated.

• Implantable drugs and certain injectable drugs including injectable infertility drugs.

• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.

- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.

• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.

- Radial keratotomy or related procedures.
- Reversal of sterilization.

• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.

- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862**.

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

Plan features and availability may vary by location and group size. For more information about Aetna plans, refer to **www.aetna.com**. © 2014 Aetna Inc.



2020 Plan Documents

HENDRY DISTRICT SCHOOL BOARD Aetna and Other Benefit Rates Calendar Year 2020 Aetna PREMIUMS (For Period January 1 through December 31, 2020)

Employees	Aenta	Aetna	Aetna
	CY 2020	CY 2020	CY 2020
	24 PAY	21 PAY	Annual
FAMILY HEALTH INSURANCE COVERAGE	Per Pay	Per Pay	Cost
FAMILY HEALTH INSURANCE COVERAGE		геггау	COSI
Open Access MC 1			
Employee	\$0	\$0	\$0
Employee-Spouse	\$422	\$482	\$10,120
Employee-Children	\$351	\$402	\$8,433
Family	\$632	\$723	\$15,180
Both spouses work for District (Family)	\$281	\$321	\$6,747
Open Access MC 2			
Employee	\$0	\$0	\$0
Employee-Spouse	\$271	\$310	\$6,500
Employee-Children	\$214	\$245	\$5,142
Family	\$441	\$503	\$10,573
Both spouses work for District (Family)	\$89	\$102	\$2,140
Open Access MC3 HRA/HSA			
Employee (HRA)	\$0	\$0	\$0
Employee-Spouse (Health Savings Plan)	\$167	\$190	\$3,999
Employee-Children (Health Savings Plan	\$120	\$137	\$2,869
Family (Health Savings Plan)	\$308	\$352	\$7,390
Both spouses work for District (Family) (Health Savings Plan)	\$0	\$0	\$0
DENTAL, LIFE INSURANCE, DISABILITY			**
Employee	\$0	\$0	\$0
Employee-Family	\$9	\$10	\$216
EMPLOYEE LIFE INSURANCE	\$0	\$0	\$0

Employees may purchase family dental insurance, spouse or children life insurance, additional life insurance on themselves, or additional disability insurance at their own expense.

\$9,0000 Board Benefit Contribution Maximum Per Employee Benefit for dental and life insurance is \$612 Per Employee

Aetna Retiree Premium Rates RATE FOR CALENDAR YEAR 2020 (For Period January 1 through December 31, 2020)

If retiree chooses to remain on one of the District's Aetna Health Care Plans the retiree pays the FULL cost.

A descision to elect retiree benefits must be made within 30 working days prior to retirement. Failure to respond to enrollment indicates a refusal of coverage. Once a benefit is refused or not elected it cannot be reinstated at a later date. Upon retirement you cannot change or switch medical plan coverage. You are given the oportunity to change plan coverage during the District's annual Open Enrollment period

Retirees

	2020	2020
FAMILY HEALTH INSURANCE COVERAGE	Per Month	Annual
Open Access Plan 1		
Retiree	\$702.75	\$8,433.00
Retiree-Spouse	\$1,546.07	\$18,552.84
Retiree-Children	\$1,405.51	\$16,866.12
Family	\$1,967.71	\$23,612.52
Open Access Plan 2		
Retiree	\$565.63	\$6,787.56
Retiree-Spouse	\$1,244.43	\$14,933.16
Retiree-Children	\$1,131.29	\$13,575.48
Family	\$1,583.80	\$19,005.60
Open Acces Plan 3 HRA/HSA		
Retiree	\$470.91	\$5,650.92
Retiree-Spouse	\$1,036.01	\$12,432.12
Retiree-Children	\$941.82	\$11,301.84
Family	\$1,318.56	\$15,822.72
DENTAL		
Employee	\$7	\$84
Employee-Family	\$27	\$324
RETIREE LIFE INSURANCE		
Can be purchased at the age based negotiated rate for retirees. Retiree pay	s full Age Based	Age Based

Can be purchased at the age based negotiated rate for retirees. Retiree pays full cost for life insurance.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	\$2,000 Individual	\$4,000 Individual
	\$4,000 Family	\$8,000 Family
All covered expenses accumulate sep	arately toward the preferred or non-prefe	erred Deductible.
Unless otherwise indicated, the deduc	tible must be met prior to benefits being	payable.
	es, as indicated in the plan, are exclude	
Pharmacy expenses do not apply towa		Ū.
	Deductible for all family members. The f	amily Deductible can be met by a
	ver, no single individual within the family	
individual Deductible amount.	, , ,	,
Member Coinsurance	Covered 100%	20%
Applies to all expenses unless otherwi	se stated.	
Payment Limit (per calendar year)	\$4,000 Individual	\$9,000 Individual
· · · · · · · · · · · · · · · · · · ·	\$8,000 Family	\$18,000 Family
All covered expenses accumulate sep	arately toward the preferred or non-prefe	
	s may not apply toward the Payment Lin	
Pharmacy expenses apply towards the		
	sulting from the application of coinsurance	ce perceptage copays and deductibles
(except any penalty amounts) may be		be percentage, copays, and deductioned
	ive Payment Limit for all family members	The family Payment Limit can be met
	nowever, no single individual within the f	
individual Payment Limit amount.		
Lifetime Maximum		
Unlimited except where otherwise indi	cated	
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare
		Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -	Optional	Νοι πρριοαδίο
	referred care must be obtained to avoid	a reduction in benefits paid for that
	ons, Treatment Facility Admissions, Co	
		nount applied separately to each type of
expense is \$400 per occurrence.		
	None	
Referral Requirement		None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE Routine Adult Physical Exams/		
PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations	IN-NETWORK Covered 100%; deductible waived	OUT-OF-NETWORK 20%; after deductible
PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members	IN-NETWORK Covered 100%; deductible waived age 22 to age 65; 1 exam every 12 more	OUT-OF-NETWORK 20%; after deductible oths for adults age 65 and older.
PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members Routine Well Child	IN-NETWORK Covered 100%; deductible waived	OUT-OF-NETWORK 20%; after deductible
PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members Routine Well Child Exams/Immunizations	IN-NETWORK Covered 100%; deductible waived age 22 to age 65; 1 exam every 12 mon Covered 100%; deductible waived	OUT-OF-NETWORK 20%; after deductible oths for adults age 65 and older. 20%; deductible waived
PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 3	IN-NETWORK Covered 100%; deductible waived age 22 to age 65; 1 exam every 12 mon Covered 100%; deductible waived 3 exams in the second 12 months of life,	OUT-OF-NETWORK 20%; after deductible oths for adults age 65 and older. 20%; deductible waived
Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 3 exam per 12 months thereafter to age	IN-NETWORK Covered 100%; deductible waived age 22 to age 65; 1 exam every 12 mon Covered 100%; deductible waived B exams in the second 12 months of life, 22.	OUT-OF-NETWORK 20%; after deductible hths for adults age 65 and older. 20%; deductible waived 3 exams in the third 12 months of life, 1
PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 3	IN-NETWORK Covered 100%; deductible waived age 22 to age 65; 1 exam every 12 mon Covered 100%; deductible waived 3 exams in the second 12 months of life,	OUT-OF-NETWORK 20%; after deductible hths for adults age 65 and older. 20%; deductible waived

1 obgyn exam and pap smear per calendar year



EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care	IN-NETWORK \$75 copay; deductible waived Not Covered	\$75 copay; after deductible Not Covered
EMERGENCY MEDICAL CARE		
		OUT-OF-NETWORK
Imaging		
applicable physician's office visit mem Diagnostic Outpatient Complex	Covered 100%; after deductible	20%; after deductible
	office visit and billed by the physician, ex	penses are covered subject to the
Diagnostic Laboratory	Covered 100%; deductible waived	20%; after deductible
applicable physician's office visit mem		
	office visit and billed by the physician, ex	penses are covered subject to the
Diagnostic X-ray	Covered 100%; deductible waived	20%; after deductible
DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
		performed
		type of service and where it is
Allergy Injections	\$10 copay; deductible waived	Your cost sharing is based on the
	performed	performed
	type of service and where it is	type of service and where it is
Allergy Testing	Your cost sharing is based on the	Your cost sharing is based on the
	of a hospital, shall be considered a Walk	
not an alternative for emergency roon	n services or the ongoing care provided I	by a physician. Neither an emergency
	pency illnesses and injuries and the admi	
Walk-in Clinics are network, free-stan	ding health care facilities. They are an a	
Walk-in Clinics	\$25 copay; deductible waived	20%; after deductible
Pre-Natal Maternity	Covered 100%; deductible waived	20%; after deductible
	performed	performed
5	type of service and where it is	type of service and where it is
Hearing Exams	Your cost sharing is based on the	Your cost sharing is based on the
Specialist Office Visits	\$50 copay; deductible waived	20%; after deductible
Includes services of an internist, gene	eral physician, family practitioner or pedia	-
Office Visits to PCP	\$25 copay; deductible waived	20%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Routine Hearing Screening	Covered 100%; deductible waived	20%; after deductible
Routine Eye Exams	Not Covered	Not Covered
Recommended: For all members age		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For covered males a		
Prostate-specific Antigen Test	Covered 100%; deductible waived	20%; after deductible
Recommended: For covered males a		
Routine Digital Rectal Exam	Covered 100%; deductible waived	20%; after deductible
	procedures, patient education and course	
	breastfeeding support, supplies and cou	
	screening for human immunodeficiency	
	abetes, HPV (Human- Papillomavirus) D	
Routine Mammograms Vomen's Health	Covered 100%; deductible waived Covered 100%; deductible waived	Covered 100%; deductible waived 20%; after deductible



Emergency Room	\$125 copay; deductible waived	Same as in-network care
Copay waived if admitted	• •	
Non-Émergency Care in an	Not Covered	Not Covered
Emergency Room		
Emergency Use of Ambulance	Covered 100%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	Covered 100%; after deductible	20%; after deductible
	benefits incurred during your inpatient s	
Inpatient Maternity Coverage	Covered 100%; after deductible	20%; after deductible
(includes delivery and postpartum		
care)		
	benefits incurred during your inpatient s	
Outpatient Hospital Expenses	Covered 100%; after deductible	20%; after deductible
	benefits incurred during your outpatient	
Outpatient Surgery - Hospital	Covered 100%; after deductible	20%; after deductible
	benefits incurred during your outpatient	
Outpatient Surgery - Freestanding Facility	Covered 100%; after deductible	20%; after deductible
	benefits incurred during your outpatient	
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%; deductible waived	20%; deductible waived
	benefits incurred during your inpatient s	
Mental Health Office Visits	Covered 100%; deductible waived	20%; deductible waived
	benefits incurred during your outpatient	
Other Mental Health Services	Covered 100%; deductible waived	20%; deductible waived
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%; deductible waived	20%; after deductible
	benefits incurred during your inpatient s	
Residential Treatment Facility	Covered 100%; deductible waived	20%; after deductible
Substance Abuse Office Visits	Covered 100%; deductible waived	20%; after deductible
*	benefits incurred during your outpatient	
Other Substance Abuse Services	Covered 100%; deductible waived	20%; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility	Covered 100%; after deductible	20%; after deductible
Limited to 60 days per calendar year.		
	benefits incurred during your inpatient s	
Home Health Care	Covered 100%; after deductible	20%; after deductible
Limited to 60 visits per calendar year.		
Coverage includes nutritional counselin	g and services of a medical social worke	r.
Each visit by a nurse or therapist is one	visit. Each visit up to 4 hours by a home	health care aide is one visit.
Hospice Care - Inpatient	Covered 100%; after deductible	20%; after deductible
	benefits incurred during your inpatient s	tay.
	benefits incurred during your inpatient s Covered 100%; after deductible	tay. 20%; after deductible



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	\$25 copay; deductible waived	20%; after deductible
Limited to 20 visits per calendar year.		
Outpatient Short-Term	\$25 copay; deductible waived	20%; after deductible
Rehabilitation		
	ational Therapy, limited to 20 visits per t	
Autism Behavioral Therapy	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
	Health	Health
Covered same as any other Outpatient	Mental Health benefit	
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
	Health Other Services	Health Other Services
Covered same as any other Outpatient		
Autism Physical Therapy	\$25 copay; deductible waived	20%; after deductible
Autism Occupational Therapy	\$25 copay; deductible waived	20%; after deductible
Autism Speech Therapy	\$25 copay; deductible waived	20%; after deductible
Durable Medical Equipment	Covered 100%; after deductible	20%; after deductible
Diabetic Supplies (if not covered	Covered same as any other medical	Covered same as any other medical
under Pharmacy benefit)	expense.	expense.
Women's Contraceptive drugs and	Covered 100%; deductible waived	Covered same as any other expense
devices not obtainable at a		
pharmacy		
Affordable Care Act mandated	Covered 100%; deductible waived	Covered same as any other expense
Women's Contraceptives		
Infusion Therapy	Your cost sharing is based on the	Your cost sharing is based on the
Administered in the home or	type of service and where it is	type of service and where it is
physician's office	performed	performed
Infusion Therapy	Your cost sharing is based on the	Your cost sharing is based on the
Administered in an outpatient hospital	type of service and where it is	type of service and where it is
department or freestanding facility	performed	performed
Vision Eyewear	Not Covered	Not Covered
Transplants	Covered 100%; after deductible	20%; after deductible
	Preferred coverage is provided at an	Non-Preferred coverage is provided
	IOE contracted facility only.	at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferre	d benefit level of the plan if in-network
-	provider is not available.	
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Your cost sharing is based on the	Your cost sharing is based on the
-	type of service and where it is	type of service and where it is
	performed	performed
Diagnosis and treatment of the underly	•	•

Diagnosis and treatment of the underlying medical condition only.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation ind	uction	
Advanced Reproductive	Not Covered	Not Covered
Technology (ART)		
In-vitro fertilization (IVF), zygote intrafa	llopian transfer (ZIFT), gamete intrafallo	pian transfer (GIFT), cryopreserved
	rm injection (ICSI), or ovum microsurger	
Vasectomy	Covered 100%; after deductible	20%; after deductible
Tubal Ligation	Covered 100%; deductible waived	20%; after deductible
PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs	· · ·	
Retail	\$10 copay	\$10 copay
90 Day Retail	\$30 copay	
Mail Order	\$20 copay	Not Covered
Preferred Brand-Name Drugs		
Retail	\$30 copay	\$30 copay
90 Day Retail	\$90 copay	
Mail Order	\$60 copay	Not Covered
Non-Preferred Generic and Brand-Na		
Retail	\$50 copay	\$50 copay
90 Day Retail	\$150 copay	
Mail Order	\$100 copay	Not Covered
Pharmacy Day Supply and Requirem	nents	
Retail	Up to a 30 day supply from Aetna Star	ndard National Network
Mail Order	Up to a 31-90 day supply from Aetna F	Rx Home Delivery®.
Value Plus Specialty	Up to a 30 day supply from Aetna Spe	
First prescription fill at any retail or specialty pharmacy. Subsequent fills mu		
	be through our preferred specialty pha	rmacy network.
Choose Generics - If the member or the	he physician requests brand when gene	ric is available, the member pays the
applicable copay plus the difference be	tween the generic price and the brand p	vrice.
Plan Includes: Diabetic supplies and (Contraceptive drugs and devices obtaina	ble from a pharmacy.
A limited list of over-the-counter medica	ations are covered when filled with a pre	scription.
Oral chemotherapy drugs covered 100	%	
Value Plus Pre-certification included		
Value Plus Step Therapy included		
Seasonal Vaccinations covered 100%	in-network	
Preventive Vaccinations covered 100%	in-network	
One transition fill allowed within 90 day		
Affordable Care Act mandated female	contraceptives and preventive medicatic	ns covered 100% in-network.
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 I	egardless of student status.
	, i i i i i i i i i i i i i i i i i i i	

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.

- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

• Home births

• Immunizations for travel or work, except where medically necessary or indicated.

• Implantable drugs and certain injectable drugs including injectable infertility drugs.

• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.

- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.

• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.

- Radial keratotomy or related procedures.
- Reversal of sterilization.

• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.

- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862**.

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

Plan features and availability may vary by location and group size. For more information about Aetna plans, refer to **www.aetna.com**. © 2014 Aetna Inc.





PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	\$6,000 Individual	\$8,000 Individual
	\$12,000 Family	\$16,000 Family
All covered expenses accumulate sep	arately toward the preferred or non-pref	erred Deductible.
	tible must be met prior to benefits being	
Member cost sharing for certain servic	es, as indicated in the plan, are exclude	ed from charges to meet the Deductible.
Pharmacy expenses do not apply towa		-
The family Deductible is a cumulative	Deductible for all family members. The f	amily Deductible can be met by a
combination of family members; howe	ver, no single individual within the family	/ will be subject to more than the
individual Deductible amount.	-	
Member Coinsurance	40%	50%
Applies to all expenses unless otherwi	se stated.	
Payment Limit (per calendar year)	\$6,250 Individual	\$10,000 Individual
,	\$12,500 Family	\$20,000 Family
All covered expenses accumulate sep	arately toward the preferred or non-pref	erred Payment Limit.
Certain member cost sharing elements	s may not apply toward the Payment Lin	nit.
Pharmacy expenses apply towards the	e Payment Limit.	
Only those out-of-pocket expenses res	sulting from the application of coinsuran	ce percentage, copays, and deductibles
(except any penalty amounts) may be	used to satisfy the Payment Limit.	
The family Payment Limit is a cumulat	ive Payment Limit for all family member	s. The family Payment Limit can be met
by a combination of family members; h	nowever, no single individual within the f	amily will be subject to more than the
individual Payment Limit amount.		
Lifetime Maximum		
Unlimited except where otherwise indi		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare
		Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -		
	referred care must be obtained to avoid	
	ons, Treatment Facility Admissions, Co	
	e Duty Nursing is required - excluded ar	nount applied separately to each type o
expense is \$400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/	Covered 100%; deductible waived	50%; after deductible
Immunizations		
	age 22 to age 65; 1 exam every 12 mo	
Routine Well Child	Covered 100%; deductible waived	50%; deductible waived
Exams/Immunizations		
		, 3 exams in the third 12 months of life, 7
exam per 12 months thereafter to age		
Routine Gynecological Care	Covered 100%; deductible waived	50%; after deductible
Exams		
1 obovn exam and pap smear per cale	ndar voar	

1 obgyn exam and pap smear per calendar year



Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	50%; after deductible
	abetes, HPV (Human- Papillomavirus) D	
	d screening for human immunodeficiency	
	breastfeeding support, supplies and cou	
	procedures, patient education and course	
	Covered 100%; deductible waived	50%; after deductible
Routine Digital Rectal Exam		
Recommended: For covered males a		CO0/, ofter deductible
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males a		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age		
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to PCP	\$40 copay; deductible waived	50%; after deductible
	eral physician, family practitioner or pedia	
Specialist Office Visits	\$80 copay; deductible waived	50%; after deductible
Hearing Exams	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	\$40 copay; deductible waived	50%; after deductible
Walk-in Clinics are network, free-stan	\$40 copay; deductible waived iding health care facilities. They are an a gency illnesses and injuries and the admi	alternative to a physician's office visit for
Walk-in Clinics are network, free-stan treatment of unscheduled, non-emerged	nding health care facilities. They are an a gency illnesses and injuries and the admi	alternative to a physician's office visit for instration of certain immunizations. It is
Walk-in Clinics are network, free-stan treatment of unscheduled, non-emerg not an alternative for emergency roor	nding health care facilities. They are an a gency illnesses and injuries and the admi n services or the ongoing care provided b	alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency
Walk-in Clinics are network, free-stan treatment of unscheduled, non-emerg not an alternative for emergency roor room, nor the outpatient department of	nding health care facilities. They are an a gency illnesses and injuries and the admi n services or the ongoing care provided b of a hospital, shall be considered a Walk-	alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic.
Walk-in Clinics are network, free-stan treatment of unscheduled, non-emerg not an alternative for emergency roor room, nor the outpatient department of	nding health care facilities. They are an a gency illnesses and injuries and the admi n services or the ongoing care provided b of a hospital, shall be considered a Walk- Your cost sharing is based on the	alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the
Walk-in Clinics are network, free-stan treatment of unscheduled, non-emerg not an alternative for emergency roor room, nor the outpatient department of	nding health care facilities. They are an a gency illnesses and injuries and the admi n services or the ongoing care provided l of a hospital, shall be considered a Walk Your cost sharing is based on the type of service and where it is	alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency <u>in Clinic.</u> Your cost sharing is based on the type of service and where it is
Walk-in Clinics are network, free-star treatment of unscheduled, non-emerg not an alternative for emergency roor room, nor the outpatient department of Allergy Testing	nding health care facilities. They are an a gency illnesses and injuries and the admin in services or the ongoing care provided b of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed	alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency -in Clinic. Your cost sharing is based on the type of service and where it is performed
Walk-in Clinics are network, free-star treatment of unscheduled, non-emerg not an alternative for emergency roor room, nor the outpatient department of Allergy Testing	nding health care facilities. They are an a gency illnesses and injuries and the admi n services or the ongoing care provided l of a hospital, shall be considered a Walk Your cost sharing is based on the type of service and where it is	alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency -in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the
Walk-in Clinics are network, free-star treatment of unscheduled, non-emerg not an alternative for emergency roor room, nor the outpatient department of Allergy Testing	nding health care facilities. They are an a gency illnesses and injuries and the admin in services or the ongoing care provided b of a hospital, shall be considered a Walk Your cost sharing is based on the type of service and where it is performed	Alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency -in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is
Walk-in Clinics are network, free-star treatment of unscheduled, non-emerg not an alternative for emergency roor room, nor the outpatient department of Allergy Testing Allergy Injections	ading health care facilities. They are an a gency illnesses and injuries and the admin n services or the ongoing care provided to of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived	alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed
Walk-in Clinics are network, free-star treatment of unscheduled, non-emerg not an alternative for emergency roor room, nor the outpatient department of Allergy Testing Allergy Injections	ading health care facilities. They are an a gency illnesses and injuries and the admin in services or the ongoing care provided to of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived IN-NETWORK	alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK
Walk-in Clinics are network, free-star treatment of unscheduled, non-emerg not an alternative for emergency roor room, nor the outpatient department of Allergy Testing Allergy Injections DIAGNOSTIC PROCEDURES Diagnostic X-ray	Ading health care facilities. They are an a gency illnesses and injuries and the admin in services or the ongoing care provided b of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived	alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 50%; after deductible
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Walk-in Clinics are network, free-star treatment of unscheduled, non-emerg not an alternative for emergency roor room, nor the outpatient department of Allergy Testing Allergy Injections DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit men Diagnostic Laboratory If performed as a part of a physician of applicable physician's office visit men Diagnostic Outpatient Complex Imaging	Ading health care facilities. They are an a gency illnesses and injuries and the admin in services or the ongoing care provided b of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived office visit and billed by the physician, ex nber cost sharing. Covered 100%; deductible waived office visit and billed by the physician, ex nber cost sharing. \$300 copay; deductible waived	alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible penses are covered subject to the
Walk-in Clinics are network, free-star treatment of unscheduled, non-emerg not an alternative for emergency roor room, nor the outpatient department of Allergy Testing Allergy Injections DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit men Diagnostic Laboratory If performed as a part of a physician of applicable physician's office visit men Diagnostic Outpatient Complex Imaging EMERGENCY MEDICAL CARE	Ading health care facilities. They are an a gency illnesses and injuries and the admin in services or the ongoing care provided b of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived office visit and billed by the physician, ex nber cost sharing. Covered 100%; deductible waived office visit and billed by the physician, ex nber cost sharing. \$300 copay; deductible waived IN-NETWORK	Alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible penses are covered subject to the 50%; after deductible DUT-OF-NETWORK
treatment of unscheduled, non-emergenot an alternative for emergency roor room, nor the outpatient department of Allergy Testing Allergy Injections DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit men Diagnostic Laboratory If performed as a part of a physician of applicable physician's office visit men Diagnostic Outpatient Complex Imaging EMERGENCY MEDICAL CARE Urgent Care Provider	Ading health care facilities. They are an a gency illnesses and injuries and the admin in services or the ongoing care provided b of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived office visit and billed by the physician, ex nber cost sharing. Covered 100%; deductible waived office visit and billed by the physician, ex nber cost sharing. Covered 100%; deductible waived office visit and billed by the physician, ex nber cost sharing. \$300 copay; deductible waived IN-NETWORK \$100 copay; deductible waived	alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible penses are covered subject to the 50%; after deductible DUT-OF-NETWORK 50%; after deductible
Walk-in Clinics are network, free-star treatment of unscheduled, non-emerg not an alternative for emergency roor room, nor the outpatient department of Allergy Testing Allergy Injections Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit men Diagnostic Laboratory If performed as a part of a physician of applicable physician's office visit men Diagnostic Outpatient Complex Imaging EMERGENCY MEDICAL CARE	Ading health care facilities. They are an a gency illnesses and injuries and the admin in services or the ongoing care provided b of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived office visit and billed by the physician, ex nber cost sharing. Covered 100%; deductible waived office visit and billed by the physician, ex nber cost sharing. \$300 copay; deductible waived IN-NETWORK	Alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible penses are covered subject to the 50%; after deductible DUT-OF-NETWORK



Emergency Room Copay waived if admitted	\$300 copay; deductible waived	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	40%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	40%; after \$500 copay; after deductible	50%; after \$500 copay; after deductible
	benefits incurred during your inpatient s	
Inpatient Maternity Coverage (includes delivery and postpartum care)	40%; after \$500 copay; after deductible	50%; after \$500 copay; after deductible
Your cost sharing applies to all covered	benefits incurred during your inpatient s	stay.
Outpatient Hospital Expenses	40%; after deductible	50%; after deductible
	benefits incurred during your outpatient	visit.
Outpatient Surgery - Hospital	40%; after \$250 copay; after deductible	50%; after \$250 copay; after deductible
	benefits incurred during your outpatient	
Outpatient Surgery - Freestanding Facility	40%; after deductible	50%; after deductible
	benefits incurred during your outpatient	
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%; deductible waived	50%; deductible waived
Your cost sharing applies to all covered	benefits incurred during your inpatient s	
Mental Health Office Visits	\$80 copay; deductible waived	50%; deductible waived
	benefits incurred during your outpatient	
Other Mental Health Services	Covered 100%; deductible waived	50%; deductible waived
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%; deductible waived	50%; deductible waived
	benefits incurred during your inpatient s	
Residential Treatment Facility	Covered 100%; deductible waived	50%; deductible waived
Substance Abuse Office Visits	\$80 copay; deductible waived	50%; deductible waived
	benefits incurred during your outpatient Covered 100%; deductible waived	50%; deductible waived
		PUM, ADDICTIDID WAIVAD
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
OTHER SERVICES Skilled Nursing Facility		
OTHER SERVICES Skilled Nursing Facility Limited to 60 days per calendar year.	IN-NETWORK 40%; after deductible	OUT-OF-NETWORK 50%; after deductible
OTHER SERVICES Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered	IN-NETWORK 40%; after deductible benefits incurred during your inpatient s	OUT-OF-NETWORK 50%; after deductible stay.
OTHER SERVICES Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered Home Health Care Limited to 60 visits per calendar year.	IN-NETWORK 40%; after deductible benefits incurred during your inpatient s 40%; after deductible	OUT-OF-NETWORK 50%; after deductible stay. 50%; after deductible
Home Health Care Limited to 60 visits per calendar year. Coverage includes nutritional counselin	IN-NETWORK 40%; after deductible benefits incurred during your inpatient s 40%; after deductible g and services of a medical social worke	OUT-OF-NETWORK 50%; after deductible 50%; after deductible er.
OTHER SERVICES Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered Home Health Care Limited to 60 visits per calendar year. Coverage includes nutritional counselin Each visit by a nurse or therapist is one	IN-NETWORK 40%; after deductible benefits incurred during your inpatient s 40%; after deductible g and services of a medical social worke visit. Each visit up to 4 hours by a home	OUT-OF-NETWORK 50%; after deductible stay. 50%; after deductible er. e health care aide is one visit.
OTHER SERVICES Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered Home Health Care Limited to 60 visits per calendar year. Coverage includes nutritional counselin Each visit by a nurse or therapist is one Hospice Care - Inpatient	IN-NETWORK 40%; after deductible benefits incurred during your inpatient s 40%; after deductible g and services of a medical social worke visit. Each visit up to 4 hours by a home 40%; after deductible	OUT-OF-NETWORK 50%; after deductible stay. 50%; after deductible er. a health care aide is one visit. 50%; after deductible
OTHER SERVICES Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered Home Health Care Limited to 60 visits per calendar year. Coverage includes nutritional counselin Each visit by a nurse or therapist is one Hospice Care - Inpatient	IN-NETWORK 40%; after deductible benefits incurred during your inpatient s 40%; after deductible g and services of a medical social worke visit. Each visit up to 4 hours by a home	OUT-OF-NETWORK 50%; after deductible stay. 50%; after deductible er. a health care aide is one visit. 50%; after deductible



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	\$40 copay; deductible waived	50%; after deductible
Limited to 20 visits per calendar year.		
Outpatient Short-Term	\$40 copay; deductible waived	50%; after deductible
Rehabilitation		
Includes Speech, Physical, and Occupa	ational Therapy, limited to 20 visits per th	nerapy per calendar year.
Autism Behavioral Therapy	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
	Health	Health
Covered same as any other Outpatient	Mental Health benefit	
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
	Health Other Services	Health Other Services
Covered same as any other Outpatient	Mental Health Other Services benefit	
Autism Physical Therapy	\$40 copay; deductible waived	50%; after deductible
Autism Occupational Therapy	\$40 copay; deductible waived	50%; after deductible
Autism Speech Therapy	\$40 copay; deductible waived	50%; after deductible
Durable Medical Equipment	40%; after deductible	50%; after deductible
Diabetic Supplies (if not covered	Covered same as any other medical	Covered same as any other medical
under Pharmacy benefit)	expense.	expense.
Women's Contraceptive drugs and	Covered 100%; deductible waived	Covered same as any other expense
devices not obtainable at a		
pharmacy		
Affordable Care Act mandated	Covered 100%; deductible waived	Covered same as any other expense
Women's Contraceptives		
Infusion Therapy	Your cost sharing is based on the	Your cost sharing is based on the
Administered in the home or	type of service and where it is	type of service and where it is
physician's office	performed	performed
Infusion Therapy	Your cost sharing is based on the	Your cost sharing is based on the
Administered in an outpatient hospital	type of service and where it is	type of service and where it is
department or freestanding facility	performed	performed
Vision Eyewear	Not Covered	Not Covered
Transplants	40%; after \$500 copay; after	50%; after deductible
-	deductible	
	Preferred coverage is provided at an	Non-Preferred coverage is provided
		Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Preferred coverage is provided at an	
Bariatric Surgery Out of Area Dependents	Preferred coverage is provided at an IOE contracted facility only.	at a Non-IOE facility. Not Covered
	Preferred coverage is provided at an IOE contracted facility only. Not Covered	at a Non-IOE facility. Not Covered
Out of Area Dependents	Preferred coverage is provided at an IOE contracted facility only. Not Covered Coverage provided at the non-preferred provider is not available.	at a Non-IOE facility. Not Covered
	Preferred coverage is provided at an IOE contracted facility only. Not Covered Coverage provided at the non-preferred provider is not available. IN-NETWORK	at a Non-IOE facility. Not Covered d benefit level of the plan if in-network
Out of Area Dependents FAMILY PLANNING	Preferred coverage is provided at an IOE contracted facility only. Not Covered Coverage provided at the non-preferred provider is not available.	at a Non-IOE facility. Not Covered d benefit level of the plan if in-network OUT-OF-NETWORK

Diagnosis and treatment of the underlying medical condition only.



Comprehensive Infertility Services Artificial insemination and ovulation ind	Not Covered uction	Not Covered
Advanced Reproductive	Not Covered	Not Covered
Technology (ART)		
In-vitro fertilization (IVF), zygote intrafal	llopian transfer (ZIFT), gamete intrafallo	opian transfer (GIFT), cryopreserved
embryo transfers, intracytoplasmic sper		
Vasectomy	Covered 100%; after deductible	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	\$10 copay	20% of submitted cost; after
	4.0 copa)	applicable copay
90 Day Retail	\$30 copay	11
Mail Order	\$20 copay	Not Applicable
Preferred Brand-Name Drugs	+=	
Retail	\$40 copay	20% of submitted cost; after
		applicable copay
90 Day Retail	\$120 copay	
Mail Order	\$80 copay	Not Applicable
Non-Preferred Generic and Brand-Na		
Retail	\$80 copay	20% of submitted cost; after
		applicable copay
90 Day Retail	\$240 copay	
Mail Order	\$160 copay	Not Applicable
Pharmacy Day Supply and Requirem		
Retail	Up to a 30 day supply from Aetna Sta	ndard National Network
Mail Order	Up to a 31-90 day supply from Aetna	
Value Plus Specialty	Up to a 30 day supply from Aetna Spe	
		ecialty pharmacy. Subsequent fills must
	be through our preferred specialty pha	armacy network.
Choose Generics - If the member or th		
applicable copay plus the difference be	tween the generic price and the brand	price.
Plan Includes: Diabetic supplies and C	Contraceptive drugs and devices obtain	able from a pharmacy.
A limited list of over-the-counter medica	ations are covered when filled with a pr	escription.
Oral chemotherapy drugs covered 1009	%	
Value Plus Pre-certification included		
Value Plus Step Therapy included		
Seasonal Vaccinations covered 100% i		
Preventive Vaccinations covered 100%		
One transition fill allowed within 90 day		
Affordable Care Act mandated female of	contraceptives and preventive medication	ons covered 100% in-network.
GENERAL PROVISIONS		
GENERAL PROVISIONS		



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.

- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

• Home births

• Immunizations for travel or work, except where medically necessary or indicated.

• Implantable drugs and certain injectable drugs including injectable infertility drugs.

• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.

- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.

• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.

- Radial keratotomy or related procedures.
- Reversal of sterilization.

• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.

- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862**.

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

Plan features and availability may vary by location and group size. For more information about Aetna plans, refer to **www.aetna.com**. © 2014 Aetna Inc.





PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

FUND FEATURES HealthFund Amount \$1,500 Employee

Amount contributed to the Fund by the employer

Fund amount reflected is on a per calendar year basis. The fund received may be prorated based on your effective date of coverage.

The Family HealthFund amount applies to all family members combined. There is no Individual HealthFund limit within the Family HealthFund amount.

Fund Coinsurance	100%	
Percentage at which the Fund will rein		
Fund Administration	The Fund will be used to pay for your member responsibility, including your deductible and coinsurance. Once the deductible is met, the underlying	
		rage and if a Fund balance still exists, the Fund
		nsibility (i.e. your share of coinsurance) until the
		s been reached or the Fund has been exhausted,
		ices covered at 100% with no deductible will be
	paid by the plan and not by	
Employee Termination from Your	Any remaining HealthFund benefit amount is forfeited (or terminated) wher	
HealthFund	the employee's HealthFund coverage terminates.	
Fund Rollover	Any remaining HealthFund benefit amount at end of the plan year is rolled	
	over into next year's HealthFund benefit amount.	
Eligible Fund Expenses	Fund covers same expenses as the medical plan. Expenses above the	
		mit, any plan limits, and any non covered
	expenses are not eligible for reimbursement under the Fund.	
Fund Payment/Assignment	Network Providers: Automatic Assignment to provider. Non-Network Providers: Member may assign payment to provider.	
Pro-ration for New Employees	Monthly	
Pro-ration for Family Status	No pro-ration. Change to new tier based on new employee status.	
Change		
		are integrated with the medical plan (i.e., subject
	to medical Deductible and applied towards the medical Out-of-Pocket Limit	
		ble for reimbursement from the Fund).
PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	\$5,000 Individual	\$15,000 Individual
	\$10,000 Family	\$30,000 Family
All covered expenses accumulate sep		
Unless otherwise indicated, the deduc	tible must be met prior to bene	efits being payable.
Member cost sharing for certain service	ces, as indicated in the plan, ar	re excluded from charges to meet the Deductible.
Pharmacy expenses apply towards th	e Deductible.	
The family Deductible is a cumulative	Deductible for all family memb	ers. The family Deductible can be met by a
combination of family members; howe	ver, no single individual within	the family will be subject to more than the
individual Deductible amount.	-	· · ·
Member Coinsurance	50%	50%

Member Coinsurance	50%	50%
Applies to all expenses unless otherwi	se stated.	
Payment Limit (per calendar year)	\$6,250 Individual	\$20,000 Individual
	\$12,500 Family	\$40,000 Family
All covered expenses accumulate sep	arately toward the preferred or non-prefe	rred Payment Limit

All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit.



PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Certain member cost sharing elements may not apply toward the Payment Limit.

Pharmacy expenses apply towards the Payment Limit.

Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit.

The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.

individual Payment Limit amount.		
Lifetime Maximum		
Unlimited except where otherwise indi		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare
		Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -		
	Preferred care must be obtained to avoid	
	ions, Treatment Facility Admissions, Co	
Health Care, Hospice Care and Privat	e Duty Nursing is required - excluded ar	mount applied separately to each type o
expense is \$400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/	Covered 100%; deductible waived	50%; after deductible
Immunizations		
1 exam every 12 months for members	age 22 to age 65; 1 exam every 12 mo	nths for adults age 65 and older.
Routine Well Child	Covered 100%; deductible waived	50%; deductible waived
Exams/Immunizations		
7 exams in the first 12 months of life, 3	3 exams in the second 12 months of life	, 3 exams in the third 12 months of life,
exam per 12 months thereafter to age	22.	
Routine Gynecological Care	Covered 100%; deductible waived	50%; after deductible
Exams		
1 obgyn exam and pap smear per cale	endar year	
Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	50%; after deductible
	abetes, HPV (Human- Papillomavirus) D	
	screening for human immunodeficiency	
	preastfeeding support, supplies and cou	
	rocedures, patient education and couns	
Routine Digital Rectal Exam	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males ag		
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males ag		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age		
Routine Eye Exams	Covered 100%; deductible waived	50%; after deductible
1 routine exam per 24 months.		
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to PCP	50%; after deductible	50%; after deductible
Includes condition of an intermint more	volunia volutional foncilu un sontitione a sur podiu	

Includes services of an internist, general physician, family practitioner or pediatrician.



Specialist Office Visits	50%; after deductible	50%; after deductible
Hearing Exams	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	50%; after deductible	50%; after deductible
	ding health care facilities. They are an a	
	ency illnesses and injuries and the admi	
	services or the ongoing care provided I	
	f a hospital, shall be considered a Walk-	
Allergy Testing	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
Allergy Injections	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray	50%; after deductible	50%; after deductible
	ffice visit and billed by the physician, ex	penses are covered subject to the
applicable physician's office visit mem		
Diagnostic Laboratory	50%; after deductible	50%; after deductible
	ffice visit and billed by the physician, ex	penses are covered subject to the
applicable physician's office visit mem		
Diagnostic Outpatient Complex	50%; after deductible	50%; after deductible
Imaging	-	
Imaging EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Imaging EMERGENCY MEDICAL CARE Urgent Care Provider	IN-NETWORK 50%; after deductible	OUT-OF-NETWORK 50%; after deductible
Imaging EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care	IN-NETWORK	OUT-OF-NETWORK
Imaging EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider	IN-NETWORK 50%; after deductible	OUT-OF-NETWORK 50%; after deductible
Imaging EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider Emergency Room	IN-NETWORK 50%; after deductible Not Covered	OUT-OF-NETWORK 50%; after deductible Not Covered
Imaging EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider Emergency Room Non-Emergency Care in an	IN-NETWORK 50%; after deductible Not Covered 50%; after deductible	OUT-OF-NETWORK 50%; after deductible Not Covered Same as in-network care
Imaging EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider Emergency Room Non-Emergency Care in an Emergency Room	IN-NETWORK 50%; after deductible Not Covered 50%; after deductible	OUT-OF-NETWORK 50%; after deductible Not Covered Same as in-network care
Imaging EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider Emergency Room Non-Emergency Care in an Emergency Room Emergency Use of Ambulance	IN-NETWORK 50%; after deductible Not Covered 50%; after deductible Not Covered 50%; after deductible	OUT-OF-NETWORK 50%; after deductible Not Covered Same as in-network care Not Covered
Imaging EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider Emergency Room Non-Emergency Care in an Emergency Room Emergency Use of Ambulance Non-Emergency Use of Ambulance	IN-NETWORK 50%; after deductible Not Covered 50%; after deductible Not Covered 50%; after deductible	OUT-OF-NETWORK 50%; after deductible Not Covered Same as in-network care Not Covered Same as in-network care Same as in-network care
Imaging EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider Emergency Room Non-Emergency Care in an Emergency Room Emergency Use of Ambulance Non-Emergency Use of Ambulance HOSPITAL CARE	IN-NETWORK50%; after deductibleNot Covered50%; after deductibleNot Covered50%; after deductibleNot Covered	OUT-OF-NETWORK 50%; after deductible Not Covered Same as in-network care Not Covered Same as in-network care Not Covered OUT-OF-NETWORK
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Imaging EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider Emergency Room Non-Emergency Care in an Emergency Room Emergency Use of Ambulance Non-Emergency Use of Ambulance HOSPITAL CARE Inpatient Coverage	IN-NETWORK50%; after deductibleNot Covered50%; after deductibleNot Covered50%; after deductibleNot CoveredIN-NETWORK50%; after \$500 copay per admission; after deductible	OUT-OF-NETWORK 50%; after deductible Not Covered Same as in-network care Not Covered Same as in-network care Not Covered OUT-OF-NETWORK 50%; after \$500 copay per admission; after deductible
Imaging EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider Emergency Room Non-Emergency Care in an Emergency Room Emergency Use of Ambulance Non-Emergency Use of Ambulance HOSPITAL CARE Inpatient Coverage Your cost sharing applies to all covere	IN-NETWORK 50%; after deductible Not Covered IN-NETWORK 50%; after \$500 copay per admission; after deductible d benefits incurred during your inpatient	OUT-OF-NETWORK 50%; after deductible Not Covered Same as in-network care Not Covered Same as in-network care Not Covered OUT-OF-NETWORK 50%; after \$500 copay per admission; after deductible t stay.
Imaging EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider Emergency Room Non-Emergency Care in an Emergency Room Emergency Use of Ambulance Non-Emergency Use of Ambulance Non-Emergency Use of Ambulance Non-Emergency Use of Ambulance Non-Emergency Use of Ambulance Your cost sharing applies to all covere Inpatient Maternity Coverage	IN-NETWORK 50%; after deductible Not Covered 50%; after deductible Not Covered 50%; after deductible Not Covered IN-NETWORK 50%; after \$500 copay per admission; after deductible d benefits incurred during your inpatient 50%; after \$500 copay per	OUT-OF-NETWORK 50%; after deductible Not Covered Same as in-network care Not Covered Same as in-network care Not Covered OUT-OF-NETWORK 50%; after \$500 copay per admission; after deductible t stay. 50%; after \$500 copay per
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Imaging EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider Emergency Room Non-Emergency Care in an Emergency Room Emergency Use of Ambulance Non-Emergency Use of Ambulance HOSPITAL CARE Inpatient Coverage Your cost sharing applies to all covere Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covere Outpatient Hospital Expenses	IN-NETWORK 50%; after deductible Not Covered IN-NETWORK 50%; after \$500 copay per admission; after deductible d benefits incurred during your inpatient 50%; after \$500 copay per admission; after deductible d benefits incurred during your inpatient 50%; after \$250 copay; after deductible d benefits incurred during your inpatient 50%; after \$250 copay; after deductible d benefits incurred during your outpatient 50%; after \$250 copay; after deductible d benefits incurred during your outpatient	OUT-OF-NETWORK 50%; after deductible Not Covered Same as in-network care Not Covered Same as in-network care Not Covered OUT-OF-NETWORK 50%; after \$500 copay per admission; after deductible t stay. 50%; after \$500 copay per admission; after deductible t stay. 50%; after \$250 copay; after deductible t stay. 50%; after \$250 copay; after 50%; after \$250 copay; after
maging EMERGENCY MEDICAL CARE Urgent Care Provider Non-Urgent Use of Urgent Care Provider Emergency Room Non-Emergency Care in an Emergency Room Emergency Room Emergency Room Emergency Room Emergency Use of Ambulance Non-Emergency Use of Ambulance Your cost sharing applies to all covere Outpatient Hospital Expenses Your cost sharing applies to all covere Outpatient Surgery - Hospital	IN-NETWORK 50%; after deductible Not Covered IN-NETWORK 50%; after \$500 copay per admission; after deductible d benefits incurred during your inpatient 50%; after \$500 copay per admission; after deductible d benefits incurred during your inpatient 50%; after \$250 copay; after deductible d benefits incurred during your outpatient	OUT-OF-NETWORK 50%; after deductible Not Covered Same as in-network care Not Covered Same as in-network care Not Covered OUT-OF-NETWORK 50%; after \$500 copay per admission; after deductible t stay. 50%; after \$500 copay per admission; after deductible t stay. 50%; after \$250 copay; after deductible nt visit. 50%; after \$250 copay; after deductible

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PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Outpatient Surgery - Freestanding Facility	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered	henefits incurred during your out	patient visit
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	50%; after \$500 copay per	50%; after \$500 copay per
	admission; after deductible	admission; after deductible
Your cost sharing applies to all covered		
Mental Health Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered		
Other Mental Health Services	50%; after deductible	50%; after deductible
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	50%; after \$500 copay per	50%; after \$500 copay per
-	admission; after deductible	admission; after deductible
Your cost sharing applies to all covered		
Residential Treatment Facility	50%; after \$500 copay per	50%; after \$500 copay per
· · · · · · · · · · · · · · · · · · ·	admission; after deductible	admission; after deductible
Substance Abuse Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered		
Other Substance Abuse Services	50%; after deductible	50%; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility	50%; after deductible	50%; after deductible
Limited to 60 days per calendar year.		
Your cost sharing applies to all covered	d benefits incurred during your inpa	atient stay.
Home Health Care	50%; after deductible	50%; after deductible
Limited to 60 visits per calendar year.		
Coverage includes nutritional counselir		
Each visit by a nurse or therapist is one		
Hospice Care - Inpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered		
Hospice Care - Outpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered		
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	50%; after deductible	50%; after deductible
Limited to 20 visits per calendar year. Outpatient Short-Term	50%; after deductible	EQ0/, ofter deductible
CUITOSTION SPARE OF	SU%: after deductible	50%; after deductible
Rehabilitation		

Includes Speech, Physical, and Occupational Therapy, limited to 20 visits per therapy per calendar year.

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Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Covered same as any other Outpatien	t Mental Health benefit	
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health Other Services	Refer to MBH Outpatient Mental Health Other Services
Covered same as any other Outpatien	t Mental Health Other Services benefit	
Autism Physical Therapy	50%; after deductible	50%; after deductible
Autism Occupational Therapy	50%; after deductible	50%; after deductible
Autism Speech Therapy	50%; after deductible	50%; after deductible
Durable Medical Equipment	50%; after deductible	50%; after deductible
Diabetic Supplies (if not covered	Covered same as any other medical	Covered same as any other medical
under Pharmacy benefit)	expense.	expense.
Women's Contraceptive drugs and	Covered 100%; deductible waived	Covered same as any other expense
devices not obtainable at a		
pharmacy		
Affordable Care Act mandated	Covered 100%; deductible waived	Covered same as any other expense
Women's Contraceptives		
Infusion Therapy	50%; after deductible	50%; after deductible
Administered in the home or		
physician's office		
Infusion Therapy	50%; after deductible	50%; after deductible
Administered in an outpatient hospital		
department or freestanding facility		
Vision Eyewear	Not Covered	Not Covered
Transplants	50%; after deductible	50%; after deductible
	Preferred coverage is provided at an	Non-Preferred coverage is provided
	IOE contracted facility only.	at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferre provider is not available.	d benefit level of the plan if in-network
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
Diagnosis and treatment of the underly		
Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation inc		
Advanced Reproductive	Not Covered	Not Covered
Technology (ART)		
	allopian transfer (ZIFT), gamete intrafallo	
embryo transfers, intracytoplasmic spe	rm injection (ICSI), or ovum microsurger	У
Vasectomy	Your cost sharing is based on the	50%; after deductible
-	type of service and where it is	
	performed	
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible



PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan. Pharmacy Plan Type Aetna Value Plus Open Formulary Preferred Generic Drugs Retail \$10 copay \$10 copay 90 Day Retail \$30 copay Mail Order \$25 copay Not Covered Preferred Brand-Name Drugs Retail \$30 copay \$30 copay \$30 copay 90 Day Retail \$30 copay Not Covered Not Covered Preferred Brand-Name Drugs Retail \$30 copay \$30 copay Mail Order \$75 copay Not Covered Not Covered Non-Preferred Generic and Brand-Name Drugs Retail \$50 copay \$50 copay			
Pharmacy Plan TypeAetna Value Plus Open FormularyPreferred Generic DrugsRetail\$10 copay90 Day Retail\$30 copay\$10 copay90 Day Retail\$30 copayNot CoveredPreferred Brand-Name DrugsRetail\$30 copay90 Day Retail\$90 copay\$30 copay90 Day Retail\$90 copayNot Covered90 Day Retail\$90 copay\$30 copay90 Day Retail\$90 copayNot CoveredMail Order\$75 copayNot CoveredNon-Preferred Generic and Brand-Name Drugs Retail\$50 copay\$50 copay			
Preferred Generic DrugsRetail\$10 copay\$10 copay90 Day Retail\$30 copayNot CoveredMail Order\$25 copayNot CoveredPreferred Brand-Name Drugs\$30 copay\$30 copay90 Day Retail\$30 copay\$30 copay90 Day Retail\$90 copay\$30 copayMail Order\$75 copayNot CoveredNon-Preferred Generic and Brand-Name Drugs Retail\$50 copay\$50 copay\$50 copay\$50 copay\$50 copay			
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90 Day Retail Mail Order\$90 copay \$75 copayNot CoveredNon-Preferred Generic and Brand-Name Drugs Retail\$50 copay\$50 copay			
Mail Order\$75 copayNot CoveredNon-Preferred Generic and Brand-Name Drugs Retail\$50 copay\$50 copay			
Non-Preferred Generic and Brand-Name Drugs Retail \$50 copay\$50 copay			
Retail \$50 copay \$50 copay			
00 Deve Detell #450 eener			
90 Day Retail \$150 copay			
Mail Order \$125 copay Not Covered			
Pharmacy Day Supply and Requirements			
Retail Up to a 30 day supply from Aetna Standard National Network			
Value Plus Specialty Up to a 30 day supply from Aetna Specialty Pharmacy Network.			
	First prescription fill at any retail or specialty pharmacy. Subsequent fills must		
be through our preferred specialty pharmacy network.			
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the			
applicable copay plus the difference between the generic price and the brand price.			
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.			
A limited list of over-the-counter medications are covered when filled with a prescription.			
Oral chemotherapy drugs covered 100%			
Value Plus Pre-certification included			
Value Plus Step Therapy included			
Seasonal Vaccinations covered 100% in-network			
Preventive Vaccinations covered 100% in-network			
One transition fill allowed within 90 days of member's effective date			
Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.			
GENERAL PROVISIONS			
Dependents Eligibility Spouse, children from birth to age 26 regardless of student status.			

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.



PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.



PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.

- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

- Home births
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT,
- ICSI and other related services, unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.

• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.

- Radial keratotomy or related procedures.
- Reversal of sterilization.

• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.

- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at 1-888-982-3862.

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

Plan features and availability may vary by location and group size. For more information about Aetna plans, refer to **www.aetna.com**. © 2014 Aetna Inc.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	\$5,000 Individual	\$15,000 Individual
	\$10,000 Family	\$30,000 Family
All covered expenses accumulate sepa	arately toward the preferred or non-pref	erred Deductible.
Unless otherwise indicated, the deduc	tible must be met prior to benefits being	payable.
Member cost sharing for certain servic	es, as indicated in the plan, are exclude	d from charges to meet the Deductible.
Pharmacy expenses apply towards the	e Deductible.	C C
The family Deductible is a cumulative	Deductible for all family members. The f	amily Deductible can be met by a
combination of family members; howe	ver, no single individual within the family	/ will be subject to more than the
individual Deductible amount.		
Member Coinsurance	50%	50%
Applies to all expenses unless otherwi	se stated.	
Payment Limit (per calendar year)	\$6,250 Individual	\$20,000 Individual
, (1) , , , ,	\$12,500 Family	\$40,000 Family
All covered expenses accumulate sepa	arately toward the preferred or non-pref	
	s may not apply toward the Payment Lin	
Pharmacy expenses apply towards the		
		ce percentage, copays, and deductibles
(except any penalty amounts) may be		
		s. The family Payment Limit can be met
	nowever, no single individual within the f	
ndividual Payment Limit amount.		
Lifetime Maximum		
Unlimited except where otherwise indi	cated.	
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare
· .,		Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -		
	referred care must be obtained to avoid	a reduction in benefits paid for that
	ons, Treatment Facility Admissions, Co	
		nount applied separately to each type o
expense is \$400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/	Covered 100%; deductible waived	50%; after deductible
Immunizations		
	age 22 to age 65; 1 exam every 12 mo	nths for adults age 65 and older.
Routine Well Child	Covered 100%; deductible waived	50%; deductible waived
Exams/Immunizations		
	exams in the second 12 months of life	3 exams in the third 12 months of life,
exam per 12 months thereatter to ade		
exam per 12 months thereafter to age Routine Gynecological Care		50%: after deductible
exam per 12 months thereafter to age Routine Gynecological Care Exams	Covered 100%; deductible waived	50%; after deductible

1 obgyn exam and pap smear per calendar year



Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	50%; after deductible
	abetes, HPV (Human- Papillomavirus) D	
	d screening for human immunodeficiency	
	breastfeeding support, supplies and cou	
	procedures, patient education and counse	
Routine Digital Rectal Exam	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males a		,
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males a		,
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age		
Routine Eye Exams	Covered 100%; deductible waived	50%; after deductible
1 routine exam per 24 months.		
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to PCP	50%; after deductible	50%; after deductible
	eral physician, family practitioner or pedia	
Specialist Office Visits	50%; after deductible	50%; after deductible
Hearing Exams	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	50%; after deductible	50%; after deductible
	nding health care facilities. They are an a	
	gency illnesses and injuries and the admi	
	n services or the ongoing care provided I	
	of a hospital, shall be considered a Walk-	
Allergy Testing	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
Allergy Injections	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	
	type of service and where it is performed	type of service and where it is
DIAGNOSTIC PROCEDURES	performed	type of service and where it is performed
	performed IN-NETWORK	type of service and where it is performed OUT-OF-NETWORK
Diagnostic X-ray	performed IN-NETWORK 50%; after deductible	type of service and where it is performed OUT-OF-NETWORK 50%; after deductible
Diagnostic X-ray If performed as a part of a physician (performed IN-NETWORK 50%; after deductible office visit and billed by the physician, ex	type of service and where it is performed OUT-OF-NETWORK 50%; after deductible
Diagnostic X-ray If performed as a part of a physician of a physician of a physician of the physician's office visit mer	performed IN-NETWORK 50%; after deductible office visit and billed by the physician, ex nber cost sharing.	type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the
Diagnostic X-ray If performed as a part of a physician applicable physician's office visit mer Diagnostic Laboratory	performed IN-NETWORK 50%; after deductible office visit and billed by the physician, ex nber cost sharing. 50%; after deductible	type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible
Diagnostic X-ray If performed as a part of a physician applicable physician's office visit mer Diagnostic Laboratory If performed as a part of a physician	performed IN-NETWORK 50%; after deductible office visit and billed by the physician, ex nber cost sharing. 50%; after deductible office visit and billed by the physician, ex	type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible
Diagnostic X-ray If performed as a part of a physician applicable physician's office visit mer Diagnostic Laboratory If performed as a part of a physician applicable physician's office visit mer	IN-NETWORK 50%; after deductible office visit and billed by the physician, ex nber cost sharing. 50%; after deductible office visit and billed by the physician, ex nber cost sharing.	type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible penses are covered subject to the
Diagnostic X-ray If performed as a part of a physician applicable physician's office visit mer Diagnostic Laboratory If performed as a part of a physician applicable physician's office visit mer Diagnostic Outpatient Complex	performed IN-NETWORK 50%; after deductible office visit and billed by the physician, ex nber cost sharing. 50%; after deductible office visit and billed by the physician, ex	type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible
Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit mer Diagnostic Laboratory If performed as a part of a physician of applicable physician's office visit mer Diagnostic Outpatient Complex Imaging	IN-NETWORK 50%; after deductible office visit and billed by the physician, ex nber cost sharing. 50%; after deductible office visit and billed by the physician, ex nber cost sharing. 50%; after deductible	type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible penses are covered subject to the 50%; after deductible
applicable physician's office visit mer Diagnostic Laboratory If performed as a part of a physician applicable physician's office visit mer Diagnostic Outpatient Complex Imaging EMERGENCY MEDICAL CARE	in-NETWORK 50%; after deductible office visit and billed by the physician, ex nber cost sharing. 50%; after deductible office visit and billed by the physician, ex nber cost sharing. 50%; after deductible IN-NETWORK	type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible penses are covered subject to the 50%; after deductible OUT-OF-NETWORK
Diagnostic X-ray If performed as a part of a physician of applicable physician's office visit mer Diagnostic Laboratory If performed as a part of a physician of applicable physician's office visit mer Diagnostic Outpatient Complex Imaging EMERGENCY MEDICAL CARE Urgent Care Provider	performed IN-NETWORK 50%; after deductible office visit and billed by the physician, ex nber cost sharing. 50%; after deductible office visit and billed by the physician, ex nber cost sharing. 50%; after deductible office visit and billed by the physician, ex nber cost sharing. 50%; after deductible IN-NETWORK 50%; after deductible	type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible penses are covered subject to the 50%; after deductible OUT-OF-NETWORK 50%; after deductible
Diagnostic X-ray If performed as a part of a physician applicable physician's office visit mer Diagnostic Laboratory If performed as a part of a physician applicable physician's office visit mer Diagnostic Outpatient Complex Imaging EMERGENCY MEDICAL CARE	in-NETWORK 50%; after deductible office visit and billed by the physician, ex nber cost sharing. 50%; after deductible office visit and billed by the physician, ex nber cost sharing. 50%; after deductible IN-NETWORK	type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible penses are covered subject to the 50%; after deductible OUT-OF-NETWORK



Emergency Room	50%; after deductible	Same as in-network care
Non-Emergency Care in an	Not Covered	Not Covered
Emergency Room		
Emergency Use of Ambulance	50%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	50%; after \$500 copay per	50%; after \$500 copay per
	admission; after deductible	admission; after deductible
Your cost sharing applies to all covered	d benefits incurred during your inpatien	t stay.
Inpatient Maternity Coverage	50%; after \$500 copay per	50%; after \$500 copay per
(includes delivery and postpartum	admission; after deductible	admission; after deductible
care)		
	d benefits incurred during your inpatien	
Outpatient Hospital Expenses	50%; after \$250 copay; after	50%; after \$250 copay; after
	deductible	deductible
	d benefits incurred during your outpatie	
Outpatient Surgery - Hospital	50%; after \$250 copay; after	50%; after \$250 copay; after
	deductible	deductible
	d benefits incurred during your outpatie	
Outpatient Surgery - Freestanding	50%; after deductible	50%; after deductible
Facility		
	d benefits incurred during your outpatie	
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	50%; after \$500 copay per	50%; after \$500 copay per
	admission; after deductible	admission; after deductible
	d benefits incurred during your inpatien	
Mental Health Office Visits	50%; after deductible	50%; after deductible
	d benefits incurred during your outpatie	
Other Mental Health Services	50%; after deductible	50%; after deductible
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	50%; after \$500 copay per	50%; after \$500 copay per
	admission; after deductible	admission; after deductible
Your cost sharing applies to all covered	d benefits incurred during your inpatien	t stay.
Residential Treatment Facility	50%; after \$500 copay per	50%; after \$500 copay per
-	admission; after deductible	admission; after deductible
Substance Abuse Office Visits	50%; after deductible	50%; after deductible
	d benefits incurred during your outpatie	•
Other Substance Abuse Services	50%; after deductible	50%; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility	50%; after deductible	50%; after deductible
Limited to 60 days per calendar year.		
	d benefits incurred during your inpatien	t stay.
Home Health Care	50%; after deductible	50%; after deductible
Limited to 60 visits per calendar year.		
Coverage includes nutritional counseli	ng and services of a medical social wor	ker.
	e visit. Each visit up to 4 hours by a hor	



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

Hospice Care - Inpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered	d benefits incurred during your inpatient s	stay.
Hospice Care - Outpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered	benefits incurred during your outpatient	t visit.
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	50%; after deductible	50%; after deductible
Limited to 20 visits per calendar year.		
Outpatient Short-Term	50%; after deductible	50%; after deductible
Rehabilitation		
Includes Speech, Physical, and Occupa	ational Therapy, limited to 20 visits per th	nerapy per calendar year.
Autism Behavioral Therapy	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
	Health	Health
Covered same as any other Outpatient	Mental Health benefit	
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
	Health Other Services	Health Other Services
Covered same as any other Outpatient		
Autism Physical Therapy	50%; after deductible	50%; after deductible
Autism Occupational Therapy	50%; after deductible	50%; after deductible
Autism Speech Therapy	50%; after deductible	50%; after deductible
Durable Medical Equipment	50%; after deductible	50%; after deductible
Diabetic Supplies (if not covered	Covered same as any other medical	Covered same as any other medical
under Pharmacy benefit)	expense.	expense.
Women's Contraceptive drugs and	Covered 100%; deductible waived	Covered same as any other expense
devices not obtainable at a		covered came de any earer experies
pharmacy		
Affordable Care Act mandated	Covered 100%; deductible waived	Covered same as any other expense
Women's Contraceptives		
Infusion Therapy	50%; after deductible	50%; after deductible
Administered in the home or		
physician's office		
Infusion Therapy	50%; after deductible	50%; after deductible
Administered in an outpatient hospital		
department or freestanding facility		
Vision Eyewear	Not Covered	Not Covered
Transplants	50%; after deductible	50%; after deductible
	Preferred coverage is provided at an	Non-Preferred coverage is provided
	IOE contracted facility only.	at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents	Coverage provided at the non-preferred	
out of Alea Dependents	provider is not available.	
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
	penonneu	penonneu

Diagnosis and treatment of the underlying medical condition only.



Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation inc		
Advanced Reproductive	Not Covered	Not Covered
Technology (ART)		
	Ilopian transfer (ZIFT), gamete intrafallo	
	rm injection (ICSI), or ovum microsurge	
Vasectomy	Your cost sharing is based on the	50%; after deductible
	type of service and where it is	
	performed	
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	IN-NETWORK	OUT-OF-NETWORK
The full cost of the drug is applied to th pharmacy plan.	e deductible before any benefits are cor	nsidered for payment under the
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	\$10 copay	\$10 copay
90 Day Retail	\$30 copay	
Mail Order	\$25 copay	Not Covered
Preferred Brand-Name Drugs	· · ·	
Retail	\$30 copay	\$30 copay
90 Day Retail	\$90 copay	
Mail Order	\$75 copay	Not Covered
Non-Preferred Generic and Brand-Na	ame Drugs	
Retail	\$50 copay	\$50 copay
90 Day Retail	\$150 copay	
Mail Order	\$125 copay	Not Covered
Pharmacy Day Supply and Requiren		
Retail	Up to a 30 day supply from Aetna Star	
Mail Order	Up to a 31-90 day supply from Aetna I	
Value Plus Specialty	Up to a 30 day supply from Aetna Spe	
		ecialty pharmacy. Subsequent fills must
	be through our preferred specialty pha	
	he physician requests brand when gene	
	etween the generic price and the brand p	
	Contraceptive drugs and devices obtaina	
	ations are covered when filled with a pre	escription.
Oral chemotherapy drugs covered 100	%	
Value Plus Pre-certification included		
Value Plus Step Therapy included Seasonal Vaccinations covered 100%	in-network	
Preventive Vaccinations covered 100%		
One transition fill allowed within 90 day		
	contraceptives and preventive medication	ons covered 100% in-network
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26	regardless of student status
	opouse, ormaren nom birtir to age 20	iogardiess of student status.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.

- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

• Home births

• Immunizations for travel or work, except where medically necessary or indicated.

• Implantable drugs and certain injectable drugs including injectable infertility drugs.

• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.

- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.

• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.

- Radial keratotomy or related procedures.
- Reversal of sterilization.

• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.

- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862**.

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

Plan features and availability may vary by location and group size. For more information about Aetna plans, refer to **www.aetna.com**. © 2014 Aetna Inc.



2021 Plan Documents

HENDRY DISTRICT SCHOOL BOARD Aetna and Other Benefit Rates Calendar Year 2021 Aetna PREMIUMS

(For Period January 1 through December 31, 2021)

Employees	Aenta	Aetna	Aetna
	CY 2021	CY 2021	CY 2021
	24 PAY	21 PAY	Annual
FAMILY HEALTH INSURANCE COVERAGE	Per Pay	Per Pay	Cost
Open Access MC 1			
Employee	\$0	\$0	\$0
Employee-Spouse	\$431	\$493	\$10,350
Employee-Children	\$359	\$411	\$8,625
Family	\$647	\$739	\$15,524
Both spouses work for District (Family)	\$288	\$329	\$6,900
		· ·	
Open Access MC 2			
Employee	\$0	\$0	\$0
Employee-Spouse	\$277	\$317	\$6,648
Employee-Children	\$219	\$250	\$5,259
Family	\$451	\$515	\$10,813
Both spouses work for District (Family)	\$91	\$104	\$2,188
Open Access MC3 HRA/HSA			
Employee (HRA)	\$0	\$0	\$0
Employee-Spouse (Health Savings Plan)	\$170	\$195	\$4,090
Employee-Children (Health Savings Plan	\$122	\$140	\$2,934
Family (Health Savings Plan)	\$315	\$360	\$7,557
Both spouses work for District (Family) (Health Savings Plan)	\$0	\$0	\$0
DENTAL, LIFE INSURANCE, DISABILITY			
Employee	\$0	\$0	\$0
Employee-Family	\$9	\$10	\$216
EMPLOYEE LIFE INSURANCE	\$0	\$0	\$0

Employees may purchase family dental insurance, spouse or children life insurance, additional life insurance on themselves, or additional disability insurance at their own expense.

\$9,0000 Board Benefit Contribution Maximum Per Employee Benefit for dental and life insurance is \$612 Per Employee

Aetna Retiree Premium Rates RATE FOR CALENDAR YEAR 2021 (For Period January 1 through December 31, 2021)

If retiree chooses to remain on one of the District's Aetna Health Care Plans the retiree pays the FULL cost.

A descision to elect retiree benefits must be made within 30 working days prior to retirement. Failure to respond to enrollment indicates a refusal of coverage. Once a benefit is refused or not elected it cannot be reinstated at a later date. Upon retirement you cannot change or switch medical plan coverage. You are given the oportunity to change plan coverage during the District's annual Open Enrollment period

Retirees

	2021	2021
FAMILY HEALTH INSURANCE COVERAGE	Per Month	Annual
Open Access Plan 1		
Retiree	\$718.70	\$8,624.40
Retiree-Spouse	\$1,581.17	\$18,974.04
Retiree-Children	\$1,437.42	\$17,249.04
Family	\$2,012.38	\$24,148.56
Open Access Plan 2		
Retiree	\$578.47	\$6,941.64
Retiree-Spouse	\$1,272.68	\$15,272.16
Retiree-Children	\$1,156.97	\$13,883.64
Family	\$1,619.75	\$19,437.00
Open Acces Plan 3 HRA Only - No Card Issued		
Retiree	\$481.60	\$5,779.20
Retiree-Spouse	\$1,059.53	\$12,714.36
Retiree-Children	\$963.20	\$11,558.40
Family	\$1,348.49	\$16,181.88
DENTAL		<u> </u>
DENTAL	\$7	\$84
Employee	\$27	\$324
Employee-Family	ΦΖΙ	\$324
RETIREE LIFE INSURANCE		
Can be purchased at the age based negotiated rate for retirees. Retiree pays full	Age Based	Age Based
cost for life insurance.		



Plan Open Access School District of Hendry County MCI Effective Date: 01-01-2021

Open Access[®] Managed Choice[®] POS – Florida

PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	\$2,000 Individual	\$4,000 Individual
	\$4,000 Family	\$8,000 Family
	arately toward the preferred or non-prefe	
	tible must be met prior to benefits being	
	ces, as indicated in the plan, are exclude	a from charges to meet the Deductible.
Pharmacy expenses do not apply towa		iomily Doductible can be mat by a
The family Deductible is a cumulative	Deductible for all family members. The f ver, no single individual within the family	will be subject to more than the
individual Deductible amount.	ver, no single individual within the family	
Member Coinsurance	Covered 100%	20%
Applies to all expenses unless otherw		2070
Payment Limit (per calendar year)	\$4,000 Individual	\$9,000 Individual
Fayment Linnt (per calendar year)	\$8,000 Family	\$18,000 Family
All covered expenses accumulate sen	arately toward the preferred or non-prefe	
	s may not apply toward the Payment Lin	
Pharmacy expenses apply towards the		
		ce percentage, copays, and deductibles
(except any penalty amounts) may be		5, 1, 5,
The family Payment Limit is a cumulat	ive Payment Limit for all family member	s. The family Payment Limit can be met
by a combination of family members; I	however, no single individual within the f	amily will be subject to more than the
individual Payment Limit amount.		
Lifetime Maximum		
Unlimited except where otherwise indi		3
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare
		Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -		
Certification for certain types of Non-F	Preferred care must be obtained to avoid	a reduction in benefits paid for that
care. Certification for Hospital Admiss	ions, Treatment Facility Admissions, Co	nvalescent Facility Admissions, Home
	e Duty Nursing is required - excluded ar	mount applied separately to each type of
expense is \$400 per occurrence.		Manager
Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/	Covered 100%; deductible waived	20%; after deductible
Immunizations		when for adulta and GE and aldor
	age 22 to age 65; 1 exam every 12 mo	nths for adults age 65 and older.
Routine Well Child	Covered 100%; deductible waived	20%; deductible waived
Exams/Immunizations	2 avama in the second 12 months of life	, 3 exams in the third 12 months of life, 1
	S EXAMS IN THE SECOND 12 MONTHS OF THE	a exams in the mild 12 months of file. 1
exam per 12 months thereafter to age	22.	
		20%; after deductible

1 obgyn exam and pap smear per calendar year



Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	20%; after deductible
Includes: Screening for gestational	diabetes, HPV (Human- Papillomavirus) D	NA testing, counseling for sexually
transmitted infections, counseling a	nd screening for human immunodeficiency	virus, screening and counseling for
interpersonal and domestic violence	, breastfeeding support, supplies and could	nseling.
Contraceptive methods, sterilization	procedures, patient education and counse	eling. Limitations may apply.
Routine Digital Rectal Exam	Covered 100%; deductible waived	20%; after deductible
Recommended: For covered males	age 40 and over.	
Prostate-specific Antigen Test	Covered 100%; deductible waived	20%; after deductible
Recommended: For covered males	age 40 and over.	
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members ag		
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	20%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to PCP	\$25 copay; deductible waived	20%; after deductible
	neral physician, family practitioner or pedia	
Specialist Office Visits	\$50 copay; deductible waived	20%; after deductible
Hearing Exams	Your cost sharing is based on the	Your cost sharing is based on the
inouring	type of service and where it is	type of service and where it is
	performed	performed
Pre-Natal Maternity	Covered 100%; deductible waived	20%; after deductible
Walk-in Clinics	\$25 copay; deductible waived	20%; after deductible
	anding health care facilities. They are an a	
	rgency illnesses and injuries and the admi	
	om services or the ongoing care provided t	
room, nor the outpatient department	t of a hospital, shall be considered a Walk-	in Clinic.
	t of a hospital, shall be considered a Walk- Your cost sharing is based on the	in Clinic. Your cost sharing is based on the
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Emergency Room Copay waived if admitted	\$125 copay; deductible waived	Same as in-network care
Ion-Emergency Care in an	Not Covered	Not Covered
Emergency Room	Not Govered	Not Covered
mergency Use of Ambulance	Covered 100%; after deductible	Same as in-network care
Ion-Emergency Use of Ambulance	Not Covered	Not Covered
IOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
npatient Coverage	Covered 100%; after deductible	20%; after deductible
	I benefits incurred during your inpatient	stay.
npatient Maternity Coverage	Covered 100%; after deductible	20%; after deductible
includes delivery and postpartum		
are)		
	benefits incurred during your inpatient	
Dutpatient Hospital Expenses	Covered 100%; after deductible	20%; after deductible
	l benefits incurred during your outpatier	
Dutpatient Surgery - Hospital	Covered 100%; after deductible	20%; after deductible
	I benefits incurred during your outpatier	
Dutpatient Surgery - Freestanding Facility	Covered 100%; after deductible	20%; after deductible
our cost sharing applies to all covered	l benefits incurred during your outpatier	nt visit.
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
npatient	Covered 100%; deductible waived	20%; deductible waived
	l benefits incurred during your inpatient	stay.
Iental Health Office Visits	Covered 100%; deductible waived	20%; deductible waived
our cost sharing applies to all covered	l benefits incurred during your outpatier	nt visit.
Other Mental Health Services	Covered 100%; deductible waived	20%; deductible walved
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
npatient	Covered 100%; deductible waived	20%; after deductible
our cost sharing applies to all covered	benefits incurred during your inpatient	stay.
Residential Treatment Facility	Covered 100%; deductible waived	20%; after deductible
Substance Abuse Office Visits	Covered 100%; deductible waived	20%; after deductible
	benefits incurred during your outpatier	nt visit.
Other Substance Abuse Services	Covered 100%; deductible waived	20%; after deductible
DTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility	Covered 100%; after deductible	20%; after deductible
imited to 60 days per calendar year.		
our cost sharing applies to all covered	I benefits incurred during your inpatient	stay.
Iome Health Care	Covered 100%; after deductible	20%; after deductible
imited to 60 visits per calendar year.		
	g and services of a medical social work	
	e visit. Each visit up to 4 hours by a hom	
lospice Care - Inpatient	Covered 100%; after deductible	20%; after deductible
	benefits incurred during your inpatient	stay.
lospice Care - Outpatient	Covered 100%; after deductible	20%; after deductible



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	\$25 copay; deductible waived 20%; after deductible	
Limited to 20 visits per calendar year.		
Outpatient Short-Term	\$25 copay; deductible waived	20%; after deductible
Rehabilitation		
	ational Therapy, limited to 20 visits per t	herapy per calendar year.
Autism Behavioral Therapy	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
	Health	Health
Covered same as any other Outpatient		
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
	Health Other Services	Health Other Services
Covered same as any other Outpatient		
Autism Physical Therapy	\$25 copay; deductible waived	20%; after deductible
Autism Occupational Therapy	\$25 copay; deductible waived	20%; after deductible
Autism Speech Therapy	\$25 copay; deductible waived	20%; after deductible
Durable Medical Equipment	Covered 100%; after deductible	20%; after deductible
Diabetic Supplies (if not covered	Covered same as any other medical	Covered same as any other medical
under Pharmacy benefit)	expense.	expense.
Women's Contraceptive drugs and	Covered 100%; deductible waived	Covered same as any other expense
devices not obtainable at a		
pharmacy		
Affordable Care Act mandated	Covered 100%; deductible waived	Covered same as any other expense
Women's Contraceptives		
Infusion Therapy	Your cost sharing is based on the	Your cost sharing is based on the
Administered in the home or	type of service and where it is	type of service and where it is
physician's office	performed	performed
Infusion Therapy	Your cost sharing is based on the	Your cost sharing is based on the
Administered in an outpatient hospital	type of service and where it is	type of service and where it is
department or freestanding facility	performed	performed
Vision Eyewear	Not Covered	Not Covered
Transplants	Covered 100%; after deductible	20%; after deductible
	Preferred coverage is provided at an	Non-Preferred coverage is provided
	IOE contracted facility only.	at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Out of Area Dependents		d benefit level of the plan if in-network
	provider is not available.	
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed

Diagnosis and treatment of the underlying medical condition only.



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School District of Hendry County Effective Date: 01-01-2021 Open Access[®] Managed Choice[®] POS – Florida

PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation ind		
Advanced Reproductive	Not Covered	Not Covered
Technology (ART)		
In-vitro fertilization (IVF), zygote intrafal		
embryo transfers, intracytoplasmic sper		
Vasectomy	Covered 100%; after deductible	20%; after deductible
Tubal Ligation	Covered 100%; deductible waived	20%; after deductible
PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		• • •
Retail	\$10 copay	\$10 copay
90 Day Retail	\$30 copay	
Mail Order	\$20 copay	Not Covered
Preferred Brand-Name Drugs		
Retail	\$30 copay	\$30 copay
90 Day Retail	\$90 copay	
Mail Order	\$60 copay	Not Covered
Non-Preferred Generic and Brand-Na		
Retail	\$50 copay	\$50 copay
90 Day Retail	\$150 copay	
Mail Order	\$100 copay	Not Covered
Pharmacy Day Supply and Requirem	ients	
Retail	Up to a 30 day supply from Aetna Sta	
Mail Order	Up to a 31-90 day supply from Aetna	
Value Plus Specialty	Up to a 30 day supply from Aetna Spe	
		ecialty pharmacy. Subsequent fills must
	be through our preferred specialty pha	
Choose Generics - If the member or the		
applicable copay plus the difference be		
Plan Includes: Diabetic supplies and C		
A limited list of over-the-counter medica		escription.
Oral chemotherapy drugs covered 1009	%	
Value Plus Pre-certification included		
Value Plus Step Therapy included		
Seasonal Vaccinations covered 100% i		
Preventive Vaccinations covered 100%		
One transition fill allowed within 90 day		
Affordable Care Act mandated female of	contraceptives and preventive medication	ons covered 100% in-network.
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26	rogardiage of etudant status

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.

- · Cosmetic surgery, including breast reduction.
- · Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

Home births

• Immunizations for travel or work, except where medically necessary or indicated.

• Implantable drugs and certain injectable drugs including injectable infertility drugs.

• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.

· Long-term rehabilitation therapy.

• Non-medically necessary services or supplies.

• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.

- Radial keratotomy or related procedures.
- Reversal of sterilization.

• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.

- · Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at 1-888-982-3862.

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al 1-888-982-3862.

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to www.aetna.com. © 2014 Aetna Inc.



Plan Open Access MC2



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES		OUT-OF-NETWORK
Deductible (per calendar year)	\$6,000 Individual	\$8,000 Individual
All	\$12,000 Family	\$16,000 Family
	arately toward the preferred or non-pref	
	tible must be met prior to benefits being	
		ed from charges to meet the Deductible.
Pharmacy expenses do not apply towa		ionaily. Deductible can be mot by a
	Deductible for all family members. The f ver, no single individual within the family	
	ver, no single individual within the family	will be subject to more than the
individual Deductible amount. Member Coinsurance	40%	50%
		50%
Applies to all expenses unless otherwi	\$6,250 Individual	\$10,000 Individual
Payment Limit (per calendar year)	\$6,250 Individual \$12,500 Family	\$20,000 Family
All severed eveneses assumulate con	arately toward the preferred or non-prefe	
Pharmacy expenses apply towards the	s may not apply toward the Payment Lin	
		ce percentage, copays, and deductibles
(except any penalty amounts) may be		ce percentage, copays, and deductibles
		s. The family Payment Limit can be met
by a combination of family mombars:	nowever, no single individual within the f	S. The family Payment Limit can be met
individual Payment Limit amount.	lowever, no single individual within the i	anny win be subject to more than the
Lifetime Maximum		
Unlimited except where otherwise indi	cated	
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare
a symetric for Non-1 referred bare	Νοι Αρρίοαρίο	Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -	optional	Ποι πρριοαρίο
	referred care must be obtained to avoid	a reduction in benefits paid for that
	ons, Treatment Facility Admissions, Co	
		mount applied separately to each type of
expense is \$400 per occurrence.	, , ,	
Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/	Covered 100%; deductible waived	50%; after deductible
Immunizations		
1 exam every 12 months for members	age 22 to age 65; 1 exam every 12 mo	nths for adults age 65 and older.
Routine Well Child	Covered 100%; deductible waived	50%; deductible waived
Exams/Immunizations		
		, 3 exams in the third 12 months of life, 1
exam per 12 months thereafter to age		
Routine Gynecological Care	Covered 100%; deductible waived	50%; after deductible
Exams		
A second seco	•	

1 obgyn exam and pap smear per calendar year



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Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Nomen's Health	Covered 100%; deductible waived	50%; after deductible
ncludes: Screening for gestational d	liabetes, HPV (Human- Papillomavirus) D	NA testing, counseling for sexually
ransmitted infections, counseling an	d screening for human immunodeficiency	virus, screening and counseling for
	, breastfeeding support, supplies and cour	
Contraceptive methods, sterilization	procedures, patient education and counse	eling. Limitations may apply.
Routine Digital Rectal Exam	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males a	age 40 and over.	
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males a	age 40 and over.	
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age	e 50 and over.	
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to PCP	\$40 copay; deductible waived	50%; after deductible
includes services of an internist, gen	eral physician, family practitioner or pedia	atrician.
Specialist Office Visits	\$80 copay; deductible waived	50%; after deductible
Hearing Exams	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Pre-Natal Maternity Walk-in Clinics		50%; after deductible 50%; after deductible
Walk-in Clinics	\$40 copay; deductible waived	50%; after deductible
Walk-in Clinics Walk-in Clinics are network, free-sta	\$40 copay; deductible waived nding health care facilities. They are an a	50%; after deductible Ilternative to a physician's office visit fo
Walk-in Clinics Walk-in Clinics are network, free-stat treatment of unscheduled, non-emer	\$40 copay; deductible waived nding health care facilities. They are an a gency illnesses and injuries and the admi	50%; after deductible Iternative to a physician's office visit fon nistration of certain immunizations. It is
Walk-in Clinics Walk-in Clinics are network, free-sta treatment of unscheduled, non-emer not an alternative for emergency roo	\$40 copay; deductible waived nding health care facilities. They are an a gency illnesses and injuries and the admi m services or the ongoing care provided b	50%; after deductible Iternative to a physician's office visit fon nistration of certain immunizations. It is by a physician. Neither an emergency
Walk-in Clinics Walk-in Clinics are network, free-star treatment of unscheduled, non-emer not an alternative for emergency roo room, nor the outpatient department	\$40 copay; deductible waived nding health care facilities. They are an a gency illnesses and injuries and the admi	50%; after deductible Iternative to a physician's office visit fon nistration of certain immunizations. It is by a physician. Neither an emergency
Walk-in Clinics Walk-in Clinics are network, free-sta treatment of unscheduled, non-emer not an alternative for emergency roo	\$40 copay; deductible waived nding health care facilities. They are an a gency illnesses and injuries and the admi m services or the ongoing care provided to of a hospital, shall be considered a Walk- Your cost sharing is based on the	50%; after deductible Iternative to a physician's office visit fon nistration of certain immunizations. It is by a physician. Neither an emergency in Clinic.
Walk-in Clinics Walk-in Clinics are network, free-star treatment of unscheduled, non-emer not an alternative for emergency roo room, nor the outpatient department	\$40 copay; deductible waived nding health care facilities. They are an a gency illnesses and injuries and the admi m services or the ongoing care provided b of a hospital, shall be considered a Walk-	50%; after deductible Iternative to a physician's office visit for nistration of certain immunizations. It is oy a physician. Neither an emergency in Clinic. Your cost sharing is based on the
Walk-in Clinics Walk-in Clinics are network, free-star treatment of unscheduled, non-emer not an alternative for emergency roo room, nor the outpatient department Allergy Testing	\$40 copay; deductible waived nding health care facilities. They are an a gency illnesses and injuries and the admi m services or the ongoing care provided to of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed	50%; after deductible alternative to a physician's office visit for nistration of certain immunizations. It i oy a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is
Walk-in Clinics Walk-in Clinics are network, free-star treatment of unscheduled, non-emer not an alternative for emergency roo room, nor the outpatient department	\$40 copay; deductible waived nding health care facilities. They are an a gency illnesses and injuries and the admi m services or the ongoing care provided to of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is	50%; after deductible alternative to a physician's office visit for nistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed
Walk-in Clinics Walk-in Clinics are network, free-star treatment of unscheduled, non-emer not an alternative for emergency roo room, nor the outpatient department Allergy Testing	\$40 copay; deductible waived nding health care facilities. They are an a gency illnesses and injuries and the admi m services or the ongoing care provided to of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed	50%; after deductible alternative to a physician's office visit for nistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the
Walk-in Clinics Walk-in Clinics are network, free-star treatment of unscheduled, non-emer not an alternative for emergency roo room, nor the outpatient department Allergy Testing Allergy Injections	\$40 copay; deductible waived nding health care facilities. They are an a gency illnesses and injuries and the admi m services or the ongoing care provided to of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed	50%; after deductible alternative to a physician's office visit for nistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is
Walk-in Clinics Walk-in Clinics are network, free-star treatment of unscheduled, non-emer not an alternative for emergency roo room, nor the outpatient department Allergy Testing Allergy Injections DIAGNOSTIC PROCEDURES	\$40 copay; deductible waived nding health care facilities. They are an a gency illnesses and injuries and the admi m services or the ongoing care provided b of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived IN-NETWORK	50%; after deductible alternative to a physician's office visit for instration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed
Walk-in Clinics Walk-in Clinics are network, free-star treatment of unscheduled, non-emer not an alternative for emergency roo room, nor the outpatient department Allergy Testing Allergy Injections DIAGNOSTIC PROCEDURES Diagnostic X-ray	\$40 copay; deductible waived nding health care facilities. They are an a gency illnesses and injuries and the admi m services or the ongoing care provided b of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived	50%; after deductible alternative to a physician's office visit for nistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 50%; after deductible
Walk-in Clinics Walk-in Clinics are network, free-star Ireatment of unscheduled, non-emer not an alternative for emergency roo room, nor the outpatient department Allergy Testing Allergy Injections DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician	\$40 copay; deductible waived nding health care facilities. They are an a gency illnesses and injuries and the admi m services or the ongoing care provided b of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived office visit and billed by the physician, ex	50%; after deductible alternative to a physician's office visit for nistration of certain immunizations. It i by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 50%; after deductible
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Walk-in Clinics Walk-in Clinics are network, free-star treatment of unscheduled, non-emer not an alternative for emergency roo room, nor the outpatient department Allergy Testing Allergy Injections DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician applicable physician's office visit mer Diagnostic Laboratory	\$40 copay; deductible waived nding health care facilities. They are an a gency illnesses and injuries and the admi m services or the ongoing care provided to of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived office visit and billed by the physician, ex mber cost sharing. Covered 100%; deductible waived	50%; after deductible alternative to a physician's office visit for nistration of certain immunizations. It is oy a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible
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Walk-in Clinics Walk-in Clinics are network, free-star treatment of unscheduled, non-emer not an alternative for emergency roo room, nor the outpatient department Allergy Testing Allergy Injections Diagnostic X-ray If performed as a part of a physician applicable physician's office visit mer Diagnostic Laboratory If performed as a part of a physician applicable physician's office visit mer Diagnostic Cutpatient Complex Imaging EMERGENCY MEDICAL CARE	\$40 copay; deductible waived nding health care facilities. They are an a gency illnesses and injuries and the admi m services or the ongoing care provided b of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived office visit and billed by the physician, ex mber cost sharing. Covered 100%; deductible waived office visit and billed by the physician, ex mber cost sharing. \$300 copay; deductible waived IN-NETWORK	50%; after deductible alternative to a physician's office visit for nistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible penses are covered subject to the 50%; after deductible penses are covered subject to the
Walk-in Clinics Walk-in Clinics are network, free-stat treatment of unscheduled, non-emer not an alternative for emergency roo room, nor the outpatient department Allergy Testing Allergy Injections Diagnostic X-ray If performed as a part of a physician applicable physician's office visit mer Diagnostic Laboratory If performed as a part of a physician applicable physician's office visit mer Diagnostic Laboratory If performed as a part of a physician applicable physician's office visit mer Diagnostic Laboratory If performed as a part of a physician applicable physician's office visit mer Diagnostic Outpatient Complex Imaging	\$40 copay; deductible waived nding health care facilities. They are an a gency illnesses and injuries and the admi m services or the ongoing care provided b of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived office visit and billed by the physician, ex mber cost sharing. Covered 100%; deductible waived office visit and billed by the physician, ex mber cost sharing. \$300 copay; deductible waived	50%; after deductible alternative to a physician's office visit for nistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible penses are covered subject to the



Emergency Room Copay waived if admitted	\$300 copay; deductible waived	Same as in-network care
Non-Emergency Care in an	Not Covered	Not Covered
Emergency Room		
Emergency Use of Ambulance	40%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
npatient Coverage	40%; after \$500 copay; after deductible	50%; after \$500 copay; after deductible
	benefits incurred during your inpatient	stay.
npatient Maternity Coverage	40%; after \$500 copay; after	50%; after \$500 copay; after
includes delivery and postpartum	deductible	deductible
care)		
	benefits incurred during your inpatient	stay.
Dutpatient Hospital Expenses	40%; after deductible	50%; after deductible
	benefits incurred during your outpatien	
Outpatient Surgery - Hospital	40%; after \$250 copay; after	50%; after \$250 copay; after
	deductible	deductible
	I benefits incurred during your outpatien	t visit.
Outpatient Surgery - Freestanding Facility	40%; after deductible	50%; after deductible
	benefits incurred during your outpatien	t visit.
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
npatient	Covered 100%; deductible waived	50%; deductible waived
	benefits incurred during your inpatient	stay.
Mental Health Office Visits	\$80 copay; deductible waived	50%; deductible waived
Your cost sharing applies to all covered	benefits incurred during your outpatien	it visit.
Other Mental Health Services	Covered 100%; deductible waived	50%; deductible waived
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
npatient	Covered 100%; deductible waived	50%; deductible waived
Your cost sharing applies to all covered	benefits incurred during your inpatient	stay.
Residential Treatment Facility	Covered 100%; deductible waived	50%; deductible waived
Substance Abuse Office Visits	\$80 copay; deductible waived	50%; deductible waived
Your cost sharing applies to all covered	benefits incurred during your outpatien	it visit.
Other Substance Abuse Services	Covered 100%; deductible waived	50%; deductible waived
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility	40%; after deductible	50%; after deductible
Limited to 60 days per calendar year.		
Your cost sharing applies to all covered	benefits incurred during your inpatient	stay.
Home Health Care	40%; after deductible	50%; after deductible
Limited to 60 visits per calendar year.		
Coverage includes nutritional counselir	ng and services of a medical social work	er.
Each visit by a nurse or therapist is one	e visit. Each visit up to 4 hours by a hom	
Hospice Care - Inpatient	40%; after deductible	50%; after deductible
	benefits incurred during your inpatient	
Hospice Care - Outpatient	40%; after deductible	50%; after deductible
	benefits incurred during your outpatier	



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	\$40 copay; deductible waived	50%; after deductible
Limited to 20 visits per calendar year.		
Outpatient Short-Term	\$40 copay; deductible waived	50%; after deductible
Rehabilitation		,
	ational Therapy, limited to 20 visits per th	èrapy per calendar year.
Autism Behavioral Therapy	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
	Health	Health
Covered same as any other Outpatient		
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental
	Health Other Services	Health Other Services
Covered same as any other Outpatient		
Autism Physical Therapy	\$40 copay; deductible waived	50%; after deductible
Autism Occupational Therapy	\$40 copay; deductible waived	50%; after deductible
Autism Speech Therapy	\$40 copay; deductible waived	50%; after deductible
Durable Medical Equipment	40%; after deductible	50%; after deductible
Diabetic Supplies (if not covered	Covered same as any other medical	Covered same as any other medical
under Pharmacy benefit)	expense.	expense.
Women's Contraceptive drugs and	Covered 100%; deductible waived	Covered same as any other expense
devices not obtainable at a		
pharmacy		
Affordable Care Act mandated	Covered 100%; deductible waived	Covered same as any other expense
Women's Contraceptives		
Infusion Therapy	Your cost sharing is based on the	Your cost sharing is based on the
Administered in the home or	type of service and where it is	type of service and where it is
physician's office	performed	performed
Infusion Therapy	Your cost sharing is based on the	Your cost sharing is based on the
Administered in an outpatient hospital	type of service and where it is	type of service and where it is
department or freestanding facility	performed	performed
Vision Eyewear	Not Covered	Not Covered
	40%; after \$500 copay; after	50%; after deductible
Transplants		
	40%; after \$500 copay; after	
	40%; after \$500 copay; after deductible	50%; after deductible
Transplants	40%; after \$500 copay; after deductible Preferred coverage is provided at an	50%; after deductible Non-Preferred coverage is provided
Transplants Bariatric Surgery	40%; after \$500 copay; after deductible Preferred coverage is provided at an IOE contracted facility only. Not Covered	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility. Not Covered
Transplants	40%; after \$500 copay; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility. Not Covered
Transplants Bariatric Surgery Out of Area Dependents	40%; after \$500 copay; after deductible Preferred coverage is provided at an IOE contracted facility only. Not Covered Coverage provided at the non-preferre	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility. Not Covered
Transplants Bariatric Surgery Out of Area Dependents FAMILY PLANNING	40%; after \$500 copay; after deductible Preferred coverage is provided at an IOE contracted facility only. Not Covered Coverage provided at the non-preferre provider is not available. IN-NETWORK	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility. Not Covered d benefit level of the plan if in-network
Transplants Bariatric Surgery Out of Area Dependents	40%; after \$500 copay; after deductible Preferred coverage is provided at an IOE contracted facility only. Not Covered Coverage provided at the non-preferre provider is not available.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility. Not Covered d benefit level of the plan if in-network

Diagnosis and treatment of the underlying medical condition only.



Comprehensive Infertility Services Artificial insemination and ovulation ind	Not Covered uction	Not Covered
Advanced Reproductive	Not Covered	Not Covered
Technology (ART)		
n-vitro fertilization (IVF), zvoote intrafa	llopian transfer (ZIFT), gamete intrafalle	opian transfer (GIFT), cryopreserved
	rm injection (ICSI), or ovum microsurge	
Vasectomy	Covered 100%; after deductible	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		· · · · · · · · · · · · · · · · · · ·
Retail	\$10 copay	20% of submitted cost; after
	+	applicable copay
90 Day Retail	\$30 copay	
Mail Order	\$20 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	\$40 copay	20% of submitted cost; after
	+ ·····	applicable copay
90 Day Retail	\$120 copay	
Mail Order	\$80 copay	Not Applicable
Non-Preferred Generic and Brand-Na		
Retail	\$80 copay	20% of submitted cost; after
	*** **F+J	applicable copay
90 Day Retail	\$240 copay	
Mail Order	\$160 copay	Not Applicable
Pharmacy Day Supply and Requirem		
Retail	Up to a 30 day supply from Aetna Sta	ndard National Network
Mail Order	Up to a 31-90 day supply from Aetna	
Value Plus Specialty	Up to a 30 day supply from Aetna Sp	
value i lue opeolally		ecialty pharmacy. Subsequent fills mus
	be through our preferred specialty ph	
Choose Generics - If the member or t	he physician requests brand when gen	eric is available, the member pays the
applicable conaviolus the difference be	tween the generic price and the brand	price.
Plan Includes: Diabetic supplies and (Contraceptive drugs and devices obtain	able from a pharmacy.
	ations are covered when filled with a pr	
Oral chemotherapy drugs covered 100		
Value Plus Pre-certification included	<i>,</i> ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Value Plus Step Therapy included		
Seasonal Vaccinations covered 100%	in-network	
Preventive Vaccinations covered 100%		
One transition fill allowed within 90 day		
Affordable Care Act mandated female	contraceptives and preventive medicati	ons covered 100% in-network
GENERAL PROVISIONS	contracoptives and proventive medical	
Dependents Eligibility	Spouse, children from birth to age 26	regardless of student status



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.

- · Cosmetic surgery, including breast reduction.
- · Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

Home births

• Immunizations for travel or work, except where medically necessary or indicated.

• Implantable drugs and certain injectable drugs including injectable infertility drugs.

• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.

- · Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.

• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.

- Radial keratotomy or related procedures.
- · Reversal of sterilization.

• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.

- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at 1-888-982-3862.

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al 1-888-982-3862.

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to www.aetna.com. © 2014 Aetna Inc.



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Plan Open Access MC 3 HRA

School District of Hendry County Effective Date: 01-01-2021 Aetna HealthFund[™] Open Access[®] Managed Choice[®] POS - Florida

FUND FEATURES		
HealthFund Amount	\$1,500 Employee	
Amount contributed to the Fund by the		
		ceived may be prorated based on your effective
date of coverage.		
	es to all family members com	bined. There is no Individual HealthFund limit
within the Family HealthFund amount.		
Fund Coinsurance	100%	
Percentage at which the Fund will reir		
Fund Administration		ay for your member responsibility, including your
		e. Once the deductible is met, the underlying
		erage and if a Fund balance still exists, the Fund
		onsibility (i.e. your share of coinsurance) until the
		as been reached or the Fund has been exhausted, rvices covered at 100% with no deductible will be
	paid by the plan and not b	
Employee Termination from Your		benefit amount is forfeited (or terminated) when
HealthFund Fund Rollover	the employee's HealthFun	
Fund Rollover		benefit amount at end of the plan year is rolled
	over into next year's Healt	
Eligible Fund Expenses		es as the medical plan. Expenses above the
		limit, any plan limits, and any non covered
		or reimbursement under the Fund.
Fund Payment/Assignment	Network Providers: Automatic Assignment to provider.	
		lember may assign payment to provider.
Pro-ration for New Employees	Monthly	
Pro-ration for Family Status	No pro-ration. Change to	new tier based on new employee status.
Change		
Prescription Drug Plan		es are integrated with the medical plan (i.e., subject
		applied towards the medical Out-of-Pocket Limit)
·		gible for reimbursement from the Fund).
PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	\$5,000 Individual	\$15,000 Individual
	\$10,000 Family	\$30,000 Family
All covered expenses accumulate sep		
Unless otherwise indicated, the deduc		
		are excluded from charges to meet the Deductible.
Pharmacy expenses apply towards the		
		bers. The family Deductible can be met by a
	ver, no single individual withi	n the family will be subject to more than the
individual Deductible amount.		
Member Coinsurance	50%	50%
Applies to all expenses unless otherw	ise stated.	
Payment Limit (per calendar year)	\$6,250 Individual	\$20,000 Individual
	\$12,500 Family	\$40,000 Family
All covered expenses accumulate sep		



School District of Hendry County Effective Date: 01-01-2021 Aetna HealthFund[™] Open Access[®] Managed Choice[®] POS - Florida

PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Certain member cost sharing elements may not apply toward the Payment Limit.

Pharmacy expenses apply towards the Payment Limit.

Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit.

The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.

Lifetime Maximum

Unlimited except where otherwise indicated.

Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable

Certification Requirements -

Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is \$400 per occurrence.

Referral Requirement			
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK	
Routine Adult Physical Exams/	Covered 100%; deductible waived	50%; after deductible	
Immunizations			
1 exam every 12 months for member	s age 22 to age 65; 1 exam every 12 mo	nths for adults age 65 and older.	
Routine Well Child	Covered 100%; deductible waived	50%; deductible waived	
Exams/Immunizations			
7 exams in the first 12 months of life,	3 exams in the second 12 months of life	, 3 exams in the third 12 months of life, 1	
exam per 12 months thereafter to ag	e 22.		
Routine Gynecological Care	Covered 100%; deductible waived	50%; after deductible	
Exams			
1 obgyn exam and pap smear per ca			
Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived	
Nomen's Health	Covered 100%; deductible waived	50%; after deductible	
	abetes, HPV (Human- Papillomavirus) D		
	d screening for human immunodeficiency		
	breastfeeding support, supplies and cou		
Contraceptive methods, sterilization	procedures, patient education and counse	eling. Limitations may apply.	
Routine Digital Rectal Exam	Covered 100%; deductible waived	50%; after deductible	
Recommended: For covered males a	ge 40 and over.		
Prostate-specific Antigen Test		50%; after deductible	
Recommended: For covered males a	ge 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived	
Recommended: For all members age	e 50 and over.		
Routine Eye Exams	Covered 100%; deductible waived	50%; after deductible	
1 routine exam per 24 months.			
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible	
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK	
Office Visits to PCP	50%; after deductible	50%; after deductible	
Includes services of an internist, gen	eral physician, family practitioner or pedia	atrician.	

Includes services of an internist, general physician, family practitioner or pediatrician.



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Specialist Office Visits	50%; after deductible	50%; after deductible
Hearing Exams	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
,	performed	performed
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	50%; after deductible	50%; after deductible
Walk-in Clinics are network, free-stan	ding health care facilities. They are an a	alternative to a physician's office visit for
	ency illnesses and injuries and the admi	
	n services or the ongoing care provided l	
	of a hospital, shall be considered a Walk	
Allergy Testing	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
Allergy Injections	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
DIAGNOSTIC PROCEDURES	performed IN-NETWORK	performed OUT-OF-NETWORK
Diagnostic X-ray	50%; after deductible	50%; after deductible
	office visit and billed by the physician, ex	
applicable physician's office visit men		penaes are covered subject to the
Diagnostic Laboratory	50%; after deductible	50%; after deductible
	office visit and billed by the physician, ex	
applicable physician's office visit men		
Diagnostic Outpatient Complex	50%; after deductible	50%; after deductible
Imaging		····
EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Provider	50%; after deductible	50%; after deductible
Non-Urgent Use of Urgent Care	Not Covered	Not Covered
Provider		
Emergency Room	50%; after deductible	Same as in-network care
Non-Emergency Care in an	Not Covered	Not Covered
Emergency Room		
Emergency Use of Ambulance	50%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance		Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	50%; after \$500 copay per	50%; after \$500 copay per
	admission; after deductible	admission; after deductible
Your cost sharing applies to all cover	ed benefits incurred during your inpatien	t stay
Inpatient Maternity Coverage	50%; after \$500 copay per	50%; after \$500 copay per
(includes delivery and postpartum care)	admission; after deductible	admission; after deductible
	ed benefits incurred during your inpatien	t stay.
Outpatient Hospital Expenses	50%; after \$250 copay; after	50%; after \$250 copay; after
• • • • • • • • • •	deductible	deductible
Your cost sharing applies to all cover	ed benefits incurred during your outpatie	
Outpatient Surgery - Hospital	50%; after \$250 copay; after	50%; after \$250 copay; after
	deductible	deductible
Your cost sharing applies to all cover	ed benefits incurred during your outpatie	nt visit.

Your cost sharing applies to all covered benefits incurred during your outpatient visit.

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Outpatient Surgery - Freestanding	50%; after deductible	50%; after deductible
Facility Your cost sharing applies to all covere	d honofite incurred during your o	utratiant visit
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	50%; after \$500 copay per	50%; after \$500 copay per
Inpatient	admission; after deductible	admission; after deductible
	-	-
Your cost sharing applies to all covered		
Mental Health Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered		
Other Mental Health Services	50%; after deductible	50%; after deductible
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	50%; after \$500 copay per	50%; after \$500 copay per
	admission; after deductible	admission; after deductible
Your cost sharing applies to all covered		
Residential Treatment Facility	50%; after \$500 copay per	50%; after \$500 copay per
	admission; after deductible	admission; after deductible
Substance Abuse Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered	d benefits incurred during your o	utpatient visit.
Other Substance Abuse Services	50%; after deductible	50%; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility	50%; after deductible	50%; after deductible
Limited to 60 days per calendar year.		
Your cost sharing applies to all covered	d benefits incurred during your in	ipatient stay.
Home Health Care	50%; after deductible	50%; after deductible
Limited to 60 visits per calendar year.		
Coverage includes nutritional counselin		
Each visit by a nurse or therapist is one		
Hospice Care - Inpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered		
Hospice Care - Outpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered		
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	50%; after deductible	50%; after deductible
Limited to 20 visits per calendar year.		
Outpatient Short-Term	50%; after deductible	50%; after deductible
Rehabilitation		
Includes Speech Physical and Occur	ational Thorany, limited to 20 vie	ite nor thorany nor calendar year

Includes Speech, Physical, and Occupational Therapy, limited to 20 visits per therapy per calendar year.

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Refer to MBH Outpatient Mental Health Mental Health benefit Refer to MBH Outpatient Mental Health Other Services Mental Health Other Services benefit 50%; after deductible 50%; after deductible 50%; after deductible 50%; after deductible Covered same as any other medical expense.	Refer to MBH Outpatient Mental Health Refer to MBH Outpatient Mental Health Other Services 50%; after deductible 50%; after deductible 50%; after deductible 50%; after deductible Covered same as any other medical expense.	
Refer to MBH Outpatient Mental Health Other Services Mental Health Other Services benefit 50%; after deductible 50%; after deductible 50%; after deductible 50%; after deductible Covered same as any other medical expense.	Health Other Services 50%; after deductible 50%; after deductible 50%; after deductible 50%; after deductible Covered same as any other medical expense.	
Health Other Services Mental Health Other Services benefit 50%; after deductible 50%; after deductible 50%; after deductible 50%; after deductible Covered same as any other medical expense.	Health Other Services 50%; after deductible 50%; after deductible 50%; after deductible 50%; after deductible Covered same as any other medical expense.	
50%; after deductible 50%; after deductible 50%; after deductible 50%; after deductible Covered same as any other medical expense.	50%; after deductible 50%; after deductible 50%; after deductible Covered same as any other medical expense.	
50%; after deductible 50%; after deductible 50%; after deductible Covered same as any other medical expense.	50%; after deductible 50%; after deductible 50%; after deductible Covered same as any other medical expense.	
50%; after deductible 50%; after deductible Covered same as any other medical expense.	50%; after deductible 50%; after deductible Covered same as any other medical expense.	
50%; after deductible Covered same as any other medical expense.	50%; after deductible Covered same as any other medical expense.	
Covered same as any other medical expense.	Covered same as any other medical expense.	
expense.	expense.	
Couperad 1000/ dadustible mained		
Covered 100%; deductible waived	Covered same as any other expense	
Covered 100%; deductible waived	Covered same as any other expense	
50%; after deductible	50%; after deductible	
50%; after deductible	50%; after deductible	
	Not Covered	
	50%; after deductible	
	Non-Preferred coverage is provid	
	at a Non-IOE facility.	
	Not Covered	
Coverage provided at the non-preferred benefit level of the plan if in-neprovider is not available.		
IN-NETWORK	OUT-OF-NETWORK	
Your cost sharing is based on the	Your cost sharing is based on the	
type of service and where it is	type of service and where it is	
performed	performed	
ng medical condition only.		
Not Covered	Not Covered	
	Not Covered	
lopian transfer (ZIFT), gamete intrafallop m injection (ICSI), or ovum microsurgery		
	50%; after deductible	
	50%; after deductible	
	50%; after deductible 50%; after deductible Not Covered 50%; after deductible Preferred coverage is provided at an IOE contracted facility only. Not Covered Coverage provided at the non-preferrec provider is not available. IN-NETWORK Your cost sharing is based on the type of service and where it is performed ng medical condition only. Not Covered Interference Not Covered Interference Int	



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PHARMACY	IN-NETWORK	OUT-OF-NETWORK	
The full cost of the drug is applied to th	e deductible before any benefits	are considered for payment under the	
pharmacy plan.			
Pharmacy Plan Type	Aetna Value Plus Open Formul	ary	
Preferred Generic Drugs			
Retail	\$10 copay	\$10 copay	
90 Day Retail	\$30 copay		
Mail Order	\$25 copay	Not Covered	
Preferred Brand-Name Drugs			
Retail	\$30 copay	\$30 copay	
90 Day Retail	\$90 copay		
Mail Order	\$75 copay	Not Covered	
Non-Preferred Generic and Brand-Na	ime Drugs		
Retail	\$50 copay	\$50 copay	
90 Day Retail	\$150 copay		
Mail Order	\$125 copay	Not Covered	
Pharmacy Day Supply and Requirem	ents		
Retail	Up to a 30 day supply from Aetna Standard National Network		
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.		
Value Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network.		
		I or specialty pharmacy. Subsequent fills must	
	be through our preferred specia		
		n generic is available, the member pays the	
applicable copay plus the difference be			
Plan Includes: Diabetic supplies and C			
A limited list of over-the-counter medica	itions are covered when filled wit	th a prescription.	
Oral chemotherapy drugs covered 100°	6		
Value Plus Pre-certification included			
Value Plus Step Therapy included			
Seasonal Vaccinations covered 100% i			
Preventive Vaccinations covered 100%			
One transition fill allowed within 90 day			
Affordable Care Act mandated female of	contraceptives and preventive me	edications covered 100% in-network.	
GENERAL PROVISIONS			
Dependents Eligibility	Spouse, children from birth to a	ge 26 regardless of student status.	

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.



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Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

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• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.

- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

Home births

• Immunizations for travel or work, except where medically necessary or indicated.

• Implantable drugs and certain injectable drugs including injectable infertility drugs.

· Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT,

ICSI and other related services, unless specifically listed as covered in your plan documents.

- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.

• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.

• Radial keratotomy or related procedures.

Reversal of sterilization.

· Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or

- prescription drugs.
- · Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at 1-888-982-3862.

Puede estar disponible la traduccion de este material en otro idloma. Por favor llame a Servicios al Miembro al 1-888-982-3862.

Plan features and availability may vary by location and group size. For more information about Aetna plans, refer to **www.aetna.com**. © 2014 Aetna Inc.



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PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

	IN NETWORK	
PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	\$5,000 Individual	\$15,000 Individual
	\$10,000 Family	\$30,000 Family
	arately toward the preferred or non-pref	
	tible must be met prior to benefits being	
		ed from charges to meet the Deductible.
Pharmacy expenses apply towards the	Deductible for all family members. The f	iomily Doductible can be mot by a
	ver, no single individual within the family	
individual Deductible amount.	ver, no single individual within the family	will be subject to more than the
Member Coinsurance	50%	50%
Applies to all expenses unless otherwi		50 /8
Payment Limit (per calendar year)	\$6,250 Individual	\$20,000 Individual
rayment Linnt (per calendar year)	\$12,500 Family	\$40,000 Family
All covered expenses accumulate con	arately toward the preferred or non-pref	
	s may not apply toward the Payment Lin	
Pharmacy expenses apply towards the		int.
		ce percentage, copays, and deductibles
(except any penalty amounts) may be		ce percentage, copays, and deductibles
		s. The family Payment Limit can be met
	nowever, no single individual within the f	
individual Payment Limit amount.	lowever, no single individual within the i	
Lifetime Maximum		
Unlimited except where otherwise indi	cated	
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare
		Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -		
	referred care must be obtained to avoid	a reduction in benefits paid for that
	ons, Treatment Facility Admissions, Co	
		nount applied separately to each type of
expense is \$400 per occurrence.	, , , , , , , , , , , , , , , , , , , ,	
Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/	Covered 100%; deductible waived	50%; after deductible
Immunizations		
1 exam every 12 months for members	age 22 to age 65; 1 exam every 12 mo	nths for adults age 65 and older.
Routine Well Child	Covered 100%; deductible waived	50%; deductible waived
Exams/Immunizations		terrereleven en en 1950 - en 1950 de la 1950
7 exams in the first 12 months of life, 3	exams in the second 12 months of life,	, 3 exams in the third 12 months of life, 1
exam per 12 months thereafter to age		
Routine Gynecological Care	Covered 100%; deductible waived	50%; after deductible
Exams		
1 obove even and pap smear per cale	ndar voar	

1 obgyn exam and pap smear per calendar year



Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	50%; after deductible
Includes: Screening for gestational d	iabetes, HPV (Human- Papillomavirus) D	NA testing, counseling for sexually
transmitted infections, counseling an	d screening for human immunodeficiency	virus, screening and counseling for
	breastfeeding support, supplies and cou	
Contraceptive methods, sterilization	procedures, patient education and couns	eling. Limitations may apply.
Routine Digital Rectal Exam	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males a	ige 40 and over.	
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males a	ige 40 and over.	
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For all members age	e 50 and over.	
Routine Eye Exams	Covered 100%; deductible waived	50%; after deductible
1 routine exam per 24 months.		
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to PCP	50%; after deductible	50%; after deductible
Includes services of an internist, gen	eral physician, family practitioner or pedia	atrician.
Specialist Office Visits	50%; after deductible	50%; after deductible
Hearing Exams	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	in a sufficience and	performed
	performed	penonneu
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Pre-Natal Maternity Walk-in Clinics		
Walk-in Clinics	Covered 100%; deductible waived	50%; after deductible 50%; after deductible
Walk-in Clinics Walk-in Clinics are network, free-star	Covered 100%; deductible waived 50%; after deductible	50%; after deductible 50%; after deductible alternative to a physician's office visit for
Walk-in Clinics Walk-in Clinics are network, free-star treatment of unscheduled, non-emery not an alternative for emergency room	Covered 100%; deductible waived 50%; after deductible nding health care facilities. They are an a gency illnesses and injuries and the admi n services or the ongoing care provided l	50%; after deductible 50%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency
Walk-in Clinics Walk-in Clinics are network, free-star treatment of unscheduled, non-emery not an alternative for emergency roor room, nor the outpatient department	Covered 100%; deductible waived 50%; after deductible nding health care facilities. They are an a gency illnesses and injuries and the admi m services or the ongoing care provided l of a hospital, shall be considered a Walk-	50%; after deductible 50%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic.
Walk-in Clinics Walk-in Clinics are network, free-star treatment of unscheduled, non-emery not an alternative for emergency room	Covered 100%; deductible waived 50%; after deductible nding health care facilities. They are an a gency illnesses and injuries and the admi m services or the ongoing care provided l of a hospital, shall be considered a Walk- Your cost sharing is based on the	50%; after deductible 50%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the
Walk-in Clinics Walk-in Clinics are network, free-star treatment of unscheduled, non-emery not an alternative for emergency roor room, nor the outpatient department	Covered 100%; deductible waived 50%; after deductible nding health care facilities. They are an a gency illnesses and injuries and the admi m services or the ongoing care provided l of a hospital, shall be considered a Walk-	50%; after deductible 50%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is
Walk-in Clinics Walk-in Clinics are network, free-star treatment of unscheduled, non-emer not an alternative for emergency roor room, nor the outpatient department Allergy Testing	Covered 100%; deductible waived 50%; after deductible nding health care facilities. They are an a gency illnesses and injuries and the admi m services or the ongoing care provided I of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed	50%; after deductible 50%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed
Walk-in Clinics Walk-in Clinics are network, free-star treatment of unscheduled, non-emery not an alternative for emergency roor room, nor the outpatient department	Covered 100%; deductible waived 50%; after deductible nding health care facilities. They are an a gency illnesses and injuries and the admi m services or the ongoing care provided l of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the	50%; after deductible 50%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is
Walk-in Clinics Walk-in Clinics are network, free-star treatment of unscheduled, non-emer not an alternative for emergency roor room, nor the outpatient department Allergy Testing	Covered 100%; deductible waived 50%; after deductible nding health care facilities. They are an a gency illnesses and injuries and the admi m services or the ongoing care provided I of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed	50%; after deductible 50%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency in Clinic. Your cost sharing is based on the type of service and where it is performed
Walk-in Clinics Walk-in Clinics are network, free-star treatment of unscheduled, non-emer not an alternative for emergency roor room, nor the outpatient department Allergy Testing	Covered 100%; deductible waived 50%; after deductible nding health care facilities. They are an a gency illnesses and injuries and the admi m services or the ongoing care provided l of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the	50%; after deductible 50%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency -in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the
Walk-in Clinics Walk-in Clinics are network, free-star treatment of unscheduled, non-emer not an alternative for emergency roor room, nor the outpatient department Allergy Testing	Covered 100%; deductible waived 50%; after deductible nding health care facilities. They are an a gency illnesses and injuries and the admi m services or the ongoing care provided l of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is	50%; after deductible 50%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency -in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is
Walk-in Clinics Walk-in Clinics are network, free-star treatment of unscheduled, non-emery not an alternative for emergency roor room, nor the outpatient department Allergy Testing Allergy Injections	Covered 100%; deductible waived 50%; after deductible nding health care facilities. They are an a gency illnesses and injuries and the admi m services or the ongoing care provided I of a hospital, shall be considered a Walk- Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed	50%; after deductible 50%; after deductible alternative to a physician's office visit for inistration of certain immunizations. It is by a physician. Neither an emergency -in Clinic. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed
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PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

Emergency Room	50%; after deductible	Same as in-network care
Non-Emergency Care in an	Not Covered	Not Covered
Emergency Room		
Emergency Use of Ambulance	50%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	50%; after \$500 copay per	50%; after \$500 copay per
	admission; after deductible	admission; after deductible
Your cost sharing applies to all covered	benefits incurred during your inpatient	
Inpatient Maternity Coverage	50%; after \$500 copay per	50%; after \$500 copay per
(includes delivery and postpartum care)	admission; after deductible	admission; after deductible
	benefits incurred during your inpatient	
Outpatient Hospital Expenses	50%; after \$250 copay; after deductible	50%; after \$250 copay; after deductible
Your cost sharing applies to all covered		nt visit.
Outpatient Surgery - Hospital	50%; after \$250 copay; after	50%; after \$250 copay; after
	deductible	deductible
	benefits incurred during your outpatie	
Outpatient Surgery - Freestanding Facility	50%; after deductible	50%; after deductible
	benefits incurred during your outpatie	
MENTAL HEALTH SERVICES		
Inpatient	50%; after \$500 copay per	50%; after \$500 copay per
	admission; after deductible	admission; after deductible
	t benefits incurred during your inpatient	i stay.
Mental Health Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered	50%; after deductible	50%; after deductible
Other Mental Health Services SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	50%; after \$500 copay per	50%; after \$500 copay per
mpatient	admission; after deductible	admission; after deductible
Martin Carlo and Brack all and and	-	
	benefits incurred during your inpatient	
Residential Treatment Facility	50%; after \$500 copay per	50%; after \$500 copay per
	admission; after deductible	admission; after deductible
Substance Abuse Office Visits	50%; after deductible	50%; after deductible
	d benefits incurred during your outpatie	nt Visit.
Other Substance Abuse Services	50%; after deductible	50%; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility	50%; after deductible	50%; after deductible
Limited to 60 days per calendar year.	d honofite incurred during your innetion	tetav
	d benefits incurred during your inpatient 50%; after deductible	50%; after deductible
Hama Haalth ('ara		
Home Health Care		
Limited to 60 visits per calendar year.	ng and services of a medical social wor	

Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

Hospice Care - Inpatient	50%; after deductible	50%; after deductible	
	d benefits incurred during your inpatient s		
Hospice Care - Outpatient	50%; after deductible	50%; after deductible	
	d benefits incurred during your outpatient		
Private Duty Nursing - Outpatient	Not Covered	Not Covered	
Spinal Manipulation Therapy	50%; after deductible	50%; after deductible	
Limited to 20 visits per calendar year.			
Outpatient Short-Term	50%; after deductible	50%; after deductible	
Rehabilitation			
Includes Speech, Physical, and Occup	ational Therapy, limited to 20 visits per th	herapy per calendar year.	
Autism Behavioral Therapy	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental	
	Health	Health	
Covered same as any other Outpatient	Mental Health benefit		
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental	Refer to MBH Outpatient Mental	
-	Health Other Services	Health Other Services	
Covered same as any other Outpatient	Mental Health Other Services benefit		
Autism Physical Therapy	50%; after deductible	50%; after deductible	
Autism Occupational Therapy	50%; after deductible	50%; after deductible	
Autism Speech Therapy	50%; after deductible	50%; after deductible	
Durable Medical Equipment	50%; after deductible	50%; after deductible	
Diabetic Supplies (if not covered	Covered same as any other medical	Covered same as any other medical	
under Pharmacy benefit)	expense.	expense.	
Women's Contraceptive drugs and	Covered 100%; deductible waived	Covered same as any other expense	
devices not obtainable at a	·	, , , , , , , , , , , , , , , , , , ,	
pharmacy			
Affordable Care Act mandated	Covered 100%; deductible waived	Covered same as any other expense	
Women's Contraceptives	·	, , , , , , , , , , , , , , , , , , ,	
Infusion Therapy	50%; after deductible	50%; after deductible	
Administered in the home or	· · · · , · · · · · · · · · · · · · · · · · · ·		
physician's office			
Infusion Therapy	50%; after deductible	50%; after deductible	
Administered in an outpatient hospital	,	· · · · · · · · · · · · · · · · · · ·	
department or freestanding facility			
Vision Eyewear	Not Covered	Not Covered	
Transplants	50%; after deductible	50%; after deductible	
•	Preferred coverage is provided at an	Non-Preferred coverage is provided	
	IOE contracted facility only.	at a Non-IOE facility.	
Bariatric Surgery	Not Covered	Not Covered	
Out of Area Dependents	Coverage provided at the non-preferred		
	provider is not available.	a second for or and plan in an indework	
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK	
Infertility Treatment	Your cost sharing is based on the	Your cost sharing is based on the	
		type of service and where it is	
	performed	performed	
Diagnosis and treatment of the underly		perormeu	

Diagnosis and treatment of the underlying medical condition only.

ς.



Comprehensive Infertility Services Artificial insemination and ovulation ind	Not Covered	Not Covered
Advanced Reproductive	Not Covered	Not Covered
Technology (ART)		101 0010,00
	llopian transfer (ZIFT), gamete intrafallo	ppian transfer (GIFT), cryopreserved
	rm injection (ICSI), or ovum microsurge	
Vasectomy	Your cost sharing is based on the	50%; after deductible
	type of service and where it is	
	performed	
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	IN-NETWORK	OUT-OF-NETWORK
	e deductible before any benefits are co	
pharmacy plan.		
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	\$10 copay	\$10 copay
90 Day Retail	\$30 copay	
Mail Order	\$25 copay	Not Covered
Preferred Brand-Name Drugs	aan oo ahaa ahaa ahaa ahaa ahaa ahaa aha	
Retail	\$30 copay	\$30 copay
90 Day Retail	\$90 copay	
Mail Order	\$75 copay	Not Covered
Non-Preferred Generic and Brand-Na	ame Drugs	
Retail	\$50 copay	\$50 copay
90 Day Retail	\$150 copay	
Mail Order	\$125 copay	Not Covered
Pharmacy Day Supply and Requiren		
Retail	Up to a 30 day supply from Aetna Sta	
Mail Order	Up to a 31-90 day supply from Aetna	
Value Plus Specialty	Up to a 30 day supply from Aetna Spe	
		ecialty pharmacy. Subsequent fills mus
	be through our preferred specialty pha	
	he physician requests brand when gene	
	tween the generic price and the brand	
	Contraceptive drugs and devices obtain	
	ations are covered when filled with a pr	escription.
Oral chemotherapy drugs covered 100	%	
Value Plus Pre-certification included		
Value Plus Step Therapy included	the second se	
Seasonal Vaccinations covered 100%		
Preventive Vaccinations covered 100%		
One transition fill allowed within 90 day		one powered 100% is notwork
	contraceptives and preventive medicati	ons covered 100% In-network.
GENERAL PROVISIONS	On surger schildness from blidte to surge OO	regardlage of student status
Dependents Eligibility	Spouse, children from birth to age 26	regardless of student status.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.

- · Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

Home births

· Immunizations for travel or work, except where medically necessary or indicated.

• Implantable drugs and certain injectable drugs including injectable infertility drugs.

• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.

· Long-term rehabilitation therapy.

• Non-medically necessary services or supplies.

• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.

• Radial keratotomy or related procedures.

Reversal of sterilization.

• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.

Special duty nursing.

• Therapy or rehabilitation other than those listed as covered.

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at 1-888-982-3862.

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

Plan features and availability may vary by location and group size. For more information about Aetna plans, refer to **www.aetna.com**.

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Medical Plans

QUALIFYING EVENTS

HOME I'M NEW BUNEFITS -

HENDRY COUNTY DISTRICT SCHOOLS Employee Benefits Center (EBC)

RETIREMENT HOW TO ENROLL

your Hendry County Pocketpal to find answers to all of your benefit questions.

RETIREE BENEFITS

The information included in this portal is a high-level summary of common benefits. For more details about your plans, please refer to your Plan Document, Summary Plan Description or Certificate of Insurance Coverage. The information in those formal plan documents governs.



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2022 Plan Documents

HENDRY DISTRICT SCHOOL BOARD Aetna and Other Benefit Rates Calendar Year 2022 Aetna PREMIUMS (For Period January 1 through December 31, 2022)

Employees	Aenta	Aetna	Aetna
Employeee	CY 2022	CY 2022	CY 2022
	24 PAY	21 PAY	Annual
	Per Pay	Per Pay	Cost
FAMILY HEALTH INSURANCE COVERAGE		Гентау	0031
Open Access MC 1		• -	
Employee	\$0	\$0	\$0
Employee-Spouse	\$475	\$543	\$11,395
Employee-Children	\$396	\$452	\$9,496
Family	\$712	\$814	\$17,092
Both spouses work for District (Family)	\$317	\$362	\$7,597
Open Access MC 2			
	\$0	\$0	\$0
Employee Employee-Spouse	\$305	\$349	\$7,319
	\$241	\$276	\$5,790
Employee-Children	\$496	\$567	\$11,905
Family Both spouses work for District (Family)	\$100	\$115	\$2,409
Both spouses work for District (Farmy)	<i>φ</i>100		<i>\</i>
Open Access MC3 HRA/HSA			
Employee (HRA)	\$0	\$0	\$0
Employee-Spouse (Health Savings Plan)	\$188	\$214	\$4,503
Employee-Children (Health Savings Plan	\$135	\$154	\$3,230
Family (Health Savings Plan)	\$347	\$396	\$8,321
Both spouses work for District (Family) (Health Savings Plan)	\$0	\$0	\$0
DENTAL, LIFE INSURANCE, DISABILITY			
Employee	\$0	\$0	\$0
Employee-Family	\$9	\$10	\$216
EMPLOYEE LIFE INSURANCE	\$0	\$0	\$0

Employees may purchase family dental insurance, spouse or children life insurance, additional life insurance on themselves, or additional disability insurance at their own expense.

\$9,0000 Board Benefit Contribution Maximum Per Employee Benefit for dental and life insurance is \$612 Per Employee

Aetna Retiree Premium Rates RATE FOR CALENDAR YEAR 2022 (For Period January 1 through December 31, 2022)

If retiree chooses to remain on one of the District's Aetna Health Care Plans the retiree pays the FULL cost.

A descision to elect retiree benefits must be made within 30 working days prior to retirement. Failure to respond to enrollment indicates a refusal of coverage. Once a benefit is refused or not elected it cannot be reinstated at a later date. Upon retirement you cannot change or switch medical plan coverage. You are given the oportunity to change plan coverage during the District's annual Open Enrollment period

Retirees

	2022	2022
FAMILY HEALTH INSURANCE COVERAGE	Per Month	Annual
	[]	
Or an Assess Dian 1		
Open Access Plan 1	\$791.32	\$9,495.84
Retiree	\$1,740.91	\$20,890.92
Retiree-Spouse	\$1,582.64	\$18,991.68
Retiree-Children	\$2,215.69	\$26,588.28
Family	\$2,215.05	φ20,000.20
Open Access Plan 2		
Retiree	\$636.90	\$7,642.80
Retiree-Spouse	\$1,401.26	\$16,815.12
Retiree-Children	\$1,273.86	\$15,286.32
Family	\$1,783.40	\$21,400.80
Oner Asses Plan 2 HPA Only No Card Issued		
Open Acces Plan 3 HRA Only - No Card Issued Retiree	\$530.24	\$6,362.88
Retiree-Spouse	\$1,166.57	\$13,998.84
Retiree-Children	\$1,060.51	\$12,726.12
Family	\$1,484.72	\$17,816.64
DENTAL		
Employee	\$7	\$84
Employee-Family	\$27	\$324
RETIREE LIFE INSURANCE		
Can be purchased at the age based negotiated rate for retirees. Retiree pays full	Age Based	Age Based

Can be purchased at the age based negotiated rate for retirees. Retiree pays tuil cost for life insurance.



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School Board of Hendry County Florida Effective Date: 01-01-2022 Open Access[®] Managed Choice[®] POS - Florida

PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

	IN-NETWORK	OUT-OF-NETWORK
PLAN FEATURES	IN-NET WORK	sit, day, or dollar limitation on a per
(ear basis the benefit year begins on .	anuary 1st unless otherwise mandated. F	Refer to your plan documents for more
nformation.		
Deductible (per calendar year)	\$2,000 Individual	\$4,000 Individual
	\$4,000 Family	\$8,000 Family
M covered expenses accumulate sepa	arately toward the in-network and out-of-n	etwork Deductible.
Inloss otherwise indicated the deduct	tible must be met prior to benefits being p	ayable.
Jomber cost sharing for certain service	es, as indicated in the plan, are excluded	from charges to meet the Deductible.
Pharmacy expenses do not apply towa	irds the Deductible.	a man a state in the second by a
		mily Deductible can be met by a
combination of family members; howey	ver, no single individual within the family v	will be subject to more than the
ndividual Deductible amount.		
Member Coinsurance	Covered 100%	20%
Applies to all expenses unless otherwi		
Payment Limit (per calendar year)	\$4,000 Individual	\$9,000 Individual
	to 000 Eamily	\$18,000 Family
All severed expenses accumulate sep	arately toward the in-network or out-of-network	twork Payment Limit.
Cortain member cost sharing element	s may not apply toward the Payment Limi	t.
Pharmacy expenses apply towards the	e Pavment Limit.	1. I. de estilatas
out these out of pocket evnenses ret	sulfing from the application of comsulation	e percentage, copays, and deductibles
(except any penalty amounts) may be	used to satisfy the Payment Limit.	
The family Boymont Limit is a cumulat	tive Payment Limit for all family members	. The family Payment Limit can be me
The family Fayment Limit is a summary	however, no single individual within the fa	amily will be subject to more than the
individual Payment Limit amount.		
Lifetime Maximum		
Unlimited except where otherwise ind	icated.	
Payment for Out-of-Network Care**	Not Applicable	Professional: 105% of Medicare
Payment for Out-on-Network Care		Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Cartification Poduroments -		and the standard
Certification Requirements -	f-Network care must be obtained to avoid	a reduction in benefits paid for that
Certification for certain types of Out-o	of-Network care must be obtained to avoic sions. Treatment Facility Admissions, Cor	a reduction in benefits paid for that valescent Facility Admissions, Home
Certification for certain types of Out-o	of-Network care must be obtained to avoic sions, Treatment Facility Admissions, Cor te Duty Nursing is required - excluded an	t a reduction in benefits paid for that walescent Facility Admissions, Home nount applied separately to each type
Certification for certain types of Out-o care. Certification for Hospital Admiss Health Care, Hospice Care and Priva	of-Network care must be obtained to avoic sions, Treatment Facility Admissions, Cor te Duty Nursing is required - excluded ar	nount applied separately to each type
Certification for certain types of Out-o care. Certification for Hospital Admiss Health Care, Hospice Care and Priva expense is \$400 per occurrence.	te Duty Nursing is required - excluded an	None
Certification for certain types of Out-o care. Certification for Hospital Admiss Health Care, Hospice Care and Priva expense is \$400 per occurrence. Referral Requirement	te Duty Nursing is required - excluded an None	None
Certification for certain types of Out-o care. Certification for Hospital Admiss Health Care, Hospice Care and Priva expense is \$400 per occurrence. Referral Requirement PREVENTIVE CARE	te Duty Nursing is required - excluded an None	None
Certification for certain types of Out-o care. Certification for Hospital Admiss Health Care, Hospice Care and Priva expense is \$400 per occurrence. Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/	None None None Nove	None OUT-OF-NETWORK 20%; after deductible
Certification for certain types of Out-o care. Certification for Hospital Admiss Health Care, Hospice Care and Priva expense is \$400 per occurrence. Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/	None None None Nove	None OUT-OF-NETWORK 20%; after deductible
Certification for certain types of Out-o care. Certification for Hospital Admiss Health Care, Hospice Care and Priva expense is \$400 per occurrence. Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 6	None None None Nove	None OUT-OF-NETWORK 20%; after deductible
Certification for certain types of Out-o care. Certification for Hospital Admiss Health Care, Hospice Care and Priva expense is \$400 per occurrence. Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 6 Routine Well Child	None IN-NETWORK Covered 100%; deductible waived 5, 1 exam every 12 months age 65 and o Covered 100%; deductible waived	None OUT-OF-NETWORK 20%; after deductible Ider 20%; deductible waived
Certification for certain types of Out-o care. Certification for Hospital Admiss Health Care, Hospice Care and Priva expense is \$400 per occurrence. Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 6 Routine Well Child	None IN-NETWORK Covered 100%; deductible waived 5, 1 exam every 12 months age 65 and o Covered 100%; deductible waived	None OUT-OF-NETWORK 20%; after deductible Ider 20%; deductible waived
Certification for certain types of Out-o care. Certification for Hospital Admiss Health Care, Hospice Care and Priva expense is \$400 per occurrence. Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 6 Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13	None None None Nove	None OUT-OF-NETWORK 20%; after deductible Ider 20%; deductible waived ponths, 1 exam per 12 months thereafte
Certification for certain types of Out-o care. Certification for Hospital Admiss Health Care, Hospice Care and Priva expense is \$400 per occurrence. Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 6 Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13 to age 22.	None IN-NETWORK Covered 100%; deductible waived 5, 1 exam every 12 months age 65 and o Covered 100%; deductible waived 8th - 24th months, 3 exams 25th - 36th mo	None OUT-OF-NETWORK 20%; after deductible Ider 20%; deductible waived
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Certification for certain types of Out-o care. Certification for Hospital Admiss Health Care, Hospice Care and Priva expense is \$400 per occurrence. Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 6 Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13 to age 22. Routine Gynecological Care	None IN-NETWORK Covered 100%; deductible waived 5, 1 exam every 12 months age 65 and o Covered 100%; deductible waived 8th - 24th months, 3 exams 25th - 36th mo Covered 100%; deductible waived ar	None OUT-OF-NETWORK 20%; after deductible Ider 20%; deductible waived ponths, 1 exam per 12 months thereafte



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		20%; after deductible
Routine Mammograms	Covered 100%; deductible waived	20%; after deductible
Nomen's Health	Covered 100%; deductible waived	IA testing counseling for sexually
ncludes: Screening for gestational d	iabetes, HPV (Human- Papillomavirus) DN	virus screening and counseling for
and the distortions courseling an	a screening for numan intitutious liverous	Virua, bordoning enter et
Contraceptive methods, sterilization	procedures, patient education and counse	20%; after deductible
Routine Digital Rectal Exam	Covered 100%; deductible waived	2076, alter deddensio
Recommended: For covered males	age 40 and over.	20%; after deductible
Prostate-specific Antigen Test	Covered 100%; deductible waived	20%, alter deddenble
Recommended: For covered males	age 40 and over.	20%; after deductible
Colorectal Cancer Screening	Covered 100%; deductible waived	20%; aller deddelible
Recommended: For all members ag	e 45 and over.	Not Covered
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	20%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to Primary Care	\$25 office visit copay; deductible	20%; after deductible
Dhusisian (BCD)	waived	
Includes services of an internist. del	neral physician, family practitioner or pedia	atrician.
Specialist Office Visits	\$50 office visit copay; deductible	20%; after deductible
opuolanot ennee theme	waived	
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	20%; after deductible
Walk-in Clinics	\$25 copay; deductible waived	20%; after deductible
Walk-III Olillioo	Designated Walk-in Clinics	
	Covered 100% deductible waived	
Walk-in Clinics are free-standing he	when a realition that (a) may be located	in or with a pharmacy, drug store,
basis Urgent care centers, emerge	ency rooms, the outpatient department of a	a hospital, ambulatory surgical centers,
and physician offices are not consid	dered to be walk-in clinics.	
Allergy Testing	Your cost sharing is based on the	Your cost sharing is based on the
Allergy resulig	type of service and where it is	type of service and where it is
	performed	performed
Allergy Injections	Your cost sharing is based on the	Your cost sharing is based on the
Allergy injections	type of service and where it is	type of service and where it is
	performed; Covered 100% when an	performed
	office visit charge is not applicable.	
	IN-NETWORK	OUT-OF-NETWORK
DIAGNOSTIC PROCEDURES	Covered 100%; after deductible	20%; after deductible
Diagnostic X-ray	n office visit and billed by the physician, et	xpenses are covered subject to the
It performed as a part of a physicia	omber cost sharing	
applicable physician's office visit m		20%; after deductible
Diagnostic Laboratory	n office visit and billed by the physician, e	xpenses are covered subject to the
If performed as a part of a physicia	momor cost sharing	······································
applicable physician's office visit m	Covered 100%; after deductible	20%; after deductible
Diagnostic Outpatient Complex	Covered 100%, alter deddelible	
Imaging	an office visit and billed by the physician, e	expenses are covered subject to the
If performed as a part of a physicia	an office visit and billed by the physician, e	Aponooo alo ootoloa oabjettite ale

If performed as a part of a physician office visit and billed by the physician, exp applicable physician's office visit member cost sharing.



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Interference Strice Visit copay; deductible 20%; after deductible Non-Urgent Use of Urgent Care Not Covered Not Covered Not Covered Provider Same as in-network care Same as in-network care Don-Emergency Care in an Not Covered Not Covered Non-Emergency Care in an Not Covered Not Covered Non-Emergency Use of Ambulance Covered 100%; after deductible Same as in-network care Non-Emergency Use of Ambulance Not Covered Not Covered Non-Emergency Use of Ambulance Covered 100%; after deductible 20%; after deductible Your cost sharing applies to all covered benefits incurred during your inpatient stay. Covered 100%; after deductible 20%; after deductible Your cost sharing applies to all covered benefits incurred during your outpatient visit. Covered 100%; after deductible 20%; after deductible Your cost sharing applies to all covered benefits incurred during your outpatient visit. Covered 100%; after deductible 20%; after deductible Your cost sharing applies to all covered benefits incurred during your outpatient visit. Outpatient Machating applies to all covered benefits incurred during your outpatient visit. Your cost sharing applies to all covered benefits	EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
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Users Correct 100%: after deductible 20%; after deductible			
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Hautes Care Innationt	Covered 100%; after deductible	
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PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

	Covered 100%; after deductible	20%; after deductible
Hospice Care - Outpatient	Covered 100%, alter deductions	
Your cost sharing applies to all covered	benefits incurred during your outpatient	Not Covered
Private Duty Nursing - Outpatient	Not Covered \$25 copay; deductible waived	20%; after deductible
Spinal Manipulation Therapy	\$25 copay; deductible warved	
Limited to 20 visits per year	\$25 copay; deductible waived	20%; after deductible
Outpatient Short-Term	\$25 copay, deducinie warrow	,
Rehabilitation		
Limited to 20 visits per year.		
Includes speech, physical, occupationa	Covered 100%; deductible waived	20%; after deductible
Habilitative Physical Therapy	Covered 100%; deductible waived	20%; after deductible
Habilitative Occupational Therapy	Covered 100%; deductible waived	20%; after deductible
Habilitative Speech Therapy	Covered 100%; deductible waived	20%; after deductible
Autism Behavioral Therapy	Covered 100%; deductible waived	20/01 4101 2004
Covered same as any other Outpatient	Mental Health benefit	20%; after deductible
Autom Applied Robavior Analysis	Covered 100% deductions manage	To to the second s
Covered same as any other Outpatient	Mental Health Other Services benefit	20%; after deductible
Autism Physical Therapy	Covered 100%, deductible warrod	20%; after deductible
Autism Occupational Therapy	Covered 100%; deductible waived	20%; after deductible
Autism Speech Therapy	Covered 100%; deductible waived	20%; after deductible
Durable Medical Equipment	Covered 100%; after deductible	Covered same as any other medical
Diabetic Supplies (if not covered	Covered same as any other medical	
under Pharmacy benefit)	expense.	expense. Covered same as any other expense
Women's Contraceptive drugs and	Covered 100%; deductible waived	Covered same us any earler expense
devices not obtainable at a		
pharmacy		Covered same as any other expense
Affordable Care Act Mandated	Covered 100%; deductible waived	Covered same de dity enter enter
Women's Contraceptives	and the second second	20%; after deductible
Infusion Therapy	\$50 copay; deductible waived	2078, alter deddelolo
Administered in the home or		
physician's office	1	Your cost sharing is based on the
Infusion Therapy	Your cost sharing is based on the	type of service and where it is
Administered in an outpatient hospital	type of service and where it is	performed
department or freestanding facility	performed	Not Covered
Vision Eyewear	Not Covered	20%; after deductible
Transplants	Covered 100%; after deductible	Non-Preferred coverage is provided
	Preferred coverage is provided at an	at a Non-IOE facility.
	IOE contracted facility only.	
Bariatric Surgery	Not Covered	Not Covered
Acupuncture	\$25 copay; deductible waived	20%; after deductible
Limited to 10 visits per year		the efficiency of the plan if in natwork
Out of Area Dependents	Coverage provided at the non-prefer	red benefit level of the plan if in-networ
	provider is not available.	Western Vestern
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Your cost sharing is based on the	Your cost sharing is based on the
Interdity Freedom	type of service and where it is	type of service and where it is
	performed	performed
Diagnosis and treatment of the under		

Diagnosis and treatment of the underlying medical condition only.



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PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

Advanced Reproductive	Not Covered	Not Covered
	ation (IVF), zygote intrafallopian transfer	(ZIFT), gamete intratallopian transfer
CIET) amongenied embryo transfe	rs, intracytoplasmic sperm injection (ICS	·/ ·
Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation in		
	Covered 100%; after deductible	20%; after deductible
Vasectomy	Covered 100%; deductible waived	20%; after deductible
Tubal Ligation	IN-NETWORK	OUT-OF-NETWORK
PHARMACY	Advanced Control Plan - Aetna	
Pharmacy Plan Type	Advanced Conservation	
Preferred Generic Drugs	\$10 copay	\$10 copay
Retail	. , .	
90 Day Retail		Not Applicable
Mail Order	\$20 copay	
Preferred Brand-Name Drugs	400 eepoy	\$30 copay
Retai	· • •	And Anti-1
90 Day Retai		Not Applicable
Mail Orde	\$60 copay	110(/ pp///22/1
Non-Preferred Generic and Brand-	Name Drugs	\$50 copay
Retai		400 cobray
90 Day Retai		Not Applicable
Mail Orde		Not Applicable
Pharmacy Day Supply and Require	ements	tional Notwork
Retai		alloridi Nelwork
Mail Orde		narke Mail Service Phannacy
Specialt	y Up to a 30 day supply	a date sharmoor Subsequent fills mus
	First prescription fill at any retail or s	pecialty pharmacy. Subsequent fills mus
	be through our preferred specialty p	narmacy network.
	Advanced Control Formulary Aetna	Insured List
Choose Generics - If the member o	Advanced Control Formulary Aetra r the physician requests brand when get	
mi i i i Distratia aumpliog pp	A Contracentive officis and devices opto	
A limited list of over-the-counter med	lications are covered when filled with a p	prescription.
Oral chemotherapy drugs covered 1	00%	
Precertification and quantity limits in	cluded	
Step Therapy included		
Seasonal Vaccinations covered 100	% in-network	
Affordable Care Act mandated fema	0% In-network le contraceptives and preventive medica	ations covered 100% in-network.
GENERAL PROVISIONS		
GENERAL FROVISIONS	Spouse, children from birth to age 2	26 regardless of student status.
Dependents Eligibility	opouoor entretent to the operation	

**We cover the cost of services based on whether doctors are in noticent of whether understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

 For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

 For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.



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Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and

hospitals that are affiliated with the delivery system or physician group. The following is a list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

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• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.

- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

Hearing aids

Home births

Immunizations for travel or work, except where medically necessary or indicated.

- Implantable drugs and certain injectable drugs including injectable infertility drugs. • Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT,

ICSI and other related services, unless specifically listed as covered in your plan documents.

· Long-term rehabilitation therapy.

Non-medically necessary services or supplies.

· Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.

Radial keratotomy or related procedures.

· Reversal of sterilization.

· Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.

- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary

regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at 1-888-982-3862.

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al 1-888-982-3862.

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to www.aetna.com. Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-

branded walk-in clinics) are both within the CVS Health family.

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PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit Limitations - For any service year basis, the benefit year begins on a information.	or supply that is subject to a maximum v January 1st unless otherwise mandated	risit, day, or dollar limitation on a per . Refer to your plan documents for more
Deductible (per calendar year)	\$6,000 Individual	\$8,000 Individual
Deductions (per calendar year)	\$12,000 Family	\$16,000 Family
All covered expenses accumulate sen	arately toward the in-network and out-of-	
Unless otherwise indicated the deduc	tible must be met prior to benefits being	pavable.
Member cost sharing for certain servic	es, as indicated in the plan, are exclude	d from charges to meet the Deductible.
Pharmacy expenses do not apply towa	ards the Deductible.	-
The family Deductible is a cumulative	Deductible for all family members. The fa	amily Deductible can be met by a
combination of family members; nowe	ver, no single individual within the family	Will be subject to more than the
individual Deductible amount.	400/	50%
Member Coinsurance	40%	50%
Applies to all expenses unless otherwi	se stated.	\$10,000 Individual
Payment Limit (per calendar year)	\$6,250 Individual	\$20,000 Family
	\$12,500 Family	
All covered expenses accumulate sep	arately toward the in-network or out-of-n	etwork Payment Limit.
Certain member cost sharing element	s may not apply toward the Payment Lin	llt.
Pharmacy expenses apply towards the	e Payment Limit.	
Only those out-of-pocket expenses re-	sulting from the application of coinsurance	ce percentage, copays, and deductibles
(except any penalty amounts) may be	used to satisfy the Payment Limit.	
The family Payment Limit is a cumulat	live Payment Limit for all family member	s. The family Payment Limit can be met
by a combination of family members; I	however, no single individual within the f	amily will be subject to more than the
individual Payment Limit amount.		
Lifetime Maximum		
Unlimited except where otherwise indi Payment for Out-of-Network Care**		Professional: 105% of Medicare
Payment for Out-of-Network Care**	Not Applicable	Facility: 140% of Medicare
Payment for Out-of-Network Care** Primary Care Physician Selection		
Payment for Out-of-Network Care** Primary Care Physician Selection Certification Requirements -	Not Applicable Optional	Facility: 140% of Medicare Not Applicable
Payment for Out-of-Network Care** Primary Care Physician Selection Certification Requirements - Certification for certain types of Out-of	Not Applicable Optional f-Network care must be obtained to avoi	Facility: 140% of Medicare Not Applicable d a reduction in benefits paid for that
Payment for Out-of-Network Care** Primary Care Physician Selection Certification Requirements - Certification for certain types of Out-of care. Certification for Hospital Admiss	Not Applicable Optional f-Network care must be obtained to avoid ions. Treatment Facility Admissions, Con	Facility: 140% of Medicare Not Applicable d a reduction in benefits paid for that nyalescent Facility Admissions, Home
Payment for Out-of-Network Care** Primary Care Physician Selection Certification Requirements - Certification for certain types of Out-of care. Certification for Hospital Admiss	Not Applicable Optional f-Network care must be obtained to avoid ions. Treatment Facility Admissions, Con	Facility: 140% of Medicare Not Applicable d a reduction in benefits paid for that nyalescent Facility Admissions, Home
Payment for Out-of-Network Care** Primary Care Physician Selection Certification Requirements - Certification for certain types of Out-of care. Certification for Hospital Admiss	Not Applicable Optional f-Network care must be obtained to avoi	Facility: 140% of Medicare Not Applicable d a reduction in benefits paid for that nvalescent Facility Admissions, Home nount applied separately to each type o
Payment for Out-of-Network Care** Primary Care Physician Selection Certification Requirements - Certification for certain types of Out-of care. Certification for Hospital Admiss Health Care, Hospice Care and Privat expense is \$400 per occurrence.	Not Applicable Optional f-Network care must be obtained to avoin ions, Treatment Facility Admissions, Con the Duty Nursing is required - excluded ar None	Facility: 140% of Medicare Not Applicable d a reduction in benefits paid for that nvalescent Facility Admissions, Home nount applied separately to each type o None
Payment for Out-of-Network Care** Primary Care Physician Selection Certification Requirements - Certification for certain types of Out-of care. Certification for Hospital Admiss Health Care, Hospice Care and Privat expense is \$400 per occurrence. Referral Requirement	Not Applicable Optional f-Network care must be obtained to avoi ions, Treatment Facility Admissions, Co ie Duty Nursing is required - excluded ar	Facility: 140% of Medicare Not Applicable d a reduction in benefits paid for that nvalescent Facility Admissions, Home nount applied separately to each type o None OUT-OF-NETWORK
Payment for Out-of-Network Care** Primary Care Physician Selection Certification Requirements - Certification for certain types of Out-of care. Certification for Hospital Admiss Health Care, Hospice Care and Private expense is \$400 per occurrence. Referral Requirement PREVENTIVE CARE	Not Applicable Optional f-Network care must be obtained to avoin ions, Treatment Facility Admissions, Con the Duty Nursing is required - excluded ar None	Facility: 140% of Medicare Not Applicable d a reduction in benefits paid for that nvalescent Facility Admissions, Home nount applied separately to each type o None
Payment for Out-of-Network Care** Primary Care Physician Selection Certification Requirements - Certification for certain types of Out-of care. Certification for Hospital Admiss Health Care, Hospice Care and Privat expense is \$400 per occurrence. Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/	Not Applicable Optional f-Network care must be obtained to avoid ions, Treatment Facility Admissions, Con the Duty Nursing is required - excluded ar None IN-NETWORK	Facility: 140% of Medicare Not Applicable d a reduction in benefits paid for that nvalescent Facility Admissions, Home nount applied separately to each type o None OUT-OF-NETWORK
Payment for Out-of-Network Care** Primary Care Physician Selection Certification Requirements - Certification for certain types of Out-of care. Certification for Hospital Admiss Health Care, Hospice Care and Private expense is \$400 per occurrence. Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations	Not Applicable Optional f-Network care must be obtained to avoid ions, Treatment Facility Admissions, Con the Duty Nursing is required - excluded ar None IN-NETWORK Covered 100%; deductible waived	Facility: 140% of Medicare Not Applicable d a reduction in benefits paid for that nvalescent Facility Admissions, Home nount applied separately to each type o None OUT-OF-NETWORK 50%; after deductible
Payment for Out-of-Network Care** Primary Care Physician Selection Certification Requirements - Certification for certain types of Out-of care. Certification for Hospital Admiss Health Care, Hospice Care and Privat expense is \$400 per occurrence. Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65	Not Applicable Optional f-Network care must be obtained to avoid ions, Treatment Facility Admissions, Con the Duty Nursing is required - excluded ar None IN-NETWORK Covered 100%; deductible waived 5, 1 exam every 12 months age 65 and co	Facility: 140% of Medicare Not Applicable d a reduction in benefits paid for that nvalescent Facility Admissions, Home nount applied separately to each type o None OUT-OF-NETWORK 50%; after deductible
Payment for Out-of-Network Care** Primary Care Physician Selection Certification Requirements - Certification for certain types of Out-of care. Certification for Hospital Admiss Health Care, Hospice Care and Privat expense is \$400 per occurrence. Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65 Routine Well Child Exams/Immunizations	Not Applicable Optional f-Network care must be obtained to avoid ions, Treatment Facility Admissions, Con- te Duty Nursing is required - excluded ar None IN-NETWORK Covered 100%; deductible waived 5, 1 exam every 12 months age 65 and con- Covered 100%; deductible waived	Facility: 140% of Medicare Not Applicable d a reduction in benefits paid for that nvalescent Facility Admissions, Home nount applied separately to each type o None OUT-OF-NETWORK 50%; after deductible
Payment for Out-of-Network Care** Primary Care Physician Selection Certification Requirements - Certification for certain types of Out-of care. Certification for Hospital Admiss Health Care, Hospice Care and Privat expense is \$400 per occurrence. Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65 Routine Well Child Exams/Immunizations	Not Applicable Optional f-Network care must be obtained to avoid ions, Treatment Facility Admissions, Con- te Duty Nursing is required - excluded ar None IN-NETWORK Covered 100%; deductible waived 5, 1 exam every 12 months age 65 and con- Covered 100%; deductible waived	Facility: 140% of Medicare Not Applicable d a reduction in benefits paid for that nvalescent Facility Admissions, Home nount applied separately to each type o None OUT-OF-NETWORK 50%; after deductible
Payment for Out-of-Network Care** Primary Care Physician Selection Certification Requirements - Certification for certain types of Out-ot care. Certification for Hospital Admiss Health Care, Hospice Care and Privat expense is \$400 per occurrence. Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65 Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 135	Not Applicable Optional f-Network care must be obtained to avoid ions, Treatment Facility Admissions, Con the Duty Nursing is required - excluded ar None IN-NETWORK Covered 100%; deductible waived 5, 1 exam every 12 months age 65 and co	Facility: 140% of Medicare Not Applicable d a reduction in benefits paid for that nvalescent Facility Admissions, Home nount applied separately to each type o None OUT-OF-NETWORK 50%; after deductible
Payment for Out-of-Network Care** Primary Care Physician Selection Certification Requirements - Certification for certain types of Out-of care. Certification for Hospital Admiss Health Care, Hospice Care and Privat expense is \$400 per occurrence. Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65 Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13t to age 22.	Not Applicable Optional f-Network care must be obtained to avoid ions, Treatment Facility Admissions, Con- te Duty Nursing is required - excluded ar None IN-NETWORK Covered 100%; deductible waived 5, 1 exam every 12 months age 65 and co Covered 100%; deductible waived th - 24th months, 3 exams 25th - 36th months	Facility: 140% of Medicare Not Applicable d a reduction in benefits paid for that nvalescent Facility Admissions, Home nount applied separately to each type o None OUT-OF-NETWORK 50%; after deductible older 50%; deductible waived onths, 1 exam per 12 months thereafter
Payment for Out-of-Network Care** Primary Care Physician Selection Certification Requirements - Certification for certain types of Out-of care. Certification for Hospital Admiss Health Care, Hospice Care and Privat expense is \$400 per occurrence. Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65 Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13t to age 22. Routine Gynecological Care	Not Applicable Optional f-Network care must be obtained to avoid ions, Treatment Facility Admissions, Con- te Duty Nursing is required - excluded ar None IN-NETWORK Covered 100%; deductible waived 5, 1 exam every 12 months age 65 and co Covered 100%; deductible waived	Facility: 140% of Medicare Not Applicable d a reduction in benefits paid for that nvalescent Facility Admissions, Home nount applied separately to each type o None OUT-OF-NETWORK 50%; after deductible
Payment for Out-of-Network Care** Primary Care Physician Selection Certification Requirements - Certification for certain types of Out-of care. Certification for Hospital Admiss Health Care, Hospice Care and Privat expense is \$400 per occurrence. Referral Requirement PREVENTIVE CARE Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65 Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13t to age 22.	Not Applicable Optional f-Network care must be obtained to avoid ions, Treatment Facility Admissions, Con- ice Duty Nursing is required - excluded ar None IN-NETWORK Covered 100%; deductible waived 5, 1 exam every 12 months age 65 and co Covered 100%; deductible waived th - 24th months, 3 exams 25th - 36th mark Covered 100%; deductible waived	Facility: 140% of Medicare Not Applicable d a reduction in benefits paid for that nvalescent Facility Admissions, Home nount applied separately to each type o None OUT-OF-NETWORK 50%; after deductible older 50%; deductible waived onths, 1 exam per 12 months thereafter



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Routine Mammograms	Covered 100%; deductible waived	50%; after deductible
Nomen's Health	Covered 100%: deductible waived	50%; after deductible
ncludes: Screening for gestational dia	betes, HPV (Human- Papillomavirus) D	NA testing, counseling for sexually
ransmitted infections, counseling and	screening for human immunodeficiency	virus, screening and counseling for
nterpersonal and domestic violence, t	preastfeeding support, supplies and cou	nseling.
Contraceptive methods, sterilization p	rocedures, patient education and counse	eling. Limitations may apply.
Routine Digital Rectal Exam	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males ac	ge 40 and over.	
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males ag		
Colorectal Cancer Screening	Covered 100%; deductible waived	50%; after deductible
Recommended: For all members age	45 and over.	
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to Primary Care	\$40 office visit copay; deductible	50%; after deductible
Physician (PCP)	waived	··· /
includes services of an internist gene	ral physician, family practitioner or pedia	atrician.
Specialist Office Visits	\$80 office visit copay; deductible	50%; after deductible
opeoiding, office along	waived	
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	\$40 copay; deductible waived	50%; after deductible
walk-m onnes	Designated Walk-in Clinics	
supermarket or other retail store; and	Covered 100%; deductible waived th care facilities that (a) may be located (b) provide limited medical care and ser	rvices on a scheduled or unscheduled
supermarket or other retail store; and basis. Urgent care centers, emergen	Covered 100%; deductible waived th care facilities that (a) may be located (b) provide limited medical care and ser cy rooms, the outpatient department of a red to be Walk-in Clinics.	rvices on a scheduled or unscheduled a hospital, ambulatory surgical centers,
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supermarket or other retail store; and basis. Urgent care centers, emergen and physician offices are not conside	Covered 100%; deductible waived th care facilities that (a) may be located (b) provide limited medical care and ser cy rooms, the outpatient department of a red to be Walk-in Clinics. Your cost sharing is based on the type of service and where it is	rvices on a scheduled or unscheduled a hospital, ambulatory surgical centers, Your cost sharing is based on the type of service and where it is
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supermarket or other retail store; and basis. Urgent care centers, emergen and physician offices are not consider	Covered 100%; deductible waived th care facilities that (a) may be located (b) provide limited medical care and ser cy rooms, the outpatient department of a red to be Walk-in Clinics. Your cost sharing is based on the type of service and where it is	rvices on a scheduled or unscheduled a hospital, ambulatory surgical centers, Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the
supermarket or other retail store; and basis. Urgent care centers, emergen and physician offices are not consider Allergy Testing	Covered 100%; deductible waived th care facilities that (a) may be located (b) provide limited medical care and ser cy rooms, the outpatient department of a red to be Walk-in Clinics. Your cost sharing is based on the type of service and where it is performed	rvices on a scheduled or unscheduled a hospital, ambulatory surgical centers, Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is
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supermarket or other retail store; and basis. Urgent care centers, emergen- and physician offices are not consider Allergy Testing Allergy Injections DIAGNOSTIC PROCEDURES Diagnostic X-ray	Covered 100%; deductible waived th care facilities that (a) may be located (b) provide limited medical care and ser cy rooms, the outpatient department of a red to be Walk-in Clinics. Your cost sharing is based on the type of service and where it is performed \$10 copay; deductible waived IN-NETWORK Covered 100%; deductible waived	rvices on a scheduled or unscheduled a hospital, ambulatory surgical centers, Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 50%; after deductible
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PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

om \$ admitted	3300 copay; deductible waived	Same as in-network care
	Not Covered	Not Covered
om	Vot Obvered	
	10%; after deductible	Same as in-network care
	Not Covered	Not Covered
	N-NETWORK	OUT-OF-NETWORK
	10%; after deductible	50%; after deductible
aye	penefits incurred during your inpatient st	
nity Coverage 4	40%; after deductible	50%; after deductible
y and postpartum	io ii, altor acadolidio	
y and postpartan		
annlies to all covered b	penefits incurred during your inpatient s	tav.
pital Expenses 4	40%; after deductible	50%; after deductible
	benefits incurred during your outpatient	
gery - Hospital 4	40%; after deductible; after \$250	50%; after deductible
U	copay	
	benefits incurred during your outpatient	visit.
gery - Freestanding 4	40%; after deductible; after \$250	50%; after deductible
	copay	
o a applies to all covered b	benefits incurred during your outpatient	visit.
TH SERVICES	IN-NETWORK	OUT-OF-NETWORK
	Covered 100%; after deductible	50%; after deductible
annlies to all covered b	penefits incurred during your inpatient s	
Office Visits \$	\$80 copay; deductible waived	50%; after deductible
	penefits incurred during your outpatient	
	Covered 100%; deductible waived	50%; after deductible
	IN-NETWORK	OUT-OF-NETWORK
	Covered 100%; after deductible	50%; after deductible
	penefits incurred during your inpatient s	
eatment Facility	Covered 100%; after deductible	50%; after deductible
	\$80 copay; deductible waived	50%; after deductible
	benefits incurred during your outpatient	
ce Abuse Services	Covered 100%; deductible waived	50%; after deductible
	IN-NETWORK	OUT-OF-NETWORK
	40%; after deductible	50%; after deductible
ays per year		
applies to all covered b	benefits incurred during your inpatient s	stav.
are 4	40%; after deductible	50%; after deductible
sits per year		
irsing not covered		
des nutritional counseling	and services of a medical social worke	er. Reimbursement may not be limited
000 per vear even if the m	maximum number of visits has been rea	ached.
ermittent visits per day by	a participating home health care agend	cy; 1 visit equals a period of 4 hrs or
······································	, , , , , , , , , , , , , , , , , , , ,	· · ·
- Inpatient 4	40%; after deductible	50%; after deductible
	benefits incurred during your inpatient s	•
	40%: after deductible	50%; after deductible
- Outpatient 4	40%; after deductible benefits incurred during your outpatient	50%; after dedu



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Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	\$40 copay; deductible waived	50%; after deductible
imited to 20 visits per year		
Dutpatient Short-Term	\$40 copay; deductible waived	50%; after deductible
Rehabilitation		
imited to 20 visits per year.		
ncludes speech, physical, occupationa	II therapy	
Habilitative Physical Therapy	Covered 100%; deductible waived	50%; after deductible
Habilitative Occupational Therapy	Covered 100%; deductible waived	50%; after deductible
Habilitative Speech Therapy	Covered 100%; deductible waived	50%; after deductible
Autism Behavioral Therapy	\$80 copay; deductible waived	50%; after deductible
Covered same as any other Outpatient	Mental Health benefit	
Autism Applied Behavior Analysis	Covered 100%; deductible waived	50%; after deductible
Covered same as any other Outpatient	Mental Health Other Services benefit	
Autism Physical Therapy	Covered 100%; deductible waived	50%; after deductible
Autism Occupational Therapy	Covered 100%; deductible waived	50%; after deductible
Autism Speech Therapy	Covered 100%; deductible waived	50%; after deductible
Durable Medical Equipment	40%; after deductible	50%; after deductible
Diabetic Supplies (if not covered	Covered same as any other medical	Covered same as any other medical
under Pharmacy benefit)	expense.	expense.
Nomen's Contraceptive drugs and	Covered 100%; deductible waived	Covered same as any other expense
devices not obtainable at a		
pharmacy		
Affordable Care Act Mandated	Covered 100%; deductible waived	Covered same as any other expense
Women's Contraceptives		
Infusion Therapy	\$80 copay; deductible waived	50%; after deductible
Administered in the home or	• • •	
physician's office		
Infusion Therapy	Your cost sharing is based on the	Your cost sharing is based on the
Administered in an outpatient hospital	type of service and where it is	type of service and where it is
department or freestanding facility	performed	performed
Vision Eyewear	Not Covered	Not Covered
Transplants	40%; after deductible	50%; after deductible
• • • • • • • • • • • • • • • • • • •	Preferred coverage is provided at an	Non-Preferred coverage is provided
	IOE contracted facility only.	at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Acupuncture	\$40 copay; deductible waived	50%; after deductible
Limited to 10 visits per year		
Out of Area Dependents	Coverage provided at the non-preferre	ed benefit level of the plan if in-network
	provider is not available.	•
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Your cost sharing is based on the	Your cost sharing is based on the
anoranty resources	type of service and where it is	type of service and where it is
	performed	performed
Disgnosis and treatment of the underly	1	F

Diagnosis and treatment of the underlying medical condition only.



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PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

Advanced Reproductive	Not Covered	Not Covered
Fechnology (ART)		
ART coverage includes: In vitro fertiliza	tion (IVF), zygote intrafallopian transfei	(ZIFT), gamete intrafallopian transfer
GIFT), cryopreserved embryo transfers	s, intracytoplasmic sperm injection (ICS	I) or ovum microsurgery.
Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation ind		
Vasectomy	Covered 100%; after deductible	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	Advanced Control Plan - Aetna	
Preferred Generic Drugs		
Retail	\$10 copay	20% of submitted cost; after applicable in-network cost share
90 Day Retail	\$30 copay	
Mail Order	\$20 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	\$40 copay	20% of submitted cost; after applicable in-network cost share
90 Day Retail	\$120 copay	
Mail Order	\$80 copay	Not Applicable
Non-Preferred Generic and Brand-Na	ame Drugs	· · · · · · · · ·
Retail	\$80 copay	20% of submitted cost; after applicable in-network cost share
90 Day Retail	\$240 copay	
Mail Order	\$160 copay	Not Applicable
Pharmacy Day Supply and Requirem		
Retail	Up to a 30 day supply from Aetna Na	tional Network
Mail Order	A 31-90 day supply from CVS Carem	ark® Mail Service Pharmacy
Specialty	Up to a 30 day supply	
	First prescription fill at any retail or sp	ecialty pharmacy. Subsequent fills mus
	be through our preferred specialty ph	
	Advanced Control Formulary Aetna li	nsured LIST
Choose Generics - If the member or t	ne pnysician requests brand when gen	enc is available, the member pays the
applicable copay plus the difference be	tween the generic price and the brand	price.
Plan Includes: Diabetic supplies and (Contraceptive drugs and devices obtain	able from a pharmacy.
	ations are covered when filled with a pr	escription.
Oral chemotherapy drugs covered 100		
Precertification and quantity limits inclu	laea	
Step Therapy included	in matricell	
Seasonal Vaccinations covered 100%		
Preventive Vaccinations covered 100%		ions sourced 100% in natural
	contraceptives and preventive medicat	IONS COVERED 100% IN-NELWORK.
GENERAL PROVISIONS Dependents Eligibility	Spouse, children from birth to age 26	un mondiago of student status

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.



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PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a list of services and supplies that are *generally* not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.



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PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.

Cosmetic surgery, including breast reduction.

- · Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

- Hearing aids
- Home births

· Immunizations for travel or work, except where medically necessary or indicated.

· Implantable drugs and certain injectable drugs including injectable infertility drugs.

• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.

- · Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.

• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.

- Radial keratotomy or related procedures.
- · Reversal of sterilization.

• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.

- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at 1-888-982-3862.

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al 1-888-982-3862.

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to www.aetna.com.

Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinicbranded walk-in clinics) are both within the CVS Health family.

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Aetna HealthFund[™] Open Access[®] Managed Choice[®] POS - Florida

PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

FUND FEATURES HealthFund Amount

Fund Coincurance

September 2021

\$1,500 Employee

Amount contributed to the Fund by the employer

Fund amount reflected is on a per year basis. The fund received may be prorated based on your effective date of coverage.

The Family HealthFund amount applies to all family members combined. There is no Individual HealthFund limit within the Family HealthFund amount. 100%

Fund Coinsurance	100%	
Percentage at which the Fund will rein	nburse	
Fund Administration	deductible and coinsurance. medical plan provides covera	of for your member responsibility, including your Once the deductible is met, the underlying age and if a Fund balance still exists, the Fund
	will pay your member respon	sibility (i.e. your share of coinsurance) until the
	Out of Pocket Maximum has	been reached or the Fund has been exhausted
		ces covered at 100% with no deductible will be
	paid by the plan and not by the	ne Fund.
Employee Termination from Your	Any remaining HealthFund b	enefit amount is forfeited (or terminated) when
HealthFund	the employee's HealthFund of	coverage terminates.
Fund Rollover	Any remaining HealthFund b	enefit amount at end of the year is rolled over
	into next year's HealthFund b	penefit amount.
Eligible Fund Expenses	Fund covers same expenses	as the medical plan. Expenses above the
	Reasonable & Customary lim	nit, any plan limits, and any non covered
	expenses are not eligible for	reimbursement under the Fund.
Fund Payment/Assignment	Network Providers: Automat	ic Assignment to provider.
		mber may assign payment to provider.
Pro-ration for New Employees	Monthly	with the sead on new employee statue
Pro-ration for Family Status	No pro-ration. Change to ne	w tier based on new employee status.
Change	Due sociation Dava evacances	are integrated with the medical plan (i.e., subjec
Prescription Drug Plan	Prescription Drug expenses	oplied towards the medical Out-of-Pocket Limit)
		ble for reimbursement from the Fund).
	IN-NETWORK	OUT-OF-NETWORK
PLAN FEATURES	or supply that is subject to a m	aximum visit, day, or dollar limitation on a per
benefit Limitations - For any service	January 1st unless otherwise n	nandated. Refer to your plan documents for mo
information.	Sandary 1st unless outerwise h	handated. Notor to your plan accumente for me
Deductible (per calendar year)	\$5,000 Individual	\$15,000 Individual
Deductible (per calendar year)	\$10,000 Family	\$30,000 Family
All covered expenses accumulate se		
Unless otherwise indicated, the dedu	ctible must be met prior to bene	fits being payable.
Mombor cost sharing for certain servi	ces as indicated in the plan are	e excluded from charges to meet the Deductible
Pharmacy expenses apply towards th	e Deductible	
The family Deductible is a cumulative	Deductible for all family member	ers. The family Deductible can be met by a
combination of family members: how	ever no single individual within	the family will be subject to more than the
individual Deductible amount.	stor, no enigio manualen com	
Member Coinsurance	50%	50%
Applies to all expenses unless otherv		
Payment Limit (per calendar year)	\$6,250 Individual	\$20,000 Individual
· ayment Emit (per calendar year)	\$12,500 Family	\$40,000 Family
All covered expenses accumulate se	parately toward the in-network of	
All covered expenses accumulate se		
0 + + 0001		Par



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Aetna HealthFund[™] Open Access[®] Managed Choice[®] POS - Florida

PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Certain member cost sharing elements may not apply toward the Payment Limit.

Pharmacy expenses apply towards the Payment Limit.

Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit.

The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.

Lifetime Maximum

Unlimited except where otherwise indicated.

Payment for Out-of-Network Care**	Not Applicable	Professional: 105% of Medicare
-		Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable

Certification Requirements -

Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is \$400 per occurrence.

Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/	Covered 100%; deductible waived	50%; after deductible
mmunizations		
1 exam every 12 months up to age 65	5, 1 exam every 12 months age 65 and o	lder
Routine Well Child	Covered 100%; deductible waived	50%; deductible waived
Exams/Immunizations		
	h - 24th months, 3 exams 25th - 36th mo	onths, 1 exam per 12 months thereafter
to age 22.		
Routine Gynecological Care	Covered 100%; deductible waived	50%; after deductible
Exams		
1 obgyn exam and pap smear per yea		
ncludes routine tests and related lab		
Routine Mammograms	Covered 100%; deductible waived	50%; after deductible
Women's Health	Covered 100%; deductible waived	50%; after deductible
ncludes: Screening for gestational di	abetes, HPV (Human- Papillomavirus) D	NA testing, counseling for sexually
transmitted infections, counseling and	screening for human immunodeficiency	virus, screening and counseling for
interpersonal and domestic violence,	breastfeeding support, supplies and cou	nseling.
Contraceptive methods, sterilization p	procedures, patient education and counse	eling. Limitations may apply.
Routine Digital Rectal Exam	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males a		
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males a		50%; after deductible 50%; after deductible
Recommended: For covered males a Colorectal Cancer Screening	ge 40 and over. Covered 100%; deductible waived	
Recommended: For covered males a Colorectal Cancer Screening Recommended: For all members age	ge 40 and over. Covered 100%; deductible waived	
Recommended: For covered males a Colorectal Cancer Screening Recommended: For all members age Routine Eye Exams	ge 40 and over. Covered 100%; deductible waived 45 and over.	50%; after deductible
Recommended: For covered males a Colorectal Cancer Screening Recommended: For all members age Routine Eye Exams 1 routine exam per 24 months.	ge 40 and over. Covered 100%; deductible waived 45 and over.	50%; after deductible
Recommended: For covered males a Colorectal Cancer Screening Recommended: For all members age Routine Eye Exams 1 routine exam per 24 months. Routine Hearing Screening	ge 40 and over. Covered 100%; deductible waived 45 and over. Covered 100%; deductible waived	50%; after deductible 50%; after deductible 50%; after deductible OUT-OF-NETWORK
Recommended: For covered males a Colorectal Cancer Screening Recommended: For all members age Routine Eye Exams 1 routine exam per 24 months. Routine Hearing Screening PHYSICIAN SERVICES	ge 40 and over. Covered 100%; deductible waived 45 and over. Covered 100%; deductible waived Covered 100%; deductible waived	50%; after deductible 50%; after deductible 50%; after deductible
Recommended: For covered males a Colorectal Cancer Screening Recommended: For all members age Routine Eye Exams 1 routine exam per 24 months. Routine Hearing Screening PHYSICIAN SERVICES Office Visits to Primary Care	ge 40 and over. Covered 100%; deductible waived 45 and over. Covered 100%; deductible waived Covered 100%; deductible waived IN-NETWORK	50%; after deductible 50%; after deductible 50%; after deductible OUT-OF-NETWORK
Recommended: For covered males a Colorectal Cancer Screening Recommended: For all members age Routine Eye Exams 1 routine exam per 24 months. Routine Hearing Screening PHYSICIAN SERVICES Office Visits to Primary Care Physician (PCP)	ge 40 and over. Covered 100%; deductible waived 45 and over. Covered 100%; deductible waived Covered 100%; deductible waived IN-NETWORK 50%; after deductible	50%; after deductible 50%; after deductible 50%; after deductible OUT-OF-NETWORK 50%; after deductible
	ge 40 and over. Covered 100%; deductible waived 45 and over. Covered 100%; deductible waived Covered 100%; deductible waived IN-NETWORK 50%; after deductible eral physician, family practitioner or pedia	50%; after deductible 50%; after deductible 50%; after deductible OUT-OF-NETWORK 50%; after deductible
Recommended: For covered males a Colorectal Cancer Screening Recommended: For all members age Routine Eye Exams 1 routine exam per 24 months. Routine Hearing Screening PHYSICIAN SERVICES Office Visits to Primary Care Physician (PCP)	ge 40 and over. Covered 100%; deductible waived 45 and over. Covered 100%; deductible waived Covered 100%; deductible waived IN-NETWORK 50%; after deductible	50%; after deductible 50%; after deductible 50%; after deductible OUT-OF-NETWORK 50%; after deductible atrician.



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Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Walk-in Clinics	50%; after deductible	50%; after deductible
	Designated Walk-in Clinics	
	Covered 100%; deductible waived	
Nalk-in Clinics are free-standing heall	h care facilities that (a) may be located	in or with a pharmacy, drug store,
upermarket or other retail store; and	(b) provide limited medical care and ser	vices on a scheduled or unscheduled
pasis. Urgent care centers, emergenc	cy rooms, the outpatient department of a	a hospital, ambulatory surgical centers,
and physician offices are not consider	ed to be Walk-in Clinics.	•
Allergy Testing	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
Allergy Injections	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray	50%; after deductible	50%; after deductible
f performed as a part of a physician of	ffice visit and billed by the physician, ex	
applicable physician's office visit mem	her cost sharing	
Diagnostic Laboratory	50%; after deductible	50%; after deductible
Jaynoshi Laboralory	office visit and billed by the physician, ex	
applicable physician's office visit mem	ther cost sharing	
	50%; after deductible	50%; after deductible
Diagnostic Outpatient Complex	50%, alter deductible	
Imaging	office visit and billed by the physician, ex	nenses are covered subject to the
ir performed as a part of a physician o	her east sharing	penses are covered subject to the
applicable physician's office visit mem		OUT-OF-NETWORK
EMERGENCY MEDICAL CARE	IN-NETWORK	50%; after deductible
Urgent Care Provider	50%; after deductible	Not Covered
Non-Urgent Use of Urgent Care	Not Covered	Not Covered
Provider	EQ2() often deductible	Same as in-network care
Emergency Room	50%; after deductible	Not Covered
Non-Emergency Care in an	Not Covered	Not Covered
Emergency Room	COOL - Development - Joseffels	Same as in-network care
Emergency Use of Ambulance	50%; after deductible	
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	50%; after deductible	50%; after deductible
Your cost sharing applies to all covere	ed benefits incurred during your inpatier	nt stay.
Inpatient Maternity Coverage	50%; after deductible	50%; after deductible
(includes delivery and postpartum		
care)		
	ed benefits incurred during your inpatier	nt stay.
Outpatient Hospital Expenses	50%; after deductible	50%; after deductible
Your cost sharing applies to all cover	ed benefits incurred during your outpatie	ent visit.
Outpatient Surgery - Hospital	50%; after deductible	50%; after deductible
Your cost sharing applies to all cover	ed benefits incurred during your outpatie	ent visit.
Outpatient Surgery - Freestanding Facility	50%; after deductible	50%; after deductible
Your cost sharing applies to all cover	ed benefits incurred during your outpation	ent visit.
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	50%; after deductible	50%; after deductible
Your cost sharing annlies to all cover	ed benefits incurred during your inpatier	
Tour cost sharing applies to all cover	ea benefite mounda dannig your inpation	
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to be still be E00/ coftee deductible
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	E09/ coffee deductible
50%; atter deductible	50%; after deductible
E00/ ft d tu-tible	50%; after deductible
50%; after deductible	50%, aller deductione
National	Not Covered
	50%; after deductible
	Non-Preferred coverage is provided
	at a Non-IOE facility.
	Not Covered
50%; after deductible	50%; after deductible
Coverage provided at the non-preferre	d benefit level of the plan if in-network
provider is not available.	
IN-NETWORK	OUT-OF-NETWORK
IN-NETWORK Your cost sharing is based on the	Your cost sharing is based on the
Your cost sharing is based on the	Your cost sharing is based on the
Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is
Your cost sharing is based on the type of service and where it is	Your cost sharing is based on the type of service and where it is
Your cost sharing is based on the type of service and where it is performed ring medical condition only.	Your cost sharing is based on the type of service and where it is performed
Your cost sharing is based on the type of service and where it is performed ring medical condition only. Not Covered	Your cost sharing is based on the type of service and where it is performed Not Covered
Your cost sharing is based on the type of service and where it is performed ring medical condition only. Not Covered ation (IVF), zygote intrafallopian transfer	Your cost sharing is based on the type of service and where it is performed Not Covered (ZIFT), gamete intrafallopian transfer
Your cost sharing is based on the type of service and where it is performed ring medical condition only. Not Covered ation (IVF), zygote intrafallopian transfer s, intracytoplasmic sperm injection (ICSI	Your cost sharing is based on the type of service and where it is performed Not Covered (ZIFT), gamete intrafallopian transfer
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Your cost sharing is based on the type of service and where it is performed ing medical condition only. Not Covered ation (IVF), zygote intrafallopian transfer s, intracytoplasmic sperm injection (ICSI Not Covered Juction Your cost sharing is based on the	Your cost sharing is based on the type of service and where it is performed Not Covered (ZIFT), gamete intrafallopian transfer I) or ovum microsurgery. Not Covered
	 50%; after deductible 50%; after deductible Not Covered 50%; after deductible Preferred coverage is provided at an IOE contracted facility only. Not Covered 50%; after deductible Coverage provided at the non-preferred provider is not available.



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PHARMACY	IN-NETWORK	OUT-OF-NETWORK
The full cost of the drug is applied to th	e deductible before any benefits are cor	nsidered for payment under the
pharmacy plan.		
Pharmacy Plan Type	Advanced Control Plan - Aetna	
Preferred Generic Drugs		
Retail	\$10 copay	\$10 copay
90 Day Retail	\$30 copay	
Mail Order	\$25 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	\$30 copay	\$30 copay
90 Day Retail	\$90 copay	
Mail Order	\$75 copay	Not Applicable
Non-Preferred Generic and Brand-Na	ame Drugs	
Retail	\$50 copay	\$50 copay
90 Day Retail	\$150 copay	
Mail Order	\$125 copay	Not Applicable
Pharmacy Day Supply and Requirem	nents	
Retail	Up to a 30 day supply from Aetna Nat	ional Network
Mail Order	A 31-90 day supply from CVS Carema	ark® Mail Service Pharmacy
Specialty	Up to a 30 day supply	
		ecialty pharmacy. Subsequent fills must
	be through our preferred specialty pha	
	Advanced Control Formulary Aetna In	
Choose Generics - If the member or t	he physician requests brand when gene	
	tween the generic price and the brand	
	Contraceptive drugs and devices obtain	
	ations are covered when filled with a pre	
Oral chemotherapy drugs covered 100		
Precertification and quantity limits inclu		
Step Therapy included		
Seasonal Vaccinations covered 100%	in-network	
Preventive Vaccinations covered 100%		
	contraceptives and preventive medication	ons covered 100% in-network.
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26	regardless of student status.
	. .	
**We cover the cost of services based	on whether doctors are "in network" or '	'out of network." We want to help vou
understand how much we pay for your	out-of-network care. At the same time,	we want to make it clear how much
more you will need to pay for this "out-		

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

September 2021



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PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a list of services and supplies that are *generally* not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.

· Cosmetic surgery, including breast reduction.

· Custodial care.

· Dental care and dental X-rays.

Donor egg retrieval

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

Hearing aids

Home births

· Immunizations for travel or work, except where medically necessary or indicated.

· Implantable drugs and certain injectable drugs including injectable infertility drugs.

• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.

· Long-term rehabilitation therapy.

· Non-medically necessary services or supplies.

• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.

· Radial keratotomy or related procedures.

Reversal of sterilization.

· Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or

prescription drugs.

Special duty nursing.

· Therapy or rehabilitation other than those listed as covered.

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.** September 2021 Page 7



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PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to www.aetna.com.

Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinicbranded walk-in clinics) are both within the CVS Health family.

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PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit Limitations - For any service	or supply that is subject to a maximum	visit, day, or dollar limitation on a per
year basis, the benefit year begins on	January 1st unless otherwise mandated	I. Refer to your plan documents for more
nformation.	,	
Deductible (per calendar year)	\$5,000 Individual	\$15,000 Individual
	\$10,000 Family	\$30,000 Family
All covered expenses accumulate sep	arately toward the in-network and out-of	
Inless otherwise indicated the deduc	tible must be met prior to benefits being	payable.
Member cost sharing for certain servic	es, as indicated in the plan, are exclude	ed from charges to meet the Deductible.
Pharmacy expenses apply towards the	Deductible.	•
The family Deductible is a cumulative	Deductible for all family members. The	family Deductible can be met by a
combination of family members: howe	ver, no single individual within the family	will be subject to more than the
individual Deductible amount.	,	Entry Ending Conductor and Mathematics of the
Member Coinsurance	50%	50%
Applies to all expenses unless otherwi		
Payment Limit (per calendar year)	\$6,250 Individual	\$20,000 Individual
	\$12,500 Family	\$40,000 Family
All covered expenses accumulate sep	arately toward the in-network or out-of-r	network Payment Limit.
Certain member cost sharing elements	s may not apply toward the Payment Lir	nit.
Pharmacy expenses apply towards the	e Payment Limit.	
Only those out-of-pocket expenses res	sulting from the application of coinsuran	ce percentage, copays, and deductibles
(except any penalty amounts) may be	used to satisfy the Payment Limit.	
The family Payment Limit is a cumulat	ive Payment Limit for all family member	s. The family Payment Limit can be met
by a combination of family members:	nowever, no single individual within the	family will be subject to more than the
individual Payment Limit amount.		
Lifetime Maximum		
Unlimited except where otherwise indi	cated.	
Payment for Out-of-Network Care**	Not Applicable	Professional: 105% of Medicare
		Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -		N N
Certification for certain types of Out-of	-Network care must be obtained to avo	id a reduction in benefits paid for that
care. Certification for Hospital Admissi	ons, Treatment Facility Admissions, Co	nvalescent Facility Admissions, Home
Health Care, Hospice Care and Privat	e Duty Nursing is required - excluded a	mount applied separately to each type o
expense is \$400 per occurrence.	, , ,	
Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/	Covered 100%; deductible waived	50%; after deductible
Immunizations		
	, 1 exam every 12 months age 65 and o	older
Routine Well Child	Covered 100%; deductible waived	50%; deductible waived
Exams/Immunizations		
7 exams first 12 months, 3 exams 13t	h - 24th months, 3 exams 25th - 36th m	onths, 1 exam per 12 months thereafter
to age 22.	na an ant the second for an and the second for the second s	na yearan ya sa
Routine Gynecological Care	Covered 100%; deductible waived	50%; after deductible
Exams		
1 obgyn exam and pap smear per yea	ır	
Includes routine tests and related lab		



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Routine Mammograms	Covered 100%; deductible waived	50%; after deductible
Vomen's Health	Covered 100%: deductible waived	50%; after deductible
ncludes: Screening for gestational d	liabetes, HPV (Human- Papillomavirus) DI	NA testing, counseling for sexually
ransmitted infections, counseling ar	d screening for human immunodeficiency	virus, screening and counseling for
nterpersonal and domestic violence	, breastfeeding support, supplies and could	nseling.
Contraceptive methods, sterilization	procedures, patient education and counse	eling. Limitations may apply.
Routine Digital Rectal Exam	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males		
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males	age 40 and over.	
Colorectal Cancer Screening	Covered 100%; deductible waived	50%; after deductible
Recommended: For all members ag	e 45 and over.	
Routine Eye Exams	Covered 100%; deductible waived	50%; after deductible
1 routine exam per 24 months.		
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to Primary Care	50%; after deductible	50%; after deductible
Physician (PCP)		
Includes services of an internist, ger	neral physician, family practitioner or pedia	atrician.
Specialist Office Visits	50%; after deductible	50%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
re-natal materialy		EO9/ · ofter deductible
Walk-in Clinics	50%; after deductible	50%; after deductible
	Designated Walk-in Clinics	50%, anel deductible
Walk-in Clinics	Designated Walk-in Clinics Covered 100%; after deductible	
Walk-in Clinics Walk-in Clinics are free-standing he	Designated Walk-in Clinics Covered 100%; after deductible alth care facilities that (a) may be located	in or with a pharmacy, drug store,
Walk-in Clinics Walk-in Clinics are free-standing he supermarket or other retail store: an	Designated Walk-in Clinics Covered 100%; after deductible alth care facilities that (a) may be located d (b) provide limited medical care and ser	in or with a pharmacy, drug store, vices on a scheduled or unscheduled
Walk-in Clinics Walk-in Clinics are free-standing he supermarket or other retail store; an basis. Urgent care centers, emerge	Designated Walk-in Clinics Covered 100%; after deductible alth care facilities that (a) may be located d (b) provide limited medical care and ser ncy rooms, the outpatient department of a	in or with a pharmacy, drug store, vices on a scheduled or unscheduled
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Emergency Room	50%; after deductible	Same as in-network care
Non-Emergency Care in an	Not Covered	Not Covered
Emergency Room		
Emergency Use of Ambulance	50%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
npatient Coverage	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered		itient stay.
npatient Maternity Coverage	50%; after deductible	50%; after deductible
includes delivery and postpartum		
care)		
Your cost sharing applies to all covered	I benefits incurred during your inpa	itient stay.
Outpatient Hospital Expenses	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered	benefits incurred during your outp	patient visit.
Outpatient Surgery - Hospital	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered		patient visit.
Outpatient Surgery - Freestanding	50%; after deductible	50%; after deductible
Facility		
Your cost sharing applies to all covered	d benefits incurred during your outp	patient visit.
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered	t benefits incurred during your inpa	atient stay.
Mental Health Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered	d benefits incurred during your outp	patient visit.
Other Mental Health Services	50%; after deductible	50%; after deductible
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered	d benefits incurred during your inpa	atient stay.
Residential Treatment Facility	50%; after deductible	50%; after deductible
Substance Abuse Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered	d benefits incurred during your outp	patient visit.
Other Substance Abuse Services	50%; after deductible	50%; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility	50%; after deductible	50%; after deductible
Limited to 60 days per year		
Your cost sharing applies to all covere	d benefits incurred during your inpa	atient stay.
Home Health Care	50%; after deductible	50%; after deductible
Limited to 60 visits per year		
Private Duty Nursing not covered		
Coverage includes nutritional counseli	ng and services of a medical social	I worker. Reimbursement may not be limited
to less than \$1,000 per year even if the	e maximum number of visits has be	een reached.
Limited to 3 intermittent visits per day I	by a participating home health care	e agency; 1 visit equals a period of 4 hrs or
less.		
Hospice Care - Inpatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covere	d benefits incurred during your inpa	atient stay.
<u>, , , , , , , , , , , , , , , , , , , </u>	50%; after deductible	50%; after deductible
Hospice Care - Outpatient		
		patient visit.
Hospice Care - Outpatient	d benefits incurred during your out Not Covered	patient visit. Not Covered
Hospice Care - Outpatient Your cost sharing applies to all covere	d benefits incurred during your out	patient visit.



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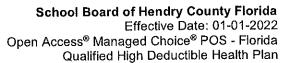
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Dutpatient Short-Term	50%; after deductible	50%; after deductible
Rehabilitation		
imited to 30 visits per year.		
ncludes speech, physical, occupationa	al therapy	
abilitative Physical Therapy	50%; after deductible	50%; after deductible
labilitative Occupational Therapy	50%; after deductible	50%; after deductible
labilitative Speech Therapy	50%; after deductible	50%; after deductible
Autism Behavioral Therapy	50%; after deductible	50%; after deductible
Covered same as any other Outpatient	t Mental Health benefit	
Autism Applied Behavior Analysis	50%; after deductible	50%; after deductible
Covered same as any other Outpatient	t Mental Health Other Services benefit	
Autism Physical Therapy	50%; after deductible	50%; after deductible
Autism Occupational Therapy	50%; after deductible	50%; after deductible
Autism Speech Therapy	50%; after deductible	50%; after deductible
Durable Medical Equipment	50%; after deductible	50%; after deductible
Diabetic Supplies (if not covered	Covered same as any other medical	Covered same as any other medical
inder Pharmacy benefit)	expense.	expense.
Nomen's Contraceptive drugs and	Covered 100%; deductible waived	Covered same as any other expense
levices not obtainable at a		
oharmacy		
Affordable Care Act Mandated	Covered 100%; deductible waived	Covered same as any other expense
Nomen's Contraceptives		
nfusion Therapy	50%; after deductible	50%; after deductible
Administered in the home or		
physician's office		
nfusion Therapy	50%; after deductible	50%; after deductible
Administered in an outpatient hospital		
department or freestanding facility		
Vision Eyewear	Not Covered	Not Covered
Transplants	50%; after deductible	50%; after deductible
	Preferred coverage is provided at an	Non-Preferred coverage is provided
	IOE contracted facility only.	at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Acupuncture	50%; after deductible	50%; after deductible
Limited to 10 visits per year		
Out of Area Dependents		ed benefit level of the plan if in-network
	provider is not available.	
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
	Your cost sharing is based on the	Your cost sharing is based on the
Infertility Treatment		
Infertility Treatment	type of service and where it is performed	type of service and where it is performed

Diagnosis and treatment of the underlying medical condition only.

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PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

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Advanced Reproductive	Not Covered	Not Covered
Technology (ART)		
ART coverage includes: In vitro fertiliza	tion (IVF), zygote intrafallopian transfe	r (ZIFT), gamete intrafallopian transfer
	s, intracytoplasmic sperm injection (ICS	SI) or ovum microsurgery.
Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation ind		CO2(, after deductible
Vasectomy	Your cost sharing is based on the	50%; after deductible
	type of service and where it is	
Tuballingtion	performed Covered 100%; deductible walved	50%; after deductible
Tubal Ligation PHARMACY	IN-NETWORK	OUT-OF-NETWORK
The full cost of the drug is applied to the	e deductible before any benefits are co	Control of August August August and August Aug
pharmacy plan.		
Pharmacy Plan Type	Advanced Control Plan - Aetna	
Preferred Generic Drugs		
Retail	\$10 copay	\$10 copay
90 Day Retail	\$30 copay	
Mail Order	\$25 copay	Not Applicable
Preferred Brand-Name Drugs		· ·
Retail	\$30 copay	\$30 copay
90 Day Retail	\$90 copay	
Mail Order	\$75 copay	Not Applicable
Non-Preferred Generic and Brand-N		450
Retail	\$50 copay	\$50 copay
90 Day Retail	\$150 copay	Net Applicable
Mail Order	\$125 copay	Not Applicable
Pharmacy Day Supply and Requirem	nents	tional Notwork
Retail Mail Order	Up to a 30 day supply from Aetna Na A 31-90 day supply from CVS Carem	arke Mail Service Pharmacy
Mail Order	Up to a 30 day supply	arke Mail Gervice Filamacy
Specialty	First prescription fill at any retail or sr	becialty pharmacy. Subsequent fills mu
	be through our preferred specialty ph	
	Advanced Control Formulary Aetna I	
Choose Generics - If the member or	the physician requests brand when gen	eric is available, the member pays the
applicable copay plus the difference be	etween the generic price and the brand	price.
Plan Includes: Diabetic supplies and	Contraceptive drugs and devices obtair	able from a pharmacy.
A limited list of over-the-counter medic	ations are covered when filled with a p	rescription.
Oral chemotherapy drugs covered 100)%	
Precertification and quantity limits inclu		
Step Therapy included		
Seasonal Vaccinations covered 100%		
Preventive Vaccinations covered 1009	6 in-network	in a second 100% in a short
	contraceptives and preventive medicat	IONS COVERED 100% IN-NELWORK.
GENERAL PROVISIONS	Oracina shildren from birth to are 26	Progordloss of student status
Dependents Eligibility	Spouse, children from birth to age 26	regardiess of student status.

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.



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• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

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Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a list of services and supplies that are *generally* not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.



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 All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.

- · Cosmetic surgery, including breast reduction.
- · Custodial care.
- · Dental care and dental X-rays.
- Donor egg retrieval

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

- Hearing aids
- Home births

· Immunizations for travel or work, except where medically necessary or indicated.

• Implantable drugs and certain injectable drugs including injectable infertility drugs.

• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.

- · Long-term rehabilitation therapy.
- · Non-medically necessary services or supplies.

 Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.

- · Radial keratotomy or related procedures.
- · Reversal of sterilization.

• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.

- · Special duty nursing.
- · Therapy or rehabilitation other than those listed as covered.

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

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PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit Limitations - For any service	or supply that is subject to a maximum	visit, day, or dollar limitation on a per
		I. Refer to your plan documents for more
information.		
Deductible (per calendar year)	\$2,000 Individual	\$4,000 Individual
	\$4,000 Family	\$8,000 Family
All covered expenses accumulate sep	arately toward the in-network and out-of	
	tible must be met prior to benefits being	
		d from charges to meet the Deductible.
Pharmacy expenses do not apply towa		5
	Deductible for all family members. The	family Deductible can be met by a
	ver, no single individual within the family	
individual Deductible amount.		,
Member Coinsurance	Covered 100%	20%
Applies to all expenses unless otherwi		
Payment Limit (per calendar year)	\$4,000 Individual	\$9,000 Individual
	\$8,000 Family	\$18,000 Family
All covered expenses accumulate sep	arately toward the in-network or out-of-r	
	s may not apply toward the Payment Lin	
Pharmacy expenses apply towards the		
		ce percentage, copays, and deductibles
(except any penalty amounts) may be		
		s. The family Payment Limit can be met
	nowever, no single individual within the f	
individual Payment Limit amount.		
Lifetime Maximum		
Unlimited except where otherwise indi	cated.	
Payment for Out-of-Network Care**	Not Applicable	Professional: 105% of Medicare
<u>,</u>		Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -	- 1	
	-Network care must be obtained to avoi	d a reduction in benefits paid for that
	ons, Treatment Facility Admissions, Co	
		nount applied separately to each type of
expense is \$400 per occurrence.	, , , , , , , , , , , , , , , , , , , ,	
Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/	Covered 100%; deductible waived	20%; after deductible
Immunizations	,	- ,
	, 1 exam every 12 months age 65 and o	lder
Routine Well Child	Covered 100%; deductible waived	20%; deductible waived
Exams/Immunizations	, <u></u> , <u></u> , <u></u> , , , _, , _	,
	h - 24th months, 3 exams 25th - 36th mo	onths, 1 exam per 12 months thereafter
to age 22.		
Routine Gynecological Care	Covered 100%; deductible waived	20%; after deductible
Exams		
1 obgyn exam and pap smear per yea	r	
Includes routing tests and related lab t		

Includes routine tests and related lab fees.



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Routine Mammograms	Covered 100%; deductible waived	20%; after deductible
Women's Health	Covered 100%; deductible waived	20%; after deductible
Includes: Screening for gestational d	liabetes, HPV (Human- Papillomavirus) DN	NA testing, counseling for sexually
transmitted infections, counseling an	d screening for human immunodeficiency	virus, screening and counseling for
interpersonal and domestic violence	, breastfeeding support, supplies and cour	nseling.
Contraceptive methods, sterilization	procedures, patient education and counse	eling. Limitations may apply.
Routine Digital Rectal Exam	Covered 100%; deductible waived	20%; after deductible
Recommended: For covered males	age 40 and over.	
Prostate-specific Antigen Test	Covered 100%; deductible waived	20%; after deductible
Recommended: For covered males		
Colorectal Cancer Screening	Covered 100%; deductible waived	20%; after deductible
Recommended: For all members ag		- ,
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	20%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to Primary Care	\$25 office visit copay; deductible	20%; after deductible
Physician (PCP)	waived	
	eral physician, family practitioner or pedia	trician
Specialist Office Visits	\$50 office visit copay; deductible	20%; after deductible
	waived	
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	20%; after deductible
Walk-in Clinics	\$25 copay; deductible waived	20%; after deductible
	Designated Walk-in Clinics	
	Covered 100%; deductible waived	
Walk in Clinics are free standing her	alth care facilities that (a) may be located in	n or with a pharmacy, drug store
	d (b) provide limited medical care and serv	
	ncy rooms, the outpatient department of a	
and physician offices are not conside		nospital, ambulatory surgical centers,
Allergy Testing	Your cost sharing is based on the	Your cost sharing is based on the
Allergy resultg	type of service and where it is	type of service and where it is
	performed	performed
Allergy Injections		
Allergy Injections	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed; Covered 100% when an	performed
	office visit charge is not applicable.	
DIAGNOSTIC PROCEDURES		OUT-OF-NETWORK
Diagnostic X-ray	Covered 100%; after deductible	20%; after deductible
	office visit and billed by the physician, exp	benses are covered subject to the
applicable physician's office visit me		
Diagnostic Laboratory	Covered 100%; after deductible	20%; after deductible
	office visit and billed by the physician, exp	penses are covered subject to the
applicable physician's office visit me		
Diagnostic Outpatient Complex	mber cost sharing. Covered 100%; after deductible	20%; after deductible
Diagnostic Outpatient Complex Imaging		

applicable physician's office visit member cost sharing.



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EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Provider	\$75 office visit copay; deductible	20%; after deductible
	waived	
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	\$300 copay; deductible waived	Same as in-network care
Copay waived if admitted		
Non-Emergency Care in an	Not Covered	Not Covered
Emergency Room		
Emergency Use of Ambulance	Covered 100%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered		
Inpatient Maternity Coverage	Covered 100%; after deductible	20%; after deductible
(includes delivery and postpartum		
care)	I han ofita in ourrad during your inpation	t ato /
Your cost sharing applies to all covered Outpatient Hospital Expenses	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered		
Outpatient Surgery - Hospital	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered		
Outpatient Surgery - Freestanding	Covered 100%; after deductible	20%; after deductible
Facility		
Your cost sharing applies to all covered	benefits incurred during your outpatie	nt visit.
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered		
Mental Health Office Visits	Covered 100%; deductible waived	20%; after deductible
Your cost sharing applies to all covered	I benefits incurred during your outpatie	nt visit.
Other Mental Health Services	Covered 100%; deductible waived	20%; after deductible
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered		
Residential Treatment Facility	Covered 100%; after deductible	20%; after deductible
Substance Abuse Office Visits	Covered 100%; deductible waived	20%; after deductible
Your cost sharing applies to all covered		
Other Substance Abuse Services	Covered 100%; deductible waived	20%; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility	Covered 100%; after deductible	20%; after deductible
Limited to 60 days per year		4 - 4
Your cost sharing applies to all covered		
Home Health Care	Covered 100%; after deductible	20%; after deductible
Limited to 60 visits per year		
Private Duty Nursing not covered	a and convision of a modical appoint war	ker. Reimbursement may not be limited
to less than \$1,000 per year even if the		
Limited to 3 intermittent visits per day b		
less.	y a participating nome nearth call age	noy, i visit equais a perioù or 4 mis or
Hospice Care - Inpatient	Covered 100%; after deductible	20%; after deductible
Your cost sharing applies to all covered		
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Hospice Care - Outpatient	Covered 100%; after deductible	20%; after deductible
	benefits incurred during your outpatien	
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy Limited to 20 visits per year	\$25 copay; deductible waived	20%; after deductible
Outpatient Short-Term	\$25 copay; deductible waived	20%; after deductible
Rehabilitation		
Limited to 20 visits per year.		
Includes speech, physical, occupationa		
Habilitative Physical Therapy	Covered 100%; deductible waived	20%; after deductible
Habilitative Occupational Therapy	Covered 100%; deductible waived	20%; after deductible
Habilitative Speech Therapy	Covered 100%; deductible waived	20%; after deductible
Autism Behavioral Therapy	Covered 100%; deductible waived	20%; after deductible
Covered same as any other Outpatient		
Autism Applied Behavior Analysis	Covered 100%; deductible waived	20%; after deductible
Covered same as any other Outpatient		
Autism Physical Therapy	Covered 100%; deductible waived	20%; after deductible
Autism Occupational Therapy	Covered 100%; deductible waived	20%; after deductible
Autism Speech Therapy	Covered 100%; deductible waived	20%; after deductible
Durable Medical Equipment	Covered 100%; after deductible	20%; after deductible
Diabetic Supplies (if not covered	Covered same as any other medical	Covered same as any other medica
under Pharmacy benefit)	expense.	expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expens
Affordable Care Act Mandated	Covered 100%; deductible waived	Covered same as any other expension
Women's Contraceptives		
Infusion Therapy	\$50 copay; deductible waived	20%; after deductible
Administered in the home or		
physician's office		
Infusion Therapy	Your cost sharing is based on the	Your cost sharing is based on the
Administered in an outpatient hospital	type of service and where it is	type of service and where it is
department or freestanding facility	performed Not Covered	performed Not Covered
Vision Eyewear		-
Transplants	Covered 100%; after deductible	20%; after deductible
	Preferred coverage is provided at an	Non-Preferred coverage is provided
Bariatria Surgany	IOE contracted facility only. Not Covered	at a Non-IOE facility. Not Covered
Bariatric Surgery		
Acupuncture	\$25 copay; deductible waived	20%; after deductible
Limited to 10 visits per year	Coverage provided at the per preferre	d honofit lovel of the plan if in patwork
Out of Area Dependents	Coverage provided at the non-preferre	
FAMILY PLANNING	provider is not available.	
	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed

Diagnosis and treatment of the underlying medical condition only.



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Advanced Reproductive	Not Covered	Not Covered	
Technology (ART)		-	
	tion (IVF), zygote intrafallopian transfer	(ZIFT), gamete intrafallopian transfer	
	, intracytoplasmic sperm injection (ICSI		
Comprehensive Infertility Services	Not Covered	Not Covered	
Artificial insemination and ovulation indu	uction		
Vasectomy	Covered 100%; after deductible	20%; after deductible	
Tubal Ligation	Covered 100%; deductible waived	20%; after deductible	
PHARMĂCY	IN-NETWORK	OUT-OF-NETWORK	
Pharmacy Plan Type	Advanced Control Plan - Aetna		
Preferred Generic Drugs			
Retail	\$15 copay	\$15 copay	
90 Day Retail	\$45 copay		
Mail Order	\$30 copay	Not Applicable	
Preferred Brand-Name Drugs	· · ·	••	
Retail	\$50 copay	\$50 copay	
90 Day Retail	\$150 copay		
Mail Order	\$100 copay	Not Applicable	
Non-Preferred Generic and Brand-Na	me Drugs		
Retail	\$85 copay	\$85 copay	
90 Day Retail	\$255 copay		
Mail Order	\$170 copay	Not Applicable	
Pharmacy Day Supply and Requirem	ents		
Retail	Up to a 30 day supply from Aetna National Network		
Mail Order			
Specialty	Up to a 30 day supply		
	First prescription fill at any retail or specialty pharmacy. Subsequent fills must		
	be through our preferred specialty pharmacy network. Advanced Control Formulary Aetna Insured List		
	e physician requests brand when gener		
	tween the generic price and the brand p		
	contraceptive drugs and devices obtaina		
	tions are covered when filled with a pre-	scription.	
Oral chemotherapy drugs covered 100%			
Precertification and quantity limits inclue	ded		
Step Therapy included			
Seasonal Vaccinations covered 100% in			
Preventive Vaccinations covered 100%			
	ontraceptives and preventive medicatio	ns covered 100% in-network.	
GENERAL PROVISIONS Dependents Eligibility	Spouse, children from birth to age 26 r		

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- Dental care and dental X-rays.
- Donor egg retrieval

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

- Hearing aids
- Home births

• Immunizations for travel or work, except where medically necessary or indicated.

• Implantable drugs and certain injectable drugs including injectable infertility drugs.

• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.

- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.

• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.

- Radial keratotomy or related procedures.
- Reversal of sterilization.

• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.

- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

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Includes routine tests and related lab fees.

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PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

Routine Mammograms	Covered 100%; deductible waived	50%; after deductible
Nomen's Health	Covered 100%; deductible waived	50%; after deductible
	abetes, HPV (Human- Papillomavirus) D	
	d screening for human immunodeficiency	
	breastfeeding support, supplies and cou	
	procedures, patient education and course	
Routine Digital Rectal Exam	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males a		
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males a		,
Colorectal Cancer Screening	Covered 100%; deductible waived	50%; after deductible
Recommended: For all members age		
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to Primary Care	\$40 office visit copay; deductible	50%; after deductible
Physician (PCP)	waived	
	eral physician, family practitioner or pedia	atrician.
Specialist Office Visits	\$80 office visit copay; deductible	50%; after deductible
· · · · · · · · · · · · · · · · · · ·	waived	
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
Valk-in Clinics	\$40 copay; deductible waived	50%; after deductible
	Designated Walk-in Clinics	
	Covered 100%; deductible waived	
Valk-in Clinics are free-standing heat		in or with a pharmacy, drug store
	Ith care facilities that (a) may be located	
supermarket or other retail store; and	Ith care facilities that (a) may be located (b) provide limited medical care and ser	vices on a scheduled or unscheduled
supermarket or other retail store; and basis. Urgent care centers, emergen	Ith care facilities that (a) may be located (b) provide limited medical care and ser cy rooms, the outpatient department of a	vices on a scheduled or unscheduled
supermarket or other retail store; and basis. Urgent care centers, emergen and physician offices are not conside	Ith care facilities that (a) may be located (b) provide limited medical care and ser cy rooms, the outpatient department of a red to be Walk-in Clinics.	vices on a scheduled or unscheduled hospital, ambulatory surgical centers
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PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

Emergency Room	\$300 copay; deductible waived	Same as in-network care
Copay waived if admitted		
Non-Emergency Care in an	Not Covered	Not Covered
Emergency Room		
Emergency Use of Ambulance	40%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	40%; after deductible	50%; after deductible
	d benefits incurred during your inpatien	
npatient Maternity Coverage	40%; after deductible	50%; after deductible
(includes delivery and postpartum		
care)		
	d benefits incurred during your inpatien	
Outpatient Hospital Expenses	40%; after deductible	50%; after deductible
	d benefits incurred during your outpatie	
Outpatient Surgery - Hospital	40%; after deductible; after \$250	50%; after deductible
	copay	
	d benefits incurred during your outpatie	
Outpatient Surgery - Freestanding	40%; after deductible; after \$250	50%; after deductible
Facility	copay	
	d benefits incurred during your outpatie	
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%; after deductible	50%; after deductible
	d benefits incurred during your inpatien	
Mental Health Office Visits	\$80 copay; deductible waived	50%; after deductible
	d benefits incurred during your outpatie	
Other Mental Health Services	Covered 100%; deductible waived	50%; after deductible
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	Covered 100%; after deductible	50%; after deductible
	d benefits incurred during your inpatien	
Residential Treatment Facility	Covered 100%; after deductible	50%; after deductible
Substance Abuse Office Visits	\$80 copay; deductible waived	50%; after deductible
	d benefits incurred during your outpatie	
Other Substance Abuse Services	Covered 100%; deductible waived	50%; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility	40%; after deductible	50%; after deductible
Limited to 60 days per year		
	d benefits incurred during your inpatien	t stay.
Home Health Care	40%; after deductible	50%; after deductible
Limited to 60 visits per year		
Private Duty Nursing not covered	, , ,	
		ker. Reimbursement may not be limited
	e maximum number of visits has been r	
	by a participating home health care age	ncy; 1 visit equals a period of 4 hrs or
less.	400/ 51 1 1 1	500/ (t)) (")
	100/ Lottor doductible	50%; after deductible
	40%; after deductible	
Your cost sharing applies to all covere	d benefits incurred during your inpatien	t stay.
Hospice Care - Outpatient		t stay. 50%; after deductible

Your cost sharing applies to all covered benefits incurred during your outpatient visit.



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Private Duty Nursing - Outpatient	Not Covered	Not Covered
Spinal Manipulation Therapy	\$40 copay; deductible waived	50%; after deductible
Limited to 20 visits per year		
Outpatient Short-Term	\$40 copay; deductible waived	50%; after deductible
Rehabilitation		
Limited to 20 visits per year.		
Includes speech, physical, occupationa	l therapy	
Habilitative Physical Therapy	Covered 100%; deductible waived	50%; after deductible
Habilitative Occupational Therapy	Covered 100%; deductible waived	50%; after deductible
Habilitative Speech Therapy	Covered 100%; deductible waived	50%; after deductible
Autism Behavioral Therapy	\$80 copay; deductible waived	50%; after deductible
Covered same as any other Outpatient	Mental Health benefit	
Autism Applied Behavior Analysis	Covered 100%; deductible waived	50%; after deductible
Covered same as any other Outpatient	Mental Health Other Services benefit	
Autism Physical Therapy	Covered 100%; deductible waived	50%; after deductible
Autism Occupational Therapy	Covered 100%; deductible waived	50%; after deductible
Autism Speech Therapy	Covered 100%; deductible waived	50%; after deductible
Durable Medical Equipment	40%; after deductible	50%; after deductible
Diabetic Supplies (if not covered	Covered same as any other medical	Covered same as any other medical
under Pharmacy benefit)	expense.	expense.
Women's Contraceptive drugs and	Covered 100%; deductible waived	Covered same as any other expense
devices not obtainable at a	,	- , , , ,
pharmacy		
Affordable Care Act Mandated	Covered 100%; deductible waived	Covered same as any other expense
Women's Contraceptives		••••••••••••••••••••••••••••••••••••••
Infusion Therapy	\$80 copay; deductible waived	50%; after deductible
Administered in the home or		,
physician's office		
Infusion Therapy	Your cost sharing is based on the	Your cost sharing is based on the
Administered in an outpatient hospital	type of service and where it is	type of service and where it is
department or freestanding facility	performed	performed
Vision Eyewear	Not Covered	Not Covered
Transplants	40%; after deductible	50%; after deductible
	Preferred coverage is provided at an	Non-Preferred coverage is provided
	IOE contracted facility only.	at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Acupuncture	\$40 copay; deductible waived	50%; after deductible
Limited to 10 visits per year		
Out of Area Dependents	Coverage provided at the non-preferre	d benefit level of the plan if in-network
eat of fillow Bopondonto	provider is not available.	
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Your cost sharing is based on the	Your cost sharing is based on the
morancy reachent	type of service and where it is	type of service and where it is
	performed	51
Diagnosis and treatment of the underly	1	performed

Diagnosis and treatment of the underlying medical condition only.



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Advanced Reproductive	Not Covered	Not Covered
Technology (ART)		
ART coverage includes: In vitro fertiliza	tion (IVF), zygote intrafallopian transfer	r (ZIFT), gamete intrafallopian transfer
(GIFT), cryopreserved embryo transfers	s, intracytoplasmic sperm injection (ICS	SI) or ovum microsurgery.
Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation ind	uction	
Vasectomy	Covered 100%; after deductible	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	Advanced Control Plan - Aetna	
Preferred Generic Drugs		
Retail	\$15 copay	20% of submitted cost; after
Ketan	φ10 copay	applicable in-network cost share
90 Day Retail	\$30 copay	applicable in-network cost shale
-		Not Applicable
Mail Order	\$30 copay	Not Applicable
Preferred Brand-Name Drugs	* = •	
Retail	\$50 copay	20% of submitted cost; after
		applicable in-network cost share
90 Day Retail	\$150 copay	
Mail Order	\$100 copay	Not Applicable
Non-Preferred Generic and Brand-Na	ame Drugs	
Retail	\$85 copay	20% of submitted cost; after
		applicable in-network cost share
90 Day Retail	\$255 copay	
Mail Order	\$170 copay	Not Applicable
Pharmacy Day Supply and Requirem		
Retail	Up to a 30 day supply from Aetna Nat	tional Network
Mail Order	A 31-90 day supply from CVS Carema	
Specialty	Up to a 30 day supply	
Opecially		ecialty pharmacy. Subsequent fills must
	be through our preferred specialty pha	
Chasse Constine If the mean h	Advanced Control Formulary Aetna Ir	
Choose Generics - If the member or the		
applicable copay plus the difference be		
Plan Includes: Diabetic supplies and C		
A limited list of over-the-counter medica		escription.
Oral chemotherapy drugs covered 100°	%	
Precertification and quantity limits inclue	ded	
Step Therapy included		
Seasonal Vaccinations covered 100% i	n-network	
Preventive Vaccinations covered 100%		
Affordable Care Act mandated female of		ons covered 100% in-network
GENERAL PROVISIONS		
	Spouse, children from birth to age 26	regardless of student status
Dependents Eligibility	opouse, ormuler normorention age 20	าธิบุลเนเธออิบเ อเนนธ์ที่ไ อิเลเนอ.

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

September 2021



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• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a list of services and supplies that are *generally* not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.



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• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.

• Cosmetic surgery, including breast reduction.

- · Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

- Hearing aids
- Home births

• Immunizations for travel or work, except where medically necessary or indicated.

• Implantable drugs and certain injectable drugs including injectable infertility drugs.

• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.

- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.

• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.

- Radial keratotomy or related procedures.
- Reversal of sterilization.

• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.

- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862**.

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **www.aetna.com.**

Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinicbranded walk-in clinics) are both within the CVS Health family.

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PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit Limitations - For any service	or supply that is subject to a maximum	visit, day, or dollar limitation on a per
year basis, the benefit year begins on	January 1st unless otherwise mandated	d. Refer to your plan documents for more
information.	2	
Deductible (per calendar year)	\$5,000 Individual	\$15,000 Individual
	\$10,000 Family	\$30,000 Family
All covered expenses accumulate ser	parately toward the in-network and out-o	
	tible must be met prior to benefits being	
		ed from charges to meet the Deductible.
Pharmacy expenses apply towards th		ed norm charges to meet the Deductible.
	Deductible for all family members. The	family Doductible can be mot by a
	ever, no single individual within the family	y will be subject to more than the
individual Deductible amount.	FO 0/	500/
Member Coinsurance	50%	50%
Applies to all expenses unless otherw		
Payment Limit (per calendar year)	\$6,250 Individual	\$20,000 Individual
	\$12,500 Family	\$40,000 Family
	parately toward the in-network or out-of-r	
Certain member cost sharing element	s may not apply toward the Payment Lir	nit.
Pharmacy expenses apply towards th	e Payment Limit.	
Only those out-of-pocket expenses re	sulting from the application of coinsuran	ce percentage, copays, and deductibles
(except any penalty amounts) may be		
		rs. The family Payment Limit can be met
	however, no single individual within the	
individual Payment Limit amount.	, 5	j
Lifetime Maximum		
Unlimited except where otherwise indi	icated	
Payment for Out-of-Network Care**		Professional: 105% of Medicare
ayment for out-or-network care	Not Applicable	Facility: 140% of Medicare
Primary Caro Physician Salastian	Ontional	Not Applicable
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -	()))))))))))))))))))	
	f-Network care must be obtained to avoi	
	ions, Treatment Facility Admissions, Co	
	e Duty Nursing is required - excluded ar	mount applied separately to each type o
expense is \$400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/	Covered 100%; deductible waived	50%; after deductible
Immunizations		
	5, 1 exam every 12 months age 65 and c	older
Routine Well Child		
	Covered 100%: deductible waived	
Exams/Immunizations	Covered 100%; deductible waived	50%; deductible waived
Exams/Immunizations 7 exams first 12 months 3 exams 13t		50%; deductible waived
7 exams first 12 months, 3 exams 13t		
7 exams first 12 months, 3 exams 13t to age 22.	h - 24th months, 3 exams 25th - 36th mo	50%; deductible waived onths, 1 exam per 12 months thereafter
7 exams first 12 months, 3 exams 13t to age 22. Routine Gynecological Care		50%; deductible waived
7 exams first 12 months, 3 exams 13t to age 22. Routine Gynecological Care Exams	h - 24th months, 3 exams 25th - 36th mo Covered 100%; deductible waived	50%; deductible waived onths, 1 exam per 12 months thereafter
	h - 24th months, 3 exams 25th - 36th mo Covered 100%; deductible waived	50%; deductible waived onths, 1 exam per 12 months thereafter

Includes routine tests and related lab fees.



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Routine Mammograms	Covered 100%; deductible waived	50%; after deductible
Nomen's Health	Covered 100%; deductible waived	50%; after deductible
	diabetes, HPV (Human- Papillomavirus) D	
	nd screening for human immunodeficiency	
	e, breastfeeding support, supplies and cou	
	procedures, patient education and counse	
Routine Digital Rectal Exam	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males		CON/, often deductible
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males Colorectal Cancer Screening	Covered 100%; deductible waived	50%; after deductible
Recommended: For all members ag		50%, alter deductible
Routine Eye Exams	Covered 100%; deductible waived	50%; after deductible
1 routine exam per 24 months.	Covered 100%, deductible walved	
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to Primary Care	50%; after deductible	50%; after deductible
Physician (PCP)		
	neral physician, family practitioner or pedia	atrician
Specialist Office Visits	50%; after deductible	50%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	50%; after deductible
		50%; after deductible
Walk-in Clinics		
Walk-in Clinics	50%; after deductible Designated Walk-in Clinics	
Walk-in Clinics	Designated Walk-in Clinics	
	Designated Walk-in Clinics Covered 100%; after deductible	
Walk-in Clinics are free-standing he	Designated Walk-in Clinics Covered 100%; after deductible ealth care facilities that (a) may be located	in or with a pharmacy, drug store,
Walk-in Clinics are free-standing he supermarket or other retail store; ar	Designated Walk-in Clinics Covered 100%; after deductible ealth care facilities that (a) may be located and (b) provide limited medical care and ser	in or with a pharmacy, drug store, vices on a scheduled or unscheduled
Walk-in Clinics are free-standing he supermarket or other retail store; ar basis. Urgent care centers, emerge	Designated Walk-in Clinics Covered 100%; after deductible ealth care facilities that (a) may be located ind (b) provide limited medical care and ser ency rooms, the outpatient department of a	in or with a pharmacy, drug store, vices on a scheduled or unscheduled
Walk-in Clinics are free-standing he supermarket or other retail store; ar basis. Urgent care centers, emerge and physician offices are not consid	Designated Walk-in Clinics Covered 100%; after deductible ealth care facilities that (a) may be located ind (b) provide limited medical care and ser ency rooms, the outpatient department of a	in or with a pharmacy, drug store, vices on a scheduled or unscheduled hospital, ambulatory surgical centers
Walk-in Clinics are free-standing he supermarket or other retail store; ar basis. Urgent care centers, emerge	Designated Walk-in Clinics Covered 100%; after deductible ealth care facilities that (a) may be located ind (b) provide limited medical care and ser ency rooms, the outpatient department of a dered to be Walk-in Clinics.	in or with a pharmacy, drug store, vices on a scheduled or unscheduled
Walk-in Clinics are free-standing he supermarket or other retail store; ar basis. Urgent care centers, emerge and physician offices are not consid	Designated Walk-in Clinics Covered 100%; after deductible ealth care facilities that (a) may be located ind (b) provide limited medical care and ser ency rooms, the outpatient department of a dered to be Walk-in Clinics. Your cost sharing is based on the	in or with a pharmacy, drug store, vices on a scheduled or unscheduled hospital, ambulatory surgical centers Your cost sharing is based on the
Walk-in Clinics are free-standing he supermarket or other retail store; ar basis. Urgent care centers, emerge and physician offices are not consid	Designated Walk-in Clinics Covered 100%; after deductible ealth care facilities that (a) may be located ind (b) provide limited medical care and ser ency rooms, the outpatient department of a dered to be Walk-in Clinics. Your cost sharing is based on the type of service and where it is	in or with a pharmacy, drug store, vices on a scheduled or unscheduled hospital, ambulatory surgical centers Your cost sharing is based on the type of service and where it is
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Walk-in Clinics are free-standing he supermarket or other retail store; ar basis. Urgent care centers, emerge and physician offices are not consid Allergy Testing	Designated Walk-in Clinics Covered 100%; after deductible ealth care facilities that (a) may be located in the (b) provide limited medical care and serve ency rooms, the outpatient department of a dered to be Walk-in Clinics. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the	in or with a pharmacy, drug store, vices on a scheduled or unscheduled hospital, ambulatory surgical centers Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the
Walk-in Clinics are free-standing he supermarket or other retail store; ar basis. Urgent care centers, emerge and physician offices are not consid Allergy Testing Allergy Injections	Designated Walk-in Clinics Covered 100%; after deductible ealth care facilities that (a) may be located in ad (b) provide limited medical care and ser- ency rooms, the outpatient department of a dered to be Walk-in Clinics. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is	in or with a pharmacy, drug store, vices on a scheduled or unscheduled hospital, ambulatory surgical centers Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is
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Walk-in Clinics are free-standing he supermarket or other retail store; ar basis. Urgent care centers, emerge and physician offices are not consid Allergy Testing Allergy Injections DIAGNOSTIC PROCEDURES Diagnostic X-ray	Designated Walk-in Clinics Covered 100%; after deductible ealth care facilities that (a) may be located ind (b) provide limited medical care and ser- ency rooms, the outpatient department of a dered to be Walk-in Clinics. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed IN-NETWORK 50%; after deductible n office visit and billed by the physician, ex	in or with a pharmacy, drug store, vices on a scheduled or unscheduled hospital, ambulatory surgical centers Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 50%; after deductible
Walk-in Clinics are free-standing he supermarket or other retail store; ar basis. Urgent care centers, emerge and physician offices are not consid Allergy Testing Allergy Injections DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physicial	Designated Walk-in Clinics Covered 100%; after deductible ealth care facilities that (a) may be located ind (b) provide limited medical care and ser- ency rooms, the outpatient department of a dered to be Walk-in Clinics. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed IN-NETWORK 50%; after deductible n office visit and billed by the physician, ex	in or with a pharmacy, drug store, vices on a scheduled or unscheduled hospital, ambulatory surgical centers Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 50%; after deductible
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Walk-in Clinics are free-standing he supermarket or other retail store; ar basis. Urgent care centers, emerge and physician offices are not consid Allergy Testing Allergy Injections DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician applicable physician's office visit me Diagnostic Laboratory If performed as a part of a physician applicable physician's office visit me Diagnostic Outpatient Complex Imaging	Designated Walk-in Clinics Covered 100%; after deductible ealth care facilities that (a) may be located in d (b) provide limited medical care and ser- ency rooms, the outpatient department of a dered to be Walk-in Clinics. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed Nour cost sharing is based on the type of service and where it is performed IN-NETWORK 50%; after deductible n office visit and billed by the physician, ex ember cost sharing. 50%; after deductible n office visit and billed by the physician, ex ember cost sharing.	in or with a pharmacy, drug store, vices on a scheduled or unscheduled hospital, ambulatory surgical centers. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible penses are covered subject to the
Walk-in Clinics are free-standing he supermarket or other retail store; ar basis. Urgent care centers, emerge and physician offices are not consid Allergy Testing Allergy Injections DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician applicable physician's office visit me Diagnostic Laboratory If performed as a part of a physician applicable physician's office visit me Diagnostic Outpatient Complex Imaging If performed as a part of a physician applicable physician's office visit me	Designated Walk-in Clinics Covered 100%; after deductible ealth care facilities that (a) may be located ind (b) provide limited medical care and ser- ency rooms, the outpatient department of a dered to be Walk-in Clinics. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed IN-NETWORK 50%; after deductible n office visit and billed by the physician, ex ember cost sharing. 50%; after deductible n office visit and billed by the physician, ex ember cost sharing. 50%; after deductible n office visit and billed by the physician, ex	in or with a pharmacy, drug store, vices on a scheduled or unscheduled hospital, ambulatory surgical centers. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible penses are covered subject to the
Walk-in Clinics are free-standing he supermarket or other retail store; ar basis. Urgent care centers, emerge and physician offices are not consid Allergy Testing Allergy Injections DIAGNOSTIC PROCEDURES Diagnostic X-ray if performed as a part of a physician applicable physician's office visit me Diagnostic Laboratory if performed as a part of a physician applicable physician's office visit me Diagnostic Outpatient Complex imaging if performed as a part of a physician applicable physician's office visit me	Designated Walk-in Clinics Covered 100%; after deductible ealth care facilities that (a) may be located ind (b) provide limited medical care and ser- ency rooms, the outpatient department of a dered to be Walk-in Clinics. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed IN-NETWORK 50%; after deductible n office visit and billed by the physician, ex ember cost sharing. 50%; after deductible n office visit and billed by the physician, ex ember cost sharing. 50%; after deductible n office visit and billed by the physician, ex ember cost sharing. 50%; after deductible n office visit and billed by the physician, ex ember cost sharing.	in or with a pharmacy, drug store, vices on a scheduled or unscheduled hospital, ambulatory surgical centers. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible penses are covered subject to the 50% ; after deductible penses are covered subject to the 0UT-OF-NETWORK
Walk-in Clinics are free-standing he supermarket or other retail store; ar basis. Urgent care centers, emerge and physician offices are not consid Allergy Testing Allergy Injections DIAGNOSTIC PROCEDURES Diagnostic X-ray f performed as a part of a physician applicable physician's office visit me Diagnostic Laboratory f performed as a part of a physician applicable physician's office visit me Diagnostic Outpatient Complex Imaging f performed as a part of a physician applicable physician's office visit me Diagnostic Outpatient Complex Imaging f performed as a part of a physician applicable physician's office visit me Diagnostic Outpatient Complex Imaging	Designated Walk-in Clinics Covered 100%; after deductible ealth care facilities that (a) may be located ind (b) provide limited medical care and ser- ency rooms, the outpatient department of a dered to be Walk-in Clinics. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed IN-NETWORK 50%; after deductible n office visit and billed by the physician, ex ember cost sharing. 50%; after deductible n office visit and billed by the physician, ex ember cost sharing. 50%; after deductible	in or with a pharmacy, drug store, vices on a scheduled or unscheduled hospital, ambulatory surgical centers. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible penses are covered subject to the
Walk-in Clinics are free-standing he supermarket or other retail store; ar basis. Urgent care centers, emerge and physician offices are not consid Allergy Testing Allergy Injections DIAGNOSTIC PROCEDURES Diagnostic X-ray If performed as a part of a physician applicable physician's office visit me Diagnostic Laboratory If performed as a part of a physician applicable physician's office visit me Diagnostic Outpatient Complex Imaging If performed as a part of a physician	Designated Walk-in Clinics Covered 100%; after deductible ealth care facilities that (a) may be located ind (b) provide limited medical care and ser- ency rooms, the outpatient department of a dered to be Walk-in Clinics. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed IN-NETWORK 50%; after deductible n office visit and billed by the physician, ex ember cost sharing. 50%; after deductible n office visit and billed by the physician, ex ember cost sharing. 50%; after deductible n office visit and billed by the physician, ex ember cost sharing. 50%; after deductible n office visit and billed by the physician, ex ember cost sharing.	in or with a pharmacy, drug store, vices on a scheduled or unscheduled hospital, ambulatory surgical centers. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed OUT-OF-NETWORK 50%; after deductible penses are covered subject to the 50%; after deductible penses are covered subject to the 50% ; after deductible penses are covered subject to the 0UT-OF-NETWORK



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Emergency Room	50%; after deductible	Same as in-network care
Non-Emergency Care in an	Not Covered	Not Covered
Emergency Room		
Emergency Use of Ambulance	50%; after deductible	Same as in-network care
Ion-Emergency Use of Ambulance	Not Covered	Not Covered
IOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
npatient Coverage	50%; after deductible	50%; after deductible
our cost sharing applies to all covered	benefits incurred during your inpation	ent stay.
npatient Maternity Coverage	50%; after deductible	50%; after deductible
includes delivery and postpartum		
are)		
our cost sharing applies to all covered	benefits incurred during your inpation	ent stay.
Dutpatient Hospital Expenses	50%; after deductible	50%; after deductible
our cost sharing applies to all covered		
Outpatient Surgery - Hospital	50%; after deductible	50%; after deductible
our cost sharing applies to all covered		
Outpatient Surgery - Freestanding	50%; after deductible	50%; after deductible
acility		
our cost sharing applies to all covered	benefits incurred during your outpa	tient visit.
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
npatient	50%; after deductible	50%; after deductible
our cost sharing applies to all covered		
Iental Health Office Visits	50%; after deductible	50%; after deductible
our cost sharing applies to all covered		tient visit.
Other Mental Health Services	50%; after deductible	50%; after deductible
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
npatient	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered		
Residential Treatment Facility	50%; after deductible	50%; after deductible
Substance Abuse Office Visits	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered		
Other Substance Abuse Services	50%; after deductible	50%; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility	50%; after deductible	50%; after deductible
imited to 60 days per year		
our cost sharing applies to all covered	benefits incurred during your inpation	ent stay.
Iome Health Care	50%; after deductible	50%; after deductible
limited to 60 visits per year		
Private Duty Nursing not covered	g and services of a medical social w	orker. Reimbursement may not be limite
Private Duty Nursing not covered Coverage includes nutritional counselin		
Private Duty Nursing not covered Coverage includes nutritional counselin o less than \$1,000 per year even if the	maximum number of visits has been	
Private Duty Nursing not covered Coverage includes nutritional counselin o less than \$1,000 per year even if the .imited to 3 intermittent visits per day b	maximum number of visits has been	n reached.
Private Duty Nursing not covered Coverage includes nutritional counselin o less than \$1,000 per year even if the Limited to 3 intermittent visits per day b ess.	maximum number of visits has been	n reached.
Private Duty Nursing not covered Coverage includes nutritional counselin o less than \$1,000 per year even if the Limited to 3 intermittent visits per day b ess. Hospice Care - Inpatient	maximum number of visits has been y a participating home health care a 50%; after deductible	n reached. gency; 1 visit equals a period of 4 hrs or 50%; after deductible
Private Duty Nursing not covered Coverage includes nutritional counselin o less than \$1,000 per year even if the Limited to 3 intermittent visits per day b ess. Hospice Care - Inpatient Your cost sharing applies to all covered	maximum number of visits has been y a participating home health care a 50%; after deductible	n reached. gency; 1 visit equals a period of 4 hrs or 50%; after deductible
Private Duty Nursing not covered Coverage includes nutritional counselin to less than \$1,000 per year even if the Limited to 3 intermittent visits per day b tess. Hospice Care - Inpatient Your cost sharing applies to all covered Hospice Care - Outpatient	maximum number of visits has been y a participating home health care a 50%; after deductible benefits incurred during your inpatio 50%; after deductible	n reached. gency; 1 visit equals a period of 4 hrs or 50%; after deductible ent stay. 50%; after deductible
Private Duty Nursing not covered Coverage includes nutritional counselin o less than \$1,000 per year even if the Limited to 3 intermittent visits per day b ess. Hospice Care - Inpatient Your cost sharing applies to all covered Hospice Care - Outpatient Your cost sharing applies to all covered	maximum number of visits has been y a participating home health care a 50%; after deductible benefits incurred during your inpatio 50%; after deductible	n reached. gency; 1 visit equals a period of 4 hrs or 50%; after deductible ent stay. 50%; after deductible
o less than \$1,000 per year even if the	maximum number of visits has been y a participating home health care a 50%; after deductible benefits incurred during your inpatio 50%; after deductible benefits incurred during your outpa	gency; 1 visit equals a period of 4 hrs or 50%; after deductible ent stay. 50%; after deductible tient visit.



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Outpatient Short-Term	50%; after deductible	50%; after deductible
Rehabilitation		
Limited to 30 visits per year.		
Includes speech, physical, occupationa	al therapy	
Habilitative Physical Therapy	50%; after deductible	50%; after deductible
Habilitative Occupational Therapy	50%; after deductible	50%; after deductible
Habilitative Speech Therapy	50%; after deductible	50%; after deductible
Autism Behavioral Therapy	50%; after deductible	50%; after deductible
Covered same as any other Outpatien	t Mental Health benefit	
Autism Applied Behavior Analysis	50%; after deductible	50%; after deductible
Covered same as any other Outpatien		
Autism Physical Therapy	50%; after deductible	50%; after deductible
Autism Occupational Therapy	50%; after deductible	50%; after deductible
Autism Speech Therapy	50%; after deductible	50%; after deductible
Durable Medical Equipment	50%; after deductible	50%; after deductible
Diabetic Supplies (if not covered	Covered same as any other medical	Covered same as any other medical
under Pharmacy benefit)	expense.	expense.
Women's Contraceptive drugs and	Covered 100%; deductible waived	Covered same as any other expense.
devices not obtainable at a	,	5
pharmacy		
Affordable Care Act Mandated	Covered 100%; deductible waived	Covered same as any other expense.
Women's Contraceptives		
Infusion Therapy	50%; after deductible	50%; after deductible
Administered in the home or		
physician's office		
Infusion Therapy	50%; after deductible	50%; after deductible
Administered in an outpatient hospital		
department or freestanding facility		
Vision Eyewear	Not Covered	Not Covered
Transplants	50%; after deductible	50%; after deductible
-	Preferred coverage is provided at an	Non-Preferred coverage is provided
	IOE contracted facility only.	at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Acupuncture	50%; after deductible	50%; after deductible
Limited to 10 visits per year	<i>.</i>	·
Out of Area Dependents	Coverage provided at the non-preferre	d benefit level of the plan if in-network
• • • • •	provider is not available.	•
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Your cost sharing is based on the	Your cost sharing is based on the
-	type of service and where it is	type of service and where it is
	performed	performed
Diagnosis and treatment of the underly	•	L

Diagnosis and treatment of the underlying medical condition only.



PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

Advanced Reproductive	Not Covered	Not Covered
Technology (ART)	Noteovered	
	ition (IVF), zygote intrafallopian transfer	(ZIFT), gamete intrafallopian transfer
	s, intracytoplasmic sperm injection (ICS	
Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation ind		
Vasectomy	Your cost sharing is based on the	50%; after deductible
•	type of service and where it is	
	performed	
Tubal Ligation	Covered 100%; deductible waived	50%; after deductible
PHARMACY	IN-NETWORK	OUT-OF-NETWORK
The full cost of the drug is applied to th	e deductible before any benefits are co	nsidered for payment under the
pharmacy plan.		
Pharmacy Plan Type	Advanced Control Plan - Aetna	
Preferred Generic Drugs		
Retail	\$10 copay	\$10 copay
90 Day Retail	\$30 copay	
Mail Order	\$25 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	\$30 copay	\$30 copay
90 Day Retail	\$90 copay	
Mail Order	\$75 copay	Not Applicable
Non-Preferred Generic and Brand-Na		
Retail	\$50 copay	\$50 copay
90 Day Retail	\$150 copay	
Mail Order	\$125 copay	Not Applicable
Pharmacy Day Supply and Requirem		in an all Minda and a
Retail Mail Order	Up to a 30 day supply from Aetna Nat	
Specialty	A 31-90 day supply from CVS Carema Up to a 30 day supply	
Specially		ecialty pharmacy. Subsequent fills must
	be through our preferred specialty pha	
	Advanced Control Formulary Aetna In	
Choose Generics - If the member or the	he physician requests brand when gene	
	etween the generic price and the brand i	
	Contraceptive drugs and devices obtain	
	ations are covered when filled with a pre-	
Oral chemotherapy drugs covered 100	•	•
Precertification and quantity limits inclu		
Step Therapy included		
Seasonal Vaccinations covered 100%	in-network	
Preventive Vaccinations covered 100%		
Affordable Care Act mandated female	contraceptives and preventive medication	ons covered 100% in-network.
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26	regardless of student status.
	-	

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.



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• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a list of services and supplies that are *generally* not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.



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• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.

- Cosmetic surgery, including breast reduction.
- · Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

- Hearing aids
- Home births

• Immunizations for travel or work, except where medically necessary or indicated.

• Implantable drugs and certain injectable drugs including injectable infertility drugs.

• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT,

ICSI and other related services, unless specifically listed as covered in your plan documents.

- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.

• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.

- Radial keratotomy or related procedures.
- Reversal of sterilization.

• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.

- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to www.aetna.com.

Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinicbranded walk-in clinics) are both within the CVS Health family.

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PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

FUND FEATURES

HealthFund Amount

\$1,500 Employee

Amount contributed to the Fund by the employer

Fund amount reflected is on a per year basis. The fund received may be prorated based on your effective date of coverage.

The Family HealthFund amount applies to all family members combined. There is no Individual HealthFund limit within the Family HealthFund amount.

Fund Coinsurance	100%	
Percentage at which the Fund will rein	nburse	
Fund Administration	deductible and coinsurance. On medical plan provides coverage will pay your member responsib Out of Pocket Maximum has be whichever comes first. Services paid by the plan and not by the	
Employee Termination from Your		efit amount is forfeited (or terminated) when
HealthFund	the employee's HealthFund cov	
Fund Rollover	into next year's HealthFund ben	
Eligible Fund Expenses	Reasonable & Customary limit, expenses are not eligible for rei	
Fund Payment/Assignment	Network Providers: Automatic	0 1
		er may assign payment to provider.
Pro-ration for New Employees	Monthly	
Pro-ration for Family Status Change		tier based on new employee status.
Prescription Drug Plan	to medical Deductible and appli	e integrated with the medical plan (i.e., subject ed towards the medical Out-of-Pocket Limit) for reimbursement from the Fund).
PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
		mum visit, day, or dollar limitation on a per ndated. Refer to your plan documents for more
Deductible (per calendar year)	\$5,000 Individual	\$15,000 Individual
	\$10,000 Family	\$30,000 Family
All covered expenses accumulate sep		
Unless otherwise indicated, the deduc		
		xcluded from charges to meet the Deductible.
Pharmacy expenses apply towards the		
		The family Deductible can be met by a family will be subject to more than the
Member Coinsurance	50%	50%
Applies to all expenses unless otherwi	se stated.	
Applies to all expenses unless otherwine Payment Limit (per calendar year)	se stated. \$6,250 Individual \$12,500 Family	\$20,000 Individual \$40,000 Family



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Certain member cost sharing elements may not apply toward the Payment Limit.

Pharmacy expenses apply towards the Payment Limit.

Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit.

The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.

Lifetime Maximum

Unlimited except where otherwise indicated.

Payment for Out-of-Network Care**	Not Applicable	Professional: 105% of Medicare
		Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable

Certification Requirements -

Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is \$400 per occurrence.

expense is \$400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/	Covered 100%; deductible waived	50%; after deductible
mmnizations		
1 exam every 12 months up to age 6	5, 1 exam every 12 months age 65 and c	older
Routine Well Child	Covered 100%; deductible waived	50%; deductible waived
Exams/Immunizations		
	8th - 24th months, 3 exams 25th - 36th m	onths, 1 exam per 12 months thereafter
to age 22.		
Routine Gynecological Care	Covered 100%; deductible waived	50%; after deductible
Exams		
1 obgyn exam and pap smear per ye	ar	
Includes routine tests and related lab	o fees.	
Routine Mammograms	Covered 100%; deductible waived	50%; after deductible
Women's Health	Covered 100%; deductible waived	50%; after deductible
ncludes: Screening for gestational d	iabetes, HPV (Human- Papillomavirus) D	NA testing, counseling for sexually
ransmitted infections, counseling an	d screening for human immunodeficiency	/ virus, screening and counseling for
interpersonal and domestic violence,	breastfeeding support, supplies and cou	inseling.
Contraceptive methods, sterilization	procedures, patient education and couns	eling. Limitations may apply.
Routine Digital Rectal Exam	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males a		
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males a	age 40 and over.	
Colorectal Cancer Screening	Covered 100%; deductible waived	50%; after deductible
Recommended: For all members age	e 45 and over.	
Routine Eye Exams	Covered 100%; deductible waived	50%; after deductible
1 routine exam per 24 months.		
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to Primary Care	50%; after deductible	50%; after deductible
Physician (PCP)		
Includes services of an internist, gen	eral physician, family practitioner or pedia	atrician.
Specialist Office Visits	50%; after deductible	50%; after deductible
Hearing Exams	Not Covered	Not Covered
Sontombor 2021		Paga
Sontompor 2021		Logo



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Covered 100%; deductible waived	50%; after deductible
50%; after deductible	50%; after deductible
Designated Walk-in Clinics	
(b) provide limited medical care and ser	vices on a scheduled or unscheduled
y rooms, the outpatient department of a	hospital, ambulatory surgical centers,
ed to be Walk-in Clinics.	
Your cost sharing is based on the	Your cost sharing is based on the
type of service and where it is	type of service and where it is
performed	performed
Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is
	performed
	OUT-OF-NETWORK
	50%; after deductible
	3
	50%; after deductible
	50%; after deductible
fice visit and hilled by the physician ex	penses are covered subject to the
	OUT-OF-NETWORK
	50%; after deductible
	Not Covered
Not Covered	Not Covered
E00/ Lafter deductible	Same as in-network care
Not Covered	Not Covered
	O and a sector water and
	Same as in-network care
	Not Covered
	OUT-OF-NETWORK
	50%; after deductible
50%; after deductible	50%; after deductible
d benefits incurred during your inpatien	
50%; after deductible	50%; after deductible
d benefits incurred during your outpatie	
50%; after deductible	50%; after deductible
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d benefits incurred during your outpatie	nt visit
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	50%; after deductible
	JU /0, AILEI UEUUUUUU
d honofite incurred during your inneties	t ctov
d benefits incurred during your inpatien	t stay.
	50%; after deductible Designated Walk-in Clinics Covered 100%; deductible waived h care facilities that (a) may be located (b) provide limited medical care and ser y rooms, the outpatient department of a ed to be Walk-in Clinics. Your cost sharing is based on the type of service and where it is performed Your cost sharing is based on the type of service and where it is performed IN-NETWORK 50%; after deductible ffice visit and billed by the physician, ex- ber cost sharing. 50%; after deductible ffice visit and billed by the physician, ex- ber cost sharing. 50%; after deductible ffice visit and billed by the physician, ex- ber cost sharing. 50%; after deductible ffice visit and billed by the physician, ex- ber cost sharing. 50%; after deductible ffice visit and billed by the physician, ex- ber cost sharing. IN-NETWORK 50%; after deductible Not Covered 50%; after deductible Not Covered 50%; after deductible Not Covered 1N-NETWORK 50%; after deductible Not Covered 1N-NETWORK 50%; after deductible Not Covered 1N-NETWORK 50%; after deductible d benefits incurred during your inpatient 50%; after deductible d benefits incurred during your outpatient 50%; after deductible



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50%; after deductible	50%; after deductible
	50%; after deductible
	OUT-OF-NETWORK
	50%; after deductible
	50%; after deductible
	50%; after deductible
	50%; after deductible
	OUT-OF-NETWORK
50%; after deductible	50%; after deductible
50%; after deductible	50%; after deductible
by a participating home health care ager	ncy; 1 visit equals a period of 4 hrs or
50%; after deductible	50%; after deductible
d benefits incurred during your inpatient	stay.
50%; after deductible	50%; after deductible
d benefits incurred during your outpatien	it visit.
Not Covered	Not Covered
50%; after deductible	50%; after deductible
50%; after deductible	50%; after deductible
al therapy	
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50%; after deductible	50%; after deductible
	50%; after deductible 50%; after deductible
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	d benefits incurred during your outpatier 50%; after deductible IN-NETWORK 50%; after deductible d benefits incurred during your inpatient 50%; after deductible IN-NETWORK 50%; after deductible IN-NETWORK 50%; after deductible d benefits incurred during your inpatient 50%; after deductible d benefits incurred during your inpatient 50%; after deductible ng and services of a medical social work e maximum number of visits has been re by a participating home health care ager 50%; after deductible d benefits incurred during your inpatient 50%; after deductible d benefits incurred during your outpatier Not Covered 50%; after deductible 50%; after deductible 50%; after deductible after deductible



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Infusion Therapy	50%; after deductible	50%; after deductible
Administered in the home or		
physician's office		
nfusion Therapy	50%; after deductible	50%; after deductible
Administered in an outpatient hospital		
department or freestanding facility		
Vision Eyewear	Not Covered	Not Covered
Transplants	50%; after deductible	50%; after deductible
	Preferred coverage is provided at an	Non-Preferred coverage is provided
	IOE contracted facility only.	at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
Acupuncture	50%; after deductible	50%; after deductible
Limited to 10 visits per year		
Out of Area Dependents	Coverage provided at the non-preferred	d benefit level of the plan if in-network
-	provider is not available.	
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Your cost sharing is based on the	Your cost sharing is based on the
	type of service and where it is	type of service and where it is
	performed	performed
Diagnosis and treatment of the underlyi	•	performed
	•	performed Not Covered
Diagnosis and treatment of the underly Advanced Reproductive Technology (ART)	ng medical condition only.	•
Advanced Reproductive Technology (ART)	ng medical condition only. Not Covered	Not Covered
Advanced Reproductive Technology (ART) ART coverage includes: In vitro fertiliza	ng medical condition only. Not Covered tion (IVF), zygote intrafallopian transfer (· Not Covered (ZIFT), gamete intrafallopian transfer
Advanced Reproductive Technology (ART) ART coverage includes: In vitro fertiliza	ng medical condition only. Not Covered	· Not Covered (ZIFT), gamete intrafallopian transfer
Advanced Reproductive Technology (ART) ART coverage includes: In vitro fertiliza (GIFT), cryopreserved embryo transfers Comprehensive Infertility Services	ng medical condition only. Not Covered tion (IVF), zygote intrafallopian transfer (s, intracytoplasmic sperm injection (ICSI) Not Covered	Not Covered (ZIFT), gamete intrafallopian transfer) or ovum microsurgery.
Advanced Reproductive Technology (ART) ART coverage includes: In vitro fertiliza (GIFT), cryopreserved embryo transfers	ng medical condition only. Not Covered tion (IVF), zygote intrafallopian transfer (s, intracytoplasmic sperm injection (ICSI) Not Covered uction	Not Covered (ZIFT), gamete intrafallopian transfer) or ovum microsurgery.
Advanced Reproductive Technology (ART) ART coverage includes: In vitro fertiliza (GIFT), cryopreserved embryo transfers Comprehensive Infertility Services Artificial insemination and ovulation ind	ng medical condition only. Not Covered tion (IVF), zygote intrafallopian transfer (s, intracytoplasmic sperm injection (ICSI) Not Covered uction Your cost sharing is based on the	Not Covered ZIFT), gamete intrafallopian transfer or ovum microsurgery. Not Covered
Advanced Reproductive Technology (ART) ART coverage includes: In vitro fertiliza (GIFT), cryopreserved embryo transfers Comprehensive Infertility Services Artificial insemination and ovulation ind	ng medical condition only. Not Covered tion (IVF), zygote intrafallopian transfer (s, intracytoplasmic sperm injection (ICSI) Not Covered uction	Not Covered ZIFT), gamete intrafallopian transfer or ovum microsurgery. Not Covered



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PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

PHARMACY	IN-NETWORK	OUT-OF-NETWORK
	e deductible before any be	nefits are considered for payment under the
pharmacy plan.		
Pharmacy Plan Type	Advanced Control Plan -	Aetna
Preferred Generic Drugs		
Retail	\$10 copay	\$10 copay
90 Day Retail	\$30 copay	
Mail Order	\$25 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	\$30 copay	\$30 copay
90 Day Retail	\$90 copay	
Mail Order	\$75 copay	Not Applicable
Non-Preferred Generic and Brand-Na	ame Drugs	
Retail	\$50 copay	\$50 copay
90 Day Retail	\$150 copay	
Mail Order	\$125 copay	Not Applicable
Pharmacy Day Supply and Requirem	ients	
Retail	Up to a 30 day supply fro	m Aetna National Network
Mail Order	A 31-90 day supply from	CVS Caremark® Mail Service Pharmacy
Specialty	Up to a 30 day supply	
		/ retail or specialty pharmacy. Subsequent fills must
		specialty pharmacy network.
	Advanced Control Formu	
		d when generic is available, the member pays the
applicable copay plus the difference be		
Plan Includes: Diabetic supplies and C		
A limited list of over-the-counter medica		ed with a prescription.
Oral chemotherapy drugs covered 100		
Precertification and quantity limits inclu	ded	
Step Therapy included		
Seasonal Vaccinations covered 100% i		
Preventive Vaccinations covered 100%		
	contraceptives and prevent	ve medications covered 100% in-network.
GENERAL PROVISIONS		
Dependents Eligibility	O 111 (111	h to age 26 regardless of student status.

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.



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If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The following is a list of services and supplies that are *generally* not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.

- Cosmetic surgery, including breast reduction.
- · Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval

• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.

- Hearing aids
- Home births

• Immunizations for travel or work, except where medically necessary or indicated.

• Implantable drugs and certain injectable drugs including injectable infertility drugs.

• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.

- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.

• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and overthe-counter medications (except as provided in a hospital) and supplies.

- Radial keratotomy or related procedures.
- Reversal of sterilization.

• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.

- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.

• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862**. September 2021 Page 7



Effective Date: 01-01-2022 Aetna HealthFund[™] Open Access[®] Managed Choice[®] POS - Florida

PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **www.aetna.com.**

Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinicbranded walk-in clinics) are both within the CVS Health family.

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EXHIBIT 2

Medical and Prescription Experience Reports

Monitoring by Utilization and Enrollment

Company: SCHOOL DISTRICT OF HENDRY CNTY

Group: 51504

Current Paid Period: From 01/2017 to 12/2017

	Enrollment		Premium		Capitation			Fee for Service Claims						
Service	Contracts	Members	Premium	PCP	Specialty	Total	Inpatient	Outpatient	Physician	Other	Total Medical	Pharmacy	Grand Total	MLR
Year Month						Capitation								
201701	863	1,037	\$576,871.64	\$0.00	\$1,108.50	\$1,108.50	\$81,620.48	\$173,284.69	\$100,652.69	\$32,825.92	\$388,383.78	\$70,527.89	\$460,020.17	79.74%
201702	863	1,038	\$567,850.19	\$0.00	\$1,106.32	\$1,106.32	\$37,132.64	\$74,387.48	\$70,358.55	\$35,853.14	\$217,731.81	\$73,955.99	\$292,794.12	51.56%
201703	866	1,043	\$572,892.70	\$0.00	\$1,112.86	\$1,112.86	\$163,912.46	\$119,771.55	\$104,792.27	\$16,074.48	\$404,550.76	\$105,278.91	\$510,942.53	89.19%
201704	865	1,043	\$576,956.84	\$0.00	\$1,112.86	\$1,112.86	\$320,686.04	\$79,382.43	\$81,204.60	\$52,026.65	\$533,299.72	\$98,495.41	\$632,907.99	109.70%
201705	864	1,043	\$574,857.32	\$0.00	\$1,112.86	\$1,112.86	\$278,999.39	\$101,264.30	\$95,511.10	\$23,201.73	\$498,976.52	\$102,975.02	\$603,064.40	104.91%
201706	862	1,036	\$572,287.93	\$0.00	\$1,107.60	\$1,107.60	\$150,478.77	\$196,961.65	\$126,701.62	\$62,275.87	\$536,417.91	\$104,814.84	\$642,340.35	112.24%
201707	857	1,035	\$568,683.37	\$0.00	\$1,105.42	\$1,105.42	\$260,230.47	\$113,427.80	\$101,534.40	\$42,470.71	\$517,663.38	\$105,006.41	\$623,775.21	109.69%
201708	782	956	\$530,673.76	\$0.00	\$1,018.22	\$1,018.22	\$20,812.28	\$102,822.59	\$90,254.74	\$42,411.18	\$256,300.79	\$83,794.43	\$341,113.44	64.28%
201709	829	1,011	\$537,358.05	\$0.00	\$1,077.08	\$1,077.08	\$66,925.31	\$94,391.04	\$60,928.68	\$28,468.55	\$250,713.58	\$88,286.43	\$340,077.09	63.29%
201710	848	1,032	\$580,831.31	\$0.00	\$1,104.33	\$1,104.33	\$150,043.45	\$77,319.78	\$87,648.41	\$19,218.38	\$334,230.02	\$108,358.74	\$443,693.09	76.39%
201711	847	1,034	\$558,208.66	\$0.00	\$1,105.16	\$1,105.16	\$35,333.25	\$65,160.95	\$79,080.78	\$12,728.33	\$192,303.31	\$90,125.93	\$283,534.40	50.79%
201712	842	1,027	\$568,523.71	\$0.00	\$1,096.25	\$1,096.25	\$19,105.38	\$70,235.69	\$49,949.07	\$15,236.16	\$154,526.30	\$60,080.30	\$215,702.85	37.94%
Total	10,188	12,335	\$6,785,995.48	\$0.00	\$13,167.46	\$13,167.46	\$1,585,279.92	\$1,268,409.95	\$1,048,616.91	\$382,791.10	\$4,285,097.88	\$1,091,700.30	\$5,389,965.64	79.43%
Grouping	637	771	\$424,124.72	\$0.00	\$822.97	\$822.97	\$99,080.00	\$79,275.62	\$65,538.56	\$23,924.44	\$267,818.62	\$68,231.27	\$336,872.85	79.43%
Ανα														
Monthly Ava	637	771	\$424,124.72	\$0.00	\$822.97	\$822.97	\$99,080.00	\$79,275.62	\$65,538.56	\$23,924.44	\$267,818.62	\$68,231.27	\$336,872.85	79.43%

Notes:

- Grand Total includes Medical FFS, Pharmacy FFS and Capitation.

- Enrollment is recast to reflect retroactive adjustments.

- Grouping Avg – Average of the distinct groupings chosen by the user.

- Monthly Avg – Average of a measure over Service/Paid time period.

- FFS = Fee For Service.

- MLR = Medical Loss Ratio.

Monitoring by Utilization and Enrollment

Company: SCHOOL DISTRICT OF HENDRY CNTY

Group: 51504

Current Service Period: From 01/2018 to 12/2018

Current Paid Period: From 01/2018 to 03/2019

	Enrol	ment	Premium	Capitation				Fee for Service Claims							
Paid Year Month	Contracts	Members	Premium	PCP	Specialty	Total	Total	Inpatient	Outpatient	Physician	Other	Total Medical	Pharmacy	Grand Total	MLR
						Capitation	Incentive								
201801	847	991	\$658,703.37	\$0.00	\$1,232.41	\$1,232.41	\$0.00	\$19,624.54	\$14,418.13	\$46,451.88	\$20,146.24	\$100,640.79	\$81,278.23	\$183,151.43	27.80%
201802	845	985	\$661,978.31	\$0.00	\$1,212.19	\$1,212.19	\$0.00	\$77,320.08	\$87,307.44	\$73,365.54	\$17,867.29	\$255,860.35	\$117,546.56	\$374,619.10	56.59%
201803	841	979	\$650,742.48	\$0.00	\$1,212.45	\$1,212.45	\$0.00	\$87,655.13	\$58,056.02	\$101,446.55	\$27,151.43	\$274,309.13	\$108,947.35	\$384,468.93	59.08%
201804	836	976	\$651,390.14	\$0.00	\$1,196.64	\$1,196.64	\$0.00	\$67,810.35	\$53,822.04	\$65,376.64	\$20,269.98	\$207,279.01	\$78,176.92	\$286,652.57	44.01%
201805	830	970	\$652,077.47	\$0.00	\$1,203.04	\$1,203.04	\$0.00	\$75,144.26	\$29,292.62	\$96,089.51	\$15,886.48	\$216,412.87	\$123,963.21	\$341,579.12	52.38%
201806	827	964	\$643,045.42	\$0.00	\$1,190.24	\$1,190.24	\$0.00	\$81,797.14	\$115,928.80	\$69,398.70	\$24,055.45	\$291,180.09	\$107,504.29	\$399,874.62	62.18%
201807	824	963	\$639,555.79	\$0.00	\$1,183.84	\$1,183.84	\$0.00	\$119,091.25	\$196,479.67	\$146,727.84	\$27,307.82	\$489,606.58	\$92,850.00	\$583,640.42	91.26%
201808	752	888	\$595,717.01	\$0.00	\$1,100.12	\$1,100.12	\$0.00	\$10,755.22	\$157,032.64	\$71,684.65	\$20,152.25	\$259,624.76	\$119,699.21	\$380,424.09	63.86%
201809	753	891	\$587,772.43	\$0.00	\$1,106.52	\$1,106.52	\$0.00	\$265,330.87	\$71,510.61	\$59,852.43	\$16,804.04	\$413,497.95	\$95,818.43	\$510,422.90	86.84%
201810	821	960	\$585,357.11	\$0.00	\$1,182.94	\$1,182.94	\$0.00	\$162,949.49	\$34,891.98	\$55,257.76	\$32,287.80	\$285,387.03	\$122,137.05	\$408,707.02	69.82%
201811	828	965	\$686,234.98	\$0.00	\$1,195.36	\$1,195.36	\$0.00	\$53,554.68	\$79,725.12	\$92,398.13	\$26,905.15	\$252,583.08	\$114,841.62	\$368,620.06	53.72%
201812	838	978	\$657,709.08	\$0.00	\$1,191.59	\$1,191.59	\$0.00	\$15,932.89	\$81,865.12	\$132,710.71	\$25,342.02	\$255,850.74	\$102,406.08	\$359,448.41	54.65%
201901	0	0	\$0.00	\$0.00	(\$2.56)	(\$2.56)	\$0.00	\$13,592.64	\$120,307.23	\$45,993.28	\$8,992.43	\$188,885.58	\$40,625.47	\$229,508.49	0.00%
201902	0	0	\$0.00	\$0.00	\$1.28	\$1.28	\$0.00	\$38,033.00	\$15,897.28	\$1,322.14	\$3,559.03	\$58,811.45	\$120.15	\$58,932.88	0.00%
201903	0	0	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$3,206.71	\$1,364.79	\$410.90	\$4,982.40	\$0.00	\$4,982.40	0.00%
Total	9,842	11,510	\$7,670,283.59	\$0.00	\$14,206.06	\$14,206.06	\$0.00	\$1,088,591.54	\$1,119,741.41	\$1,059,440.55	\$287,138.31	\$3,554,911.81	\$1,305,914.57	\$4,875,032.44	63.56%
Grouping Avg	656	767	\$511,352.24	\$0.00	\$947.07	\$947.07	\$0.00	\$72,572.77	\$74,649.43	\$70,629.37	\$19,142.55	\$236,994.12	\$87,060.97	\$325,002.16	63.56%
Monthly Avg	656	767	\$511,352.24	\$0.00	\$947.07	\$947.07	\$0.00	\$72,572.77	\$74,649.43	\$70,629.37	\$19,142.55	\$236,994.12	\$87,060.97	\$325,002.16	63.56%

Notes:

- Grand Total includes Medical FFS, Pharmacy FFS, Incentives and Capitation.

- Grouping Avg – Average of the distinct groupings chosen by the user.

- Monthly Avg – Average of a measure over Service/Paid time period.

- Enrollment is recast to reflect retroactive adjustments.

- FFS = Fee For Service.

- MLR = Medical Loss Ratio.



Group/Control#: 00109695

Experience Exhibit

- Claims displayed are incurred and completed through December 2019.
- Claims displayed are based on a rolling 12 months of data.
- Claims paid through February 2020.

Monthly Claims:

						AHF Fund	Payments
Month	Subscribers	Members	Monthly Billed	Total Medical	Total	(Included	l in Totals)
			Premium	FFS/Caps	Rx Claims	Medical	Pharmac
January 2019	864	1,025	\$637,090	\$381,117	\$65,072	\$3,447	\$559
February 2019	861	1,021	\$631,928	\$239,987	\$127,739	\$3,450	\$1,069
March 2019	866	1,032	\$637,931	\$397,383	\$148,661	\$1,853	\$862
April 2019	866	1,030	\$639,208	\$371,136	\$161,408	\$748	\$282
May 2019	869	1,029	\$636,790	\$352,494	\$182,236	\$1,357	\$308
June 2019	843	998	\$618,460	\$540,866	\$141,873	\$1,837	\$309
July 2019	833	988	\$610,712	\$395,940	\$217,204	\$980	\$96
August 2019	773	912	\$568,109	\$253,701	\$163,482	\$2,151	\$190
September 2019	772	914	\$567,555	\$422,219	\$118,569	\$2,708	\$268
October 2019	862	1,013	\$632,701	\$374,359	\$203,666	\$1,654	\$127
November 2019	864	1,012	\$632,973	\$299,586	\$137,072	\$423	\$68
December 2019	865	1,013	\$634,792	\$374,667	\$159,369	\$803	\$321

Aggregate Premium Billed	\$7,448,249
Aggregate Incurred Claims	\$6,229,809
Cost Ratio	84%

Premium amounts and lives counts displayed on this report are unaudited

For purposes of this report, the Premium amount may include broker commissions and/or Service Fees. If you have elected to compensate your broker a Service Fee and have also elected for Aetna to serve as a billing and collection agent for such fee, then the Premium amount identified in this report also includes the Service Fee as identified in your Billing and Collection Agreement. For clarification, the Service Fee is not a component of your Premium but is reflected in the "Total Amount Due" identified in your monthly invoice.



Experience Exhibit

- Claims displayed are incurred and completed through December 2020.
- Claims displayed are based on a rolling 12 months of data.Claims paid through February 2021.

Monthly Claims:

Month	Subscribers	Members	Monthly Billed	Total Medical	Total		l Payments I in Totals)
			Premium	FFS/Caps	Rx Claims	Medical	Pharmacy
January 2020	891	1,046	\$671,819	\$317,650	\$171,053	\$3,435	\$822
February 2020	891	1,042	\$669,430	\$314,816	\$123,165	\$620	\$1,559
March 2020	890	1,042	\$669,430	\$531,537	\$192,675	\$1,444	\$418
April 2020	892	1,046	\$671,401	\$239,793	\$176,663	\$169	\$325
May 2020	888	1,040	\$667,746	\$318,321	\$152,663	\$522	\$326
June 2020	863	1,017	\$651,485	\$443,113	\$187,501	\$165	\$154
July 2020	857	1,009	\$647,518	\$435,205	\$211,740	\$464	\$151
August 2020	814	965	\$614,915	\$321,006	\$175,016	\$321	\$272
September 2020	811	966	\$614,385	\$343,103	\$201,862	\$1,168	\$148
October 2020	878	1,043	\$661,512	\$608,431	\$181,894	\$1,620	\$105
November 2020	875	1,037	\$658,001	\$828,792	\$186,373	\$1,311	\$315
December 2020	882	1,043	\$662,921	\$459,078	\$210,106	\$1,379	\$191

Aggregate Premium Billed
Aggregate Incurred Claims
Cost Ratio

\$7,860,562 \$7,331,557 93%

Premium amounts and lives counts displayed on this report are unaudited

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The months of March, 2020 and forward may show lower claims amounts than the average claim month due to the COVID 19 pandemic. These months may not be reflective of normal utilization patterns and we do not recommend using these months in projecting future utilization" Medical and dental utilization began to return to normal levels in June and July. We expect utilization in the second half of the year to remain at these levels with some regions continuing to be affected by COVID-19 waves.



Group/Control#: 00109695

Experience Exhibit

- Claims displayed are incurred and completed through September 2021.
- Claims displayed are based on a rolling 12 months of data.
- Claims paid through November 2021.

Monthly Claims:

						AHF Fund	Payments
Month	Subscribers	Members	Monthly Billed	Total Medical	Total	(Included	l in Totals)
			Premium	FFS/Caps	Rx Claims	Medical	Pharmac
October 2020	878	1,043	\$661,512	\$593,812	\$181,894	\$1,620	\$105
November 2020	874	1,034	\$656,683	\$641,341	\$186,373	\$850	\$315
December 2020	881	1,040	\$661,602	\$464,099	\$210,139	\$1,231	\$191
January 2021	934	1,085	\$440,941	\$533,773	\$194,094	\$6,535	\$892
February 2021	920	1,072	\$730,756	\$349,850	\$181,860	\$3,135	\$417
March 2021	934	1,086	\$740,920	\$382,470	\$164,650	\$1,623	\$505
April 2021	948	1,099	\$752,930	\$358,621	\$193,979	\$2,422	\$92
May 2021	942	1,096	\$748,915	\$625,356	\$196,259	\$3,994	\$473
June 2021	899	1,055	\$717,129	\$462,789	\$235,905	\$3,305	\$152
July 2021	876	1,023	\$698,882	\$623,009	\$193,244	\$933	\$759
August 2021	823	968	\$658,071	\$929,167	\$189,768	\$1,976	\$52
September 2021	820	961	\$656,604	\$459,941	\$186,153	\$495	\$38

Aggregate Premium Billed	\$8,124,944
Aggregate Incurred Claims	\$8,738,547
Cost Ratio	108%

Premium amounts and lives counts displayed on this report are unaudited

For purposes of this report, the Premium amount may include broker commissions and/or Service Fees. If you have elected to compensate your broker a Service Fee and have also elected for Aetna to serve as a billing and collection agent for such fee, then the Premium amount identified in this report also includes the Service Fee as identified in your Billing and Collection Agreement. For clarification, the Service Fee is not a component of your Premium but is reflected in the "Total Amount Due" identified in your monthly invoice.

The months of March 2020 and forward may show lower claim amounts than the average claim month due to the COVID-19 pandemic. These months may not be reflective of normal utilization patterns, and we do not recommend using these months in projecting future utilization. Medical and dental utilization began to return to normal levels in June and July. We expect utilization in the second half of the year to remain at these levels with some regions continuing to be affected by COVID-19 waves

Large Claim Listing

Policyholder Number - 109695 Group Number - 109695

- This report is designed to meet your need for data in evaluating your benefit plan. We have removed individual member identifiers (e.g., name, ID number, etc.) because most plan sponsors find that their needs can be met without identifiers and also to comply with state and federal health information privacy regulations.
- Amounts below reflect Medical and RX costs.

Total Group

Claimants with over \$25,000 in claims for 10/1/2020 - 9/30/2021

Claimant	Total	ICD-10 Code Description
Claimant 1	\$200,974	Secondary Malignant Neoplasm Of Retroperitoneum And Peritoneum
Claimant 2	\$197,048	Non-st Elevation (nstemi) Myocardial Infarction
Claimant 3	\$193,286	Partial Traumatic Amputation At Knee Level, Right Lower Leg, Initial Encounter
Claimant 4	\$185,719	Unspecified Urethral Stricture, Male, Unspecified Site
Claimant 5	\$174,988	Restricted Diagnosis
Claimant 6	\$169,827	Noninfective Gastroenteritis And Colitis, Unspecified
Claimant 7	\$155,668	Atypical Atrial Flutter
Claimant 8	\$153,958	Non-st Elevation (nstemi) Myocardial Infarction
Claimant 9	\$152,384	Displaced Bimalleolar Fracture Of Right Lower Leg, Initial Encounter For Closed Fracture
Claimant 10	\$128,698	Restricted Diagnosis
Claimant 11	\$126,820	Malignant Neoplasm Of Overlapping Sites Of Right Bronchus And Lung
Claimant 12	\$117,493	Thrombosis Due To Vascular Prosthetic Devices, Implants And Grafts, Initial Encounter
Claimant 13	\$114,304	Infection Following A Procedure, Deep Incisional Surgical Site, Initial Encounter
Claimant 14	\$109,573	Diverticulitis Of Large Intestine With Perforation And Abscess Without Bleeding
Claimant 15	\$107,830	Chronic Inflammatory Demyelinating Polyneuritis
Claimant 16	\$101,653	Encounter For Screening For Malignant Neoplasm Of Colon
Claimant 17	\$96,749	Hypertensive Emergency
Claimant 18	\$90,611	Supraventricular Tachycardia
Claimant 19	\$89,698	Contusion Of Scalp, Initial Encounter
Claimant 20	\$88,828	Multiple Sclerosis
Claimant 21	\$87,252	Restricted Diagnosis
	222,102	nestricted Diagrosis
Claimant 22	\$84,475	Encounter For Screening For Malignant Neoplasm Of Colon



Large Claim Listing

Policyholder Number - 109695 Group Number - 109695

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- Amounts below reflect Medical and RX costs.

Total Group

Claimants with over \$25,000 in claims for 10/1/2020 - 9/30/2021

Claimant	Total	ICD-10 Code Description
Claimant 23	\$82,294	Multiple Sclerosis
Claimant 24	\$81,626	Malignant Neoplasm Of Overlapping Sites Of Left Female Breast
Claimant 25	\$73,758	Cutaneous Abscess Of Left Foot
Claimant 26	\$72,417	Epigastric Pain
Claimant 27	\$72,104	Radiculopathy, Lumbar Region
Claimant 28	\$71,677	Rheumatoid Arthritis, Unspecified
Claimant 29	\$71,369	Encounter For Sterilization
Claimant 30	\$70,540	Other Specified Sepsis
Claimant 31	\$68,659	Disease Of Intestine, Unspecified
Claimant 32	\$67,498	Panic Disorder Episodic Paroxysmal Anxietyy
Claimant 33	\$67,395	Unilateral Primary Osteoarthritis, Left Hip
Claimant 34	\$64,724	Encounter For Screening Mammogram For Malignant Neoplasm Of Breast
Claimant 35	\$60,685	Hepatic Failure, Unspecified Without Coma
Claimant 36	\$55,009	Sepsis Due To Escherichia Coli (e. Coli)
Claimant 37	\$54,472	Paroxysmal Atrial Fibrillation
Claimant 38	\$52,484	Non-st Elevation (nstemi) Myocardial Infarction
Claimant 39	\$49,154	Covid-19
Claimant 40	\$48,122	Unilateral Primary Osteoarthritis, Right Hip
Claimant 41	\$47,167	Restricted Diagnosis
Claimant 42	\$45,460	Ischemic Cardiomyopathy
Claimant 43	\$44,934	Paroxysmal Atrial Fibrillation
Claimant 44	\$44,621	Contact With And (suspected) Exposure To Other Viral Communicable Diseases
Claimant 45	\$44,154	Sepsis, Unspecified Organism



Large Claim Listing

Policyholder Number - 109695 Group Number - 109695

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- Amounts below reflect Medical and RX costs.

Total Group

Claimants with over \$25,000 in claims for 10/1/2020 - 9/30/2021

Claimant	Total	ICD-10 Code Description
Claimant 46	\$42,625	Supraventricular Tachycardia
Claimant 47	\$42,368	Restricted Diagnosis
Claimant 48	\$41,678	Calculus Of Gallbladder Without Cholecystitis Without Obstruction
Claimant 49	\$39,203	Restricted Diagnosis
Claimant 50	\$38,469	Paroxysmal Atrial Fibrillation
Claimant 51	\$37,794	Migraine With Aura, Not Intractable, Without Status Migrainosus
Claimant 52	\$37,643	Sensorineural Hearing Loss, Bilateral
Claimant 53	\$37,569	Other Synovitis And Tenosynovitis, Left Hand
Claimant 54	\$35,520	Unilateral Primary Osteoarthritis, Right Knee
Claimant 55	\$34,246	Atherosclerotic Heart Disease Of Native Coronary Artery Without Angina Pectoris
Claimant 56	\$33,497	Unilateral Primary Osteoarthritis, Right Hip
Claimant 57	\$30,534	Atherosclerotic Heart Disease Of Native Coronary Artery With Other Forms Of Angina Pectoris
Claimant 58	\$30,532	Covid-19
Claimant 59	\$30,253	Restricted Diagnosis
Claimant 60	\$29,966	Restricted Diagnosis
Claimant 61	\$29,656	Idiopathic Urticaria
Claimant 62	\$27,494	Hypertensive Encephalopathy
Claimant 63	\$27,230	Atherosclerotic Heart Disease Of Native Coronary Artery Without Angina Pectoris
Claimant 64	\$26,721	Calculus Of Gallbladder With Chronic Cholecystitis Without Obstruction
Claimant 65	\$25,862	Unilateral Primary Osteoarthritis, Left Knee
Claimant 66	\$25,695	Serous Retinal Detachment, Right Eye
Claimant 67	\$25,632	Restricted Diagnosis

Large Claim Listing

Policyholder Number - 109695 Group Number - 109695

- This report is designed to meet your need for data in evaluating your benefit plan. We have removed individual member identifiers (e.g., name, ID number, etc.) because most plan sponsors find that their needs can be met without identifiers and also to comply with state and federal health information privacy regulations.
- Amounts below reflect Medical and RX costs.

Total Group

Claimants with over \$25,000 in claims for 10/1/2020 - 9/30/2021

Claimant	Total	ICD-10 Code Description
Claimant 68	\$25,504	Encounter For Screening For Malignant Neoplasm Of Colon
Claimant 69	\$25,373	Covid-19

The months of March 2020 and forward may show lower claim amounts than the average claim month due to the COVID-19 pandemic. These months may not be reflective of normal utilization patterns, and we do not recommend using these months in projecting future utilization. Medical and dental utilization began to return to normal levels in June and July. We expect utilization in the second half of the year to remain at these levels with some regions continuing to be affected by COVID-19 waves

COVID All-Time Experience: Jan 2020 - Dec 2021, paid through December 2021



lan - Dec 2020 paid through December 2020

Jan - Dec 2021, paid through December 2021

Prior: Current:

Why use this report?

Gain a deeper understanding of the impacts from the COVID pandemic.

This detailed Monthly Analytic Report provides insights into the following key areas:

- COVID-19 specific claim activity
- Telemedicine volumes and impact
- Risk profile for severe illness based on CDC guidance
- Counties that have high or emerging levels of COVID-19
- COVID-19 vaccinations

This data can help you more fully explore the types of services and population being impacted during the pandemic and will help you answer your key questions such as:

- How many members have evidence of the condition or been tested?
- How many hospitalizations have there been?
- How many people have been vaccinated?
- Where are people seeking care?
- What is the demand and utilization for telehealth services?
- What is the higher risk for severe illness profile within this population? What is the risk profile for employees specifically?

Things to consider when reviewing this data

Reporting is based on diagnosis and procedure codes that are billed on a claim

Standard codes and coding guidance have rapidly evolved throughout the pandemic. While healthcare institutions adjust to new codes and coding changes, claims may be understated based on:

- Provider variance in understanding billing guidance
- Inability to confirm diagnosis due to testing limitations

• Test results received by provider post-claim submission

- No claim submission (e.g., testing covered by public health entity or inpatient)
- Claim submis
 COVID-19 vac
- Claim submission prior to the introduction of COVID-19 specific ICD-10 codes
 - COVID-19 vaccine administration information included in this report represents claims covered under the Aetna medical or Aetna pharmacy benefits. International claims may not be billed and processed in accordance with the coding and definitions used in this report and may impact the data/results shown.
 - Data in this report is compiled at the group number level. Member movement between group numbers may impac aggregate claimant counts.

What codes are used in the COVID monthly view?

The following diagnoses and procedures are used to identify likely COVID-19 related claims in this report. **These codes represent our** current best efforts to identify likely COVID-19 activity. References to COVID-19 in this report are based on the codes below, some of which are not COVID-specific.

COVID-19- Specific Diagnosis and Related Codes - These are codes that are specific to COVID-19 related illness:

- U07.1 COVID-19 confirmed cases Data is included when this code is billed as the primary, secondary or tertiary diagnosis
- J12.82 Pneumonia due to COVID-19 (new 1/1/2021)
- M35.81 Multi-inflammatory syndrome (new 1/1/2021) M35.89 - Other specified systemic involvement of connective tissue (new 1/1/2021)

Coronavirus Diagnosis Codes - Providers were guided to bill these in the initial outbreak:

- **B97.29** Other coronavirus as the cause of diseased
- B34.2 Coronavirus infection, unspecified

Exposure Diagnosis Codes - Pre-existing and new codes used for COVID-19 exposure and non-confirmed/non-presumptive cases. Because these codes may also be used for suspected exposure to other biological agents and viral communicable diseases, some claims may be for non-COVID related cases:

Z03.818 - Suspected exposure to other biological agents ruled out

- Z20.828 Exposure to other viral communicable diseases
- Z20.822 Contact with and (suspected) exposure to COVID-19 (new 1/1/2021)

Encounter Diagnosis Code - New code introduced specifically for visits related to COVID screenings: Z11.52 - Encounter for screening for COVID-19- (new 1/1/2021)

Testing Procedure Codes - Used to identify COVID-19 and antibody testing: 86328, 86408, 86409, 86413, 86769, 87426, 87428, 87635, 87636, 87637, 87811, C9803, G2023, G2024, U0001, U0002, U0003, U0004, U0005, 0202U, 0223U, 0224U, 0225U, 0226U, 0240U, 0241U

Vaccination Administration Procedure / NDC Codes - Used to identify COVID-19 vaccination administration. The actual vaccine cost is being paid by the federal government; data in this report represents administration cost / utilization: 0001A,0002A, 0003A, 0004A, 0011A, 0012A, 0013A, 0031A, 0034A, 0064A and NDCs 59267100001, 59267100002, 59267100003, 80777027310, 80777027399, 80777027398, 80777027315, 59676058005, 59676058015.

Telemedicine - Metrics include Teladoc as well as community based providers performing approved telemedicine services.

Here are more specific details behind terms used in this report: Claimant Distribution Definitions:

• Confirmed Cases - The number of members who had a claim with the COVID-19 specific diagnosis code U07.1 billed as one of the first 3 diagnoses on a claim or had a claim with J12.82, M35.81 or M35.89 as a primary diagnosis

• Probable Cases - The number of members who have either of the general coronavirus codes shown on the left (B97.29 or B34.2) billed as the primary diagnosis on a claim

• Exposure Cases - The number of members who have any of the 3 exposure diagnosis codes shown on the left (Z03.818, Z20.828, Z20.822) billed as the primary diagnosis on a claim

• Lab Test, Vaccine or Encounter Only Cases - The number of members who had a lab test with a diagnosis code other than those identified above or only had evidence of an encounter for screening (Z11.52) or a vaccination with no other diagnosis codes used in this report. These members have ONLY had claims for testing, screening encounters or vaccines and do not have other claims that fit the criteria outlined above

High Risk Members - We used the CDC guidance to identify members within the population that may be at higher risk for severe illness. This includes members who are over 64 as well as those that have one or more conditions outlined by the CDC such as serious heart conditions, diabetes, chronic kidney disease, etc. The CDC guidance can be found here: <u>https://www.cdc.gov/coronavirus/2019ncov/need-extra-precautions/people-at-higher-risk.html</u>. Customers new to Aetna 1/1/2021 will not have condition-based risk data populated until there is sufficient information to identify disease states.

Time Periods - There are 2 time periods used in this report:

COVID All-Time Experience represents incurred claims for COVID-related expenses from January 1, 2020 through the most recent incurred month

• Year Over Year Experience (Current and Prior) represents 2021 and 2020 incurred claims for the dates shown at the top of this report. The claim lag for both time periods is the same to provide a consistent year over year comparison.





Section I COVID-19 Population Alerts

COVID-19 population alerts

Hot Spots In the United States - Map (to the right)

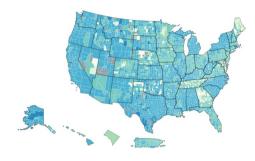
The map shows how the number of new cases have CHANGED in the last two weeks across the U.S. (not plan sponsor-specific). This provides an indication of which direction the level of new cases is trending.

County Alerts (below)

The tables below show the average daily new cases per 100,000 individuals by county over the past 7 days. These rates are reflective of the overall population of the county, not of your specific membership. This data is to highlight where you have membership in counties experiencing high or emerging rates of new cases.

We use information collected by the CDC to calculate a '7 day average new case count.' This data is normalized for population size (new cases per 100,000 individuals) to smooth unusual daily highs or lows, caused by data collection fluctuations.

The data below is for your top 25 counties (by membership) that are identified as having either a high or emerging average daily case rates. There could be less than 25 counties in the tables (or none) if the alert criteria is not met.



O-25.01% or less O-25% - 10.01% O-10% - 0.01% O% - 10% O% - 10% O10.01% - 25% O25.01% or more ON Data

Heat map of recent growth by county: This map shows the average growth between the last seven days and the previous seven days. Darker colors indicate an increasing trend while lighter colors indicate a decreasing trend. Last Update: 01708/2022 | Source: CDC

High risk counties (red) had greater than 25 daily new cases per 100,000 individuals Emerging risk counties (orange) had between 10 and 25 daily new cases per 100,000 individuals

High Risk (>=25 new cases per 100,000 individuals)				
	County	Your	Avg daily new	
State, County	population	members	cases per 100K	
Florida, Hendry	42,022	831	232.9	
Florida, Lee	770,577	97	196.7	
Florida, Glades	13,811	47	77.6	
Florida, Palm Beach	1,496,770	12	278.2	
Florida, Charlotte	188,910	11	121.0	
Florida, Collier	384,902	5	180.5	
Florida, Sumter	132,420	2	88.8	
North Dakota, Cass	181,923	2	194.6	
Florida, Highlands	106,221	2	127.9	
Florida, Alachua	269,043	2	200.6	
Indiana, Delaware	114,135	1	110.8	
Florida, Okeechobee	42,168	1	201.9	
North Carolina, Rutherford	67,029	1	84.8	
Florida, Hillsborough	1,471,968	1	214.6	
Tennessee, Dickson	53,948	1	75.2	
Georgia, Gwinnett	936,250	1	138.6	
Florida, Miami-Dade	2,716,940	1	580.7	

Data is for week ending: 01/09/2022 Note: Counties with less than 20 new cases in the prior week will not appear in this report. New case data is not available for approximately 30 counties. "Your members" represents your total commercial Aetna self-insured membership.

Emerging Risk (10-24 new cases per 100,000 individuals)

State, County	County	Your	Avg daily new
	population	members	cases per 100K
No emerging risk counties			





Section II All-Time COVID-19 Experience

Time period: Claims incurred Jan 2020 - Dec 2021, paid through December 2021

At a glance COVID-19 All-time experience

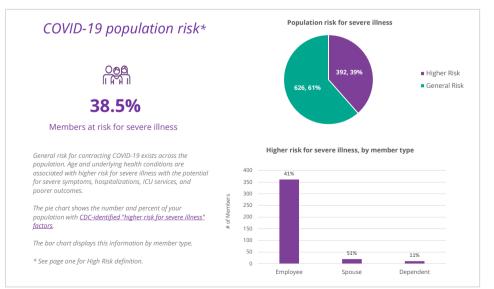
Average Members: 1,032



More detailed information is found on the next page to help you answer critical questions:

- ✓ How is COVID-19 impacting our health care spend? What is the context of trends and spend distribution across cost categories?
- ✓ How many members are affected?
- ✓ How many claims-based tests have been conducted for the virus and antibodies?
- ✓ How many individuals have received vaccinations?
- ✓ How is COVID spend trending in 2021 compared to 2020?

Additional views and detailed data tables following the main report also provide specific cost and utilization metrics across age band categories as well as service categories





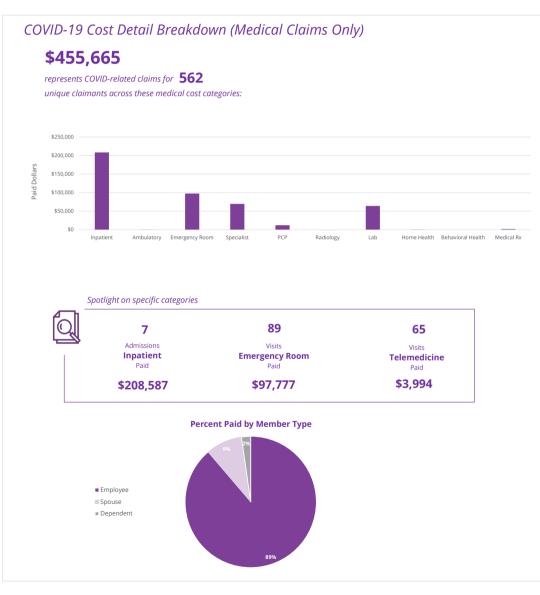


Testing		Ż		ğ
\$71,789	465	7	56	24
Total Paid - All Tests	Unique Claimants	# of Vir	al Tests	#of Antibody Tests
Vaccine Administratio	on (Medical & Pharm	nacy)*		
		Unique Claimants	0	\checkmark
\$17,927	288		183	14.57%
Total Paid for Vaccine Administration	Members with a Vaccination		Members Fully Vaccinated**	v % Fully Vaccinated
*Includes claims paid under the Aetna Pl **The unique count of members => 5 ye			ses based on clain	as received



COVID-19 All-time experience details

Average Members: 1,032



Time neriod:	lan 2020 -	Dec 2021	naid through	December 2021
rime periou.	Jan 2020 -	Dec 2021,	paiu un ough	December 2021

bution - All Members* mants break down based on diagnosis cou	le
\$363,413	Confirmed
\$696	Probable
\$82,969	Exposure
\$8,588	Lab test, screening encounter or vaccine only
	\$363,413 \$696 \$82,969

*refer to Report terms on page 1

Claimant distribution - Employees*

ation

how your total claimants break	k down based on diagnosis code informa	ntion
147	\$326,284	Confirmed
5	\$696	Probable
286	\$70,266	Exposure
70	\$7,124	Lab test, screening encounter or vaccine only
	147 5 286	5 \$696 286 \$70,266

*refer to Report terms on page 1

Claimant distribution - Spouse & Dependents* how your total claimants break down based on diagnosis code information

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5	\$37,128	Confirmed
0	\$0	Probable
36	\$12,703	Exposure
13	\$1,464	Lab test, screening encounter or vaccine only
	0 36	0 \$0 36 \$12,703

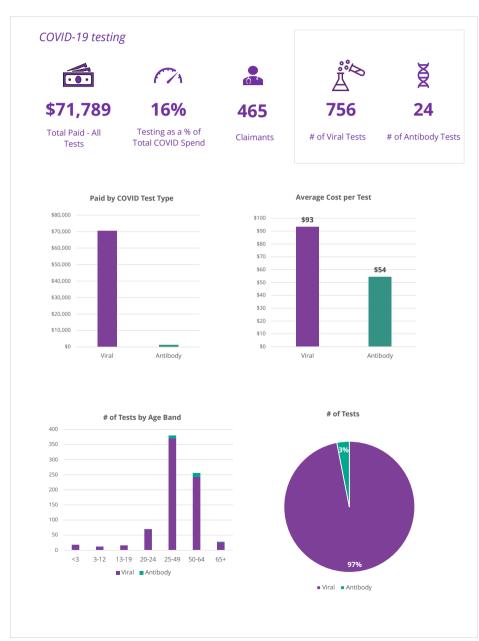
*refer to Report terms on page 1

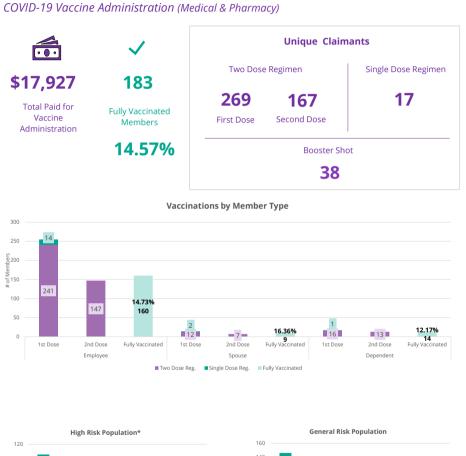


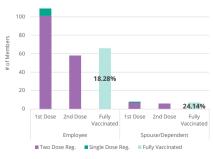
Time period: Jan 2020 - Dec 2021, paid through December 2021

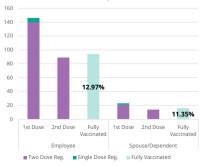
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Average Members: 1,032









* See page one for High Risk definition



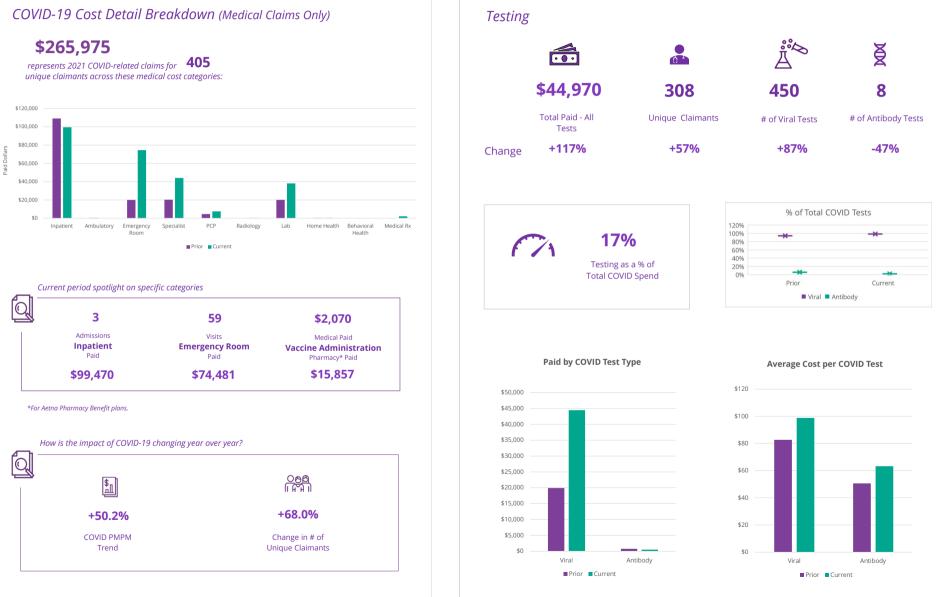
Section III Year Over Year Results

Current period: Claims incurred Jan - Dec 2021, paid through December 2021 Prior period: Claims incurred Jan - Dec 2020, paid through December 2020



COVID experience - year over year

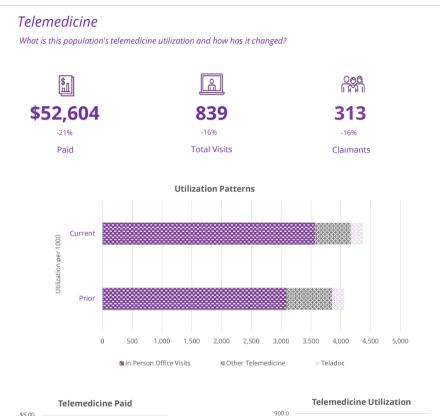
Average Current Members: 1,040

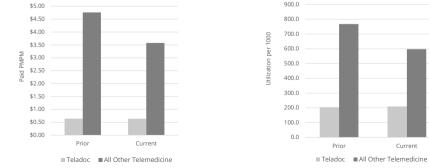


Current period: Claims incurred Jan - Dec 2021, paid through December Prior period: Claims incurred Jan - Dec 2020, paid through December 2020

Telemedicine experience - year over year

Average Current Members: 1,040





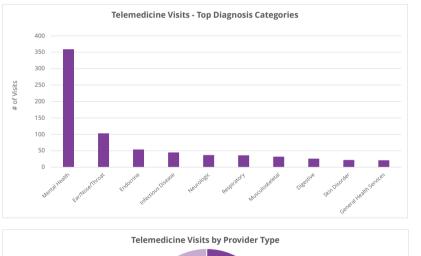
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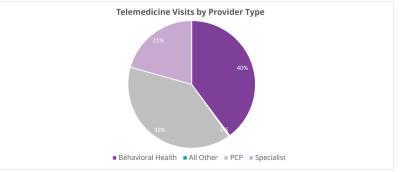
Current period: Claims incurred Jan - Dec 2021, paid through December

Prior period: Claims incurred Jan - Dec 2020, paid through December 2020

How telemedicine is being used in the context of the pandemic

Changes in the use of telemedicine services are an immediate observable side effect of the pandemic. Stay at home orders and social distancing resulted in many healthcare providers ceasing non-emergent office visits and providing them virtually via secured technology. This change in practice has and will result in large increases in telemedicine utilization with expected decreases in office-based utilization.





Why is this population turning to telemedicine?

Current



Section IV Appendix

Data tables - year over year COVID trends

Current period: Claims incurred Jan - Dec 2021, paid through December 2021 Prior period: Claims incurred Jan - Dec 2020, paid through December 2020

of Members at risk by state

COVID-19 alerts - top 50 counties with highest and emerging risk

Vaccination summary by state



COVID trends - year over year

Table 1: Total COVID-19 Medical Cost and Utilization:

	# of Unique Claimants		ants	Medical Paid			Medical Paid PMPM			Visits				Visits per 1,0	00	Cost per Visit		
Age Band	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change
<3 years	4	6	50.0%	\$259	\$1,717	563.0%	\$0.02	\$0.14	552.8%	5	18	260.0%	4.9	17.3	254.5%	\$52	\$95	84.2%
3 - 12 years	1	6	500.0%	\$82	\$2,889	3,404.0%	\$0.01	\$0.23	3,350.4%	1	21	2,000.0%	1.0	20.2	1,967.9%	\$82	\$138	66.9%
13 - 19 years	4	9	125.0%	\$956	\$1,635	71.0%	\$0.08	\$0.13	68.4%	7	16	128.6%	6.8	15.4	125.1%	\$137	\$102	-25.2%
20 - 24 years	22	27	22.7%	\$5,241	\$4,704	-10.2%	\$0.43	\$0.38	-11.6%	53	64	20.8%	51.7	61.5	18.9%	\$99	\$74	-25.7%
25 - 49 years	108	222	105.6%	\$31,829	\$216,869	581.4%	\$2.59	\$17.38	570.9%	185	561	203.2%	180.6	539.4	198.6%	\$172	\$387	124.7%
50 - 64 years	95	120	26.3%	\$134,544	\$28,577	-78.8%	\$10.95	\$2.29	-79.1%	244	263	7.8%	238.2	252.9	6.1%	\$551	\$109	-80.3%
65+ years	7	15	114.3%	\$1,486	\$9,584	545.0%	\$0.12	\$0.77	535.1%	12	40	233.3%	11.7	38.5	228.2%	\$124	\$240	93.5%
Total	241	405	68.0%	\$174,397	\$265,975	52.5%	\$14.19	\$21.31	50.2%	507	983	93.9%	495.0	945.1	90.9%	\$344	\$271	-21.3%
							L											

Table 2: COVID-19 Viral Testing

	# of Unique Claimants # of Tests				м	edical Paid Am	ount		Medical Paid PM	IPM	Cost per Test				
Age Band	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change
<3 years	2	6	200.0%	3	14	366.7%	\$124	\$1,462	1,078.9%	\$0.01	\$0.12	1,060.8%	\$41	\$104	152.6%
3 - 12 years	0	5	-	0	11	-	\$0	\$1,342	-	\$0.00	\$0.11	-	\$0	\$122	-
13 - 19 years	4	6	50.0%	4	9	125.0%	\$357	\$931	160.6%	\$0.03	\$0.07	156.6%	\$89	\$103	15.8%
20 - 24 years	21	20	-4.8%	31	32	3.2%	\$2,083	\$2,599	24.8%	\$0.17	\$0.21	22.9%	\$67	\$81	20.9%
25 - 49 years	76	169	122.4%	98	243	148.0%	\$8,554	\$23,652	176.5%	\$0.70	\$1.90	172.3%	\$87	\$97	11.5%
50 - 64 years	78	85	9.0%	99	122	23.2%	\$8,270	\$12,428	50.3%	\$0.67	\$1.00	48.0%	\$84	\$102	21.9%
65+ years	5	14	180.0%	6	19	216.7%	\$536	\$2,049	282.1%	\$0.04	\$0.16	276.2%	\$89	\$108	20.7%
Total	186	305	64.0%	241	450	86.7%	\$19,924	\$44,463	123.2%	\$1.62	\$3.56	119.7%	\$83	\$99	19.5%

Table 2a: COVID-19 Antibody Testing

	# of Unique Claimants			1	# of Tests			Medical Paid Amount			Medical Paid PN	IPM	Cost per Test			
Age Band	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	
<3 years	0	0	-	0	0	-	\$0	\$0	-	\$0.00	\$0.00	-	\$0	\$0	-	
3 - 12 years	0	0	-	0	0	-	\$0	\$0	-	\$0.00	\$0.00	-	\$0	\$0	-	
13 - 19 years	0	0	-	0	0	-	\$0	\$0	-	\$0.00	\$0.00	-	\$0	\$0	-	
20 - 24 years	0	0	-	0	0	-	\$0	\$0	-	\$0.00	\$0.00	-	\$0	\$0	-	
25 - 49 years	6	3	-50.0%	6	3	-50.0%	\$303	\$127	-58.0%	\$0.02	\$0.01	-58.7%	\$50	\$42	-16.1%	
50 - 64 years	7	5	-28.6%	7	5	-28.6%	\$330	\$379	14.9%	\$0.03	\$0.03	13.2%	\$47	\$76	60.9%	
65+ years	2	0	-100.0%	2	0	-100.0%	\$126	\$0	-100.0%	\$0.01	\$0.00	-100.0%	\$63	\$0	-100.0%	
Total	15	8	-46.7%	15	8	-46.7%	\$759	\$506	-33.3%	\$0.06	\$0.04	-34.3%	\$51	\$63	25.0%	

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Table 3: COVID-19 Vaccinations (Medical)

	#0	f Unique Claim	ants	# of Vaccinations				edical Paid Amo	ount		Medical Paid PN	IPM	Cost per Vaccination			
Age Band	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	
<3 years	0	0	-	0	0	-	\$0	\$0	-	\$0.00	\$0.00	-	\$0	\$0	-	
3 - 12 years	0	0	-	0	0	-	\$0	\$0	-	\$0.00	\$0.00	-	\$0	\$0	-	
13 - 19 years	0	1	-	0	1	-	\$0	\$40	-	\$0.00	\$0.00	-	\$0	\$40	-	
20 - 24 years	0	2	-	0	3	-	\$0	\$149	-	\$0.00	\$0.01	-	\$0	\$50	-	
25 - 49 years	0	14	-	0	22	-	\$0	\$832	-	\$0.00	\$0.07	-	\$0	\$38	-	
50 - 64 years	0	18	-	0	31	-	\$0	\$917	-	\$0.00	\$0.07	-	\$0	\$30	-	
65+ years	0	3	-	0	5	-	\$0	\$131	-	\$0.00	\$0.01	-	\$0	\$26	-	
Total	0	38	-	0	62	-	\$0	\$2,070	-	\$0.00	\$0.17	-	\$0	\$33	-	

Table 3a: COVID-19 Vaccinations (Pharmacy) - This table will only be populated for customers who have coverage under the Aetna Pharmacy Benefit plan. This data is not included in the total in any of the other data tables.

	# o	f Unique Claim	ants	# of Vaccinations			Rx Paid Amount				Rx Paid PMPN	4	Cost per Vaccination			
Age Band	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	
<3 years	0	0	-	0	0	-	\$0	\$0	-	\$0.00	\$0.00	-	\$0	\$0	-	
3 - 12 years	0	2		0	3	-	\$0	\$120		\$0.00	\$0.01	-	\$0	\$40	-	
13 - 19 years	0	9	-	0	15	-	\$0	\$600	-	\$0.00	\$0.05	-	\$0	\$40	-	
20 - 24 years	0	17		0	32	-	\$0	\$1,199		\$0.00	\$0.10	-	\$0	\$37	-	
25 - 49 years	0	136	-	0	235	-	\$0	\$8,615	-	\$0.00	\$0.69	-	\$0	\$37	-	
50 - 64 years	0	82		0	130	-	\$0	\$4,842		\$0.00	\$0.39	-	\$0	\$37	-	
65+ years	0	9		0	12	-	\$0	\$480		\$0.00	\$0.04	-	\$0	\$40	-	
Total	0	255		0	427	-	\$0	\$15,857		\$0.00	\$1.27	-	\$0	\$37	-	

Table 4: Emergency Room Cost and Utilization of COVID-19:

[# of Unique Claimants		ants	Medical Paid			N	Medical Paid PMPM			Visits			Visits per 1,0	00	Cost per Visit		
Age Band	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change
<3 years	0	2		\$0	\$494	-	\$0.00	\$0.04		0	2	-	0.0	1.9		\$0	\$247	-
3 - 12 years	0	3	-	\$0	\$364	-	\$0.00	\$0.03	-	0	3	-	0.0	2.9		\$0	\$121	-
13 - 19 years	1	2	100.0%	\$83	\$209	153.1%	\$0.01	\$0.02	149.3%	1	2	100.0%	1.0	1.9	96.9%	\$83	\$104	26.6%
20 - 24 years	3	1	-66.7%	\$745	\$87	-88.4%	\$0.06	\$0.01	-88.6%	3	1	-66.7%	2.9	1.0	-67.2%	\$248	\$87	-65.2%
25 - 49 years	14	26	85.7%	\$16,481	\$62,851	281.4%	\$1.34	\$5.04	275.5%	14	29	107.1%	13.7	27.9	104.0%	\$1,177	\$2,167	84.1%
50 - 64 years	7	13	85.7%	\$2,581	\$4,137	60.3%	\$0.21	\$0.33	57.8%	8	15	87.5%	7.8	14.4	84.6%	\$323	\$276	-14.5%
65+ years	1	6	500.0%	\$82	\$6,340	7,640.6%	\$0.01	\$0.51	7,522.2%	1	7	600.0%	1.0	6.7	589.3%	\$82	\$906	1,005.8%
Total	26	53	103.8%	\$19,972	\$74,481	272.9%	\$1.63	\$5.97	267.2%	27	59	118.5%	26.4	56.7	115.2%	\$740	\$1,262	70.7%

Table 5: Teladoc/Telemedicine Cost and Utilization of COVID-19:

	# 0	f Unique Claim	ants	1	Medical Paid		N	Aedical Paid PM	IPM	1	Visits			Visits per 1,00	00	1	Cost per Visit	:
Age Band	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change
<3 years	1	0	-100.0%	\$82	\$0	-100.0%	\$0.01	\$0.00	-100.0%	1	0	-100.0%	1.0	0.0	-100.0%	\$82.45	\$0.00	-100.0%
3 - 12 years	1	0	-100.0%	\$82	\$0	-100.0%	\$0.01	\$0.00	-100.0%	1	0	-100.0%	1.0	0.0	-100.0%	\$82.45	\$0.00	-100.0%
13 - 19 years	0	0	-	\$0	\$0	-	\$0.00	\$0.00	-	0	0		0.0	0.0	-	\$0.00	\$0.00	-
20 - 24 years	0	1	-	\$0	\$54	-	\$0.00	\$0.00		0	2		0.0	1.9		\$0.00	\$27.00	-
25 - 49 years	7	20	185.7%	\$505	\$1,556	208.4%	\$0.04	\$0.12	203.6%	8	29	262.5%	7.8	27.9	257.0%	\$63.06	\$53.64	-14.9%
50 - 64 years	11	5	-54.5%	\$1,036	\$327	-68.4%	\$0.08	\$0.03	-68.9%	14	5	-64.3%	13.7	4.8	-64.8%	\$73.99	\$65.40	-11.6%
65+ years	0	2	-	\$0	\$184	-	\$0.00	\$0.01		0	3		0.0	2.9		\$0.00	\$61.28	-
Total	20	28	40.0%	\$1,705	\$2,120	24.3%	\$0.14	\$0.17	22.4%	24	39	62.5%	23.4	37.5	60.0%	\$71.05	\$54.37	-23.5%

Table 5a: All Telemedicine (regardless of diagnosis)

[# o	f Unique Claim	ants	1	Medical Paid			Aedical Paid PM	PM	1	Visits			Visits per 1,00	00	1	Cost per Visit	:
Telemedicine	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change
All Telemedicine	372	313	-15.9%	\$66,348	\$52,604	-20.7%	\$5.40	\$4.21	-21.9%	995	839	-15.7%	971.5	806.7	-17.0%	\$67	\$63	-6.0%



Table 6: Urgent Care / Retail and Minute Clinic Cost and Utilization of COVID-19:

[# 0	f Unique Claim	ants	1	Medical Paid		N	Aedical Paid PM	IPM	1	Visits		Π	Visits per 1,0	00	1	Cost per Visit	:
Age Band	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change
<3 years	1	1	0.0%	\$53	\$255	385.7%	\$0.00	\$0.02	378.3%	1	2	100.0%	1.0	1.9	96.9%	\$52.50	\$127.50	142.9%
3 - 12 years	0	3		\$0	\$180	-	\$0.00	\$0.01	-	0	3	-	0.0	2.9	-	\$0.00	\$60.00	-
13 - 19 years	1	3	200.0%	\$168	\$510	203.6%	\$0.01	\$0.04	198.9%	2	4	100.0%	2.0	3.8	96.9%	\$84.00	\$127.50	51.8%
20 - 24 years	8	17	112.5%	\$1,367	\$1,659	21.4%	\$0.11	\$0.13	19.5%	12	26	116.7%	11.7	25.0	113.4%	\$113.88	\$63.80	-44.0%
25 - 49 years	43	113	162.8%	\$3,202	\$13,840	332.3%	\$0.26	\$1.11	325.7%	47	153	225.5%	45.9	147.1	220.6%	\$68.12	\$90.46	32.8%
50 - 64 years	30	47	56.7%	\$2,217	\$5,020	126.4%	\$0.18	\$0.40	122.9%	33	59	78.8%	32.2	56.7	76.1%	\$67.19	\$85.09	26.6%
65+ years	3	6	100.0%	\$406	\$760	87.3%	\$0.03	\$0.06	84.4%	4	9	125.0%	3.9	8.7	121.6%	\$101.49	\$84.49	-16.8%
Total	86	190	120.9%	\$7,412	\$22,225	199.8%	\$0.60	\$1.78	195.3%	99	256	158.6%	96.7	246.1	154.6%	\$74.87	\$86.81	16.0%

Table 7: Inpatient Cost and Utilization of COVID-19:

[# o	f Unique Claim	nants	Π	Medical Paid		N	Aedical Paid PM	IPM		# of Admission	ns	1	Admissions per	,000	C 0	st per Admiss	ion	Avera	age Length	of Stay
Age Band	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	: Change
<3 years	0	0	-	\$0	\$0	-	\$0.00	\$0.00	-	0	0	-	0.0	0.0	-	\$0	\$0		0.0	0.0	-
3 - 12 years	0	0	-	\$0	\$0	-	\$0.00	\$0.00	-	0	0		0.0	0.0	-	\$0	\$0		0.0	0.0	-
13 - 19 years	0	0	-	\$0	\$0	-	\$0.00	\$0.00	-	0	0		0.0	0.0	-	\$0	\$0		0.0	0.0	-
20 - 24 years	0	0	-	\$0	\$0	-	\$0.00	\$0.00	-	0	0		0.0	0.0	-	\$0	\$0		0.0	0.0	-
25 - 49 years	0	3	-	\$0	\$99,470	-	\$0.00	\$7.97	-	0	3		0.0	2.9	-	\$0	\$33,157		0.0	7.7	-
50 - 64 years	4	0	-100.0%	\$109,117	\$0	-100.0%	\$8.88	\$0.00	-100.0%	4	0	-100.0%	3.9	0.0	-100.0%	\$27,279	\$0	-100.0%	3.8	0.0	-100.0%
65+ years	0	0	-	\$0	\$0	-	\$0.00	\$0.00	-	0	0		0.0	0.0	-	\$0	\$0	-	0.0	0.0	-
Total	4	3	-25.0%	\$109,117	\$99,470	-8.8%	\$8.88	\$7.97	-10.2%	4	3	-25.0%	3.9	2.9	-26.1%	\$27,279	\$33,157	21.5%	3.8	7.7	104.4%

Table 8: Cost and Utilization of COVID-19 by Medical Cost Category

Γ	# of	Unique Claim	ants]	Medical Paid		N	edical Paid PM	РМ	1	Visits		1	Visits per 1,00	0	1	Cost per Visit	1
Med Cost Category	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change
Inpatient	4	3	-25.0%	\$109,117	\$99,470	-8.8%	\$8.88	\$7.97	-10.2%	4	3	-25.0%	3.9	2.9	-26.1%	\$27,279	\$33,157	21.5%
Ambulatory	6	2	-66.7%	\$264	\$0	-100.0%	\$0.02	\$0.00	-100.0%	6	2	-66.7%	5.9	1.9	-67.2%	\$44	\$0	-100.0%
Emergency Room	26	53	103.8%	\$19,972	\$74,481	272.9%	\$1.63	\$5.97	267.2%	27	59	118.5%	26.4	56.7	115.2%	\$740	\$1,262	70.7%
Specialist	96	193	101.0%	\$20,293	\$44,005	116.9%	\$1.65	\$3.53	113.5%	147	270	83.7%	143.5	259.6	80.9%	\$138	\$163	18.1%
PCP	47	52	10.6%	\$4,524	\$7,472	65.2%	\$0.37	\$0.60	62.6%	62	101	62.9%	60.5	97.1	60.4%	\$73	\$74	1.4%
Radiology	0	4		\$0	\$174	-	\$0.00	\$0.01		0	4		0.0	3.8		\$0	\$44	
Lab	178	281	57.9%	\$20,032	\$38,105	90.2%	\$1.63	\$3.05	87.3%	271	521	92.3%	264.6	500.9	89.3%	\$74	\$73	-1.1%
Home Health	1	2	100.0%	\$195	\$197	0.9%	\$0.02	\$0.02	-0.7%	1	2	100.0%	1.0	1.9	96.9%	\$195	\$99	-49.6%
Behavioral Health	0	0	-	\$0	\$0	-	\$0.00	\$0.00	-	0	0		0.0	0.0	-	\$0	\$0	-
Medical Rx	0	40	-	\$0	\$2,070	-	\$0.00	\$0.17	-	0	64	-	0.0	61.5	-	\$0	\$32	-
Total	241	405	68.0%	\$174,397	\$265,975	52.5%	\$14.19	\$21.31	50.2%	507	983	93.9%	495.0	945.1	90.9%	\$344	\$271	-21.3%

Table 9: Total COVID-19 Medical Cost by Member Type:

	# o	f Unique Claim	ants]	Medical Paid		N	ledical Paid PM	PM	Distributi	on of Spend
Member Type	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	Prior	Current
Employee	219	366	67.1%	\$145,700	\$243,992	67.5%	\$11.86	\$19.55	64.9%	84%	92%
Spouse	6	14	133.3%	\$26,022	\$14,766	-43.3%	\$2.12	\$1.18	-44.1%	15%	6%
Child	16	25	56.3%	\$2,674	\$7,217	169.9%	\$0.22	\$0.58	165.7%	2%	3%
Total	241	405	68.0%	\$174,397	\$265,975	52.5%	\$14.19	\$21.31	50.2%	100.0%	100.0%

IMPORTANT: Testing and treatment for the new coronavirus is still evolving and as a result claims experience may be effected as the industry adapts to the changing circumstances. Information is believed to be accurate as of the production date; however, it is subject to change. Aetna makes no representation or warranty of any kind, whether express or implied, with respect to the information in this report and cannot guarantee its accuracy or completeness. Aetna shall not be liable for any act or omissions made in reliance on the information.

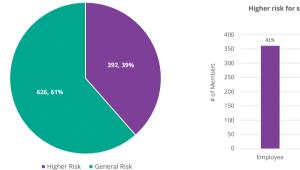


Risk of the Population

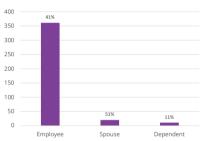
392

38.5% members are at higher risk for severe illness, representing

of the population, using CDC-identified higher risk factors like age and pre-existing chronic conditions



Higher risk for severe illness, by member type

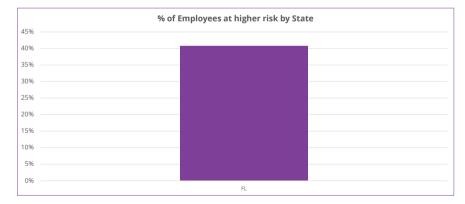


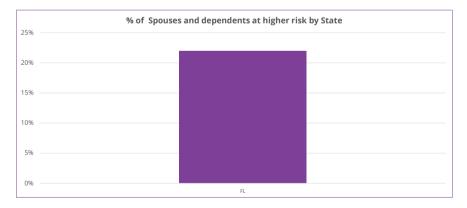
General risk for contracting COVID-19 exists across the population. Age and underlying health conditions are associated with higher risk for severe illness with the potential for severe symptoms, hospitalizations, ICU services, and poorer outcomes. The CDC provides guidelines, recommendations, and resources for those who are considered at higher-risk for severe illness.

The pie chart shows the percent of members with <u>CDC-identified "higher risk for severe illness"</u> factors.

The bar chart to the left shows risk by member type.

The bar charts below provide a sense of risk by state.





Data in these charts is only shown for states where there are at least 50 employees

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Alerts for the top 50 counties with high new cases rates in which you have membership

	County	Your	Average daily new	
State, County	population	members	cases per 100K	Risk Level
Florida, Miami-Dade	2,716,940	1	580.7	High Risk
Florida, Palm Beach	1,496,770	12	278.2	High Risk
Florida, Hendry	42,022	831	232.9	High Risk
Florida, Hillsborough	1,471,968	1	214.6	High Risk
Florida, Okeechobee	42,168	1	201.9	High Risk
Florida, Alachua	269,043	2	200.6	High Risk
Florida, Lee	770,577	97	196.7	High Risk
North Dakota, Cass	181,923	2	194.6	High Risk
Florida, Collier	384,902	5	180.5	High Risk
Georgia, Gwinnett	936,250	1	138.6	High Risk
Florida, Highlands	106,221	2	127.9	High Risk
Florida, Charlotte	188,910	11	121.0	High Risk
Indiana, Delaware	114,135	1	110.8	High Risk
Florida, Sumter	132,420	2	88.8	High Risk
North Carolina, Rutherford	67,029	1	84.8	High Risk
Florida, Glades	13,811	47	77.6	High Risk
Tennessee, Dickson	53,948	1	75.2	High Risk

County Alerts

This table shows the rate of average daily new cases per 100,000 individuals that live in that county. These rates are reflective of the overall general population of the county, not of your specific membership in that county. We are providing this information to inform you which counties you have membership in that are experiencing a high incidence rate of new cases.

The CDC collects new case counts at the county level. We use this information to calculate a '7 day average new case count.' This data is then normalized for population size (new cases per 100,000 individuals) to smooth unusual daily highs or lows, often caused by data collection fluctuations.

The county information is for your top 50 counties in which you have membership that have the highest average daily new cases over the past seven days. Average daily new cases of 25 per 100k members are denoted as high risk (red) and those with 10-24.9 are denoted as emerging risk (orange).

Note: There may be less than 50 counties or none at all depending upon where you have membership vs .the counties with the highest risk.



					Two Dose	Regimen	Single Dose Regimen	Booster
accinations by State* I Eligible Members	State	Your Members >= Age 5	Fully Vac Members		# of Members 1st Dose	# Members 2nd Dose	# Members	# Members
	AK AL	-	-	-	-	-	-	-
ttps://covid.cdc.gov/	AR		-	-				
<u>covid-data-</u>	AZ CA	-	-	-	-	-	-	-
			-	-		-		-
acker/#vaccinations	CO CT			-		-		-
	DC	-	-	-	-	-	-	-
	DE FL	1,246	177	14%	259	161	17	37
	GA	-	-	-	-	-	-	-
	GU	-	-	-	-	-		-
1,256	HI	-	-	-	-	-	-	-
-	ID IL	-	-	-		-	-	-
Eligible Members	IN			-				
	IA	-		-	-	-	-	-
		-	-	-	-	-	- 1	-
	KS KY	-	-	-		-	-	-
	LA	-	-	-	-	-	-	-
	MA		-	-		-		-
	MD ME	-	-	-	-	-	- 1	-
	MI		-	-	-	-		-
	MN			-				-
	MO	-	-	-	-		-	-
	MS	-	-	-	-	-	-	-
	MT	-	-	-	-	-	-	-
	NC	-	-	-	-	-	-	-
	ND	-	-	-		-	-	-
	NE NH		-	-	-	-	-	-
	NH NJ		-	-	-	-	-	-
	NM			-				-
	NV	-		-	-	-	-	-
	NY	-	-	-	-	-	-	-
	OH	-	-	-	-	-	-	-
	OK	-	-	-	-	-	-	-
	OR			-				-
	PA PR		-	-	-	-	-	-
	RI		-	-		-	-	-
	SC		-	-		-		-
	SD	-	-	-	-	-	-	-
	TN	-	-	-	-	-	-	-
	TX	-	-	-	-	-	-	-
	UT	-	-	-	-	-	-	-
	VT		-	-				
	VA	-	-	-	-	-	-	-
	WA WI		-	-			-	-
	WV							
with less than 10 members will not te on this page	WY							



					Two Dose	Regimen	Single Dose Regimen	Booster
Vaccinations by State* All Eligible Employees	State	Your Employees >= Age 5	Fully Vac Employees		# of Employees 1st Dose	# Employees 2nd Dose	# Employees	# Employees
5 1 5	AK	-	-	-	-	-	-	-
	AL	-	-	-	-	-	-	-
https://covid.cdc.gov/	AR AZ							
<u>covid-data-</u>	CA	_	_	_	_	_	_	-
tracker/#vaccinations	CO CT	-	-	-	-	-	-	-
		-	-	-	-	-	-	-
	DC	-	-	-	-	-	-	
	DE FL	- 1,076	 154		- 231			- 36
	GA	-	-	14%	- 231	-	- 14	- 30
	GU	-	-	-	-	-	-	-
1,086	HI	-	-	-	-	-	-	-
1,000	ID	-	-	-	-	-	-	-
Eligible Members	IL				·	-		-
Eligible Members	IN IA	-	-	-	-	-	-	-
	KS		-	-	-	-	-	-
	KY	- 1	-	-		-		-
	LA	-	-	-	-	-	-	-
	MA							
	MD	-	-	-	-	-	-	-
	ME MI	-	-	-	-	-	-	-
	MN					-		-
	MO	-	-	-	-	-	-	-
	MS	-	-	-	-	-	-	-
	MT	-	-	-	-	-	-	-
	NC	-	-	-	-	-	-	-
	ND NE		-			-	-	-
	NH		-	-		-		
	NJ	-	-	-	-	-	-	-
	NM		-	-		-		-
	NV	-	-	-	-	-	-	-
	NY	-			-	-		-
	ОН ОК	-	-	-	-	-		-
	OR		-	_		-		
	PA		-	-	-	-	-	-
	PR	-	-	-	-	-	-	-
	RI			-		-	-	
	SC	-	-	-	-	-	-	-
	SD TN							
	TX	-	-	-	-	-		-
	UT	-	-	-	-	-	-	-
	VT	_	-	-		-		-
	VA	-	-	-	-	-	-	-
	WA	-	-	-	-	-	-	-
* States with less than 10 members will not	WI							-
populate on this page	WY	_	-	-		-	-	-
								·

Billable Top 100 Drugs by Paid Amount

 GROUP:
 '00109695'

 RETAIL/MOD:
 ALL

 Begin Date:
 2021-01-01

 End Date:
 2021-12-31

DRUG FORM NONFO BRANDGEN COMMON USE #MBR AVGCOPAY CLAIM CNT QTY AVGDAYS HUMIRA PEN Formulary Brand AUTO-IMMUNE 5 \$32.73 44 121 30 **IMBRUVICA** 28 CANCER 13 364 Formulary Brand 1 \$0.00 VERZENIO CANCER \$0.00 560 28 Formulary Brand 1 10 37 TRULICITY Formulary Brand DIABETES 12 \$37.00 75 198 COSENTYX PEN 22 28 Formulary Brand **PSORIASIS** 2 \$30.00 8 OZEMPIC 45 Brand DIABETES 14 \$47.29 59 174 Formulary 57 JARDIANCE Brand DIABETES 16 \$56.07 61 3510 Formulary TRESIBA FLEX Formulary Brand DIABETES 10 \$56.54 52 1344 53 GAMMAGARD 28 **IMMUNOGLOBULIN** 4400 Formulary Brand 1 \$36.36 11 ENBREL MINI 28 AUTO-IMMUNE 1 9 Formulary Brand \$30.00 36 28 ENBREL Formulary Brand AUTO-IMMUNE 1 \$30.00 9 36 OTEZLA Formulary Brand AUTO-IMMUNE 2 \$30.00 11 660 30 ROSUVASTATIN 72 13692 Formularv Generic HIGH CHOLESTEROL 49 \$23.69 191 BIKTARVY \$30.00 12 360 30 Formularv Brand HIV 1 NORDITROPIN Formulary Brand **GROWTH HORMONE DEFICIENCY** \$30.00 10 45 24 1 JANUVIA 10 37 2220 60 Formulary Brand DIABETES \$47.84 TREMFYA 46 **PSORIASIS** 3 Formulary Brand 1 \$11.68 3 **ATORVASTATIN** Formularv Generic HIGH CHOLESTEROL 76 \$4.06 265 18773 71 ZEJULA CANCER 2 120 30 Formulary Brand \$0.00 1 VYVANSE 16 91 2970 31 Formulary Brand ADHD \$31.76 **ELIQUIS** ANTICOAGULANT 46 Formulary Brand 10 \$57.85 42 3900 AIMOVIG **MIGRAINE HEADACHE** 5 36 44 36 Formulary Brand \$36.67 EPIDIOLEX 30 Brand SEIZURE DISORDERS \$50.00 9 1770 Formulary 1 NOVOLOG 715 Formulary Brand DIABETES 8 \$32.90 29 41 OCTAGAM IMMUNOGLOBULIN \$50.00 1200 28 Formulary Brand 1 1 FARXIGA DIABETES \$39.68 31 1230 39 Formulary Brand 7 XARELTO 79 ANTICOAGULANT 7 \$80.63 16 1544 Formulary Brand LINZESS Formulary Brand **IRRITABLE BOWEL SYNDROME** 6 \$43.00 30 1200 40 ADDERALL XR 29 NonFormulary Brand ADHD 15 \$10.26 83 2455 HUMULIN R Formulary \$38.57 7 31 Brand DIABETES 1 168 TRELEGY 32 Formulary Brand ASTHMA 3 \$28.75 24 1560 DESCOVY HIV 8 210 26 Formulary Brand 1 \$40.00 **ENTRESTO** Brand CARDIOVASCULAR 2 \$67.50 8 1440 90 Formulary ADVAIR DISKU 40 7 24 Formularv Brand ASTHMA \$11.67 1920

Formulary ALL Generic ALL

DRUG	FORM NONFO	BRANDGEN	COMMON USE	<u>#MBR</u>	AVGCOPAY	CLAIM CNT	QTY	AVGDAYS
VASCEPA	Formulary	Brand	HIGH CHOLESTEROL	6	\$37.00	20	4560	57
VIMPAT	Formulary	Brand	SEIZURE DISORDERS	1	\$30.00	13	720	27
LO LOESTRIN	Formulary	Brand	CONTRACEPTION	14	\$0.00	31	2044	65
GLYXAMBI	Formulary	Brand	DIABETES	2	\$90.00	7	630	90
REXULTI	NonFormulary	Brand	PSYCHIATRIC DISORDERS	1	\$50.00	9	270	30
SYMBICORT	Formulary	Brand	ASTHMA	8	\$61.32	28	347	38
BREO ELLIPTA	Formulary	Brand	ASTHMA	7	\$45.00	20	1800	45
JANUMET	Formulary	Brand	DIABETES	4	\$84.00	10	1288	82
SLYND	NonFormulary	Brand	CONTRACEPTION	8	\$0.00	26	1344	51
ENSTILAR	Formulary	Brand	SKIN DISORDERS	2	\$30.00	6	480	20
SIMVASTATIN	Formulary	Generic	HIGH CHOLESTEROL	25	\$0.54	92	6300	68
DUPIXENT	Formulary	Brand	SKIN DISORDERS	1	\$30.00	3	12	28
NURTEC	Formulary	Brand	MIGRAINE HEADACHE	4	\$40.00	9	84	29
SPIRIVA	Formulary	Brand	RESPIRATORY DISEASE	2	\$36.92	15	76	38
SOLIQUA	Formulary	Brand	DIABETES	2	\$30.00	11	165	26
PFIZER VACC	NonFormulary	Brand	VACCINE	127	\$0.00	232	70	1
ARIPIPRAZOLE	Formulary	Generic	PSYCHIATRIC DISORDERS	4	\$16.36	11	630	57
BUPROPN HCL	Formulary	Generic	DEPRESSION	19	\$17.64	72	4515	54
VORICONAZOLE	Formulary	Generic	FUNGAL INFECTION	1	\$10.00	2	240	30
DULOXETINE	Formulary	Generic	DEPRESSION	16	\$15.95	69	3420	49
ANASTROZOLE	Formulary	Generic	CANCER	5	\$0.00	16	1365	87
NOVOLOG MIX	Formulary	Brand	DIABETES	2	\$70.00	3	190	64
ZENPEP	Formulary	Brand	METABOLIC/ENZYME DISORDERS	1	\$60.00	1	500	83
MODERNA VAC	NonFormulary	Brand	VACCINE	120	\$0.00	182	81	1
FLUCLVX QUAD	NonFormulary	Brand	VACCINE	133	\$0.37	133	126	11
PREGABALIN	Formulary	Generic	SEIZURE DISORDERS	6	\$9.13	23	1905	37
ANORO ELLIPT	Formulary	Brand	ASTHMA	2	\$38.57	7	840	60
SYNJARDY	Formulary	Brand	DIABETES	2	\$30.00	11	660	30
CONCERTA	NonFormulary	Brand	ADHD	3	\$10.00	14	420	30
JANUMET XR	Formulary	Brand	DIABETES	1	\$90.00	4	720	90
ENBREL SRCLK	Formulary	Brand	AUTO-IMMUNE	1	\$30.00	1	4	28
LOSARTAN/HCT	Formulary	Generic	CARDIOVASCULAR	18	\$22.21	68	5190	70
LEVETIRACETA	Formulary	Generic	SEIZURE DISORDERS	4	\$22.49	16	3870	75
SHINGRIX	NonFormulary	Brand	VACCINE	22	\$0.00	32	32	4
OXYCOD/APAP	Formulary	Generic	PAIN	41	\$8.37	114	8194	18
VALACYCLOVIR	Formulary	Generic	HERPES	22	\$11.05	50	1592	27
EPINEPHRINE	Formulary	Generic	ALLERGY	9	\$10.00	9	20	30
RYBELSUS	Formulary	Brand	DIABETES	2	\$75.00	2	180	90
TOVIAZ	Formulary	Brand	KIDNEY/BLADDER DISORDERS	1	\$16.15	13	390	30
OLM MED/HCTZ	Formulary	Generic	CARDIOVASCULAR	5	\$22.94	17	1350	79
SEVELAMER	Formulary	Generic	KIDNEY/BLADDER DISORDERS	2	\$18.00	5	2160	54
CLIMARA PRO	Formulary	Brand	FEMALE HORMONE REPLACEMENT	2	\$42.86	14	80	41

DRUG	FORM NONFO	BRANDGEN	COMMON USE	<u>#MBR</u>	AVGCOPAY	CLAIM CNT	<u>QTY</u>	AVGDAYS
BASAGLAR	Formulary	Brand	DIABETES	4	\$62.69	10	210	50
MYCOPHENOLIC	Formulary	Generic	IMMUNOSUPPRESSANT THERAPY	2	\$10.00	13	780	30
BREZTRI AERO	Formulary	Brand	ASTHMA	2	\$30.00	7	75	30
LEFLUNOMIDE	Formulary	Generic	AUTO-IMMUNE	3	\$9.86	22	660	30
FLUVOXAMINE	Formulary	Generic	DEPRESSION	2	\$10.00	9	510	30
EZETIMIBE	Formulary	Generic	HIGH CHOLESTEROL	5	\$28.33	12	1020	85
OLANZA/FLUOX	Formulary	Generic	PSYCHIATRIC DISORDERS	1	\$100.00	4	360	90
ALBUTEROL	Formulary	Generic	ASTHMA	87	\$10.33	180	3890	23
TRINTELLIX	Formulary	Brand	DEPRESSION	1	\$30.00	9	270	30
LEVEMIR	Formulary	Brand	DIABETES	3	\$22.50	12	119	33
BUPREN/NALOX	Formulary	Generic	PAIN	3	\$6.67	18	1320	30
TELMISA/HCTZ	Formulary	Generic	CARDIOVASCULAR	6	\$18.57	35	1935	55
RESTASIS	NonFormulary	Brand	EYE DISORDERS	2	\$75.00	4	360	45
ETONOGESTREL	Formulary	Generic	CONTRACEPTION	4	\$0.00	16	36	63
DOXYCYCL HYC	Formulary	Generic	INFECTION	68	\$9.14	75	1558	11
FLOVENT DISK	Formulary	Brand	ASTHMA	3	\$40.00	9	780	43
XIGDUO XR	Formulary	Brand	DIABETES	1	\$90.00	2	360	90
COMBIGAN	Formulary	Brand	EYE DISORDERS	2	\$42.50	12	90	32
PRAVASTATIN	Formulary	Generic	HIGH CHOLESTEROL	14	\$24.52	42	3360	80
LETROZOLE	Formulary	Generic	CANCER	3	\$0.00	7	390	53
LAMOTRIGINE	Formulary	Generic	SEIZURE DISORDERS	8	\$9.70	39	3210	50
RAYOS	NonFormulary	Brand	INFLAMMATION	1	\$50.00	1	30	30
ADVAIR HFA	Formulary	Brand	ASTHMA	1	\$18.00	5	60	30
PRALUENT	Formulary	Brand	HIGH CHOLESTEROL	1	\$30.00	6	12	28

Benefits Match-Up – a,b,c (In Word format)

A request for any documents in Word or Excel may be made to:

Theresa Conley Siver Insurance Consultants <u>tconley@siver.com</u>

Most Utilized Provider Comparison Match-Up (In Excel format)

A request for any documents in Word or Excel may be made to:

Theresa Conley Siver Insurance Consultants <u>tconley@siver.com</u>

Wellness Information

Congratulations



We won an Aetna® Workplace Well-being Above and Beyond Award.

This is based on the evaluation of our employer well-being program. And because of what we've accomplished, we're taking home the **silver**. A big thanks to everyone who participated in our well-being program. We couldn't have won this esteemed award without you. Your commitment to well-being has helped create a healthier, happier place to work.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).



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School Board of Hendry County's 2021 Well-being Communication Strategy



The right approach makes all the difference

You already know that a wellness program can help your employees understand their personal health needs and motivate them to make positive changes. But the value of the program depends on engaging your employees at the right times, in the right ways, with the right messaging.

In this strategy, you will find insight and tools to help create a communications plan to get your employees engaged and keep them more involved in their own health.

Getting Started

The more you know about our wellness program and your population, the easier it will be for you to motivate your employees.

Get buy-in from your management team

Management support is important for a successful program launch. People like to follow what their leaders believe in. Encouraging participation from your leadership team is a great way to help engage your employee population.

Decide how the Aetna program fits with your other wellness programs

Will this program serve as your core wellness offering or complement other existing wellness programs and initiatives? Coordinate communication around your wellness program to maximize effort.

Know how your employees will react to using an online wellness program

If your employees have not been exposed to online wellness tools or a health assessment, consider scheduling training sessions to introduce the program. This can help you showcase the program's value and ease potential privacy concerns.



Developing your communication strategy

Ongoing communication is critical to the success of any new program. You want a communication plan that works for your organization, based on how you communicate.

Create a communication strategy that works

Stage your communications to create awareness and keep interest going throughout the year. It may take several communications before some employees are intrigued enough to try the program.

Time your launch for maximum effect

Choose a time when your employees will be able to focus on the messages you send them. Consider avoiding your busiest times of the year (such as during tax season for accounting firms). Also, avoid times when employees usually take vacations or celebrate holidays.

Use both electronic and print communications

Multiple communications delivered around the same time will help reinforce the message. When launching the program, you may consider delivering an email or newsletter to announce the program, followed shortly by a postcard.

Communication materials

You can choose from a variety of promotional materials. Use the ones that will work best for your organization.

- **Emails:** Use the preformatted emails to send information to employees. Be creative in the subject line to catch your employee's attention so they can quickly identify the email.
- **Flyer:** Flyers can be printed and/or posted on an intranet site or in break rooms. If you use paper paychecks, flyers may be stapled or added to the envelopes.
- **Text:** Use the information from the flyers to provide text on the health topic. The text would be available for use in a newsletter or to promote the topic via an intranet or internet site.
- **Podcast:** Some of the topics provide a link to a podcast. These are approximately 7-10 minutes long and may be shared with employees.
- **Engagement:** Use the communication materials to solicit testimonials, engage members in raffle drawings, or invite members to post a picture of themselves doing something healthy. Consider creating quizzes to encourage employees to read the materials and provide the answers to enter in prize drawings.

Monthly well-being messages: In addition to these communications items listed in this document, you will receive quarterly Well-being topics with supporting communication. These may provide similar or duplicate information at times, please choose the method or document that best suits your needs.

Setting goals and achieving success

Before you launch your program, decide what your participation goals are. This will help you measure success. You will also be able to track program utilization. Reevaluate your goals each year. As your employees become more familiar with the program, you may want to set the bar higher. Our most strategic customers are ones that provide an incentive and reward program, convey management support for the program and provide a consistent communications strategy throughout the year.





Quarter 1

Month 1: January	Communication Tools	Well-being Topic
Promote benefits and registration on our Aetna member website and Aetna Health SM app.	Aetna member website and Aetna Health sm app <u>flyer</u>	Starting strong, staying well Flyer in <u>English</u> and <u>Spanish</u>
	Enhanced Wellness <u>flyer</u>	Additional Health & Wellness
Journey to your Best Health <u>Video</u>	COVID support resources	<u>Topics</u>
Month 2: February	Communication Tools	Well-being Topic
Educate members the importance of preventive care.	Preventive care flyer in English and Spanish	Exercising for a healthy heart Flyer in <u>English</u> and <u>Spanish</u>
Time for Care		
Month 3: March	Communication Tools	Well-being Topic
Teladoc [®] offers 24/7 access to	Teladoc <u>engagement</u>	Getting screened for colon
hoard-certified doctors via phone	center	cancer

Teladoc [®] offers 24/7 access to	Teladoc <u>engagement</u>	Getting screened for colon
board-certified doctors via phone,	<u>center</u>	cancer
mobile, and video that will		Flyer in English and Spanish
diagnose, treat and prescribe	Health Guide	
medications (if necessary) for		
common health issues.	Options for care <u>flyer</u>	

Quarter 2

Month 4: April	Communication Tools	Well-being Topic
Online wellness programs that offer a personalized approach to	Health Assessment & Online Coaching <u>flyer</u>	Keeping workplace stress in check
improve members health.		Flyer in English and Spanish
	Simple Steps Incentive	
	flyer in <u>English</u> & <u>Spanish</u>	Virgin Pulse <u>Get Active</u>
	-	Challenge (Great American
		Adventure)

Month 5: May	Communication Tools	Well-being Topic
Help members discover the value- added programs and services of	Discount <u>flyer & Video</u>	Nurturing mental and emotional health
their health plan.	Mind Check flyer	Flyer in <u>English</u> and <u>Spanish</u>
	Behavioral Health Site	Workplace Well-being Award

Month 6: June	Communication Tools	Well-being Topic
Our Aetna Maternity program provides support to help members have a healthy pregnancy.	Maternity <u>flyer</u> Maternity Journey <u>Video</u>	Managing migraines Flyer in <u>English</u> and <u>Spanish</u>
	Breast Feeding Support	





Quarter 3

Month 7: July	Communication Tools	Well-being Topic
A MinuteClinic is a walk-in clinic inside a CVS Pharmacy that provides convenient services for	Neighborhood well-being <u>flyer</u>	Maintaining musculoskeletal health Flyer in <u>English</u> and <u>Spanish</u>
minor illnesses and injuries. They also provide weight management and tobacco cessation coaching at no cost to the member.	HealthHub/Minute Clinic	Virgin Pulse <u>Get Active</u> <u>Challenge</u> (World Tour)

Month 8: August	Communication Tools	Well-being Topic
Preventive care covers many checkups, screenings, vaccines,	Preventive <u>brochure</u>	Getting back to better sleep Flyer in <u>English</u> and <u>Spanish</u>
prenatal care services, contraceptives and more with no	Simple Steps Health Assessment	Biometric Screenings <u>Flyer</u>
out-of-pocket costs.		

Month 9: September	Communication Tools	Well-being Topic
Disease management is available to members who need additional assistance in managing a new or	Aetna In Touch Care <u>flyer</u> <u>and Spanish</u>	Eating healthy for the whole family Flyer in <u>English</u> and <u>Spanish</u>
ongoing diagnosis.	Health Decision Support Tool <u>flyer</u>	

Quarter 4

Month 10: October	Communication Tools	Well-being Topic
The cancer support centers provide comprehensive support tools on our Aetna member secure website.	Cancer support <u>flyer</u> CVS Flu Shots	Feeling good through gratitude Flyer in <u>English</u> and <u>Spanish</u>

Month 11: November	Communication Tools	Well-being Topic
Our Aetna Maternity program provides personalized nurse	Maternity support <u>flyer</u>	Treating and preventing prediabetes
support to help members have a healthy pregnancy.	Women's Health Tips	Flyer in <u>English</u> and <u>Spanish</u>
	Tobacco cessation <u>flyer</u> Reduce Risk for <u>Diabetes</u>	

Month 12: December	Communication Tools	Well-being Topic
The 24-hour nurse line gives members access to registered nurses who can answer their questions on a variety of health topics.	Informed health line <u>flyer</u>	Staying mindful through the holidays Flyer in <u>English</u> and <u>Spanish</u>







2020 Executive Summary

Report reflects data from January 1, 2020 - December 31, 2020 Prepared by: Kim Sandmaier, Wellness Account Consultant

		Member Employees Members Average Age	ership 882 1,043 41		Gender 26% Males 74% Females	er • 4 • 1E • 2 • 10	Actna Hea 78 registered sub habled claim status EOB inquiry DocFind discounts e simple steps	
Programs		Fasting venipur completed Onsite Flu Shot	due to COVID	ng not <30). † co	Simple Steps to a Healthier completed the health assessment there is no aggregate reporting (1 impleted). This was a decrease from previous year.	• Pa nt so • Q1 3 pa om • Q2 pa • Q3 To • Q2	2 Food around th	on: 583 Ithier: 170 steps 68,274,197 e Globe: 41 teps 33,460,626 50 participants, 570 (Mindfulness)
Programs		In Touch Car Total Participa 1:1 Support=96 Digital Suppor Overall Partici (same as 2019 Unable to be F	ation = 462 6 (9.2%) t= 366 (35%) pation: 44%	Clin Level = 7	ical Care Considerations 1 + Level 2 + Level 3 = 266 + Evel 3 = 131 Condition Drug Monitoring Preventive Care		etna Maternity New pregnancy if enroll before 16 Identified = 31 (3' Total participatio • Nurse engagem • Supportive = 0 • Fulfillment = 1 • Opt-out = 0	wedge pillow 8th week %) n = 2 (66%)
Preventive	De Hy Hy Ob Dia	Top 5 sease sportension opertension operlipidemia besity abetes Mellitus w Back Pain	Clinical Con Prevalence 24.5% 21.1% 15.1% 8.3% 9.8%	BOB Prevalence 12.5% 12.2% 5.6% 4.5% 5.6%	Preventive Care - Claims Well Baby Visits Childhood Preventive Care Visits Adult Preventive Care Visits Well Woman Exam (Annual Gynecological Exam) Childhood Immunizations Pap Smear	Prior Year Compliance Rate 72.4% 43.1% 15.2% 25.2% 34.5% 25.0%	54.2% 46.8% 16.3% 25.4% 37.5% 23.7%	BOE Compliance Rate 63.8% 36.5% 15.4% 16.4% 55.2% 15.6%
	b	ncrease Comm	unications		Mammography Cholesterol Test	32.8% 9.2%	29.1% 7.7%	22.69 9.09

Increase Communications

- . Consider a monthly wellness newsletter
- Consider educational campaign with wellness coaches
- Consider communications / educational materials that focus on top chronic conditions
 - Card) after 6/1 Proprietary & Confidential - May not be copied, printed, or redistributed without prior written approval.

Encourage employees to

Colorectal Screening

Promote Get Active program

Wellness Challenge Participation

complete their health assessment

journey to earn incentive (\$50 Gift

and their online health coaching

Continued Data Analysis Start Quest biometric .

8.3%

6.0%

10.0%

- screening implementation in May 2020 •
- Monitor wellness allowance expense of \$100,000

Demographics

Enhanced Wellness

Chronic Care

inical &

Medical Census (In Excel format)

A request for any documents in Word or Excel may be made to:

Theresa Conley Siver Insurance Consultants <u>tconley@siver.com</u>