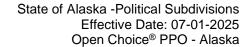


PLAN DESIGN & BENEFITS MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
	supplies have limits on them per year. T	
visits or days, or a dollar limit per year.	. In such cases, the benefit year begins o	n January 1 (unless otherwise noted).
Refer to your plan documents to learn	more.	
Deductible (per calendar year)	\$750 per Individual	\$750 per Individual
	\$2,250 per Family	\$2,250 per Family
	n your in-network and out-of-network ded	
	ore the plan begins paying benefits, unle	
The amount you pay (cost sharing) for	some medical services does not count to	oward your deductible.
	ward the deductible. Refer to your plan o	
Your family will have one deductible. Y	ou will meet it when the expenses of sev	reral family members add up to the
family deductible. No one person will h	nave to pay more than the individual dedu	uctible.
Member coinsurance	You pay 20%	You pay 40%
Applies to all expenses except as note	d.	
Out-of-pocket limit (per calendar	\$2,750 per Individual	\$2,750 per Individual
year)		
	\$8,250 per Family	\$8,250 per Family
Covered expenses add up toward both your in-network and out-of-network out-of-pocket limit at the same time.		
Your pharmacy expenses do not count	t toward your out-of-pocket limit.	
In-network expenses include coinsurar	nce/copays and deductibles.	
	surance and deductibles. Penalty amoun	
Your family will have one out-of-pocker	t limit. You will meet it when the expense	s of several family members add up to
	person will have to pay more than the indi	ividual out-of-pocket limit amount.
Lifetime maximum		
Unlimited except where otherwise indicated	cated.	
Payment for out-of-network care**	Does not apply	Professional: 185% of Medicare
		Facility: 185% of Medicare
Primary care physician selection	Does not apply	Does not apply
Precertification requirements -		
Some out-of-network services need approval by us in advance (precertification). Without this approval, we reduce		
benefits by \$400. Refer to your plan documents for a full list of services that need this approval.		
Referral requirement	Not required	None
	access covered services for telehealth vis	
your network. Log on to Aetna.com to	see a list of telehealth providers. You'll a	also find more about your options,
including cost share amounts.		
Virtual care consultations - You can	access covered services for virtual care	visits from different kinds of providers in
your network. Log on to Aetna.com to see a list of virtual care providers. You'll also find more about your options,		
including cost share amounts.		

CVS VIRTUAL CARE	IN-NETWORK	OUT-OF-NETWORK
CVS Health Virtual Primary Care (VPC) - preventive care consultations	Covered 100%; no deductible	Not applicable
Includes screening and counseling serefer to Aetna.com for more information	•	mary Care for members age 18 and older;
CVS Health Virtual Primary Care (VPC) - consultations	Covered 100%; no deductible	Not applicable
•	<u> </u>	rtual Primary Care for members age 18

and older; refer to Aetna.com for additional information.

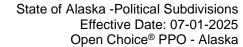




CVS Health Virtual Care (VC) -	Covered 100%; no deductible	Not applicable
general medicine		Not applicable
CVS Health Virtual Care (VC) - mental health	Covered 100%; no deductible	Not applicable
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine adult physical exams/	Covered 100%; no deductible	Covered 100%; no deductible
immunizations		
	5, then 1 exam every 12 months age 65	and older
Routine well child	Covered 100%; no deductible	Covered 100%; no deductible
exams/immunizations		,
 7 exams in the first 12 months 		
3 exams from age 13 months to 24	months	
• 3 exams from age 25 months to 36		
• 1 exam every 12 months thereafter		
Routine gynecological care exams		Covered 100%; no deductible
1 exam and pap smear per year, incl		
Routine mammogram	Covered 100%; no deductible	Covered 100%; no deductible
Recommended: One per year for me	·	
Women's health	Covered 100%; no deductible	Covered 100%; no deductible
	iabetes, HPV (Human- Papillomavirus)	
	d screening for human immunodeficience	
	breastfeeding support, supplies and co	
		ding contraceptives and devices you can
	edures (including tubal ligation), patient	
apply.		g
Pre-natal maternity	Covered 100%; no deductible	Covered 100%; no deductible
Routine digital rectal exam	Covered 100%; no deductible	Covered 100%; no deductible
Recommended: For members age 40	•	,
Prostate-specific antigen test	Covered 100%; no deductible	Covered 100%; no deductible
Recommended: For members age 40		•
Colorectal cancer screening	Covered 100%; no deductible	Covered 100%; no deductible
Recommended: For members age 4		•
Routine eye exams	Covered 100%; no deductible	Covered 100%; no deductible
1 routine exam per 12 months.	·	•
Routine hearing screening	Covered 100%; no deductible	Covered 100%; no deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office visits to non-specialist	20%; after deductible	20%; after deductible
	eral physician, family practitioner or ped	
Telehealth consultation with non-	20%; after deductible	20%; after deductible
specialist	,	,
Specialist office visits	20%; after deductible	20%; after deductible
Includes visits to a naturopath	,	,
Telehealth consultation with	20%; after deductible	20%; after deductible
specialist		
Hearing exams	Not Covered	Not Covered
Walk-in clinics	20%; after deductible	20%; after deductible
	Ith care facilities. Sometimes they may I	
	ey offer some limited medical care and	
Net all 's all a languages and a	by the some inflicted medical care and	controlled a large trade and a later

Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory

surgical centers, and physician offices.





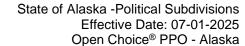
Allergy testing	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
Allergy injections	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray (Other than complex imaging services)	20%; after deductible	20%; after deductible
	s for this service at their office, you pay y	
Diagnostic laboratory	20%; after deductible	20%; after deductible
	s for this service at their office, you pay y	
Diagnostic complex imaging	20%; after deductible	20%; after deductible
	s for this service at their office, you pay y	
EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Jrgent care provider	20%; after deductible	20%; after deductible
Non-urgent use of urgent care provider	Not Covered	Not Covered
Emergency room	20%; after deductible	Same as in-network care
Non-emergency care in an emergency room	50%; after deductible	50%; after deductible
Emergency use of ambulance	20%; after deductible	Same as in-network care
Non-emergency use of ambulance	Not Covered	Not Covered
OSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
npatient coverage	20%; after deductible	40% after \$500 per visit deductible; after plan deductible
penefits you receive.	r the care you need, your cost sharing a	
npatient maternity coverage (includes delivery and postpartum care)	20%; after deductible	40% after \$500 per visit deductible; after plan deductible
When you're admitted into a hospital fo benefits you receive.	r the care you need, your cost sharing a	mount counts toward all covered
Outpatient hospital	20%; after deductible	40%; after deductible
When you receive outpatient care at a lecovered benefits during your visit.	hospital but don't stay overnight, your co	st sharing amount counts toward all
Outpatient surgery - hospital	20%; after deductible hospital but don't stay overnight, your co	40%; after deductible st sharing amount counts toward all
Outpatient surgery - freestanding facility	20%; after deductible	20%; after deductible

When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.





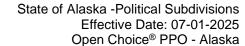
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	20%; after deductible	40% after \$500 per visit deductible;
		after plan deductible
	or the care you need, your cost sh	aring amount counts toward all covered
benefits you receive.		
Mental health office visits	20%; after deductible	20%; after deductible
Mental health telehealth	20%; after deductible	20%; after deductible
consultations		
Other mental health services	20%; after deductible	20%; after deductible
	facility but don't stay overnight, yo	our cost sharing amount counts toward all
covered benefits during your visit.		
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	20%; after deductible	40% after \$500 per visit deductible;
NATIONAL CONTRACTOR OF THE CON		after plan deductible
	or the care you need, your cost sh	aring amount counts toward all covered
benefits you receive.	000/	400/ after \$500 and init deductible.
Residential treatment facility	20%; after deductible	40% after \$500 per visit deductible;
NATIONAL STREET, AND	d	after plan deductible
	the care you need, your cost sha	ring amount counts toward all covered benefits
you receive.	000/	000/ #4
Substance abuse office visits	20%; after deductible	20%; after deductible
Substance abuse telehealth consultations	20%; after deductible	20%; after deductible
Other substance abuse services	20%; after deductible	20%; after deductible
		our cost sharing amount counts toward all
covered benefits during your visit.	racility but don't stay overlight, yo	our cost sharing amount counts toward an
THERAPY SERVICES	IN-NETWORK	OUT-OF-NETWORK
Spinal manipulation therapy	20%; after deductible	20%; after deductible
Outpatient short-term	20%; after deductible	20%; after deductible
rehabilitation	2070, arter academote	2070, and addadas
Includes physical, occupational, and s	neech therapies	
Habilitative physical therapy	20%; after deductible	20%; after deductible
Habilitative occupational therapy	20%; after deductible	20%; after deductible
Habilitative speech therapy	20%; after deductible	20%; after deductible
Autism related physical therapy	20%; after deductible	20%; after deductible
Autism related occupational	20%; after deductible	20%; after deductible
therapy	,	,
Autism related speech therapy	20%; after deductible	20%; after deductible
Autism related behavioral therapy	20%; after deductible	20%; after deductible
These benefits are combined with outp	patient mental health visits	
Autism related applied behavior	20%; after deductible	20%; after deductible
analysis		
Your benefits for these services are th	e same as any other outpatient me	ental health other services benefit





OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled nursing facility	20%; after deductible	20% after \$500 copay; after
		deductible
Limited to 120 days per year		
When you're admitted into a facility for	the care you need, your cost sharing am	nount counts toward all covered benefits
you receive.		
Home health care	20%; after deductible	20%; after deductible
Home health care services include private		
	rom a home health care agency. One vis	
Hospice care - inpatient	20%; after deductible	20% after \$500 copay; after deductible
When you're admitted into a facility for	the care you need, your cost sharing am	nount counts toward all covered benefits
you receive.	,	
Hospice care - outpatient	20%; after deductible	20%; after deductible
	facility but don't stay overnight, your cos	t sharing amount counts toward all
covered benefits during your visit.		
Private duty nursing	Covered as part of home health care	Covered as part of home health care
We count each period of up to 8 hours	as one private duty nursing shift.	
Durable medical equipment	20%; after deductible	20%; after deductible
Diabetic supplies		
 If not covered under the prescription 	You pay your PCP visit cost sharing	You pay your PCP visit cost sharing
drug benefit	amount	amount
 If covered under the prescription 	You pay your applicable prescription	You pay your applicable prescription
drug benefit	drug cost sharing amount	drug cost sharing amount
Infusion therapy - home/office	20%; after deductible	20%; after deductible
Infusion therapy - outpatient hospital/freestanding facility	20%; after deductible	20%; after deductible
Gene-based, Cellular, and other	Your cost sharing amount depends	Not Covered
Innovative Therapies (GCIT™)	on the type of service and where you	
	receive it.	
	20%: after deductible for gene	
	therapy drugs, if applicable	
	In-network coverage is provided at	
	GCIT [™] designated facilities only.	
Hearing aids	Not Covered	Not Covered
Transplants	20%; after deductible	40% after \$500 per visit deductible; after plan deductible
	In-network coverage is only available	Out-of-network coverage applies
	at Institutes of Excellence (IOE)	when you use a non-IOE facility. You
	contracted facility.	will pay more out of pocket when using a non-IOE facility.
Bariatric surgery	Not Covered	Not Covered
Acupuncture	20%; after deductible	20%; after deductible
Limited to 10 visits per year		
Alaska medical travel reimbursement	Covered 100%; no deductible	Covered 100%; no deductible

For Air Transportation to the nearest facility equipped to diagnose and treatment of a non-emergency medical condition. All non-emergency transportation services REQUIRE prior approval and are subject to limitations; see your plan documents.





"Other" health care - 20% member coinsurance, after deductible, for services that are neither in-network nor out-of-network

network.		
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Basic Infertility	Your cost sharing amount depends	Your cost sharing amount depends
	on the type of service and where you	on the type of service and where you
	receive it.	receive it.
	nd treatment of the underlying cause of i	
	nation and the diagnosis and treatment o	
Advanced Reproductive	Not Covered	Not Covered
Technology (ART)		
Fertility preservation	Not Covered	Not Covered
Vasectomy	Your cost sharing amount depends	20%; after deductible
	on the type of service and where you	
	receive it.	
Tubal ligation	Covered 100%; no deductible	20%; after deductible
PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy plan type	Advanced Control Plan - Aetna	
Prescription drug out-of-pocket	\$1,000 per Individual	\$1,000 per Individual
limit (per calendar year)		
	\$3,000 per Family	\$3,000 per Family
	rug out-of-pocket limit. You will meet it v	
	ion drug out-of-pocket limit. No one pers	son will have to pay more than the
individual prescription drug out-of-pock	et limit.	
Preferred generic drugs		
Retail	Covered 100%	20% of allowed charges
Mail order	Covered 100%	20% of allowed charges
Preferred brand-name drugs		
Retail	20% \$15 min, \$50 max	20% of allowed charges
Mail order	. , , ,	20% of allowed charges
Non-preferred generic and brand-na		
Retail	30% \$30 min, \$75 max	20% of allowed charges
Mail order	30% \$30 min, \$75 max	20% of allowed charges
Pharmacy day supply and requirement		
Retail		
	For a 31-90 day supply you will be responsible for the Mail Order Drug copay.	
	Percentage copays will not be doubled	
Mail order	5 7 11 7	
	Pharmacy.	
O		
Specialty		
Specialty	You can get up to a 30-day supply of s Advanced Control Formulary Aetna Ins	



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

Your prescription drug plan also includes:

- · Diabetic supplies
- \$25 copay maximum per fill per 30 day supply for formulary insulin drugs
- A limited list of over-the-counter medications when filled with a prescription

Family planning

- Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).
- Contraceptives covered up to a 12-month supply. Contraceptive copay strategy applies.

The following are covered 100% in-network:

- · Oral chemotherapy drugs
- Seasonal vaccinations
- Affordable Care Act (ACA) eligible preventive medications and contraceptives

Refer to Aetna.com for a complete list of eligible prescription drugs.

Precertification requirements

Some covered prescription drugs need approval from us before we will cover the drug.

Some covered prescription drugs require step therapy before we cover them. With step therapy, you must first try one or more drugs before we will pay for drugs that require step therapy.

To get the most up-to-date precertification requirements and a list of drugs that require step therapy, see your plan documents or go online to your member website.

Choose generics with dispense as written (DAW) override - Sometimes your physician may say you need a brand-name prescription drug even if a generic is available. If so, you will pay the brand-name copay. If you ask for a brand-name prescription drug when a generic is available, you will pay the applicable brand-name copay plus the difference between the generic price and the brand-name price.

GENERAL PROVISIONS

Dependents who are eligible to be on your plan

Spouse, children from birth to age 26. Student status of children does not matter.

**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.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.

- 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.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Navigator member site.

This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care innetwork. You pay your plan's copayments and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments and deductibles.

Plans are provided by: Aetna Health Inc. 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. 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.



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

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 this material into another language may be available. Please call Member Services at the number on the back of your ID card.

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.



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

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.

***This plan document provides you with an overview of some of your benefits and your cost share obligations. This information is for illustrative purposes ONLY. This document is not an official document and may differ from your Certificate of Coverage (COC), which is your official document. Refer to your COC for your coverage and services and any obligations on your part.

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