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California toolkit

Plans effective January 1, 2017
For businesses with 1 – 100 full-time equivalents

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Build sustainable, long-term health care solutions with **Aetna medical products for small businesses**

No two employer groups are alike. So to build healthy communities and keep your business healthy, we offer a portfolio of benefit solutions and insurance that meet your needs.

Your company is unique. You have your own culture, your own family of employees — and your own health care needs. We answer those unique needs with a wide selection of health benefits and insurance options. We have designed our medical, pharmacy and specialty benefits for the health of your company. Using a broad range of network, cost sharing and funding options, we can help map out a plan that works for you.

Network information

Networks available by rating area

County	Rating area	PPO	Full MC	Savings Plus	Full HMO	HMO Deductible	AVN HMO	Basic HMO
Alpine	1	–	–	–	–	–	–	–
Amador	1	**Y**	P	–	–	–	–	–
Butte	1	–	–	–	–	–	–	–
Calaveras	1	**Y**	–	–	–	–	–	–
Colusa	1	**Y**	–	–	–	–	–	–
Del Norte	1	P	–	–	–	–	–	–
Glenn	1	**Y**	–	–	–	–	–	–
Humboldt	1	**Y**	–	–	–	–	–	–
Lake	1	**Y**	–	–	–	–	–	–
Lassen	1	**Y**	–	–	–	–	–	–
Mendocino	1	–	–	–	–	–	–	–
Modoc	1	**Y**	–	–	–	–	–	–
Nevada	1	P	P	–	P	P	–	–
Plumas	1	**Y**	–	–	–	–	–	–
Shasta	1	**Y**	**Y**	–	–	–	–	–
Sierra	1	–	–	–	–	–	–	–
Siskiyou	1	**Y**	–	–	–	–	–	–
Sutter	1	**Y**	**Y**	–	–	–	–	–
Tehama	1	**Y**	–	–	–	–	–	–
Trinity	1	**Y**	–	–	–	–	–	–
Tuolumne	1	**Y**	**Y**	–	–	–	–	–
Yuba	1	**Y**	**Y**	–	–	–	–	–
Marin	2	**Y**	**Y**	**Y**	**Y**	**Y**	–	–
Napa	2	**Y**	**Y**	–	–	–	–	–
Solano	2	**Y**	**Y**	P	P	P	–	–
Sonoma	2	**Y**	**Y**	–	P	P	P	–
El Dorado	3	P	P	–	P	P	P	–
Placer	3	**Y**	**Y**	–	P	P	P	–
Sacramento	3	**Y**	**Y**	–	**Y**	**Y**	**Y**	–
Yolo	3	**Y**	**Y**	–	**Y**	**Y**	**Y**	**–**
San Francisco	4	**Y**	**Y**	–	**Y**	**Y**	**Y**	**Y**
Contra Costa	5	**Y**	**Y**	–	**Y**	**Y**	**Y**	–
Alameda	6	**Y**	**Y**	–	**Y**	**Y**	**Y**	–
Santa Clara	7	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	P
San Mateo	8	**Y**	**Y**	**Y**	**Y**	**Y**	P	P
Monterey	9	P	P	–	–	–	–	–
San Benito	9	**Y**	**Y**	–	–	–	–	–
Santa Cruz	9	**Y**	**Y**	–	**Y**	**Y**	**Y**	–
Mariposa	10	**Y**	–	–	–	–	–	–
Merced	10	**Y**	**Y**	–	**Y**	**Y**	–	–
San Joaquin	10	**Y**	**Y**	–	P	P	P	–
Stanislaus	10	**Y**	**Y**	–	**Y**	**Y**	**Y**	–
Tulare	10	**Y**	**Y**	–	P	P	–	–
Fresno	11	P	P	**Y**	P	P	–	–

Y = Network is available. P = Network is available in part of the rating area.

Networks available by rating area (continued)

County	Rating area	PPO	Full MC	Savings Plus	Full HMO	HMO Deductible	AVN HMO	Basic HMO
Kings	11	**Y**	**Y**	–	**Y**	**Y**	–	–
Madera	11	**Y**	**Y**	–	P	P	–	–
San Luis Obispo	12	**Y**	**Y**	–	**Y**	**Y**	–	–
Santa Barbara	12	**Y**	**Y**	–	**Y**	**Y**	–	–
Ventura	12	**Y**	**Y**	**Y**	**Y**	**Y**	–	–
Imperial	13	**Y**	**Y**	–	–	–	–	–
Inyo	13		–	–	–	–	–	–
Mono	13	**Y**	–	–	–	–	–	–
Kern	14	**Y**	**Y**	–	**Y**	**Y**	P	–
Los Angeles (906-912, 915, 917, 918, and 935)	15	**Y**	**Y**	**Y**	**Y**	**Y**	P	P
Los Angeles (all other)	16	**Y**	**Y**	**Y**	**Y**	**Y**	P	P
Riverside/San Bernardino	17	P	P	P	P	P	P	P
Orange	18	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
San Diego	19	**Y**	**Y**	**Y**	**Y**	**Y**	P	P

Aetna Whole Health Networks available by rating area

County	Rating area	PrimeCare MC/HMO	MemorialCare MC/EPO	Providence Health & Services MC/EPO	SCCIPA MC/EPO
Santa Clara	7	–	–	–	**Y**
Los Angeles (906-912, 915, 917, 918, and 935)	15	–	P	P	–
Los Angeles (all other)	16	–	P	P	–
Riverside/San Bernardino	17	P	–	–	–
Orange	18	–	**Y**	–	–

Y = Network is available. P = Network is available in part of the rating area.

Network information

Plans available by network

2017 plan name	HMO	AVN HMO	Basic HMO	HMO Deductible	MC	Savings Plus	PrimeCare HMO/MC	MemorialCare Providence SCCIPA
Platinum HMO 15 Copay Plan*		•	•					
Gold HMO 20	•	•	•					
Gold HMO 30 Copay Plan*		•	•				•	
Gold HMO 45	•	•	•				•	
Gold HMO Deductible 250			•	•				
Silver HMO Deductible 1500			•	•			•	
Silver HMO Deductible 2000 Copay Plan*			•	•				
Silver HMO Deductible 2000			•	•				
Bronze HMO Deductible 6300 Plan*			•					
Bronze HMO Deductible 6500			•	•			•	
Gold EPO 750 80								•
Silver EPO 2000 Copay								•
Bronze EPO 4000 Copay								•
Platinum 0 Copay Plan*						•		
Gold MC 0 Copay Plan*					•	•		
Gold MC 750 80/50					•	•	•	
Silver MC 1000 70/50					•	•		
Silver MC 2000 Copay					•	•		
Silver MC 2000 60/50					•	•	•	•
Silver MC 2000 80/50 HDHP Plan*					•	•		
Bronze MC 4000 Copay					•	•	•	
Bronze MC 6500 Copay					•	•		
Bronze MC HDHP 4800 60/50 HSA Plan*					•	•		•
Bronze MC 6550 100/50 HSA					•	•		
Gold PPO 750 80/50**	PPO network							
Silver Indemnity 1500 80**	No network							

*Mandated coverage California exchange plan.

**See underwriting guidelines regarding network/product availability.

Plan mapping

HMO for 1-100 employees

2016 plan name	2017 plan name
Platinum HMO 20 Copay Plan	Gold HMO 20
Platinum AVN HMO 20 Copay Plan	Platinum AVN HMO 15 Copay Plan
Platinum Basic HMO 20 Copay Plan	Platinum Basic HMO 15 Copay Plan
Gold HMO 10	Gold HMO 20
Gold AVN HMO 10	Gold AVN HMO 20
Gold Basic HMO 10	Gold Basic HMO 20
Gold PrimeCare HMO 10	Gold PrimeCare HMO 30 Copay Plan
Gold HMO 20	Gold HMO 20
Gold AVN HMO 20	Gold AVN HMO 20
Gold Basic HMO 20	Gold Basic HMO 20
Gold HMO 30	Gold HMO 45
Gold AVN 30	Gold AVN HMO 45
Gold Basic HMO 30	Gold Basic HMO 45
Gold PrimeCare HMO 30	Gold PrimeCare HMO 30 Copay Plan
Gold HMO 35 Copay Plan	CA Gold HMO 45
Gold AVN HMO 35 Copay Plan	Gold AVN HMO 45
Gold Basic HMO 35 Copay Plan	Gold Basic HMO 45
Gold HMO Deductible 250	Gold HMO Deductible 250
Gold Basic HMO Deductible 250	Gold Basic HMO 250
Gold HMO Deductible 500 80	Gold HMO 20
Gold Basic HMO Deductible 500 80	Gold Basic HMO 20
Gold PrimeCare HMO Deductible 500 80	Gold PrimeCare HMO 45
Silver HMO Deductible 1100	Silver HMO Deductible 1500
Silver Basic HMO Deductible 1100	Silver Basic HMO 1500
Silver PrimeCare HMO Deductible 1100	Silver PrimeCare HMO Deductible 1500
Silver HMO Deductible 1500 Copay Plan	Silver HMO Deductible 2000 Copay Plan
Silver Basic HMO Deductible 1500 Copay Plan	Silver Basic HO 2000 Copay Plan
Silver HMO Deductible 2000	Silver HMO Deductible 2000
Silver Basic HMO Deductible 2000	Silver Basic HMO 2000
Silver PrimeCare HMO Deductible 2000	Silver PrimeCare HMO Deductible 1500
Bronze HMO Deductible 5500	Bronze HMO Deductible 6500
Bronze Basic HMO Deductible 5500	Bronze Basic HMO 6500
Bronze PrimeCare HMO Deductible 5500	Bronze PrimeCare HMO Deductible 6500
Bronze HMO Deductible 6000 Plan	Bronze HMO Deductible 6500

Plan mapping

MC, Savings Plus, PPO and Indemnity for 1-100 employees

2016 plan name	2017 plan name
Platinum MC 0 Copay Plan	Gold MC 0 Copay Plan
Platinum Savings Plus 0 Copay Plan	Platinum Savings Plus 0 Copay Plan
Platinum MC 250 90/60	Gold MC 0 Copay Plan
Platinum Savings Plus 250 90/60	Gold Savings Plus 0 Copay Plan
Gold MC 0 Copay Plan	Gold MC 0 Copay Plan
Gold Savings Plus 0 Copay Plan	Gold Savings Plus 0 Copay Plan
Gold PrimeCare MC 0 Copay Plan	Gold PrimeCare MC 750 80/50
Gold MC 500 80/50	Gold MC 750 80/50
Gold Savings Plus 500 80/50	Gold Savings Plus 750 80/50
Gold MC 750 80/50	Gold MC 750 80/50
Gold Savings Plus 750 80/50	Gold Savings Plus 750 80/50
Silver MC 1000 75/50	Silver MC 1000 70/50
Silver Savings Plus 1000 75/50	Silver Savings Plus 1000 70/50
Silver MC 1000 60/50	Silver MC 1000 70/50
Silver Savings Plus 1000 60/50	Silver Savings Plus 1000 70/50
Silver PrimeCare MC 1000 60/50	Silver PrimeCare MC 2000 60/50
Silver MC 1500 80 Coinsurance Plan	Silver MC 2000 Copay
Silver Savings Plus 1500 80 Coinsurance Plan	Silver Savings Plus 2000 Copay
Silver MC 1500 60/50	Silver MC 2000 60/50
Silver Savings Plus 1500 60/50	Silver Savings Plus 2000 60/50
Silver MC 2000 60/50	Silver MC 2000 60/50
Silver Savings Plus 2000 60/50	Silver Savings Plus 2000 60/50
Bronze MC 4000 Copay Plan	Bronze MC 4000 Copay
Bronze Savings Plus 4000 Copay Plan	Bronze Savings Plus 4000 Copay
Bronze PrimeCare 4000 Copay Plan	Bronze PrimeCare 4000 Copay
Bronze MC 5000 70/50 HSA	Bronze MC 6550 100/50 HSA
Bronze Savings Plus 5000 70/50 HSA	Bronze Savings Plus 6550 100/50 HSA
Bronze PrimeCare 5000 70/50 HSA	Bronze PrimeCare MC 4000 Copay
Bronze MC 6000 Plan	Bronze MC 6500 Copay
Bronze Savings Plus 6000 Plan	Bronze Savings Plus 6500 Copay
Bronze MC 6450 100/50 HSA	Bronze MC 6550 100/50 HSA
Bronze Savings Plus 6450 100/50 HSA	Bronze Savings Plus 6550 100/50 HSA
Bronze MC 6850 100/50	Bronze MC 6500 Copay
Bronze Savings Plus 6850 100/50	Bronze Savings Plus 6500 Copay
Bronze PrimeCare MC 6850 100/50	Bronze PrimeCare MC 4000 Copay
Gold PPO 750 80/50	Gold PPO 750 80/50
Gold Indemnity 750 80	Silver Indemnity 1500 80
Silver Indemnity 1500 80	Silver Indemnity 1500 80

Medical plans

HMO

Plan name[1]	Platinum AVN HMO 15 Copay Plan* Platinum Basic HMO 15 Copay Plan*	Gold HMO 20 Gold AVN HMO 20 Gold Basic HMO 20	Gold AVN HMO 30 Copay Plan* Gold Basic HMO 30 Copay Plan*
	In network	**In network**	**In network**
Plan year deductible (individual/family)	$0/$0	$0/$0	$0/$0
Plan out-of-pocket limit (individual/family)	$4,000/$8,000	$7,000/$14,000	$6,750/$13,500
Deductible and out-of-pocket limit accumulation	Embedded[2]	Embedded[2]	Embedded[2]
Primary care physician office visit	$15 copay	$20 copay	$30 copay
Specialist office visit	$40 copay	$50 copay	$55 copay
Walk-in clinics	Not covered	Not covered	Not covered
Diagnostic testing: Lab	$20 copay	$20 copay	$35 copay
Diagnostic testing: X-ray	$40 copay	$60 copay	$55 copay
Imaging CT/PET scans MRIs	$150 copay	$250 copay	$275 copay
Inpatient hospital facility	$250/day, days 1–5	$750/day, days 1–3	$600/day, days 1–5
Outpatient surgery	$250 copay	Freestanding facility: $400 copay/hospital: $600 copay	$600 copay
Emergency room	$150 copay	$300 copay	$325 copay
Urgent care	$15 copay	$50 copay	$30 copay
Rehabilitation services (PT/OT/ST)	$15 copay	$50 copay	$30 copay
Chiropractic[3]	Not covered	$15 copay	Not covered
Pediatric dental check-up** (aka preventive/diagnostic)	Covered in full	Covered in full	Covered in full
Pediatric dental basic**	20%	30%	20%
Pediatric dental major**	50%	50%	50%
Pediatric dental ortho**	50%	50%	50%
Pediatric vision exam**	Covered in full	$20 copay	Covered in full
Pediatric vision hardware**	Covered in full	Covered in full	Covered in full
Pharmacy[4] Mail order: two times retail copay, up to 90-day supply	**In Network**	**In Network**	**In Network**
Pharmacy deductible	None	$300 individual/$600 family	None
Preferred generic drugs	Generic: $5 copay	Generic: $20 copay; deductible waived	Generic: $15 copay
Preferred brand drugs	$15 copay	$60 copay after deductible	$55 copay
Nonpreferred drugs	Generic & brand: $25 copay	Generic & brand: $100 copay after deductible	Generic & brand: $75 copay
Specialty drugs (includes self-injectable, infused and oral specialty drugs, retail and mail order up to a 30-day supply, excludes insulin)	10% up to $250	30% up to $250 after deductible	20% up to $250

Refer to page 25 for footnotes.

Medical plans

HMO (continued)

Plan name[1]	Gold AVN HMO 45 Gold HMO 45 Gold Basic HMO 45	Gold HMO Deductible 250 Gold Basic HMO 250	Silver HMO Deductible 1500 Silver Basic HMO 1500
	In network	**In network**	**In network**
Plan year deductible (individual/family)	$0/$0	$250/$500	$1,500/$3,000
Plan out-of-pocket limit (individual/family)	$7,150/$14,300	$6,000/$12,000	$7,150/$14,300
Deductible and out-of-pocket limit accumulation	Embedded[2]	Embedded[2]	Embedded[2]
Primary care physician office visit	$45 copay	$20 copay; deductible waived	$45 copay; deductible waived
Specialist office visit	$60 copay	$40 copay; deductible waived	$65 copay; deductible waived
Walk-in clinics	Not covered	Not covered	Not covered
Diagnostic testing: Lab	$30 copay	$20 copay; deductible waived	$65 copay; deductible waived
Diagnostic testing: X-ray	$60 copay	$40 copay; deductible waived	$65 copay; deductible waived
Imaging CT/PET scans MRIs	$300 copay	$250 copay; deductible waived	$400 copay; deductible waived
Inpatient hospital facility	$600/day, days 1–5	$500/day, days 1–3 after deductible	35% after deductible
Outpatient surgery	Freestanding facility: $500 copay/hospital: $750 copay	Freestanding facility: $400 copay after deductible/hospital: $600 copay after deductible	Freestanding facility: $600 copay after deductible/hospital: $800 copay after deductible
Emergency room	$325 copay	$300 copay after deductible	$325 copay after deductible
Urgent care	$60 copay	$50 copay; deductible waived	$50 copay; deductible waived
Rehabilitation services (PT/OT/ST)	$60 copay	$40 copay; deductible waived	$65 copay; deductible waived
Chiropractic[3]	$15 copay	$15 copay; deductible waived	$15 copay; deductible waived
Pediatric dental check-up** (aka preventive/diagnostic)	Covered in full	Covered in full; deductible waived	Covered in full; deductible waived
Pediatric dental basic**	30%	30% after deductible	30% after deductible
Pediatric dental major**	50%	50% after deductible	50% after deductible
Pediatric dental ortho**	50%	50% after deductible	50% after deductible
Pediatric vision exam**	$45 copay	$20 copay; deductible waived	$45 copay; deductible waived
Pediatric vision hardware**	Covered in full	Covered in full; deductible waived	Covered in full; deductible waived
Pharmacy[4] Mail order: two times retail copay, up to 90-day supply	**In Network**	**In Network**	**In Network**
Pharmacy deductible	$300 individual/$600 family	$250 individual/$500 family	$300 individual/$600 family
Preferred generic drugs	Generic: $20 copay; deductible waived	Generic: $25 copay; deductible waived	Generic: $35 copay; deductible waived
Preferred brand drugs	$60 copay after deductible	$50 copay after deductible	$60 copay after deductible
Nonpreferred drugs	Generic & brand: $100 copay after deductible	Generic & brand: $100 copay after deductible	Generic & brand: $100 copay after deductible
Specialty drugs (includes self-injectable, infused and oral specialty drugs, retail and mail order up to a 30-day supply, excludes insulin)	30% up to $250 after deductible	30% up to $250 after deductible	30% up to $250 after deductible

Refer to page 25 for footnotes.

Medical plans

HMO (continued) Silver Basic HMO 2000

Plan name[1]	Silver HMO Ded 2000 Copy Plan* Silver Basic HMO 2000 Copy Plan*	Silver HMO Deductible 2000 Silver Basic HMO 2000	Bronze HMO Deductible 6500 Bronze Basic HMO 6500
	In Network	**In Network**	**In network**
Plan year deductible (individual/family)	$2,000/$4,000	$2,000/$4,000	$6,500/$13,000
Plan out-of-pocket limit (individual/family)	$6,800/$13,600	$7,150/$14,300	$7,150/$14,300
Deductible and out-of-pocket limit accumulation	Embedded[2]	Embedded[2]	Embedded[2]
Primary care physician office visit	$45 copay; deductible waived	$40 copay; deductible waived	$50 copay; deductible waived
Specialist office visit	$75 copay; deductible waived	$60 copay; deductible waived	$75 copay; deductible waived
Walk-in clinics	Not covered	Not covered	Not covered
Diagnostic testing: Lab	$40 copay; deductible waived	$40 copay; deductible waived	$50 copay; deductible waived
Diagnostic testing: X-ray	$70 copay; deductible waived	$60 copay; deductible waived	$75 copay; deductible waived
Imaging CT/PET scans MRIs	$300 copay; deductible waived	$400 copay; deductible waived	$100 copay after deductible
Inpatient hospital facility	20% after deductible	$500/day, days 1–3 after deductible	50% after deductible
Outpatient surgery	Freestanding facility: 20% deductible waived/hospital: 20% deductible waived	Freestanding facility: $600 copay after deductible/hospital: $750 copay after deductible	$800 copay after deductible
Emergency room	$350 copay; deductible waived	$300 copay after deductible	50% after deductible
Urgent care	$45 copay; deductible waived	$50 copay; deductible waived	$50 copay; deductible waived
Rehabilitation services (PT/OT/ST)	$45 copay; deductible waived	$60 copay; deductible waived	$50 copay; deductible waived
Chiropractic[3]	Not covered	$15 copay; deductible waived	$15 copay; deductible waived
Pediatric dental check-up** (aka preventive/diagnostic)	Covered in full; deductible waived	Covered in full; deductible waived	Covered in full; deductible waived
Pediatric dental basic**	20% deductible waived	30% after deductible	30% after deductible
Pediatric dental major**	50% deductible waived	50% after deductible	50% after deductible
Pediatric dental ortho**	50% deductible waived	50% after deductible	50% after deductible
Pediatric vision exam**	Covered in full; deductible waived	$40 copay; deductible waived	$50 copay; deductible waived
Pediatric vision hardware**	Covered in full; deductible waived	Covered in full; deductible waived	Covered in full; deductible waived
Pharmacy[4] Mail order: two times retail copay, up to 90-day supply	**In Network**	**In Network**	**In Network**
Pharmacy deductible	$250 individual/$500 family	None	$500 individual/ $1,000 family
Preferred generic drugs	Generic: $15 copay; deductible waived	Generic: $15 copay	Generic: $35 copay; deductible waived
Preferred brand drugs	$55 copay after deductible	$50 copay	$100 copay after deductible
Nonpreferred drugs	Generic & brand: $85 copay after deductible	Generic & brand: $100 copay	Generic & brand: $180 copay after deductible
Specialty drugs (includes self-injectable, infused and oral specialty drugs, retail and mail order up to a 30-day supply, excludes insulin)	20% up to $250 after deductible	30% up to $250	30% up to $500 after deductible

Refer to page 25 for footnotes.

Medical plans

HMO (continued)

Plan name[1]	Bronze Basic HMO 6300 Plan*
	In Network
Plan year deductible (individual/family)	$6,300/$12,600
Plan out-of-pocket limit (individual/family)	$6,800/$13,600
Deductible and out-of-pocket limit accumulation	Embedded[2]
Primary care physician office visit	$75 copay; deductible waived
Specialist office visit	$105 copay; deductible waived
Walk-in clinics	Not covered
Diagnostic testing: Lab	$40 copay; deductible waived
Diagnostic testing: X-ray	100% after deductible
Imaging CT/PET scans MRIs	100% after deductible
Inpatient hospital facility	100% after deductible
Outpatient surgery	Freestanding facility: 100% after deductible/hospital: 100% after deductible
Emergency room	100% after deductible
Urgent care	$75 copay; deductible waived
Rehabilitation services (PT/OT/ST)	$75 copay; deductible waived
Chiropractic[3]	Not covered
Pediatric dental check-up** (aka preventive/diagnostic)	Covered in full; deductible waived
Pediatric dental basic**	20% deductible waived
Pediatric dental major**	50% deductible waived
Pediatric dental ortho**	50% deductible waived
Pediatric vision exam**	Covered in full; deductible waived
Pediatric vision hardware**	Covered in full; deductible waived
Pharmacy[4] Mail order: two times retail copay, up to 90-day supply	**In Network**
Pharmacy deductible	$500 individual/$1,000 family
Preferred generic drugs	Generic: 100% up to $500 after deductible
Preferred brand drugs	100% up to $500 after deductible
Nonpreferred drugs	Generic & brand: 100% up to $500 after deductible
Specialty drugs (includes self-injectable, infused and oral specialty drugs, retail and mail order up to a 30-day supply, excludes insulin)	100% up to $500 after deductible

Refer to page 25 for footnotes.

Medical plans

Managed Choice Open Access

Plan name[1]	Platinum Savings Plus 0 Copay Plan*		Gold MC 0 Copay Plan* Gold Savings Plus 0 Copay Plan*	
	In network	**Out of network**	**In network**	**Out of network**
Plan year deductible (individual/family)	$0/$0	$1,000/$2,000	$0/$0	$1,000/$2,000
Plan out-of-pocket limit (individual/family)	$4,000/$8,000	$8,000/$16,000	$6,750/$13,500	$13,500/$27,000
Deductible and out-of-pocket limit accumulation	Embedded[2]		Embedded[2]	
Primary care physician office visit	$15 copay	50% after deductible	$30 copay	50% after deductible
Specialist office visit	$40 copay	50% after deductible	$55 copay	50% after deductible
Walk-in clinics	$15 copay	Not covered	$30 copay	Not covered
Diagnostic testing: Lab	$20 copay	50% after deductible	$35 copay	50% after deductible
Diagnostic testing: X-ray	$40 copay	50% after deductible	$55 copay	50% after deductible
Imaging CT/PET scans MRIs	$150 copay	50% after deductible	$275 copay	50% after deductible
Inpatient hospital facility	$250/day, days 1–5	50% after deductible	$600/day, days 1–5	50% after deductible
Outpatient surgery	$250 copay	50% after deductible	$600 copay	50% after deductible
Emergency room	$150 copay	Paid as in-network	$325 copay	Paid as in-network
Urgent care	$15 copay	Paid as in-network	$30 copay	Paid as in-network
Rehabilitation services (PT/OT/ST)	$15 copay	50% after deductible	$30 copay	50% after deductible
Chiropractic[3]	Not covered	Not covered	Not covered	Not covered
Pediatric dental check-up** (aka preventive/diagnostic)	Covered in full	30% after deductible	Covered in full	30% after deductible
Pediatric dental basic**	20%	50% after deductible	20%	50% after deductible
Pediatric dental major**	50%	50% after deductible	50%	50% after deductible
Pediatric dental ortho**	50%	50% after deductible	50%	50% after deductible
Pediatric vision exam**	Covered in full	Not covered	Covered in full	Not covered
Pediatric vision hardware**	Covered in full	Not covered	Covered in full	Not covered
Pharmacy[4] Mail order: two times retail copay, up to 90-day supply	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Pharmacy deductible	None	None	None	None
Preferred generic drugs	Generic: $5 copay	Generic: Not covered	Generic: $15 copay	Generic: Not covered
Preferred brand drugs	$15 copay	Not covered	$55 copay	Not covered
Nonpreferred drugs	Generic & brand: $25 copay	Generic & brand: Not covered	Generic & brand: $75 copay	Generic & brand: Not covered
Specialty drugs (includes self-injectable, infused and oral specialty drugs, retail and mail order up to a 30-day supply, excludes insulin)	10% up to $250	Not covered	20% up to $250	Not covered

Refer to page 25 for footnotes.

Medical plans

Managed Choice Open Access (continued)

Plan name[1]	Gold MC 750 80/50 Gold Savings Plus 750 80/50		Silver MC 1000 70/50 Silver Savings Plus 1000 70/50	
	In network	**Out of network**	**In network**	**Out of network**
Plan year deductible (individual/family)	$750/$1,500	$1,500/$3,000	$1,000/$2,000	$2,000/$4,000
Plan out-of-pocket limit (individual/family)	$6,000/$12,000	$12,000/$24,000	$7,150/$14,300	$14,300/$28,600
Deductible and out-of-pocket limit accumulation	Embedded[2]		Embedded[2]	
Primary care physician office visit	$30 copay; deductible waived	50% after deductible	$30 copay; deductible waived	50% after deductible
Specialist office visit	$40 copay; deductible waived	50% after deductible	$40 copay; deductible waived	50% after deductible
Walk-in clinics	$30 copay; deductible waived	Not covered	$30 copay; deductible waived	Not covered
Diagnostic testing: Lab	$15 copay; deductible waived	50% after deductible	$30 copay; deductible waived	50% after deductible
Diagnostic testing: X-ray	$15 copay; deductible waived	50% after deductible	$50 copay; deductible waived	50% after deductible
Imaging CT/PET scans MRIs	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Inpatient hospital facility	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Outpatient surgery	Freestanding facility: $500 copay after deductible/hospital: $750 copay after deductible	Freestanding facility: 50% after deductible/hospital: 50% after deductible	Freestanding facility: $700 copay after deductible/ hospital: $1,000 copay after deductible	Freestanding facility: 50% after deductible/hospital: 50% after deductible
Emergency room	20% after deductible	Paid as in-network	30% after deductible	Paid as in-network
Urgent care	$50 copay; deductible waived	Paid as in-network	$50 copay; deductible waived	Paid as in-network
Rehabilitation services (PT/OT/ST)	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Chiropractic[3]	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Pediatric dental check-up** (aka preventive/diagnostic)	Covered in full; deductible waived	30% after deductible	Covered in full; deductible waived	30% after deductible
Pediatric dental basic**	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Pediatric dental major**	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Pediatric dental ortho**	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Pediatric vision exam**	$30 copay; deductible waived	Not covered	$30 copay; deductible waived	Not covered
Pediatric vision hardware**	Covered in full; deductible waived	Not covered	Covered in full; deductible waived	Not covered
Pharmacy[4] Mail order: two times retail copay, up to 90-day supply	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Pharmacy deductible	None	None	$250 individual/ $500 family	None
Preferred generic drugs	Generic: $20 copay	Generic: Not covered	Generic: $35 copay; deductible waived	Generic: Not covered
Preferred brand drugs	$60 copay	Not covered	$70 copay after deductible	Not covered
Nonpreferred drugs	Generic & brand: $75 copay	Generic & brand: Not covered	Generic & brand: $100 copay after deductible	Generic & brand: Not covered
Specialty drugs (includes self-injectable, infused and oral specialty drugs, retail and mail order up to a 30-day supply, excludes insulin)	30% up to $250	Not covered	30% up to $250 after deductible	Not covered

Refer to page 25 for footnotes.

Medical plans

Managed Choice Open Access (continued)

Plan name[1]	Silver MC 2000 Copay Silver Savings Plus 2000 Copay		Silver MC 2000 60/50 Silver Savings Plus 2000 60/50	
	In network	**Out of network**	**In network**	**Out of network**
Plan year deductible (individual/family)	$2,000/$4,000	$4,000/$8,000	$2,000/$4,000	$4,000/$8,000
Plan out-of-pocket limit (individual/family)	$7,000/$14,000	$14,000/$28,000	$7,150/$14,300	$14,300/$28,600
Deductible and out-of-pocket limit accumulation	Embedded[2]		Embedded[2]	
Primary care physician office visit	$35 copay; deductible waived	50% after deductible	$30 copay; deductible waived	50% after deductible
Specialist office visit	$60 copay after deductible	50% after deductible	$50 copay; deductible waived	50% after deductible
Walk-in clinics	$35 copay; deductible waived	Not covered	$30 copay; deductible waived	Not covered
Diagnostic testing: Lab	$35 copay; deductible waived	50% after deductible	$30 copay; deductible waived	50% after deductible
Diagnostic testing: X-ray	$60 copay after deductible	50% after deductible	$35 copay; deductible waived	50% after deductible
Imaging CT/PET scans MRIs	$250 copay after deductible	50% after deductible	40% after deductible	50% after deductible
Inpatient hospital facility	$750 copay per admission after deductible	50% after deductible	40% after deductible	50% after deductible
Outpatient surgery	Freestanding facility: $500 copay after deductible/hospital: $600 copay after deductible	Freestanding facility: 50% after deductible/hospital: 50% after deductible	Freestanding facility: $700 copay after deductible/hospital: $1,000 copay after deductible	Freestanding facility: 50% after deductible/hospital: 50% after deductible
Emergency room	$300 copay after deductible	Paid as in-network	40% after deductible	Paid as in-network
Urgent care	$50 copay; deductible waived	Paid as in-network	$50 copay; deductible waived	Paid as in-network
Rehabilitation services (PT/OT/ST)	$50 copay after deductible	50% after deductible	40% after deductible	50% after deductible
Chiropractic[3]	$35 copay after deductible	50% after deductible	40% after deductible	50% after deductible
Pediatric dental check-up** (aka preventive/diagnostic)	Covered in full; deductible waived	30% after deductible	Covered in full; deductible waived	30% after deductible
Pediatric dental basic**	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Pediatric dental major**	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Pediatric dental ortho**	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Pediatric vision exam**	$35 copay; deductible waived	Not covered	$30 copay; deductible waived	Not covered
Pediatric vision hardware**	Covered in full; deductible waived	Not covered	Covered in full; deductible waived	Not covered
Pharmacy[4] Mail order: two times retail copay, up to 90-day supply	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Pharmacy deductible	$150 individual/ $300 family	None	$150 individual/ $300 family	None
Preferred generic drugs	Generic: $20 copay; deductible waived	Generic: Not covered	Generic: $15 copay; deductible waived	Generic: Not covered
Preferred brand drugs	$50 copay after deductible	Not covered	$55 copay after deductible	Not covered
Nonpreferred drugs	Generic & brand: $70 copay after deductible	Generic & brand: Not covered	Generic & brand: $75 copay after deductible	Generic & brand: Not covered
Specialty drugs (includes self-injectable, infused and oral specialty drugs, retail and mail order up to a 30-day supply, excludes insulin)	30% up to $250 after deductible	Not covered	30% up to $250 after deductible	Not covered

Refer to page 25 for footnotes.

Medical plans

Managed Choice Open Access (continued)

Plan name[1]	Silver MC 2000 80/50 HDHP Plan* Silver Savings Plus 2000 80/50 HDHP Plan*		Bronze MC 4000 Copay Bronze Savings Plus 4000 Copay	
	In network	**Out of network**	**In network**	**Out of network**
Plan year deductible (individual/family)	$2,000/$4,000	$4,000/$8,000	$4,000/$8,000	$8,000/$16,000
Plan out-of-pocket limit (individual/family)	$6,550/$13,100	$13,100/$26,200	$7,150/$14,300	$14,300/$28,600
Deductible and out-of-pocket limit accumulation	Embedded[2]		Embedded[2]	
Primary care physician office visit	20% after deductible	50% after deductible	$50 copay; deductible waived	50% after deductible
Specialist office visit	20% after deductible	50% after deductible	$75 copay after deductible	50% after deductible
Walk-in clinics	20% after deductible	Not covered	$50 copay; deductible waived	Not covered
Diagnostic testing: Lab	20% after deductible	50% after deductible	$50 copay; deductible waived	50% after deductible
Diagnostic testing: X-ray	20% after deductible	50% after deductible	$125 copay after deductible	50% after deductible
Imaging CT/PET scans MRIs	20% after deductible	50% after deductible	$500 copay after deductible	50% after deductible
Inpatient hospital facility	20% after deductible	50% after deductible	$850 copay per admission after deductible	50% after deductible
Outpatient surgery	20% after deductible	50% after deductible	$500 copay after deductible	50% after deductible
Emergency room	20% after deductible	Paid as in-network	$500 copay after deductible	Paid as in-network
Urgent care	20% after deductible	Paid as in-network	$50 copay; deductible waived	Paid as in-network
Rehabilitation services (PT/OT/ST)	20% after deductible	50% after deductible	$50 copay after deductible	50% after deductible
Chiropractic[3]	Not covered	Not covered	$50 copay after deductible	50% after deductible
Pediatric dental check-up** (aka preventive/diagnostic)	Covered in full; deductible waived	20% after deductible	Covered in full; deductible waived	30% after deductible
Pediatric dental basic**	20% deductible waived	50% after deductible	30% after deductible	50% after deductible
Pediatric dental major**	50% deductible waived	50% after deductible	50% after deductible	50% after deductible
Pediatric dental ortho**	50% deductible waived	50% after deductible	50% after deductible	50% after deductible
Pediatric vision exam**	Covered in full; deductible waived	Not covered	$50 copay; deductible waived	Not covered
Pediatric vision hardware**	Covered in full; deductible waived	Not covered	Covered in full; deductible waived	Not covered
Pharmacy[4] Mail order: two times retail copay, up to 90-day supply	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Pharmacy deductible	Integrated with medical deductible	None	$500 individual/ $1,000 family	None
Preferred generic drugs	Generic: 20% up to $250 after deductible	Generic: Not covered	Generic: $35 copay; deductible waived	Generic: Not covered
Preferred brand drugs	20% up to $250 after deductible	Not covered	$100 copay after deductible	Not covered
Nonpreferred drugs	Generic & brand: 20% up to $250 after deductible	Generic & brand: Not covered	Generic & brand: $150 copay after deductible	Generic & brand: Not covered
Specialty drugs (includes self-injectable, infused and oral specialty drugs, retail and mail order up to a 30-day supply, excludes insulin)	20% up to $250 after deductible	Not covered	30% up to $500 after deductible	Not covered

Refer to page 25 for footnotes.

Medical plans

Managed Choice Open Access (continued)

Plan name[1]	Bronze MC HDHP 4800 60/50 HSA Plan* Bronze Savings Plus HDHP 4800 60/50 HSA Plan*		Bronze MC 6500 Copay Bronze Savings Plus 6500 Copay	
	In network	**Out of network**	**In network**	**Out of network**
Plan year deductible (individual/family)	$4,800/$9,600	$9,600/$19,200	$6,500/$13,000	$13,000/$26,000
Plan out-of-pocket limit (individual/family)	$6,550/$13,100	$13,100/$26,200	$7,150/$14,300	$14,300/$28,600
Deductible and out-of-pocket limit accumulation	Embedded[2]		Embedded[2]	
Primary care physician office visit	40% after deductible	50% after deductible	$40 copay; deductible waived	50% after deductible
Specialist office visit	40% after deductible	50% after deductible	$75 copay after deductible	50% after deductible
Walk-in clinics	40% after deductible	Not covered	$40 copay; deductible waived	Not covered
Diagnostic testing: Lab	40% after deductible	50% after deductible	$40 copay; deductible waived	50% after deductible
Diagnostic testing: X-ray	40% after deductible	50% after deductible	$150 copay after deductible	50% after deductible
Imaging CT/PET scans MRIs	40% after deductible	50% after deductible	$500 copay after deductible	50% after deductible
Inpatient hospital facility	40% after deductible	50% after deductible	$750/day, days 1–5 after deductible	50% after deductible
Outpatient surgery	40% after deductible	50% after deductible	Freestanding facility: $500 copay after deductible/ hospital: $750 copay after deductible	Freestanding facility: 50% after deductible/hospital: 50% after deductible
Emergency room	40% after deductible	Paid as in-network	$500 copay after deductible	Paid as in-network
Urgent care	40% after deductible	Paid as in-network	$50 copay; deductible waived	Paid as in-network
Rehabilitation services (PT/OT/ST)	40% after deductible	50% after deductible	$75 copay after deductible	50% after deductible
Chiropractic[3]	Not covered	Not covered	$40 copay after deductible	50% after deductible
Pediatric dental check-up** (aka preventive/diagnostic)	Covered in full; deductible waived	20% after deductible	0% deductible waived	30% after deductible
Pediatric dental basic**	20% deductible waived	50% after deductible	30% after deductible	50% after deductible
Pediatric dental major**	50% deductible waived	50% after deductible	50% after deductible	50% after deductible
Pediatric dental ortho**	50% deductible waived	50% after deductible	50% after deductible	50% after deductible
Pediatric vision exam**	Covered in full; deductible waived	Not covered	$40 copay; deductible waived	Not covered
Pediatric vision hardware**	Covered in full; deductible waived	Not covered	Covered in full; deductible waived	Not covered
Pharmacy[4] Mail order: two times retail copay, up to 90-day supply	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Pharmacy deductible	Integrated with medical deductible	None	$500 individual/ $1,000 family	None
Preferred generic drugs	Generic: 40% up to $500 after deductible	Generic: Not covered	Generic: $35 copay; deductible waived	Generic: Not covered
Preferred brand drugs	40% up to $500 after deductible	Not covered	$100 copay after deductible	Not covered
Nonpreferred drugs	Generic & brand: 40% up to $500 after deductible	Generic & brand: Not covered	Generic & brand: $150 copay after deductible	Generic & brand: Not covered
Specialty drugs (includes self-injectable, infused and oral specialty drugs, retail and mail order up to a 30-day supply, excludes insulin)	40% up to $500 after deductible	Not covered	30% up to $500 after deductible	Not covered

Refer to page 25 for footnotes.

Medical plans

Managed Choice Open Access (continued)

Plan name[1]	Bronze MC 6550 100/50 HSA Bronze Savings Plus 6550 100/50 HSA	
	In network	**Out of network**
Plan year deductible (individual/family)	$6,550/$13,100	$13,100/$26,200
Plan out-of-pocket limit (individual/family)	$6,550/$13,100	$14,500/$29,000
Deductible and out-of-pocket limit accumulation	Embedded[2]	
Primary care physician office visit	Covered in full after deductible	50% after deductible
Specialist office visit	Covered in full after deductible	50% after deductible
Walk-in clinics	Covered in full after deductible	Not covered
Diagnostic testing: Lab	Covered in full after deductible	50% after deductible
Diagnostic testing: X-ray	Covered in full after deductible	50% after deductible
Imaging CT/PET scans MRIs	Covered in full after deductible	50% after deductible
Inpatient hospital facility	Covered in full after deductible	50% after deductible
Outpatient surgery	Covered in full after deductible	50% after deductible
Emergency room	Covered in full after deductible	Paid as in-network
Urgent care	Covered in full after deductible	Paid as in-network
Rehabilitation services (PT/OT/ST)	Covered in full after deductible	50% after deductible
Chiropractic[3]	Covered in full after deductible	50% after deductible
Pediatric dental check-up** (aka preventive/diagnostic)	Covered in full after deductible	30% after deductible
Pediatric dental basic**	Covered in full after deductible	50% after deductible
Pediatric dental major**	Covered in full after deductible	50% after deductible
Pediatric dental ortho**	Covered in full after deductible	50% after deductible
Pediatric vision exam**	Covered in full; deductible waived	Not covered
Pediatric vision hardware**	Covered in full; deductible waived	Not covered
Pharmacy[4] Mail order: two times retail copay, up to 90-day supply	**In Network**	**Out of Network**
Pharmacy deductible	Integrated with medical deductible	None
Preferred generic drugs	Generic: Covered in full after deductible	Generic: Not covered
Preferred brand drugs	Covered in full after deductible	Not covered
Nonpreferred drugs	Generic & brand: Covered in full after deductible	Generic & brand: Not covered
Specialty drugs (includes self-injectable, infused and oral specialty drugs, retail and mail order up to a 30-day supply, excludes insulin)	Covered in full after deductible	Not covered

Refer to page 25 for footnotes.

Medical plans

Aetna Whole Health HMO

Plan name[1]	Gold PrimeCare HMO 30 Copay Plan*	Gold PrimeCare HMO 45	Silver PrimeCare HMO Deductible 1500
	In Network	**In network**	**In network**
Plan year deductible (individual/family)	$0/$0	$0/$0	$1,500/$3,000
Plan out-of-pocket limit (individual/family)	$6,750/$13,500	$7,150/$14,300	$7,150/$14,300
Deductible and out-of-pocket limit accumulation	Embedded[2]	Embedded[2]	Embedded[2]
Primary care physician office visit	$30 copay	$45 copay	$45 copay; deductible waived
Specialist office visit	$55 copay	$60 copay	$65 copay; deductible waived
Walk-in clinics	Not covered	Not covered	Not covered
Diagnostic testing: Lab	$35 copay	$30 copay	$65 copay; deductible waived
Diagnostic testing: X-ray	$55 copay	$60 copay	$65 copay; deductible waived
Imaging CT/PET scans MRIs	$275 copay	$300 copay	$400 copay; deductible waived
Inpatient hospital facility	$600/day, days 1–5	$600/day, days 1–5	35% after deductible
Outpatient surgery	$600 copay	Freestanding facility: $500 copay/ hospital: $750 copay	Freestanding facility: $600 copay after deductible/hospital: $800 copay after deductible
Emergency room	$325 copay	$325 copay	$325 copay after deductible
Urgent care	$30 copay	$60 copay	$50 copay; deductible waived
Rehabilitation services (PT/OT/ST)	$30 copay	$60 copay	$65 copay; deductible waived
Chiropractic[3]	Not covered	$15 copay	$15 copay; deductible waived
Pediatric dental check-up** (aka preventive/diagnostic)	Covered in full	Covered in full	Covered in full; deductible waived
Pediatric dental basic**	20%	30%	30% after deductible
Pediatric dental major**	50%	50%	50% after deductible
Pediatric dental ortho**	50%	50%	50% after deductible
Pediatric vision exam**	Covered in full	$45 copay	$45 copay; deductible waived
Pediatric vision hardware**	Covered in full	Covered in full	Covered in full; deductible waived
Pharmacy[4] Mail order: two times retail copay, up to 90-day supply	**In Network**	**In Network**	**In Network**
Pharmacy deductible	None	$300 individual/$600 family	$300 individual/$600 family
Preferred generic drugs	Generic: $15 copay	Generic: $20 copay; deductible waived	Generic: $35 copay; deductible waived
Preferred brand drugs	$55 copay	$60 copay after deductible	$60 copay after deductible
Nonpreferred drugs	Generic & brand: $75 copay	Generic & brand: $100 copay after deductible	Generic & brand: $100 copay after deductible
Specialty drugs (includes self-injectable, infused and oral specialty drugs, retail and mail order up to a 30-day supply, excludes insulin)	20% up to $250	30% up to $250 after deductible	30% up to $250 after deductible

Refer to page 25 for footnotes.

Medical plans

Aetna Whole Health HMO (continued)

Plan name[1]	**Bronze PrimeCare HMO Deductible 6500**
	In network
Plan year deductible (individual/family)	$6,500/$13,000
Plan out-of-pocket limit (individual/family)	$7,150/$14,300
Deductible and out-of-pocket limit accumulation	Embedded[2]
Primary care physician office visit	$50 copay; deductible waived
Specialist office visit	$75 copay; deductible waived
Walk-in clinics	Not covered
Diagnostic testing: Lab	$50 copay; deductible waived
Diagnostic testing: X-ray	$75 copay; deductible waived
Imaging CT/PET scans MRIs	$100 copay after deductible
Inpatient hospital facility	50% after deductible
Outpatient surgery	$800 copay after deductible
Emergency room	50% after deductible
Urgent care	$50 copay; deductible waived
Rehabilitation services (PT/OT/ST)	$50 copay; deductible waived
Chiropractic[3]	$15 copay; deductible waived
Pediatric dental check-up** (aka preventive/diagnostic)	Covered in full; deductible waived
Pediatric dental basic**	30% after deductible
Pediatric dental major**	50% after deductible
Pediatric dental ortho**	50% after deductible
Pediatric vision exam**	$50 copay; deductible waived
Pediatric vision hardware**	Covered in full; deductible waived
Pharmacy[4] Mail order: two times retail copay, up to 90-day supply	**In Network**
Pharmacy deductible	$500 individual/ $1,000 family
Preferred generic drugs	Generic: $35 copay; deductible waived
Preferred brand drugs	$100 copay after deductible
Nonpreferred drugs	Generic & brand: $180 copay after deductible
Specialty drugs (includes self-injectable, infused and oral specialty drugs, retail and mail order up to a 30-day supply, excludes insulin)	30% up to $500 after deductible

Refer to page 25 for footnotes.

Medical plans

Aetna Whole Health EPO****

Plan name[1]	Gold MemorialCare EPO 750 80 Gold Providence EPO 750 80 Gold SCCIPA EPO 750 80	Silver MemorialCare EPO 2000 Copay Silver Providence EPO 2000 Copay Silver SCCIPA EPO 2000 Copay	Bronze MemorialCare EPO 4000 Copay Bronze Providence EPO 4000 Copay Bronze SCCIPA EPO 4000 Copay
	In Network	**In Network**	**In Network**
Plan year deductible (individual/family)	$750/$1,500	$2,000/$4,000	$4,000/$8,000
Plan out-of-pocket limit (individual/family)	$6,000/$12,000	$7,000/$14,000	$7,150/$14,300
Deductible and out-of-pocket limit accumulation	Embedded[2]	Embedded[2]	Embedded[2]
Primary care physician office visit	$30 copay; deductible waived	$35 copay; deductible waived	$50 copay; deductible waived
Specialist office visit	$40 copay; deductible waived	$60 copay after deductible	$75 copay after deductible
Walk-in clinics	$30 copay; deductible waived	$35 copay; deductible waived	$50 copay; deductible waived
Diagnostic testing: Lab	$15 copay; deductible waived	$35 copay; deductible waived	$50 copay; deductible waived
Diagnostic testing: X-ray	$15 copay; deductible waived	$60 copay after deductible	$125 copay after deductible
Imaging CT/PET scans MRIs	20% after deductible	$250 copay after deductible	$500 copay after deductible
Inpatient hospital facility	20% after deductible	$750 copay per admission after deductible	$850 copay per admission after deductible
Outpatient surgery	Freestanding facility: $500 copay after deductible/hospital: $750 copay after deductible	Freestanding facility: $500 copay after deductible/hospital: $600 copay after deductible	$500 copay after deductible
Emergency room	20% after deductible	$300 copay after deductible	$500 copay after deductible
Urgent care	$50 copay; deductible waived	$50 copay; deductible waived	$50 copay; deductible waived
Rehabilitation services (PT/OT/ST)	20% after deductible	$50 copay after deductible	$50 copay after deductible
Chiropractic[3]	20% after deductible	$35 copay after deductible	$50 copay after deductible
Pediatric dental check-up** (aka preventive/diagnostic)	Covered in full; deductible waived	Covered in full; deductible waived	Covered in full; deductible waived
Pediatric dental basic**	30% after deductible	30% after deductible	30% after deductible
Pediatric dental major**	50% after deductible	50% after deductible	50% after deductible
Pediatric dental ortho**	50% after deductible	50% after deductible	50% after deductible
Pediatric vision exam**	$30 copay; deductible waived	$35 copay; deductible waived	$50 copay; deductible waived
Pediatric vision hardware**	Covered in full; deductible waived	Covered in full; deductible waived	Covered in full; deductible waived
Pharmacy[4] Mail order: two times retail copay, up to 90-day supply	**In Network**	**In Network**	**In Network**
Pharmacy deductible	None	$150 individual/ $300 family	$500 individual/ $1,000 family
Preferred generic drugs	Generic: $20 copay	Generic: $20 copay; deductible waived	Generic: $35 copay; deductible waived
Preferred brand drugs	$60 copay	$50 copay after deductible	$100 copay after deductible
Nonpreferred drugs	Generic & brand: $75 copay	Generic & brand: $70 copay after deductible	Generic & brand: $150 copay after deductible
Specialty drugs (includes self-injectable, infused and oral specialty drugs, retail and mail order up to a 30-day supply, excludes insulin)	30% up to $250	30% up to $250 after deductible	30% up to $500 after deductible

Refer to page 25 for footnotes.

Medical plans

Aetna Whole Health MC

Plan name[1]	Gold PrimeCare MC 750 80/50		Silver MemorialCare MC 2000 60/50 Silver PrimeCare MC 2000 60/50 Silver Providence MC 2000 60/50 Silver SCCIPA MC 2000 60/50	
	In Network	**Out of Network**	**In Network**	**Out of Network**
Plan year deductible (individual/family)	$750/$1,500	$1,500/$3,000	$2,000/$4,000	$4,000/$8,000
Plan out-of-pocket limit (individual/family)	$6,000/$12,000	$12,000/$24,000	$7,150/$14,300	$14,300/$28,600
Deductible and out-of-pocket limit accumulation	Embedded[2]		Embedded[2]	
Primary care physician office visit	$30 copay; deductible waived	50% after deductible	$30 copay; deductible waived	50% after deductible
Specialist office visit	$40 copay; deductible waived	50% after deductible	$50 copay; deductible waived	50% after deductible
Walk-in clinics	$30 copay; deductible waived	Not covered	$30 copay; deductible waived	Not covered
Diagnostic testing: Lab	$15 copay; deductible waived	50% after deductible	$30 copay; deductible waived	50% after deductible
Diagnostic testing: X-ray	$15 copay; deductible waived	50% after deductible	$35 copay; deductible waived	50% after deductible
Imaging CT/PET scans MRIs	20% after deductible	50% after deductible	40% after deductible	50% after deductible
Inpatient hospital facility	20% after deductible	50% after deductible	40% after deductible	50% after deductible
Outpatient surgery	Freestanding facility: $500 copay after deductible/hospital: $750 copay after deductible	Freestanding facility: 50% after deductible/hospital: 50% after deductible	Freestanding facility: $700 copay after deductible/hospital: $1,000 copay after deductible	Freestanding facility: 50% after deductible/hospital: 50% after deductible
Emergency room	20% after deductible	Paid as in-network	40% after deductible	Paid as in-network
Urgent care	$50 copay; deductible waived	Paid as in-network	$50 copay; deductible waived	Paid as in-network
Rehabilitation services (PT/OT/ST)	20% after deductible	50% after deductible	40% after deductible	50% after deductible
Chiropractic[3]	20% after deductible	50% after deductible	40% after deductible	50% after deductible
Pediatric dental check-up** (aka preventive/diagnostic)	Covered in full; deductible waived	30% after deductible	Covered in full; deductible waived	30% after deductible
Pediatric dental basic**	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Pediatric dental major**	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Pediatric dental ortho**	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Pediatric vision exam**	$30 copay; deductible waived	Not covered	$30 copay; deductible waived	Not covered
Pediatric vision hardware**	Covered in full; deductible waived	Not covered	Covered in full; deductible waived	Not covered
Pharmacy[4] Mail order: two times retail copay, up to 90-day supply	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Pharmacy deductible	None	None	$150 individual/ $300 family	None
Preferred generic drugs	Generic: $20 copay	Not covered	Generic: $15 copay; deductible waived	Generic: Not covered
Preferred brand drugs	$60 copay	Not covered	$55 copay after deductible	Not covered
Nonpreferred drugs	Generic & brand: $75 copay	Not covered	Generic & brand: $75 copay after deductible	Generic & brand: Not covered
Specialty drugs (includes self-injectable, infused and oral specialty drugs, retail and mail order up to a 30-day supply, excludes insulin)	30% up to $250	Not covered	30% up to $250 after deductible	Not covered

Medical plans

Aetna Whole Health MC (continued)

Plan name[1]	Bronze PrimeCare MC 4000 Copay		Bronze MemorialCare MC 6500 Copay Bronze Providence MC 6500 Copay Bronze SCCIPA MC 6500 Copay	
	In Network	**Out of Network**	**In network**	**Out of network**
Plan year deductible (individual/family)	$4,000/$8,000	$8,000/$16,000	$6,500/$13,000	$13,000/$26,000
Plan out-of-pocket limit (individual/family)	$7,150/$14,300	$14,300/$28,600	$7,150/$14,300	$14,300/$28,600
Deductible and out-of-pocket limit accumulation	Embedded[2]		Embedded[2]	
Primary care physician office visit	$50 copay; deductible waived	50% after deductible	$40 copay; deductible waived	50% after deductible
Specialist office visit	$75 copay after deductible	50% after deductible	$75 copay after deductible	50% after deductible
Walk-in clinics	$50 copay; deductible waived	Not covered	$40 copay; deductible waived	Not covered
Diagnostic testing: Lab	$50 copay; deductible waived	50% after deductible	$40 copay; deductible waived	50% after deductible
Diagnostic testing: X-ray	$125 copay after deductible	50% after deductible	$150 copay after deductible	50% after deductible
Imaging CT/PET scans MRIs	$500 copay after deductible	50% after deductible	$500 copay after deductible	50% after deductible
Inpatient hospital facility	$850 copay per admission after deductible	50% after deductible	$750/day, days 1–5 after deductible	50% after deductible
Outpatient surgery	$500 copay after deductible	50% after deductible	Freestanding facility: $500 copay after deductible/hospital: $750 copay after deductible	Freestanding facility: 50% after deductible/hospital: 50% after deductible
Emergency room	$500 copay after deductible	Paid as in-network	$500 copay after deductible	Paid as in-network
Urgent care	$50 copay; deductible waived	Paid as in-network	$50 copay; deductible waived	Paid as in-network
Rehabilitation services (PT/OT/ST)	$50 copay after deductible	50% after deductible	$75 copay after deductible	50% after deductible
Chiropractic[3]	$50 copay after deductible	50% after deductible	$40 copay after deductible	50% after deductible
Pediatric dental check-up** (aka preventive/diagnostic)	Covered in full; deductible waived	30% after deductible	0% deductible waived	30% after deductible
Pediatric dental basic**	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Pediatric dental major**	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Pediatric dental ortho**	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Pediatric vision exam**	$50 copay; deductible waived	Not covered	$40 copay; deductible waived	Not covered
Pediatric vision hardware**	Covered in full; deductible waived	Not covered	Covered in full; deductible waived	Not covered
Pharmacy[4] Mail order: two times retail copay, up to 90-day supply	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Pharmacy deductible	$500 individual/ $1,000 family	None	$500 individual/ $1,000 family	None
Preferred generic drugs	Generic: $35 copay; deductible waived	Generic: Not covered	Generic: $35 copay; deductible waived	Generic: Not covered
Preferred brand drugs	$100 copay after deductible	Not covered	$100 copay after deductible	Not covered
Nonpreferred drugs	Generic & brand: $150 copay after deductible	Generic & brand: Not covered	Generic & brand: $150 copay after deductible	Generic & brand: Not covered
Specialty drugs (includes self-injectable, infused and oral specialty drugs, retail and mail order up to a 30-day supply, excludes insulin)	30% up to $500 after deductible	Not covered	30% up to $500 after deductible	Not covered

Refer to page 25 for footnotes.

Medical plans

PPO and Indemnity

Plan name[1] See underwriting guidelines regarding network/product availability.	**Gold PPO 750 80/50**		**Silver Indemnity 1500 80**	
	In network	**Out of network**	**All providers**	
Plan year deductible (individual/family)	$750/$1,500	$1,500/$3,000	$1,500/$3,000	
Plan out-of-pocket limit (individual/family)	$6,000/$12,000	$12,000/$24,000	$7,000/$14,000	
Deductible and out-of-pocket limit accumulation	Embedded[2]		Embedded[2]	
Primary care physician office visit	$30 copay; deductible waived	50% after deductible	20% after deductible	
Specialist office visit	$40 copay; deductible waived	50% after deductible	20% after deductible	
Walk-in clinics	$30 copay; deductible waived	Not covered	Not covered	
Diagnostic testing: Lab	$15 copay; deductible waived	50% after deductible	20% after deductible	
Diagnostic testing: X-ray	$15 copay; deductible waived	50% after deductible	20% after deductible	
Imaging CT/PET scans MRIs	20% after deductible	50% after deductible	20% after deductible	
Inpatient hospital facility	20% after deductible	50% after deductible	20% after deductible	
Outpatient surgery	Freestanding facility: $500 copay after deductible/hospital: $750 copay after deductible	Freestanding facility: 50% after deductible/ hospital: 50% after deductible	Freestanding facility: 20% after deductible/ hospital: 20% after deductible	
Emergency room	20% after deductible	Paid as in-network	20% after deductible	
Urgent care	$50 copay; deductible waived	Paid as in-network	20% after deductible	
Rehabilitation services (PT/OT/ST)	20% after deductible	50% after deductible	20% after deductible	
Chiropractic[3]	20% after deductible	50% after deductible	20% after deductible	
Pediatric dental check-up** (aka preventive/diagnostic)	Covered in full; deductible waived	30% after deductible	Covered in full; deductible waived	
Pediatric dental basic**	30% after deductible	50% after deductible	30% after deductible	
Pediatric dental major**	50% after deductible	50% after deductible	50% after deductible	
Pediatric dental ortho**	50% after deductible	50% after deductible	50% after deductible	
Pediatric vision exam**	$30 copay; deductible waived	Not covered	Covered in full; deductible waived	
Pediatric vision hardware**	Covered in full; deductible waived	Not covered	Covered in full; deductible waived	
Pharmacy[4] Mail order: two times retail copay, up to 90-day supply	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Pharmacy deductible	None	None	None	None
Preferred generic drugs	Generic: $20 copay	Generic: Not covered	Generic: $30 copay	Generic: $30 copay
Preferred brand drugs	$60 copay	Not covered	$55 copay	$55 copay
Nonpreferred drugs	Generic & brand: $75 copay	Generic & brand: Not covered	Generic & brand: $80 copay	Generic & brand: $80 copay
Specialty drugs (includes self-injectable, infused and oral specialty drugs, retail and mail order up to a 30-day supply, excludes insulin)	30% up to $250	Not covered	30% up to $250	Not covered

Refer to page 25 for footnotes.

Medical footnotes

All services are subject to the deductible unless noted otherwise. Some benefits are subject to age and frequency schedules, limitations or visit maximums. Members or providers may be required to precertify or obtain approval for certain services.

Note: Please refer to Aetna's Producer World® website at **www.aetna.com** for specific Summary of Benefits and Coverage documents. Or for more information, please contact your licensed agent or Aetna sales representative.

Deductibles, copays and coinsurance apply to the out-of-pocket maximum (OOP). After the out of pocket maximum is met, members continue to be responsible for any applicable premiums, penalties for failure to precertify (where applicable) and services not covered by Aetna.

*Mandated coverage California exchange plan.

**These pediatric dental and vision plans do not cover all dental and vision expenses and have exclusions and limitations. Members should refer to their plan documents to determine which services are covered and to what extent.

These pediatric vision plan will cover the following:

- One set of eyeglass frames per 12 months.
- One pair of prescription lenses per 12 months or a one year supply of contact lenses, in lieu of glasses. Also included is contact lens evaluation, fitting and follow-up care.
- Important Notes: This plan will cover either one pair of prescription lenses for eyeglass frames or prescription contact lenses, but not both, per 12 months.

***This plan is only available for employees located in an area with no Aetna HMO, EPO, MC or PPO network.

****Aetna Whole Health EPO does not require PCP selection.

[1]**Infertility** – All 1-100 plans include comprehensive infertility. Coverage is limited to $2,000 maximum per lifetime, AI/OI & ART/GIFT combined. Excludes ZIFT, IVF, ICSI, ovum microsurgery, cryopreserved embryo transfers and injectable medications.

[2]**Embedded** – No one family member may contribute more than the individual deductible/out-of-pocket limit amount to the family deductible/out-of-pocket limit. Once the family deductible/out-of-pocket limit is met, all family members will be considered as having met their deductible/ out-of-pocket limit for the remainder of the calendar year.

[3]**Chiropractic/subluxation** – Coverage is limited to 20 visits per calendar year.

[4]**Pharmacy** – Choose Generics applies — If the physician prescribes or the member requests a covered brand name prescription drug when a generic prescription drug equivalent is available, the member will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent plus the applicable cost-sharing. The cost difference between the generic and brand does not count toward the Out of Pocket Limit. Not all drugs are covered. It is important to look at the Drug List (Aetna Four-Tier Open Value Formulary for Small Group) to understand which drugs are covered.

Network – How your out-of-network care is reimbursed: 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 Aetna pays 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 Aetna 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, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount.

PPO:

- Professional Services: 100% of Medicare
- Facility Services: 100% of Medicare

Indemnity:

- Professional Services: Fair Health 80%
- Facility Services: 300% of Medicare

Your doctor sets his or her own rate to charge you. It may be higher — sometimes much higher — than what your Aetna plan "recognizes." Your doctor may bill you for the dollar amount that your plan doesn'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 **www.aetna.com**. Type "how Aetna pays" in the search box. 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 Aetna Navigator member site.

This applies when you choose to get care out of network. When you have no choice (usually, for emergency services), some of our plans pay the bill as if you got care in network. For those plans, you pay cost sharing and deductibles based on your in-network level of benefits. You do not have to pay anything else. Other plans pay the bill differently. And, under those plans, you may be responsible for more than your in-network cost sharing. The additional amounts could be very large. Look at your plan or contact us to find out more about how your plan pays for emergency services.

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits may vary by location. Health/dental benefits and health/dental insurance and plans contain exclusions and limitations. Plan features and availability may vary by location and group size. Investment services are independently offered through PayFlex. Providers are independent contractors and not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Not all health and dental services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. 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. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **www.aetna.com**.

Dental plans

Contributory non-voluntary dental 2 – 9

Plan name	DMO Access	DMO Plus (Plan 58)	Freedom-of-Choice Coinsurance Monthly selection between DMO and PPO Max		Freedom-of-Choice Plus Monthly selection between DMO and PPO	
	Plan 42	Fixed Copay 58	DMO 100/90/60	PPO Max 100/80/50	Fixed Copay 58	PPO 100/80/50
Office visit copay	$10	$5	$5	N/A	$5	N/A
Annual deductible per member (does not apply to diagnostic & preventive services)	None	None	None	$50; 3X family maximum	None	$50; 3X family maximum
Annual maximum benefit	Unlimited	Unlimited	Unlimited	$2,000	Unlimited	$1,000
Diagnostic services						
Oral exams						
Periodic oral exam	No charge	No charge	100%	100%	No charge	100%
Comprehensive oral exam	No charge	No charge	100%	100%	No charge	100%
Problem-focused oral exam	No charge	No charge	100%	100%	No charge	100%
X-rays						
Bitewing – single film	No charge	No charge	100%	100%	No charge	100%
Complete series	No charge	No charge	100%	100%	No charge	100%
Preventive services						
Adult cleaning	No charge	No charge	100%	100%	No charge	100%
Child cleaning	No charge	No charge	100%	100%	No charge	100%
Sealants – per tooth	$10	$5	100%	100%	$5	100%
Fluoride application – child	No charge	No charge	100%	100%	No charge	100%
Space maintainers – fixed	$100	$60	100%	100%	$60	100%
Basic services						
Amalgam filling – 2 surfaces	$32	No charge	90%	80%	No charge	80%
Resin filling – 2 surfaces, anterior	$55	No charge	90%	80%	No charge	80%
Oral surgery						
Extraction – exposed root or erupted tooth	$30	No charge	90%	80%	No charge	80%
Extraction of impacted tooth – soft tissue	$80	$46	90%	80%	$46	80%
Major services*						
Complete upper denture	$500	$275	60%	50%	$275	50%
Partial upper denture (resin base)	$513	$275	60%	50%	$275	50%
Crown – Porcelain with noble metal[1]	$488	$210	60%	50%	$210	50%
Pontic – Porcelain with noble metal[1]	$488	$210	60%	50%	$210	50%
Inlay – Metallic (3 or more surfaces)	$463	$180	60%	50%	$180	50%
Oral surgery						
Removal of impacted tooth – partially bony	$175**	$58	60%	50%	$58	50%
Endodontic services						
Bicuspid root canal therapy	$195	$85	90%	50%	$85	80%
Molar root canal therapy	$435**	$240	60%	50%	$240	50%
Periodontic services						
Scaling & root planing – per quadrant	$65	$55	90%	50%	$55	80%
Osseous surgery – per quadrant	$445**	$300	60%	50%	$300	50%
Orthodontic services	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Orthodontic lifetime maximum	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply

Refer to page 29 for footnotes.

Dental plans

Contributory non-voluntary dental 2 – 9 (continued)

Plan name	PPO $1000 Active		PPO $1500	PPO $1500 Active		PPO $2000
	Preferred 100/80/50	Non-Preferred 80/60/40	PPO 1500 100/80/50	Preferred 100/80/50	Non-Preferred 80/60/40	PPO 2000 100/80/50
Office visit copay	N/A	N/A	N/A	N/A	N/A	N/A
Annual deductible per member (does not apply to diagnostic & preventive services)	$50; 3X family maximum	$50; 3X family maximum	$50; 3X family maximum	$50; 3X family maximum	$50; 3X family maximum	$50; 3X family maximum
Annual maximum benefit	$1,000	$1,000	$1,500	$1,500	$1,500	$2,000
Diagnostic services						
Oral exams						
Periodic oral exam	100%	80%	100%	100%	80%	100%
Comprehensive oral exam	100%	80%	100%	100%	80%	100%
Problem-focused oral exam	100%	80%	100%	100%	80%	100%
X-rays						
Bitewing – single film	100%	80%	100%	100%	80%	100%
Complete series	100%	80%	100%	100%	80%	100%
Preventive services						
Adult cleaning	100%	80%	100%	100%	80%	100%
Child cleaning	100%	80%	100%	100%	80%	100%
Sealants – per tooth	100%	80%	100%	100%	80%	100%
Fluoride application – child	100%	80%	100%	100%	80%	100%
Space maintainers – fixed	100%	80%	100%	100%	80%	100%
Basic services						
Amalgam filling – 2 surfaces	80%	60%	80%	80%	60%	80%
Resin filling – 2 surfaces, anterior	80%	60%	80%	80%	60%	80%
Oral surgery						
Extraction – exposed root or erupted tooth	80%	60%	80%	80%	60%	80%
Extraction of impacted tooth – soft tissue	80%	60%	80%	80%	60%	80%
Major services*						
Complete upper denture	50%	40%	50%	50%	40%	50%
Partial upper denture (resin base)	50%	40%	50%	50%	40%	50%
Crown – Porcelain with noble metal[1]	50%	40%	50%	50%	40%	50%
Pontic – Porcelain with noble metal[1]	50%	40%	50%	50%	40%	50%
Inlay – Metallic (3 or more surfaces)	50%	40%	50%	50%	40%	50%
Oral surgery						
Removal of impacted tooth – partially bony	50%	40%	50%	50%	40%	50%
Endodontic services						
Bicuspid root canal therapy	50%	40%	80%	80%	60%	80%
Molar root canal therapy	50%	40%	50%	50%	40%	50%
Periodontic services						
Scaling & root planing – per quadrant	50%	40%	80%	80%	60%	80%
Osseous surgery – per quadrant	50%	40%	50%	50%	40%	50%
Orthodontic services	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Orthodontic lifetime maximum	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply

Refer to page 29 for footnotes.

Contributory non-voluntary dental footnotes

*Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service. Does not apply to DMO in DMO Plus and Freedom-of-Choice Coinsurance & Freedom-of-Choice Plus.

**Specialist procedures are not covered by the plan when performed by a participating specialist. However, the service is available to the member at a discount.

[1]There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures: DMO Access, DMO Plus.

Fixed dollar amounts on DMO Access, DMO Plus, Freedom-of-Choice Coinsurance & Freedom-of-Choice Plus are member responsibility.

Most oral surgery, endodontic and periodontic services are covered as Basic Services on PPO in Freedom-of-Choice Plus, PPO $1,500, PPO $1,500 Active and PPO $2,000.

Freedom-of-Choice Coinsurance; PPO Max non-preferred (out of network) coverage is limited to a maximum of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Out-of-network plan payments are limited by geographic area on PPO in Freedom-of-Choice Plus, PPO $1,000, PPO $1,000 Active, PPO $1,500 and PPO $1,500 Active to the prevailing fees at the 80th percentile and the 90th percentile on PPO $2,000.

DMO Access & DMO Plus can be offered with any one of the PPO plans in a dual option package.

PPO Deductible and calendar year maximum cross-apply between in network and out of network.

Plan features and availability may vary by location and are subject to change. Information is believed to be accurate as of the production date; however, it is subject to change.

DMO Access: Apart from the DMO network and DMO plan of benefits, members under this plan also have access to the Aetna Dental Access network. This network provides access to providers who participate in the Aetna Dental Access network and have agreed to charge a negotiated discounted fee. Members can access this network for any service. However, the DMO benefits do not apply. In situations where the dentist participates in both the Aetna Dental Access network and the Aetna DMO network, DMO benefits take precedence over all other discounts including discounts through the Aetna Dental Access network.

Aetna Dental Access network is not insurance or a benefits plan. It only provides access to discounted fees for dental services obtained from providers who participate in the Aetna Dental Access network. Members are solely responsible for all charges incurred using this access, and are expected to make payment to the provider at the time of treatment.

The list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate.

Dental plans

Voluntary dental 3 – 9

Plan name	Voluntary DMO Access	Voluntary DMO Plus (Plan 58)	Voluntary PPO $1000 Active		Voluntary PPO $1500
	Plan 42	Fixed Copay DMO 58	Preferred 100/80/50	Non-Preferred 80/60/40	PPO 1500 100/80/50
Office visit copay	$15	$10	N/A	N/A	N/A
Annual deductible per member (does not apply to diagnostic & preventive services)	None	None	$75; 3X family maximum	$75; 3X family maximum	$75; 3X family maximum
Annual maximum benefit	Unlimited	Unlimited	$1,000	$1,000	$1,500
Diagnostic services					
Oral Exams					
Periodic oral exam	No charge	No charge	100%	80%	100%
Comprehensive oral exam	No charge	No charge	100%	80%	100%
Problem-focused oral exam	No charge	No charge	100%	80%	100%
X-rays					
Bitewing – single film	No charge	No charge	100%	80%	100%
Complete series	No charge	No charge	100%	80%	100%
Preventive services					
Adult cleaning	No charge	No charge	100%	80%	100%
Child cleaning	No charge	No charge	100%	80%	100%
Sealants – per tooth	$10	$5	100%	80%	100%
Fluoride application – child	No charge	No charge	100%	80%	100%
Space maintainers – fixed	$100	$60	100%	80%	100%
Basic services					
Amalgam filling – 2 surfaces	$32	No charge	80%	60%	80%
Resin filling – 2 surfaces, anterior	$55	No charge	80%	60%	80%
Oral surgery					
Extraction – exposed root or erupted tooth	$30	No charge	80%	60%	80%
Extraction of impacted tooth – soft tissue	$80	$46	80%	60%	80%
Major services*					
Complete upper denture	$500	$275	50%	40%	50%
Partial upper denture (resin base)	$513	$275	50%	40%	50%
Crown – Porcelain with noble metal[1]	$488	$210	50%	40%	50%
Pontic – Porcelain with noble metal[1]	$488	$210	50%	40%	50%
Inlay – Metallic (3 or more surfaces)	$463	$180	50%	40%	50%
Oral surgery					
Removal of impacted tooth – partially bony	$175**	$58	50%	40%	50%
Endodontic services					
Bicuspid root canal therapy	$195	$85	50%	40%	80%
Molar root canal therapy	$435**	$240	50%	40%	50%
Periodontic services					
Scaling & root planing – per quadrant	$65	$55	50%	40%	80%
Osseous surgery – per quadrant	$445**	$300	50%	40%	50%
Orthodontic services	Not covered	Not covered	Not covered	Not covered	Not covered
Orthodontic lifetime maximum	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply

Refer to page 32 for footnotes.

Dental plans

Voluntary dental 3 – 9 (continued)

Plan name	Voluntary PPO $1500 Active		Voluntary Freedom-of-Choice Coinsurance Monthly selection between DMO and PPO Max	
	Preferred 100/80/50	Non-Preferred 80/60/40	DMO 100/90/60	PPO Max 100/80/50
Office visit copay	N/A	N/A	$10	N/A
Annual deductible per member (does not apply to diagnostic & preventive services)	$75; 3X family maximum	$75; 3X family maximum	None	$75; 3X family maximum
Annual maximum benefit	$1,500	$1,500	Unlimited	$2,000
Diagnostic services				
Oral Exams				
Periodic oral exam	100%	80%	100%	100%
Comprehensive oral exam	100%	80%	100%	100%
Problem-focused oral exam	100%	80%	100%	100%
X-rays				
Bitewing – single film	100%	80%	100%	100%
Complete series	100%	80%	100%	100%
Preventive services				
Adult cleaning	100%	80%	100%	100%
Child cleaning	100%	80%	100%	100%
Sealants – per tooth	100%	80%	100%	100%
Fluoride application – child	100%	80%	100%	100%
Space maintainers – fixed	100%	80%	100%	100%
Basic services				
Amalgam filling – 2 surfaces	80%	60%	90%	80%
Resin filling – 2 surfaces, anterior	80%	60%	90%	80%
Oral surgery				
Extraction – exposed root or erupted tooth	80%	60%	90%	80%
Extraction of impacted tooth – soft tissue	80%	60%	90%	80%
Major services*				
Complete upper denture	50%	40%	60%	50%
Partial upper denture (resin base)	50%	40%	60%	50%
Crown – Porcelain with noble metal[1]	50%	40%	60%	50%
Pontic – Porcelain with noble metal[1]	50%	40%	60%	50%
Inlay – Metallic (3 or more surfaces)	50%	40%	60%	50%
Oral surgery				
Removal of impacted tooth – partially bony	50%	40%	60%	50%
Endodontic services				
Bicuspid root canal therapy	80%	60%	90%	50%
Molar root canal therapy	50%	40%	60%	50%
Periodontic services				
Scaling & root planing – per quadrant	80%	60%	90%	50%
Osseous surgery – per quadrant	50%	40%	60%	50%
Orthodontic services	Not covered	Not covered	Not covered	Not covered
Orthodontic lifetime maximum	Does not apply	Does not apply	Does not apply	Does not apply

Refer to page 32 for footnotes.

Voluntary dental footnotes

*Coverage waiting period: Must be an enrolled member of the plan for 12 months before becoming eligible for coverage of any major service. Does not apply to DMO in Voluntary DMO Plus and Voluntary Freedom-of-Choice Coinsurance.

**Specialist procedures are not covered by the plan when performed by a participating specialist. However, the service is available to the member at a discount.

[1]There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures on Voluntary DMO Access, DMO Plus.

Fixed dollar amounts on DMO in Voluntary DMO Plus & Voluntary Freedom-of-Choice Coinsurance are member responsibility.

Voluntary Freedom-of-Choice Coinsurance; PPO Max non-preferred (out-of-network) coverage is limited to a maximum of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Most oral surgery, endodontic and periodontic services are covered as basic services on the PPO in Voluntary PPO $1,500, Voluntary PPO $1,500 Active.

Out-of-network plan payments are limited by geographic area on the PPO in Voluntary PPO Active $1,000 and $1,500 and Voluntary PPO $1,500 to the prevailing fees at the 80th percentile.

PPO deductible and calendar year maximum cross-apply between in network and out of network.

Plan features and availability may vary by location and are subject to change. Information is believed to be accurate as of the production date; however, it is subject to change.

If there is a lapse in coverage, members may not re-enroll in the plan for a period of two years from the date of termination. If they are eligible for coverage at that time, they may re-enroll, subject to all provisions of the plan, including, but not limited to, the coverage waiting period.

The list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate.

DMO access: Apart from the DMO network and DMO plan of benefits, members under this plan also have access to the Aetna Dental Access network. This network provides access to providers who participate in the Aetna Dental Access network and have agreed to charge a negotiated discounted fee. Members can access this network for any service. However, the DMO benefits do not apply. In situations where the dentist participates in both the Aetna Dental Access network and the Aetna DMO network, DMO benefits take precedence over all other discounts including discounts through the Aetna Dental Access network.

Aetna Dental Access network is not insurance or a benefits plan. It only provides access to discounted fees for dental services obtained from providers who participate in the Aetna Dental Access network. Members are solely responsible for all charges incurred using this access, and are expected to make payment to the provider at the time of treatment.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).

Dental plans

Voluntary and contributory dental 10 – 100

Plan name	Option 1A DMO Copay 58	Option 1B DMO Copay 56	Option 2A DMO Coins	Option 3A DMO Copay 66	Option 3B DMO Copay 66I	Option 3C DMO Copay 63
	Fixed Copay 58	Fixed Copay 56	DMO 100/100/60	Fixed Copay 66	Fixed Copay 66i	Fixed Copay 63
Office visit copay	$5	None	$5	None	None	$5
Annual deductible per member (does not apply to diagnostic & preventive services)	None	None	None	None	None	None
Annual maximum benefit	Unlimited	None	Unlimited	Unlimited	Unlimited	Unlimited
Diagnostic services						
Oral exams						
Periodic oral exam	No charge	No charge	100%	No charge	No charge	No charge
Comprehensive oral exam	No charge	No charge	100%	No charge	No charge	No charge
Problem-focused oral exam	No charge	No charge	100%	No charge	No charge	No charge
X-rays						
Bitewing – single film	No charge	No charge	100%	No charge	No charge	No charge
Complete series	No charge	No charge	100%	No charge	No charge	No charge
Preventive services						
Adult cleaning	No charge	No charge	100%	No charge	No charge	$8
Child cleaning	No charge	No charge	100%	No charge	No charge	$7
Sealants – per tooth	$5	No charge	100%	No charge	No charge	$8
Fluoride application – child	No charge	No charge	100%	No charge	No charge	No charge
Space maintainers – fixed	$60	No charge	100%	No charge	No charge	$80
Basic services						
Amalgam filling – 2 surfaces	No charge	No charge	100%	No charge	No charge	$24
Resin filling – 2 surfaces, anterior	No charge	No charge	100%	No charge	No charge	$35
Endodontic services						
Bicuspid root canal therapy	$85	No charge	100%	No charge	No charge	$180
Periodontic services						
Scaling & root planing – per quadrant	$55	$25	100%	$35	$35	$56
Oral surgery						
Extraction – exposed root or erupted tooth	No charge	No charge	100%	No charge	No charge	$15
Extraction of impacted tooth – soft tissue	$46	No charge	100%	No charge	No charge	$60
Major services*						
Complete upper denture	$275	$185	60%	$200	$200	$300
Partial upper denture (resin base)	$275	$185	60%	$200	$200	$300
Crown – Porcelain with noble metal[1]	$210	$150	60%	$180	$180	$315
Pontic – Porcelain with noble metal[1]	$210	$150	60%	$180	$180	$315
Inlay – Metallic (3 or more surfaces)	$180	$150	60%	$180	$180	$225
Oral surgery						
Removal of impacted tooth – partially bony	$58	$45	60%	$45	$45	$72
Endodontic services						
Molar root canal therapy	$240	$125	60%	$146	$146	$303
Periodontic services						
Osseous surgery – per quadrant	$300	$140	60%	$140	$140	$325
Orthodontic services (optional)*	$2,300 copay	$2,000 copay	$2,000 copay	$2,300 copay	$2,300 copay	$2,300 copay
Orthodontic lifetime maximum	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply

Refer to page 39 for footnotes.

Dental plans

Voluntary and contributory dental 10 – 100 (continued)

Plan name	Option 4A Freedom-of-Choice Monthly selection between DMO and PPO		Option 5A Freedom-of-Choice Active Monthly selection between DMO and PPO		
	DMO 100/100/60	PPO 100/80/50	DMO 100/100/60	Preferred PPO 100/90/60	Non-Preferred PPO 100/80/50
Office visit copay	$5	N/A	$5	N/A	N/A
Annual deductible per member (does not apply to diagnostic & preventive services)	None	$50; 3X family maximum	None	$50; 3X family maximum	$50; 3X family maximum
Annual maximum benefit	Unlimited	$1,500	Unlimited	$1,500	$1,000
Diagnostic services					
Oral exams					
Periodic oral exam	100%	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%	100%
X-rays					
Bitewing – single film	100%	100%	100%	100%	100%
Complete series	100%	100%	100%	100%	100%
Preventive services					
Adult cleaning	100%	100%	100%	100%	100%
Child cleaning	100%	100%	100%	100%	100%
Sealants – per tooth	100%	100%	100%	100%	100%
Fluoride application – child	100%	100%	100%	100%	100%
Space maintainers – fixed	100%	100%	100%	100%	100%
Basic services					
Amalgam filling – 2 surfaces	100%	80%	100%	90%	80%
Resin filling – 2 surfaces, anterior	100%	80%	100%	90%	80%
Endodontic services					
Bicuspid root canal therapy	100%	80%	100%	90%	80%
Periodontic services					
Scaling & root planing – per quadrant	100%	80%	100%	90%	80%
Oral surgery					
Extraction – exposed root or erupted tooth	100%	80%	100%	90%	80%
Extraction of impacted tooth – soft tissue	100%	80%	100%	90%	80%
Major services*					
Complete upper denture	60%	50%	60%	60%	50%
Partial upper denture (resin base)	60%	50%	60%	60%	50%
Crown – Porcelain with noble metal[1]	60%	50%	60%	60%	50%
Pontic – Porcelain with noble metal[1]	60%	50%	60%	60%	50%
Inlay – Metallic (3 or more surfaces)	60%	50%	60%	60%	50%
Oral surgery					
Removal of impacted tooth – partially bony	60%	80%	60%	90%	80%
Endodontic services					
Molar root canal therapy	60%	80%	60%	90%	80%
Periodontic services					
Osseous surgery – per quadrant	60%	80%	60%	90%	80%
Orthodontic services (optional)*	$2,000 copay	50%	$2,000 copay	50%	50%
Orthodontic lifetime maximum	Does not apply	$1,000	Does not apply	$1,000	$1,000

Refer to page 39 for footnotes.

Dental plans

Voluntary and contributory dental 10 – 100 (continued)

Plan name	**Option 5B Freedom-of-Choice Active PPO 90th Monthly selection between DMO and PPO**			**Option 6A Active PPO Low**	
	Fixed Copay 66	Preferred PPO 100/90/60	Non-Preferred PPO 100/80/50	Preferred 80/80/50	Non-Preferred 70/50/50
Office visit copay	None	N/A	N/A	N/A	N/A
Annual deductible per member (does not apply to diagnostic & preventive services)	None	$50; 3X family maximum	$50; 3X family maximum	$50; 3X family maximum	$50; 3X family maximum
Annual maximum benefit	Unlimited	$2,000	$2,000	$1,500	$1,500
Diagnostic services					
Oral exams					
Periodic oral exam	No charge	100%	100%	80%	70%
Comprehensive oral exam	No charge	100%	100%	80%	70%
Problem-focused oral exam	No charge	100%	100%	80%	70%
X-rays					
Bitewing – single film	No charge	100%	100%	80%	70%
Complete series	No charge	100%	100%	80%	70%
Preventive services					
Adult cleaning	No charge	100%	100%	80%	70%
Child cleaning	No charge	100%	100%	80%	70%
Sealants – per tooth	No charge	100%	100%	80%	70%
Fluoride application – child	No charge	100%	100%	80%	70%
Space maintainers – fixed	No charge	100%	100%	80%	70%
Basic services					
Amalgam filling – 2 surfaces	No charge	90%	80%	80%	50%
Resin filling – 2 surfaces, anterior	No charge	90%	80%	80%	50%
Endodontic services					
Bicuspid root canal therapy	No charge	90%	80%	80%	50%
Periodontic services					
Scaling & root planing – per quadrant	$35	90%	80%	80%	50%
Oral surgery					
Extraction – exposed root or erupted tooth	No charge	90%	80%	80%	50%
Extraction of impacted tooth – soft tissue	No charge	90%	80%	80%	50%
Major services*					
Complete upper denture	$200	60%	50%	50%	50%
Partial upper denture (resin base)	$200	60%	50%	50%	50%
Crown – Porcelain with noble metal[1]	$180	60%	50%	50%	50%
Pontic – Porcelain with noble metal[1]	$180	60%	50%	50%	50%
Inlay – Metallic (3 or more surfaces)	$180	60%	50%	50%	50%
Oral surgery					
Removal of impacted tooth – partially bony	$45	90%	80%	80%	50%
Endodontic services					
Molar root canal therapy	$146	90%	80%	80%	50%
Periodontic services					
Osseous surgery – per quadrant	$140	90%	80%	80%	50%
Orthodontic services (optional)*	$2,300 copay	50%	50%	50%	50%
Orthodontic lifetime maximum	Does not apply	$2,000	$2,000	$1,000	$1,000

Refer to page 39 for footnotes.

Dental plans

Voluntary and contributory dental 10 – 100 (continued)

Plan name	Option 7A Active PPO		Option 8A Active PPO Plus, 90th		Option 8B Active PPO 2000 90th	
	Preferred 100/90/60	Non-Preferred 100/80/50	Preferred 100/90/60	Non-Preferred 100/80/50	Preferred 100/90/60	Non-Preferred 100/80/50
Office visit copay	N/A	N/A	N/A	N/A	N/A	N/A
Annual deductible per member (does not apply to diagnostic & preventive services)	$50; 3X family maximum	$50; 3X family maximum	$50; 3X family maximum	$50; 3X family maximum	$50; 3X family maximum	$50; 3X family maximum
Annual maximum benefit	$1,500	$1,000	$2,000	$1,500	$2,000	$2,000
Diagnostic services						
Oral exams						
Periodic oral exam	100%	100%	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%	100%	100%
X-rays						
Bitewing – single film	100%	100%	100%	100%	100%	100%
Complete series	100%	100%	100%	100%	100%	100%
Preventive services						
Adult cleaning	100%	100%	100%	100%	100%	100%
Child cleaning	100%	100%	100%	100%	100%	100%
Sealants – per tooth	100%	100%	100%	100%	100%	100%
Fluoride application – child	100%	100%	100%	100%	100%	100%
Space maintainers – fixed	100%	100%	100%	100%	100%	100%
Basic services						
Amalgam filling – 2 surfaces	90%	80%	90%	80%	90%	80%
Resin filling – 2 surfaces, anterior	90%	80%	90%	80%	90%	80%
Endodontic services						
Bicuspid root canal therapy	90%	80%	90%	80%	90%	80%
Periodontic services						
Scaling & root planing – per quadrant	90%	80%	90%	80%	90%	80%
Oral surgery						
Extraction – exposed root or erupted tooth	90%	80%	90%	80%	90%	80%
Extraction of impacted tooth – soft tissue	90%	80%	90%	80%	90%	80%
Major services*						
Complete upper denture	60%	50%	60%	50%	60%	50%
Partial upper denture (resin base)	60%	50%	60%	50%	60%	50%
Crown – Porcelain with noble metal[1]	60%	50%	60%	50%	60%	50%
Pontic – Porcelain with noble metal[1]	60%	50%	60%	50%	60%	50%
Inlay – Metallic (3 or more surfaces)	60%	50%	60%	50%	60%	50%
Oral surgery						
Removal of impacted tooth – partially bony	90%	80%	90%	80%	90%	80%
Endodontic services						
Molar root canal therapy	90%	80%	90%	80%	90%	80%
Periodontic services						
Osseous surgery – per quadrant	90%	80%	90%	80%	90%	80%
Orthodontic services (optional)*	50%	50%	50%	50%	50%	50%
Orthodontic lifetime maximum	$1,000	$1,000	$1,500	$1,500	$2,000	$2,000

Refer to page 39 for footnotes.

Dental plans

Voluntary and contributory dental 10 – 100 (continued)

Plan name	Option 8C Active PPO 2500 90th		Option 9A PPO Max 1000	Option 10A PPO Max 1500	Option 10B PPO Max 1500 Plus
	Preferred 100/90/60	Non-Preferred 100/80/50	PPO Max 1000 80/80/50	PPO Max 1500 100/80/50	PPO Max - Prev excluded from annual max
Office visit copay	N/A	N/A	N/A	N/A	N/A
Annual deductible per member (does not apply to diagnostic & preventive services)	$50; 3X family maximum	$50; 3X family maximum	$50; 3X family maximum	$50; 3X family maximum	$50; 3X family maximum
Annual maximum benefit	$2,500	$2,500	$1,000	$1,500	$1,500
Diagnostic services					
Oral exams					
Periodic oral exam	100%	100%	80%	100%	100%
Comprehensive oral exam	100%	100%	80%	100%	100%
Problem-focused oral exam	100%	100%	80%	100%	100%
X-rays					
Bitewing – single film	100%	100%	80%	100%	100%
Complete series	100%	100%	80%	100%	100%
Preventive services					
Adult cleaning	100%	100%	80%	100%	100%
Child cleaning	100%	100%	80%	100%	100%
Sealants – per tooth	100%	100%	80%	100%	100%
Fluoride application – child	100%	100%	80%	100%	100%
Space maintainers – fixed	100%	100%	80%	100%	100%
Basic services					
Amalgam filling – 2 surfaces	90%	80%	80%	80%	80%
Resin filling – 2 surfaces, anterior	90%	80%	80%	80%	80%
Endodontic services					
Bicuspid root canal therapy	90%	80%	50%	80%	80%
Periodontic services					
Scaling & root planing – per quadrant	90%	80%	50%	80%	80%
Oral surgery					
Extraction – exposed root or erupted tooth	90%	80%	50%	80%	80%
Extraction of impacted tooth – soft tissue	90%	80%	50%	80%	80%
Major services*					
Complete upper denture	60%	50%	50%	50%	50%
Partial upper denture (resin base)	60%	50%	50%	50%	50%
Crown – Porcelain with noble metal[1]	60%	50%	50%	50%	50%
Pontic – Porcelain with noble metal[1]	60%	50%	50%	50%	50%
Inlay – Metallic (3 or more surfaces)	60%	50%	50%	50%	50%
Oral surgery					
Removal of impacted tooth – partially bony	90%	80%	50%	80%	80%
Endodontic services					
Molar root canal therapy	90%	80%	50%	80%	80%
Periodontic services					
Osseous surgery – per quadrant	90%	80%	50%	80%	80%
Orthodontic services (optional)*	50%	50%	50%	50%	50%
Orthodontic lifetime maximum	$2,000	$2,000	$1,000	$1,000	$1,000

Refer to page 39 for footnotes.

Dental plans

Voluntary and contributory dental 10 – 100 (continued)

Plan name	Option 11A PPO 1500	Option 11B PPO 1500 Plus	Option 12A PPO 2000	Option 12B PPO 2000 90th
	PPO 1500 100/80/50	PPO 1500 - Prev excluded from annual max	PPO 2000 100/80/50	PPO 2000 100/80/50
Office visit copay	N/A	N/A	N/A	N/A
Annual deductible per member (does not apply to diagnostic & preventive services)	$50; 3X family maximum	$50; 3X family maximum	$50; 3X family maximum	$50; 3X family maximum
Annual maximum benefit	$1,500	$1,500	$2,000	$2,000
Diagnostic services				
Oral exams				
Periodic oral exam	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%
X-rays				
Bitewing – single film	100%	100%	100%	100%
Complete series	100%	100%	100%	100%
Preventive services				
Adult cleaning	100%	100%	100%	100%
Child cleaning	100%	100%	100%	100%
Sealants – per tooth	100%	100%	100%	100%
Fluoride application – child	100%	100%	100%	100%
Space maintainers – fixed	100%	100%	100%	100%
Basic services				
Amalgam filling – 2 surfaces	80%	80%	80%	80%
Resin filling – 2 surfaces, anterior	80%	80%	80%	80%
Endodontic services				
Bicuspid root canal therapy	80%	80%	80%	80%
Periodontic services				
Scaling & root planing – per quadrant	80%	80%	80%	80%
Oral surgery				
Extraction – exposed root or erupted tooth	80%	80%	80%	80%
Extraction of impacted tooth – soft tissue	80%	80%	80%	80%
Major services*				
Complete upper denture	50%	50%	50%	50%
Partial upper denture (resin base)	50%	50%	50%	50%
Crown – Porcelain with noble metal[1]	50%	50%	50%	50%
Pontic – Porcelain with noble metal[1]	50%	50%	50%	50%
Inlay – Metallic (3 or more surfaces)	50%	50%	50%	50%
Oral surgery				
Removal of impacted tooth – partially bony	80%	80%	80%	80%
Endodontic services				
Molar root canal therapy	80%	80%	80%	80%
Periodontic services				
Osseous surgery – per quadrant	80%	80%	80%	80%
Orthodontic services (optional)*	50%	50%	50%	50%
Orthodontic lifetime maximum	$1,000	$1,000	$1,500	$2,000

Refer to page 39 for footnotes.

Voluntary and contributory dental plan footnotes

*Coverage waiting period applies to all Voluntary PPO & PPO Max plans: Must be an enrolled member of the plan for 12 months before becoming eligible for coverage of any Major Service including orthodontic services. Does not apply to the DMO and Contributory (non-voluntary) plans.

[1]There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures: DMO Options 1A-B, 3A-C & 5B.

Fixed dollar amounts on the DMO in plan options 1A, 1B, 2A, 3A, 3B, 3C, 4A, 5A & 5B are member responsibility.

All oral surgery, endodontic and periodontic services are covered as basic services on the PPO in plan options 4A, 5A, 5B, 6A, 7A, 8A, 8B, 8C, 10A, 10B, 11A, 11B, 12A & 12B. All oral surgery, endodontic and periodontic services are covered as major services on the PPO in plan option 9A.

Plan options 9A, 10A & 10B; PPO Max non-preferred (out-of-network) coverage is limited to a maximum of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Out-of-network plan payments are limited by geographic area on the PPO in plan options 4A, 5A, 6A, 7A, 11A, 11B & 12A to the prevailing fees at the 80th percentile and the 90th percentile in plan option 5B, 8A, 8B, 8C & 12B.

DMO options 1A, 1B, 2A, 3A, 3B & 3C can be offered with any one of the PPO plans in options 6A, 7A, 8A, 8B, 8C, 9A, 10A, 10B, 11A, 11B, 12A & 12B in a dual option package.

Plan options 10B and 11B – The calendar year maximum does not apply to preventive services.

Implants are included as a major service on the PPO in plan options 5B, 8B, 8C and 12B.

PPO deductible and calendar year maximum cross-apply between in network and out of network.

The following options are only available with orthodontic coverage for adults and dependent children: 1A, 1B, 2A, 3A, 3B, 3C, 4A, 5A and 5B. All other plan options are available with and without orthodontic coverage for adults and dependent children.

Plan features and availability may vary by location and are subject to change. Information is believed to be accurate as of the production date; however, it is subject to change.

Voluntary plans: If there is a lapse in coverage, members may not re-enroll in the plan for a period of two years from the date of termination. If they are eligible for coverage at that time, they may re-enroll, subject to all provisions of the plan, including, but not limited to, the coverage waiting period.

The list of covered services is representative. Full list with limitations as determined by Aetna appears in the plan booklet/certificate.

Vision plans

Vision Preferred 2 – 100

Plan name	Aetna Vision Preferred – Basic		Aetna Vision Preferred – Plus		Aetna Vision Preferred – Premier	
	In network	**Out of network**	**In network**	**Out of network**	**In network**	**Out of network**
	In-network amount represents member copay, plan allowance or fixed discounted fee. Out-of-network amount represents the maximum reimbursement amount.					
Exam – coverage allowed for one eye exam every rolling 12 months						
Routine eye exam	$20 copay	$20 reimbursement	$10 copay	$25 reimbursement	$10 copay	$25 reimbursement
Standard contact lens fit/follow	$40 discounted fee	Not covered	$40 discounted fee	Not covered	$40 discounted fee	Not covered
Premium contact lens fit/follow	10% off retail	Not covered	10% off retail	Not covered	10% off retail	Not covered
Frames – coverage allowed for one eyeglass frame every rolling 12 or 24 months (rates vary by frame frequency)						
Any frame available at location	$100 plan allowance	$50	$130 plan allowance	$65 reimbursement	$130 plan allowance	$65 reimbursement
Lens – coverage allowed for one pair of prescription eyeglass lenses every rolling 12 months (in lieu of contact lenses per benefit period)						
Single vision lenses	$20 copay	$15 reimbursement	$25 copay	$10 reimbursement	$10 copay	$20 reimbursement
Bifocal vision lenses	$20 copay	$30 reimbursement	$25 copay	$25 reimbursement	$10 copay	$40 reimbursement
Trifocal vision lenses	$20 copay	$60 reimbursement	$25 copay	$55 reimbursement	$10 copay	$65 reimbursement
Lenticular vision lenses	$20 copay	$60 reimbursement	$25 copay	$55 reimbursement	$10 copay	$65 reimbursement
Standard progressive lenses	$85 copay	$30 reimbursement	$90 copay	$25 reimbursement	$75 copay	$40 reimbursement
Premium progressive lenses	20% discount off retail minus $85 copay = member out of pocket	$30 reimbursement	20% discount off retail minus $120 allowance plus $90 copay = member out of pocket	$25 reimbursement	20% discount off retail minus $120 allowance plus $75 copay = member out of pocket	$40 reimbursement
UV treatment	$15 discounted fee	Not covered	$15 discounted fee	Not covered	$15 discounted fee	Not covered
Tint (solid and gradient)	$15 discounted fee	Not covered	$15 discounted fee	Not covered	$15 discounted fee	Not covered
Standard plastic scratch coating	$15 discounted fee	Not covered	$0 copay	$15 reimbursement	$15 discounted fee	Not covered
Standard polycarbonate lenses – child to age 19	$40 discounted fee	Not covered	$0 copay	$35 reimbursement	$40 discounted fee	Not covered
Standard polycarbonate lenses – adult	$40 discounted fee	Not covered	$40 discounted fee	Not covered	$40 discounted fee	Not covered
Standard anti-reflective coating	$45 discounted fee	Not covered	$45 discounted fee	Not covered	$45 discounted fee	Not covered
Contacts – coverage for one order of contact lenses every rolling 12 months (in lieu of eyeglass lenses per benefit period)						
Conventional contact lenses	$105 plan allowance	$75 reimbursement	$130 plan allowance	$90 reimbursement	$115 plan allowance	$80 reimbursement
Disposable contact lenses	$105 plan allowance	$75 reimbursement	$130 plan allowance	$90 reimbursement	$115 plan allowance	$80 reimbursement
Medically necessary contact lenses	$0 copay	$200 reimbursement	$0 copay	$200 reimbursement	$0 copay	$200 reimbursement

Discounts

Available at in-network locations

- 15 percent off balance over the plan allowance on conventional contact lenses
- 20 percent off balance over the plan allowance on frames
- Up to 40 percent off additional pairs of eyeglasses or prescription sunglasses
- 15 percent discount off retail or 5 percent discount off the promotional price for LASIK vision correction or PRK from U.S. Laser Network only. Call **1-800-422-6600**
- 20 percent off noncovered items, including photochromic/transition and polarized lenses
- Receive significant savings after lens benefit has been exhausted by ordering replacement contact lenses online at **www.aetnavision.com**

Discounts may not be available in all states.

Life plans

Life benefits	2 – 9 lives	10 – 100 lives
Benefit amount	Flat dollar amounts: $10,000, $15,000, $20,000 or $50,000	Flat dollar amounts: $10,000, $15,000, $20,000, $50,000, $75,000, $100,000, or $125,000
Minimum/Maximum Amounts	$10,000/$50,000	$10,000/$125,000
Guaranteed issue	$20,000	10 – 25 eligible employees: $75,000 26 – 50 eligible employees: $100,000
Participation requirement	Non-contributory: 100%	Non-contributory: 100% Contributory: 75%
Contribution requirement	Non-contributory: 100%	Non-contributory: 100% employer paid Contributory: 50% – 99% employer paid
Eligible/Minimum Hours	Active Employees/20 hrs./wk.	Active Employees/20 hrs./wk.
Rate structure	Non-contributory: Age-graded	Non-contributory: Age-graded Contributory: Age-graded
Rate guarantee	1 year	2 years
Age reduction schedule	65% at age 65, 40% at age 70, 25% at age 75	65% at age 65, 40% at age 70, 25% at age 75
Waiver of premium	Premium waiver 60	Premium waiver 60
Funding	Prospective	Prospective
Conversion	Included	Included
Portability	Not included	Not included
Value added services	Aetna Life Essentials Beneficiary Solutions Everest Funeral Services	Aetna Life Essentials Beneficiary Solutions Everest Funeral Services
Accelerated death benefit	Included	Included
AD&D Ultra amount	Matches life benefit amount	Matches life benefit amount
Optional spouse life	Not available	Flat: $5,000
Optional child life	Not available	Flat: $2,000
Spouse/Child Life rate structure	Not available	Spouse/Child: Per $1,000 age graded (included with the Life/AD&D rates)
Spouse/Child Life guarantee issue	Not available	Spouse: $5,000 for on-time enrollees Child: $2,000 Guarantee issue for on-time enrollees
Spouse/Child AD&D	Not available	Not available
Supplemental life	Not available	Not available
Supplemental AD&D	Not available	Not available
Class schedules	Only one class allowed	Up to 3 classes (minimum 3 employees in each class)

See underwriting guidelines for ineligible industries.

Limitations & exclusions

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial 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 purchased.

- All medical or hospital services not specifically covered in or which are limited or excluded in the plan documents
- Charges related to any eye surgery mainly to correct refractive errors
- Cosmetic surgery, including breast reduction
- Custodial care
- Adult dental care and x-rays
- Donor egg retrieval
- Experimental and investigational procedures
- Immunizations for travel or work
- Infertility services, including, but not limited to, 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
- Non-medically necessary services or supplies
- Orthotics except as specified in the plan
- Over-the-counter medications and supplies
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs
- Special duty nursing
- Weight reduction programs, or dietary supplements

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation).

When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. Precertification requirements may vary.

If your plan covers outpatient prescription drugs, your plan includes a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions.

Your pharmacy benefit is generally limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law.

For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step therapy, please refer to our website at **www.aetna.com**, or the Aetna Medication Formulary Guide.

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. In addition, in circumstances where your prescription plan uses copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member.

Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage.

Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna, Inc., that is a licensed pharmacy providing mail-order pharmacy services.

Aetna's negotiated charge with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services.

Limitations & exclusions

Creditable coverage

As it relates to the waiting period creditable coverage means any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

These plans do not cover all health care expenses and include exclusions and limitations. Employers and members should refer to their plan documents to determine which health care services are covered and to what extent.

Dental

Not every dental care service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are medically necessary. Charges for the following services or supplies are limited or may be excluded:

- Dental services or supplies that are primarily used to alter, improve or enhance appearance
- Experimental services, supplies or procedures
- Treatment of any jaw joint disorder, such as temporomandibular joint disorder
- Replacement of lost, missing or stolen appliances and certain damaged appliances
- Those services that Aetna defines as not necessary for the diagnosis, care or treatment of a condition involved

Specific service limitations:

- DMO plans: Oral exams (four per year)*
- PPO plans: Oral exams (two routine and two problem focused exams per year)
- Bitewing X-rays (one set per year)*
- Complete series X-rays (one set every three years)*
- Cleanings (two per year)*
- Fluoride (one treatment per year; children under 16)*
- Sealants (one treatment per tooth, every three years on permanent molars; children under 16)*
- Scaling and root planing (four quadrants every two years)
- Osseous surgery (one per quadrant every three years)

Employee and dependent life insurance

The plan may not pay a benefit for deaths caused by suicide, while sane or insane, or from an intentionally self-inflicted injury, within two years from the effective date of the person's coverage. If death occurs after two years of the effective date but within two years of the date that any increase in coverage becomes effective, no death benefit will be payable for any such increased amount.

Vision

Go practically anywhere for your eye care. With Aetna Vision Preferred, you can see any provider you want, in the network or out. Choose from over 80,000 providers** nationwide — whether it's your trusted neighborhood eye doctor or your favorite retail store including LensCrafters®, Pearle Vision®, Sears Optical®, Target Optical®, JC Penney Optical and more. Plus you can even shop online using your in-network benefits at **Glasses.com** and **ContactsDirect.com**. You can get an eye exam at one provider and eyewear at another, if you choose. Many of our providers offer the option to schedule an eye exam online and have glasses ready within an hour. Visit **www.aetnavision.com** or download our free Aetna Vision Preferred mobile app*** to find a network vision care provider closest to you.

Vision insurance plans are underwritten by Aetna Life Insurance Company (Aetna). Certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care ("EyeMed"), LLC. Providers participating in the Aetna Vision network are contracted through EyeMed Vision Care, LLC. EyeMed and Aetna are independent contractors and not employees or agents of each other. Participating vision providers are credentialed by and subject to the credentialing requirements of EyeMed.

*The frequency limits for preventive services do not apply to DMO plans if needed more frequently due to medical necessity.

**EyeMed provider data as of July 2016

***Standard text messaging and other rates from your wireless carrier may apply. Apple, the Apple logo and iPhone are trademarks of Apple Inc., registered in the U.S. and other countries.

Limitations & exclusions

Vision

Aetna does not provide medical/vision care or treatment and is not responsible for outcomes. Aetna does not guarantee access to vision care services or access to specific vision care providers and provider network composition is subject to change without notice. Benefits are not provided for services or materials arising from: Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; Medical and/or surgical treatment of the eye, eyes or supporting structures; Any eye or vision examination, or any corrective eyewear required by a policyholder as a condition of employment; safety eyewear; Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Plano (nonprescription) lenses and/or contact lenses; Nonprescription sunglasses; Two pair of glasses in lieu of bifocals; Services or materials provided by any other group benefit plan providing vision care; Certain brand-name vision materials in which the manufacturer imposes a no-discount policy; or services rendered after the date an insured person ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days from the date of such order.

Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans.

AD&D Ultra®

Not all events that may be ruled accidental are covered by this plan. No benefits are payable for a loss caused or contributed to by:

- Air or space travel, unless a person is a passenger, with no duties at all, on an aircraft being used only to carry passengers (with or without cargo)
- Bodily or mental infirmity
- Commission of or attempt to commit a criminal act
- Illness, ptomaine or bacterial infection*
- Inhalation of poisonous gases
- Intended or accidental contact with nuclear or atomic energy by explosion and/or release
- Ligature strangulation resulting from auto-erotic asphyxiation
- Intentionally self-inflicted injury
- Medical or surgical treatment*
- Third-degree burns resulting from sunburn
- Use of alcohol
- Use of drugs, except as prescribed by a physician
- Use of intoxicants
- Use of alcohol or intoxicants or drugs while operating any form of a motor vehicle whether or not registered for land, air or water use. A motor vehicle accident will be deemed to be caused by the use of alcohol, intoxicants or drugs if it is determined that at the time of the accident the member covered dependent was:
  - Operating the motor vehicle while under the influence of alcohol at level that meets or exceeds the level at which intoxication would be presumed under the laws of the state where the accident occurred. If the accident occurs outside of the United States, intoxication will be presumed if the person's blood alcohol level meets or exceeds .08 grams per deciliter.
  - Operating the motor vehicle while under the influence of an intoxicant or illegal drug.
  - Operating the motor vehicle while under the influence of a prescription drug in excess of the amount prescribed by the physician
  - Operating the motor vehicle while under the influence of an over-the-counter medication taken in an amount above the dosage instructions.
- Suicide or attempted suicide (while sane or insane)
- War or any act of war (declared or not declared)

*These do not apply if the loss is caused by:

- An infection that results directly from the injury
- Surgery needed because of the injury

The injury must not be one that is excluded by the terms of this section.

You have more options with our network

We're proud of the doctors and facilities in our network. And we're working with them to deliver more efficient health care. We have many full network and tiered network options to lower employer costs while still providing employees with access to high quality care.

Savings come from using Aetna Whole Health℠ network plans with high-quality local health care providers and facilities. These plans include financial incentives that drive doctors to improve quality and control costs. And we do our part by providing timely information that helps doctors and patients make more informed health care decisions.

We help your employees to make wise choices

Our cost-sharing arrangements encourage employees to become more involved in their own health care. As a result, they become better health care consumers. Employees with these plans receive more preventive care, have lower overall costs and use online tools more frequently.

Consumer-directed plans offer lower premiums with optional fund or savings accounts. These accounts can help your employees pay for their own out-of-pocket expenses, helping to reduce costs for your company. Employees who enroll in consumer-directed plans engage in more preventive care. The result is a healthier work place, a healthier bottom line — and a healthier community.

You can control costs with funding options

From traditional fully insured to enhanced self-insured solutions, you can choose different levels of cost and plan controls, and information access. In addition, our defined contribution plan offers an attractive benefits package and motivates your employees to get more involved in their health care.

Let us help build a benefits plan that fits your culture and budget. To get started, call your Aetna representative or broker today.

HSAs are currently not available to HMO members in California.

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits vary by location. Health/Dental benefits, health/dental insurance, vision, life and disability insurance plans/policies contain exclusions and limitations. Policies may not be available in all states. Policies contain certain exclusions, limitations, reductions and waiting periods, which may affect the payable benefit. See policy or contact an Aetna representative for details. Specific features of life insurance policies vary, depending on employers and states. Read your policy for details. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does 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 part of the delivery system or physician group. Investment services are independently offered through PayFlex Inc. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **www.aetna.com**.

www.aetna.com

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