

Consumer Directed (Enhanced) Plan Features	In Network	Out of Network
Choice of providers	<p>You receive negotiated rates to stretch your PCA dollars and a higher level of benefits once you meet the deductible when you see providers in the PPO network</p> <p>In-network providers charge only up to the reasonable charges they've negotiated with the plan</p>	<p>You may see any licensed provider you choose, but you won't get the PPO network negotiated fees and you'll receive a lower level of benefits once you meet the deductible</p> <p>The plan pays benefits based on the reasonable charges negotiated with in-network providers—you'll pay the difference if you're charged more than the reasonable charge (in addition to your coinsurance or copay)</p>
Personal Care Account (PCA)	<p>You can use your PCA to offset your deductible. If you don't use up your PCA, the remaining balance will roll over for you to use in future years. The Company contributes the following amount to your PCA each benefit year:</p> <ul style="list-style-type: none"> ▪ \$500 per individual; ▪ \$1,000 per employee and spouse/same-gender domestic partner or employee and child(ren); or ▪ \$1,500 per family 	
Annual deductible (in- and out-of-network deductibles accumulate separately)	<p>Before the plan pays benefits for in-network care, you must meet a:</p> <ul style="list-style-type: none"> ▪ \$1,000 individual deductible; ▪ \$1,750 employee and spouse/same-gender domestic partner or employee and child(ren) deductible; or ▪ \$2,500 family deductible 	<p>Before the plan pays benefits for out-of-network care, you must meet a separate:</p> <ul style="list-style-type: none"> ▪ \$2,000 individual deductible; ▪ \$3,500 employee and spouse/same-gender domestic partner or employee and child(ren) deductible; or ▪ \$5,000 family deductible
Benefit-year out-of-pocket maximum (doesn't include annual deductibles, copays; in- and out-of-network out-of-pocket maximums are separate)	<ul style="list-style-type: none"> ▪ \$1,000 per individual ▪ \$1,500 per employee and spouse/same-gender domestic partner or employee and child(ren) \$2,000 per family 	<ul style="list-style-type: none"> ▪ \$2,000 per individual ▪ \$3,000 per employee and spouse/same-gender domestic partner or employee and child(ren) ▪ \$4,000 per family
Lifetime maximum benefit	<p>\$1.5 million per covered person (all Company-sponsored plans administered by Aetna combined; in other words, if you switch from the Open Access (Premier) Plan to the Consumer Directed (Enhanced) Plan or Coordinated Care (Core) Plan, your lifetime maximum doesn't start over)</p>	

Eligible Expenses	What the Consumer Directed (Enhanced) Plan Generally Pays for In-Network Care	What the Consumer Directed (Enhanced) Plan Generally Pays for Out-of-Network Care (Based on Reasonable Charges)
Ambulance (ground and air services)	90% after you pay deductible for emergency services only	90% after you pay deductible for emergency services only
Chemical dependency treatment—inpatient*	90% after you pay deductible, up to 30 days per benefit year (combined in-network/out-of-network and mental health/chemical dependency treatment; each partial day counts as a half-day toward the 30-day limit)	60% after you pay deductible, up to 30 days per benefit year (combined in-network/out-of-network and mental health/ chemical dependency treatment; each partial day counts as a half-day toward the 30-day limit)
Chemical dependency treatment—outpatient	100%, with no deductible, for first 3 visits per person per benefit year; then 90%, with no deductible (care must be coordinated through Aetna); lifetime maximum (combined in-network/out-of network) is \$7,500	60% after you pay deductible (care must be coordinated through Aetna); out-of-network benefits are limited to \$1,000 per benefit year; lifetime maximum (combined in-network/out-of network) is \$7,500
Chiropractic care	90% after you pay deductible, up to 26 visits per benefit year (combined in-network/out-of-network)	60% after you pay deductible, up to 26 visits per benefit year (combined in-network/out-of-network)
Doctor office visits	90% after you pay deductible	60% after you pay deductible
Diabetic equipment and supplies	Covered under the pharmacy plan subject to copays (Exception: Blood glucose monitors are covered under “Durable medical equipment.” You may be eligible for a free blood glucose monitor; contact the claims administrator for details.)	
Diagnostic lab work, X-rays and radiology	90% after you pay deductible	60% after you pay deductible
Durable medical equipment (including foot orthotics; excludes prosthetics)	90% after you pay deductible	60% after you pay deductible
Emergency room (prior notification is required if your emergency results in an inpatient stay. You must contact the claims administrator within 24 hours of admission (or as soon as reasonably possible), or benefits may be reduced by 50% of the allowed amount, up to \$1,000)	90% after you pay deductible Benefits aren't paid for non-emergency use of emergency room	90% after you pay deductible Benefits aren't paid for non-emergency use of emergency room
Hearing aids	90% after you pay deductible, up to \$1000 per ear every 3 benefit years (in-network/out-of-network combined)	60% after you pay deductible, up to \$1000 per ear every 3 benefit years (in-network/out-of-network combined)
Home health care*	90% after you pay deductible, up to \$10,000 per benefit year (combined in-network/out-of-network)	60% after you pay deductible, up to \$10,000 per benefit year (combined in-network/out-of-network)
Hospice care* (for patients who are expected to live fewer than six months)	90% after you pay deductible	60% after you pay deductible

Consumer Directed (Enhanced) Plan Features	In Network	Out of Network
Hospital services—inpatient*		
<ul style="list-style-type: none"> ▪ Hospital stay* (semi-private room and all covered services and supplies received during that hospitalization, including lab, radiology and rehabilitation) 	90% after you pay deductible	60% after you pay deductible
<ul style="list-style-type: none"> ▪ Professional fees for surgical and medical services* 	90% after you pay deductible	60% after you pay deductible
<ul style="list-style-type: none"> ▪ Inpatient rehabilitation* (speech, physical and occupational therapy) 	90% after you pay deductible	60% after you pay deductible
Hospital services—outpatient (if you seek treatment at an in-network facility, benefits for a radiologist, pathologist or anesthesiologist will be covered at the in-network coinsurance level)		
<ul style="list-style-type: none"> ▪ Surgery 	90% after you pay deductible	60% after you pay deductible
<ul style="list-style-type: none"> ▪ Diagnostic testing (including lab and X-ray) 	90% after you pay deductible	60% after you pay deductible
Immunizations		
<ul style="list-style-type: none"> ▪ For children up to 72 months of age 	100%, with no deductible (doesn't accumulate toward the preventive care allowance)	Not covered
<ul style="list-style-type: none"> ▪ For employees and dependents age 72 months or older 	90% after you pay deductible	Not covered
<ul style="list-style-type: none"> ▪ Intravenous (IV) and injectable medications (prior authorization required if given in the home) 	90% after you pay deductible	60% after you pay deductible
Maternity care		
<ul style="list-style-type: none"> ▪ Prenatal and postnatal care 	90% after you pay deductible	60% after you pay deductible
<ul style="list-style-type: none"> ▪ Inpatient hospital services* 	90% after you pay deductible	60% after you pay deductible
Mental health treatment—inpatient*	90% after you pay deductible	60% after you pay deductible,
Mental health treatment—outpatient	90% after you pay deductible	60% after you pay deductible
Oral surgery and related services (services for accidental injury, not from biting or chewing, to sound, natural teeth will be covered at the in-network deductible and coinsurance level for initial repair)	90% after you pay deductible	60% after you pay deductible

Consumer Directed (Enhanced) Plan Features	In Network	Out of Network
Outpatient rehabilitation (occupational/physical therapy and speech therapy)	90% after you pay deductible, up to 60 visits combined for all therapy types per benefit year (combined in-network/out-of-network)	60% after you pay deductible, up to 60 visits combined for all therapy types per benefit year (combined in-network/out-of-network)
Prescription drug benefits—retail (up to a 30-day supply; you may receive up to a 90-day supply for oral contraceptives but a copay is required for each month's supply)		
▪ Generic (mandatory)	100% after you pay a \$10 copay	100% of allowed amount after you pay deductible and a \$10 copay
▪ Brand-name formulary drug	100% after you pay a \$20 copay	100% of allowed amount after you pay deductible and a \$20 copay
▪ Brand-name non-formulary drug	100% after you pay a \$35 copay	100% of allowed amount after you pay deductible and a \$35 copay
Prescription drug benefits—mail order (up to a 90-day supply for maintenance drugs filled through the mail-order program or any retail or mail-order pharmacy that agrees in writing to the same terms)		
▪ Generic (mandatory)	100% after you pay a \$25 copay	N/A
▪ Brand-name formulary drug	100% after you pay a \$50 copay	N/A
▪ Brand-name non-formulary drug	100% after you pay a \$85 copay	N/A
Preventive care (includes periodic check-ups; well-baby and well-child care; immunizations for employees and dependents age 72 months or older; preventive medical care such as Prostate Screening Antigen (PSA) tests for men, PAP tests and mammograms; and routine hearing exams)	100%, with no deductible, up to \$400 per person per benefit year; then treated as any other benefit	Not covered; certain well-woman and well-man preventive benefits are covered at 60% after deductible
Skilled nursing facility/inpatient physical rehabilitation*	90% after you pay deductible	60% after you pay deductible
TMJ and MPDS	90% after you pay deductible; \$3,500 non-surgical lifetime maximum per person (combined in-network/out-of-network)	60% after you pay deductible; \$3,500 non-surgical lifetime maximum per person (combined in-network/out-of-network)
Transplant services*	90% after you pay deductible	60% after you pay deductible

Consumer Directed (Enhanced) Plan Features	In Network	Out of Network
Vision benefits		
<ul style="list-style-type: none"> ▪ Exam (once every benefit year) 	100% after you pay deductible and a \$20 copay per exam	Not covered
<ul style="list-style-type: none"> ▪ Frames (once every benefit year) 	\$82	
<ul style="list-style-type: none"> ▪ Glasses lenses (one pair every benefit year) 	<ul style="list-style-type: none"> ▪ Single: \$78 ▪ Bifocal: \$160 ▪ Trifocal or progressive: \$190 ▪ Lenticular: \$215 	
<ul style="list-style-type: none"> ▪ Contact lenses (instead of frames and lenses; one pair every benefit year) 	\$210	

*Must coordinate through Aetna

Open Access (Premier) Plan Features	In Network	Out of Network
Choice of providers	<p>You receive a higher level of benefit when you see providers in the PPO network</p> <p>In-network providers charge only up to the reasonable charges they've negotiated with the plan</p>	<p>You may see any licensed provider you choose and receive a lower level of benefit</p> <p>The plan pays benefits based on the reasonable charges negotiated with in-network providers—you'll pay the difference if you're charged more than the reasonable charge (in addition to your coinsurance or copay)</p>
Annual deductible (in- and out-of-network deductibles accumulate separately)	<p>Before the plan pays benefits for in-network care, you must meet a:</p> <ul style="list-style-type: none"> ▪ \$200 individual deductible; ▪ \$400 employee and spouse/same-gender domestic partner or employee and child(ren) deductible; or ▪ \$600 family deductible 	<p>Before the plan pays benefits for out-of-network care, you must meet a separate:</p> <ul style="list-style-type: none"> ▪ \$600 individual deductible; ▪ \$1,200 employee and spouse/same-gender domestic partner or employee and child(ren) deductible; or ▪ \$1,800 family deductible
Benefit-year out-of-pocket maximum (doesn't include annual deductibles, copays; in- and out-of-network out-of-pocket maximums are separate)	<ul style="list-style-type: none"> ▪ \$2,000 per individual ▪ \$3,000 per employee and spouse/same-gender domestic partner or employee and child(ren) ▪ \$4,000 per family 	<ul style="list-style-type: none"> ▪ \$2,000 per individual ▪ \$3,000 per employee and spouse/same-gender domestic partner or employee and child(ren) ▪ \$4,000 per family
Lifetime maximum benefit	<p>\$1.5 million per person (all Company-sponsored plans administered by Aetna combined; in other words, if you switch from the Open Access (Premier) Plan to the Consumer Directed (Enhanced) Plan or Coordinated Care (Core) Plan, your lifetime maximum doesn't start over)</p>	

Eligible Expenses	What the Open Access (Premier) Plan Generally Pays for In-Network Care	What the Open Access (Premier) Plan Generally Pays for Out-of-Network Care (Based on Reasonable Charges)
Ambulance (ground and air services)	90% after you pay deductible; for emergency services only	90% after you pay deductible; for emergency services only
Chemical dependency treatment—inpatient*	90% after you pay deductible, up to 30 days per benefit year (combined in-network/out-of-network and mental health/chemical dependency treatment; each partial day counts as a half-day toward the 30-day limit)	60% after you pay deductible, up to 30 days per benefit year (combined in-network/out-of-network and mental health/chemical dependency treatment; each partial day counts as a half-day toward the 30-day limit)
Chemical dependency treatment—outpatient	100%, with no deductible, for first 3 visits per person per benefit year; then 90%, with no deductible (care must be coordinated through Aetna); lifetime maximum (combined in-network/out-of-network) is \$7,500	60% after you pay deductible (care must be coordinated through Aetna); out-of-network benefits are limited to \$1,000 per benefit year; lifetime maximum (combined in-network/out-of-network) is \$7,500
Chiropractic care	100%, with no deductible, after you pay a \$20 copay per visit, up to 26 visits per benefit year (combined in-network/out-of-network)	60% after you pay deductible, up to 26 visits per benefit year (combined in-network/out-of-network)
Diabetic equipment and supplies	Covered under the pharmacy plan subject to copays (Exception: Blood glucose monitors are covered under “Durable medical equipment.” You may be eligible for a free blood glucose monitor; contact the claims administrator for details.)	
Diagnostic lab work, X-rays and radiology	90% after you pay deductible	60% after you pay deductible
Doctor office visits	100%, with no deductible, after you pay a \$20 copay per visit	60% after you pay deductible
Durable medical equipment (including foot orthotics and prosthetics)	90% after you pay deductible	60% after you pay deductible
Emergency room (prior notification is required if your emergency results in an inpatient stay. You must contact the claims administrator within 24 hours of admission (or as soon as reasonably possible), or benefits may be reduced by 50% of the allowed amount, up to \$1,000)	100%, with no deductible, after you pay a \$50 copay per visit (copay waived if you’re admitted) Benefits aren’t paid for non-emergency use of emergency room	100%, with no deductible, after you pay a \$50 copay per visit (copay waived if you’re admitted) Benefits aren’t paid for non-emergency use of emergency room
Hearing aids	90% after you pay deductible, up to \$1000 per ear every 3 benefit years (in-network/out-of-network combined)	60% after you pay deductible, up to \$1000 per ear every 3 benefit years (in-network/out-of-network combined)
Home health care*	90% after you pay deductible, up to \$10,000 per benefit year (combined in-network/out-of-network)	60% after you pay deductible, up to \$10,000 per benefit year (combined in-network/out-of-network)

Open Access (Premier) Plan Features	In Network	Out of Network
Hospice care* (for patients who are expected to live fewer than six months)	90% after you pay deductible	60% after you pay deductible
Hospital services—inpatient*		
<ul style="list-style-type: none"> ▪ Hospital stay* (semi-private room and all covered services and supplies received during that hospitalization, including lab, radiology and rehabilitation) 	90% after you pay deductible	60% after you pay deductible
<ul style="list-style-type: none"> ▪ Professional fees for surgical and medical services* 	90% after you pay deductible	60% after you pay deductible
<ul style="list-style-type: none"> ▪ Inpatient rehabilitation* (speech, physical and occupational therapy) 	90% after you pay deductible	60% after you pay deductible
Hospital services—outpatient (if you seek treatment at an in-network facility, benefits for a radiologist, pathologist or anesthesiologist will be covered at the in-network coinsurance level)		
<ul style="list-style-type: none"> ▪ Surgery 	90% after you pay deductible	60% after you pay deductible
<ul style="list-style-type: none"> ▪ Diagnostic testing (including lab and X-ray) 	90% after you pay deductible	60% after you pay deductible
Immunizations		
<ul style="list-style-type: none"> ▪ For children up to 72 months of age 	100%, with no deductible (doesn't accumulate toward the preventive care allowance)	Not covered
<ul style="list-style-type: none"> ▪ For employees and dependents age 72 months or older 	90% after you pay deductible	Not covered
<ul style="list-style-type: none"> ▪ Intravenous (IV) and injectable medications (prior authorization required if given in the home) 	90% after you pay deductible	60% after you pay deductible
Maternity care		
<ul style="list-style-type: none"> ▪ Prenatal and postnatal care 	100% after you pay one \$20 copay for all prenatal and postnatal visits	60% after you pay deductible
<ul style="list-style-type: none"> ▪ Inpatient hospital services* 	90% after you pay deductible	60% after you pay deductible
Mental health treatment—inpatient*	90% after you pay deductible, up to 30 days per benefit year (combined in-network/out-of-network and mental health/chemical dependency treatment; each partial day counts as a half-day toward the 30-day limit)	60% after you pay deductible, up to 30 days per benefit year (combined in-network/out-of-network and mental health/chemical dependency treatment; each partial day counts as a half-day toward the 30-day limit)
Mental health treatment—outpatient*	90% after you pay deductible	60% after you pay deductible

Open Access (Premier) Plan Features	In Network	Out of Network
Oral surgery and related services (services for accidental injury, not from biting or chewing, to sound, natural teeth will be covered at the in-network deductible and coinsurance level for initial repair)	90% after you pay deductible	60% after you pay deductible
Outpatient rehabilitation (occupational/physical therapy and speech therapy)	100%, with no deductible, after you pay a \$20 copay per visit, up to 60 visits combined for all therapy types per benefit year (combined in-network/out-of-network)	60% after you pay deductible, up to 60 visits combined for all therapy types per benefit year (combined in-network/out-of-network)
Prescription drug benefits—retail (up to a 30-day supply; you may receive up to a 90-day supply for oral contraceptives but a copay is required for each month's supply)		
▪ Generic (mandatory)	100% after you pay an \$8 copay	100% of allowed amount after you pay an \$8 copay
▪ Brand-name formulary drug	100% after you pay a \$15 copay	100% of allowed amount after you pay a \$15 copay
▪ Brand-name non-formulary drug	100% after you pay a \$30 copay	100% of allowed amount after you pay a \$30 copay
Prescription drug benefits—mail order (for up to a 90-day supply for maintenance drugs filled through the mail-order program or any retail or mail-order pharmacy that agrees in writing to the same terms)		
▪ Generic (mandatory)	100% after you pay a \$16 copay	N/A
▪ Brand-name formulary drug	100% after you pay a \$30 copay	N/A
▪ Brand-name non-formulary drug	100% after you pay a \$60 copay	N/A
Preventive care (includes periodic check-ups; well-baby and well-child care; immunizations for employees and dependents age 72 months or older; preventive medical care such as Prostate Screening Antigen (PSA) tests for men, PAP tests and mammograms; routine hearing exams)	100%, with no deductible, up to \$400 per person per benefit year; then treated as any other benefit	Not covered; certain well-woman and well-man preventive benefits are covered at 60% after deductible
Skilled nursing facility/inpatient physical rehabilitation*	90% after you pay deductible	60% after you pay deductible
TMJ	90% after you pay deductible, up to \$3,500 non-surgical lifetime maximum per person (combined in-network/out-of-network)	60% after you pay deductible, up to \$3,500 non-surgical lifetime maximum per person (combined in-network/out-of-network)
Transplant services*	90% after you pay deductible	60% after you pay deductible

Open Access (Premier) Plan Features	In Network	Out of Network
Vision benefits		
<ul style="list-style-type: none"> ▪ Exam (once every benefit year) 	100%, with no deductible, after you pay a \$20 copay per exam	Not covered
<ul style="list-style-type: none"> ▪ Frames (once every benefit year) 	\$82	
<ul style="list-style-type: none"> ▪ Glasses lenses (one pair every benefit year) 	<ul style="list-style-type: none"> ▪ Single: \$78 ▪ Bifocal: \$160 ▪ Trifocal or progressive: \$190 ▪ Lenticular: \$215 	
<ul style="list-style-type: none"> ▪ Contact lenses (instead of frames and lenses; one pair every benefit year) 	\$210	

*Must coordinate through Aetna

Coordinated Care (Core) Plan Features	In Network	Out of Network
You're encouraged to select an in-network Primary Care Physician (PCP) who will coordinate your care with other in-network providers	You receive a higher level of benefits when you use in-network providers In-network providers agree to accept the contracted charges they've negotiated with the plan for the services they provide	You may see any licensed provider you choose and receive a lower level of benefits The plan pays benefits based on the reasonable charges negotiated with in-network providers—in-network providers charge only up to the reasonable charge they've negotiated with the plan; when you use out-of-network providers, you'll pay the difference if you're charged more than the reasonable charge (in addition to your coinsurance or copay)
Annual deductible	<ul style="list-style-type: none"> ▪ None 	Before the plan pays benefits for out-of-network care, you must meet a: <ul style="list-style-type: none"> ▪ \$600 individual deductible; ▪ \$1,200 employee and spouse/same-gender domestic partner or employee and child(ren) deductible; or ▪ \$1,800 family deductible
Benefit-year out-of-pocket maximum (doesn't include annual deductibles, copays)	<ul style="list-style-type: none"> ▪ \$None 	<ul style="list-style-type: none"> ▪ \$1,500 per individual ▪ \$2,250 per employee and spouse/same-gender domestic partner or employee and child(ren) ▪ \$3,000 per family
Lifetime maximum benefit	\$1.5 million per covered person (all Company-sponsored plans administered by Aetna combined; in other words, if you switch from the Open Access (Premier) Plan to the Consumer Directed (Enhanced) Plan or Coordinated Care (Core) Plan, your lifetime maximum doesn't start over)	

Eligible Expenses	What the Consumer Directed (Enhanced) Plan Generally Pays for In-Network Care	What the Consumer Directed (Enhanced) Plan Generally Pays for Out-of-Network Care (Based on Reasonable Charges)
Ambulance (ground and air services)	100%, with no deductible, after you pay a \$20 copay for emergency services only	100%, with no deductible, after you pay a \$20 copay for emergency services only
Chemical dependency treatment—inpatient*	100%, with no deductible, after you pay a \$100 copay per admission, up to 30 days per benefit year (combined in-network/out-of-network and mental health/chemical dependency treatment; each partial day counts as a half-day toward the 30-day limit)	60% after you pay deductible, up to 30 days per benefit year (combined in-network/out-of-network and mental health/ chemical dependency treatment; each partial day counts as a half-day toward the 30-day limit)
Chemical dependency treatment—outpatient	100%, with no deductible, for first 3 visits per person per benefit year; then 100%, with no deductible, after you pay a \$20 copay per visit (care must be coordinated through Aetna); lifetime maximum (combined in-network/out-of-network) is \$7,500	60% after you pay deductible (care must be coordinated through Aetna); out-of-network benefits are limited to \$1,000 per benefit year; lifetime maximum (combined in-network/out-of-network) is \$7,500
Chiropractic care	100%, with no deductible, after you pay a \$20 copay per visit, up to 26 visits per benefit year (combined in-network/out-of-network)	60% after you pay deductible, up to 26 visits per benefit year (combined in-network/out-of-network)
Doctor office visits	100%, with no deductible, after you pay a \$20 copay per visit	60% after you pay deductible
Diabetic equipment and supplies	Covered under the pharmacy plan subject to copays (Exception: Blood glucose monitors are covered under “Durable medical equipment.” You may be eligible for a free blood glucose monitor; contact the claims administrator for details.)	
Diagnostic lab work, X-rays and radiology	100% with no deductible; a \$20 copay per visit applies if part of an office visit	60% after you pay deductible
Durable medical equipment (including foot orthotics; excludes prosthetics)	100%, with no deductible	60% after you pay deductible
Emergency room (prior notification is required if your emergency results in an inpatient stay. You must contact the claims administrator within 24 hours of admission (or as soon as reasonably possible), or benefits may be reduced by \$500)	100%, with no deductible, after you pay a \$50 copay per visit (copay waived if you’re admitted) Benefits aren’t paid for non-emergency use of emergency room, unless your PCP directed you to go there	100%, with no deductible, after you pay a \$50 copay per visit (copay waived if you’re admitted) Benefits aren’t paid for non-emergency use of emergency room, unless your PCP directed you to go there

Coordinated Care (Core) Plan Features	In Network	Out of Network
Hearing aids	100%, with no deductible, up to \$1000 per ear every 3 benefit years (in-network/out-of-network combined)	Not covered
Home health care*	100%, with no deductible, after you pay a \$20 copay per visit, up to \$10,000 per benefit year (combined in-network/out-of-network)	60% after you pay deductible, up to \$10,000 per benefit year (combined in-network/out-of-network)
Hospice care* (for patients who are expected to live fewer than six months)	100% with no deductible	60% after you pay deductible

Coordinated Care (Core) Plan Features		In Network	Out of Network
Hospital services—inpatient*			
<ul style="list-style-type: none"> Hospital stay* (semi-private room and all covered services and supplies received during that hospitalization, including lab, radiology and rehabilitation) 	100%, with no deductible, after you pay a \$100 copay per admission	60% after you pay deductible	
<ul style="list-style-type: none"> Professional fees for surgical and medical services* 	100%, with no deductible, after you pay a \$100 copay per admission	60% after you pay deductible	
<ul style="list-style-type: none"> Inpatient rehabilitation* (speech, physical and occupational therapy) 	100%, with no deductible, after you pay a \$100 copay per admission	60% after you pay deductible	
Hospital services—outpatient			
<ul style="list-style-type: none"> Surgery 	100%, with no deductible, after you pay a \$25 copay	60% after you pay deductible	
<ul style="list-style-type: none"> Diagnostic testing (including lab and X-ray) 	100%, with no deductible, after you pay a \$25 copay	60% after you pay deductible	
Immunizations			
<ul style="list-style-type: none"> For children up to 72 months of age 	100%, with no deductible (doesn't accumulate toward the preventive care allowance)	Not covered	
<ul style="list-style-type: none"> For employees and dependents age 72 months or older 	100%, with no deductible	Not covered	
<ul style="list-style-type: none"> Intravenous (IV) and injectable medications (prior authorization required if given in the home) 	100%, with no deductible	60% after you pay deductible	
Maternity care			
<ul style="list-style-type: none"> Prenatal and postnatal care 	100% after you pay one \$20 copay for all prenatal and postnatal visits	60% after you pay deductible	
<ul style="list-style-type: none"> Inpatient hospital services* 	100%, with no deductible, after you pay a \$100 copay per admission	60% after you pay deductible	
Mental health treatment—inpatient*	100%, with no deductible, after you pay a \$100 copay per admission, up to 30 days per benefit year (combined in-network/out-of-network and mental health/chemical dependency treatment; each partial day counts as a half-day toward the 30-day limit)	60% after you pay deductible, up to 30 days per benefit year (combined in-network/out-of-network and mental health/chemical dependency treatment; each partial day counts as a half-day toward the 30-day limit)	

Coordinated Care (Core) Plan Features	In Network	Out of Network
Mental health treatment—outpatient	100%, with no deductible for first 3 visits per person per benefits year; then 100% with no deductible, after you pay a \$20 copay per visit, up to 45 visits per benefit year (combined in-network/out-of-network; care must be coordinated through Aetna)	60% after you pay deductible, up to 45 visits per benefit year (combined in-network/out-of-network; care must be coordinated through Aetna)
Oral surgery and related services (services for accidental injury, not from biting or chewing, to sound, natural teeth will be covered at the in-network deductible and coinsurance level for initial repair)	100%, with no deductible	60% after you pay deductible
Outpatient rehabilitation (occupational/physical therapy and speech therapy)	100%, with no deductible, after you pay a \$20 copay per visit, up to 60 visits combined for all therapy types per benefit year (combined in-network/out-of-network)	60% after you pay deductible, up to 60 visits combined for all therapy types per benefit year (combined in-network/out-of-network)
Prescription drug benefits—retail (up to a 30-day supply; you may receive up to a 90-day supply for oral contraceptives but a copay is required for each month’s supply)		
▪ Generic (mandatory)	100% after you pay an \$8 copay	100% of reasonable charge after you pay an \$8 copay
▪ Brand-name formulary drug	100% after you pay a \$15 copay	100% of reasonable charge after you pay an \$15 copay
▪ Brand-name non-formulary drug	100% after you pay \$30 copay	100% of reasonable charge after you pay a \$30 copay
Prescription drug benefits—mail order (up to a 90-day supply for maintenance drugs filled through the mail-order program or any retail or mail-order pharmacy that agrees in writing to the same terms)		
▪ Generic (mandatory)	100% after you pay a \$16 copay	N/A
▪ Brand-name formulary drug	100% after you pay a \$30 copay	N/A
▪ Brand-name non-formulary drug	100% after you pay a \$60 copay	N/A
Preventive care (includes periodic check-ups; well-baby and well-child care; immunizations for employees and dependents age 72 months or older; preventive medical care such as Prostate Screening Antigen (PSA) tests for men, PAP tests and mammograms; and routine hearing exams)	100%, with no deductible or copay, up to \$400 per person per benefit year (all preventive care combined); then treated as any other benefit	Not covered; certain well-woman and well-man preventive benefits are covered at 60% after deductible

Coordinated Care (Core) Plan Features	In Network	Out of Network
Skilled nursing facility/inpatient physical rehabilitation*	100%, with no deductible, after you pay a \$100 copay per admission	60% after you pay deductible
TMJ and MPDS	100%, with no deductible, after you pay any applicable copays; \$3,500 non-surgical lifetime maximum per person (combined in-network/out-of-network)	60% after you pay deductible; \$3,500 non-surgical lifetime maximum per person (combined in-network/out-of-network)
Transplant services*	100%, with no deductible, after you pay any applicable copays	60% after you pay deductible

Coordinated Care (Core) Plan Features	In Network	Out of Network
Vision benefits		
▪ Exam (once every benefit year)	100%, with no deductible, after you pay a \$20 copay per exam	Not covered
▪ Frames (once every benefit year)	\$82	
▪ Glasses lenses (one pair every benefit year)	<ul style="list-style-type: none"> ▪ Single: \$78 ▪ Bifocal: \$160 ▪ Trifocal or progressive: \$190 ▪ Lenticular: \$215 	
▪ Contact lenses (instead of frames and lenses; one pair every benefit year)	\$210	

*You must contact the claims administrator for prior authorization before receiving services, or benefits are reduced by \$500.

**If a covered brand-name drug is purchased when a generic is available, the copay will be the generic copay plus the cost difference between the two drugs, even if your doctor writes a “dispense as written” prescription for the brand-name drug.

Dental Benefits at a Glance

Preferred Dental Plan	In-Network	Out-of--Network
Deductible	None	Not covered
Annual Benefit Maximum per Individual	\$1,500	Not covered
Coinsurance		
Preventive	100%	Not covered
Basic	100%	Not covered
Major	100%	Not covered
Orthodontia		
Coinsurance	50%	Not covered
Lifetime Maximum	\$1,750	Not covered

Premier Dental Plan	In-Network	Out-of-Network
Deductible	\$25	\$100
Annual Benefit Maximum per Individual	\$1,500	\$1,500
Coinsurance		
Preventive	100%	80%
Basic	80%	70%
Major	50%	50%
Orthodontia		
Coinsurance	50%	50%
Lifetime Maximum	\$1,750	\$1,750