California toolkit

Plans effective January 1, 2021

For businesses with 1–100 full-time equivalents

Updated as of 01/01/2021

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Build sustainable, long-term health care solutions

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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.

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

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Network information

Networks available by rating area

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

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

Network information

Networks available by rating area (continued)

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

County	Rating Area	Full MC	Savings Plus	AWH Southern CA	Full HMO	HMO Deductible	AVN HMO	Basic HMO	AWH Southern CA HMO
Tulare	10	Y	–	–	P	P	–	–	–
Fresno	11	Y	–	–	P	P	–	–	–
Kings	11	Y	–	–	Y	Y	–	–	–
Madera	11	Y	–	–	P	P	–	–	–
San Luis Obispo	12	Y	–	–	Y	Y	–	–	–
Santa Barbara	12	Y	–	–	Y	Y	–	–	–
Ventura	12	Y	–	–	Y	Y	–	–	–
Imperial	13	Y	–	–	–	–	–	–	–
Inyo	13	–	–	–	–	–	–	–	–
Mono	13	Y	–	–	–	–	–	–	–
Kern	14	Y	–	–	Y	Y	P	–	–
Los Angeles (906–912, 915, 917, 918, and 935)	15	Y	Y	P	Y	Y	P	P	P
Los Angeles (all other)	16	Y	Y	P	Y	Y	P	P	P
Riverside/San Bernardino	17	Y	P	P	P	P	P	P	P
Orange	18	Y	Y	P	Y	Y	Y	Y	P
San Diego	19	Y	Y	P	Y	Y	P	P	P

Network information

Plans available by network

HMO Plans	HMO				
	Full HMO	HMO Ded	AVN	Basic	AWH Southern CA
Platinum HMO $20/30 0 Ded*	•	•	•	•	•
Gold HMO $30/60 0 Ded	•	•	•	•	•
Gold HMO $35/50 250 Ded*	•	•	•	•	•
Gold HMO $25/50 500 Ded	•	•	•	•	•
Silver HMO $55/90 2250 Ded*	•	•	•	•	•
Silver HMO $50/75 2550 Ded	•	•	•	•	•
Bronze HMO $65/95 6300 Ded*				•	
Bronze HMO Ded $75/125 7900 Ded	•	•	•	•	•

MC/EPO Plans	MC Plans/Networks			EPO Plans/Networks	
	MC Open Access	Savings Plus	AWH Southern CA	EPO Open Access	AWH Southern CA
Silver EPO 60 2000 Ded				•	•
Platinum MC 90/50 0 Ded*	•	•	•		
Gold MC 80/50 750 Ded*	•	•	•		
Gold MC 80/50 1250 Ded	•	•	•		
Gold MC 80/50 1500 Ded	•	•	•		
Silver MC 60/50 2000 Ded	•	•	•		
Silver MC 70/50 2250 Ded*	•	•	•		
Silver MC 60/50 2550 Ded	•	•	•		
Bronze MC 60/50 6300 Ded*	•	•	•		
Bronze MC 100 HSA 7000 Ded*	•	•	•		
Bronze MC 50/50 8300 Ded	•	•	•		

PPO Plans	PPO Plans/Networks
Gold PPO 80/50 1000 Ded	•

*Mandated covered California exchange plan

Plan mapping

HMO plans

2020 Available Plans*	2021 Available Plans*
HMO Platinum CA $15/30 0 Ded	HMO Platinum CA $20/30 0 Ded
HMO Deductible Platinum CA $15/30 0 Ded	HMO Deductible Platinum CA $20/30 0 Ded
Aetna Value Network HMO Platinum CA $15/30 0 Ded	Aetna Value Network HMO Platinum CA $20/30 0 Ded
HMO Basic Platinum CA $15/30 0 Ded	HMO Basic Platinum CA $20/30 0 Ded
HMO Gold CA $25/50 250 Ded	HMO Gold CA $35/55 250 Ded
HMO Deductible Gold CA $25/50 250 Ded	HMO Deductible Gold CA $35/55 250 Ded
Aetna Value Network HMO Gold CA $25/50 250 Ded	Aetna Value Network HMO Gold CA $35/55 250 Ded
HMO Basic Gold CA $25/50 250 Ded	HMO Basic Gold CA $35/55 250 Ded
HMO Deductible Gold CA $25/50 500 Ded	HMO Deductible Gold CA $25/50 500 Ded
Aetna Value Network HMO Gold CA $25/50 500 Ded	Aetna Value Network HMO Gold CA $25/50 500 Ded
HMO Basic Gold CA $25/50 500 Ded	HMO Basic Gold CA $25/50 500 Ded
HMO Deductible Silver CA $50/85 2250 Ded	HMO Deductible Silver CA $55/90 2250 Ded
Aetna Value Network HMO Silver CA $50/85 2250 Ded	Aetna Value Network HMO Silver CA $55/90 2250 Ded
HMO Basic Silver CA $50/85 2250 Ded	HMO Basic Silver CA $55/90 2250 Ded
HMO Deductible Silver CA $50/75 2550 Ded	HMO Deductible Silver CA $50/75 2550 Ded
Aetna Value Network HMO Silver CA $50/75 2550 Ded	Aetna Value Network HMO Silver CA $50/75 2550 Ded
HMO Basic Silver CA $50/75 2550 Ded	HMO Basic Silver CA $50/75 2550 Ded
HMO Basic Bronze CA $65/95 6300 Ded	HMO Basic Bronze CA $65/95 6300 Ded
HMO Deductible Bronze CA $75/125 7900 Ded	HMO Deductible Bronze CA $75/125 7900 Ded
Aetna Value Network HMO Bronze CA $75/125 7900 Ded	Aetna Value Network HMO Bronze CA $75/125 7900 Ded
HMO Basic Bronze CA $75/125 7900 Ded	HMO Basic Bronze CA $75/125 7900 Ded

MC, EPO and PPO

2020 Available Plans*	2021 Available Plans*
OA Managed Choice POS Platinum CA 90/50 0 Ded	OA Managed Choice POS Platinum CA 90/50 0 Ded
Savings Plus OA Managed Choice POS Platinum CA 90/50 0 Ded	Savings Plus OA Managed Choice POS Platinum CA 90/50 0 Ded
OA Managed Choice POS Gold CA 80/50 250 Ded	OA Managed Choice POS Gold CA 80/50 350 Ded
Savings Plus OA Managed Choice POS Gold CA 80/50 250 Ded	Savings Plus OA Managed Choice POS Gold CA 80/50 350 Ded
OA Elect Choice EPO Gold CA 80 750 Ded	OA Managed Choice POS Gold CA 80/50 750 Ded
OA Managed Choice POS Gold CA 80/50 750 Ded	OA Managed Choice POS Gold CA 80/50 750 Ded
Savings Plus OA Managed Choice POS Gold CA 80/50 750 Ded	Savings Plus OA Managed Choice POS Gold CA 80/50 750 Ded
OA Elect Choice EPO Gold CA 80 1250	OA Managed Choice POS Gold CA 80/50 1250 Ded
OA Managed Choice POS Gold CA 80/50 1250 Ded	OA Managed Choice POS Gold CA 80/50 1250 Ded
Savings Plus OA Managed Choice POS Gold CA 80/50 1250 Ded	Savings Plus OA Managed Choice POS Gold CA 80/50 1250 Ded
OA Managed Choice POS Silver CA 60/50 2000 Ded	OA Managed Choice POS Silver CA 60/50 2000 Ded
Savings Plus OA Managed Choice POS Silver CA 60/50 2000 Ded	Savings Plus OA Managed Choice POS Silver CA 60/50 2000 Ded
OA Elect Choice EPO Silver CA 60 2000 Ded	OA Elect Choice EPO Silver CA 60 2000 Ded

*Suggested 2021 plans are most similar to the 2020 plan. For rating areas 1–14, Savings Plus OA Managed Choice POS network plans will be mapped to OA Managed Choice POS network plans. Group may choose up to 5 plans from the 2021 portfolio at renewal.

Plan mapping

MC, EPO and PPO

2020 Available Plans*	2021 Available Plans*
OA Managed Choice POS Silver CA Copay Plan 80/50 2250 Ded	OA Managed Choice POS Silver CA Plan 70/50 2250 Ded
Savings Plus OA Managed Choice POS Silver CA Copay Plan 80/50 2250 Ded	Savings Plus OA Managed Choice POS Silver CA Plan 70/50 2250 Ded
OA Elect Choice EPO Silver CA 60 2550 Ded	OA Managed Choice POS Silver CA 60/50 2550 Ded
OA Managed Choice POS Silver CA 60/50 2550 Ded	OA Managed Choice POS Silver CA 60/50 2550 Ded
Savings Plus OA Managed Choice POS Silver CA 60/50 2550 Ded	Savings Plus OA Managed Choice POS Silver CA 60/50 2550 Ded
OA Managed Choice POS Bronze HDHP CA 100/50 6900 Ded HSA	OA Managed Choice POS Bronze HDHP CA 100 7000 Ded HSA
Savings Plus OA Managed Choice POS Bronze HDHP CA 100/50 6900 Ded HSA	Savings Plus OA Managed Choice POS Bronze HDHP CA 100 7000 Ded HSA
OA Elect Choice EPO Bronze CA 50 7300 Ded	OA Managed Choice POS Bronze CA 50/50 8300 Ded
OA Managed Choice POS Bronze CA 50/50 7300 Ded	OA Managed Choice POS Bronze CA 50/50 8300 Ded
Savings Plus OA Managed Choice POS Bronze CA 50/50 7300 Ded	Savings Plus OA Managed Choice POS Bronze CA 50/50 8300 Ded
Open Choice PPO Gold CA 80/50 1000 Ded	Open Choice PPO Gold CA 80/50 1000 Ded

AWH/ACO plans: HMO, MC, and EPO

2020 Available Plans*	2021 Available Plans*
AWH Southern CA HMO Platinum CA $15/30 0 Ded	AWH Southern CA HMO Platinum CA $20/30 0 Ded
AWH Southern CA HMO Gold CA $25/50 250 Ded	AWH Southern CA HMO Gold CA $35/55 250 Ded
AWH Southern CA HMO Gold CA $25/50 500 Ded	AWH Southern CA HMO Gold CA $25/50 500 Ded
AWH Southern CA HMO Silver CA $50/85 2250 Ded	AWH Southern CA HMO Silver CA $55/90 2250 Ded
AWH Southern CA HMO Silver CA $50/75 2550 Ded	AWH Southern CA HMO Silver CA $50/75 2550 Ded
AWH Southern CA HMO Bronze CA $75/125 7900 Ded	AWH Southern CA HMO Bronze CA $75/125 7900 Ded
AWH Southern CA OA Managed Choice POS Platinum CA 90/50 0 Ded	AWH Southern CA OA Managed Choice POS Platinum CA 90/50 0 Ded
AWH Southern CA OA Managed Choice POS Gold CA 80/50 250 Ded	AWH Southern CA OA Managed Choice POS Gold CA 80/50 350 Ded
AWH Southern CA OA Elect Choice EPO Gold CA 80 750 Ded	AWH Southern CA OA Managed Choice POS Gold CA 80/50 750 Ded
AWH Southern CA OA Managed Choice POS Gold CA 80/50 750 Ded	AWH Southern CA OA Managed Choice POS Gold CA 80/50 750 Ded
AWH Southern CA OA Elect Choice EPO Gold CA 80 1250	AWH Southern CA OA Managed Choice POS Gold CA 80/50 1250 Ded
AWH Southern CA OA Managed Choice POS Gold CA 80/50 1250 Ded	AWH Southern CA OA Managed Choice POS Gold CA 80/50 1250 Ded
AWH Southern CA OA Elect Choice EPO Silver CA 60 2000 Ded	AWH Southern CA OA Elect Choice EPO Silver CA 60 2000 Ded
AWH Southern CA OA Managed Choice POS Silver CA 60/50 2000 Ded	AWH Southern CA OA Managed Choice POS Silver CA 60/50 2000 Ded
AWH Southern CA OA Managed Choice POS Silver CA Copay Plan 80/50 2250 Ded	AWH Southern CA OA Managed Choice POS Silver CA Plan 70/50 2250 Ded
AWH Southern CA OA Elect Choice EPO Silver CA 60 2550 Ded	AWH Southern CA OA Managed Choice POS Silver CA 60/50 2550 Ded
AWH Southern CA OA Managed Choice POS Silver CA 60/50 2550 Ded	AWH Southern CA OA Managed Choice POS Silver CA 60/50 2550 Ded
AWH Southern CA OA Managed Choice POS Bronze HDHP CA 100/50 6900 Ded HSA	AWH Southern CA OA Managed Choice POS Bronze HDHP CA 100 7000 Ded HSA
AWH Southern CA OA Elect Choice EPO Bronze CA 50 7300 Ded	AWH Southern CA OA Managed Choice POS Bronze CA 50/50 8300 Ded
AWH Southern CA OA Managed Choice POS Bronze CA 50/50 7300 Ded	AWH Southern CA OA Managed Choice POS Bronze CA 50/50 8300 Ded

*Suggested 2021 plans are most similar to the 2020 plan. For rating areas 1–14, Savings Plus OA Managed Choice POS network plans will be mapped to OA Managed Choice POS network plans. Group may choose up to 5 plans from the 2021 portfolio at renewal.

Medical plans

HMO 1–100

Plan Names	HMO Platinum CA $20/30 0 Ded HMO Deductible Platinum CA $20/30 0 Ded Aetna Value Network HMO Platinum CA $20/30 0 Ded HMO Basic Platinum CA $20/30 0 Ded AWH Southern CA HMO Platinum CA $20/30 0 Ded	HMO Gold CA $30/60 0 Ded HMO Deductible Gold CA $30/60 0 Ded Aetna Value Network HMO Gold CA $30/60 0 Ded HMO Basic Gold CA $30/60 0 Ded AWH Southern CA HMO Gold CA $30/60 0 Ded
	In network	**In network**
Deductible (individual/family)	$0/$0	$0/$0
Out-of-pocket limit (individual/family)	$4,500/$9,000	$6,500/$13,000
Deductible/out-of-pocket limit accumulation	Embedded [1]	Embedded [1]
Primary care physician office visit	$20	$30
Specialist office visit	$30	$60
Mental Health/Chemical Dependency office visits	$20	$60
Walk-in clinics[4]	$20	$30
Diagnostic testing: Lab	$20	$60
Diagnostic testing: X-ray	$30	$60
Imaging CT/PET scans MRIs	$100	$250
Inpatient hospital facility	$250 per day to a maximum of $1,250 per admission	$500 per day to a maximum of $2,000 per admission
Outpatient surgery	$100	Freestanding facility: $150 /Hospital: $250
Emergency room	$150	$250
Ambulance	$150	20%
Urgent care	$20	$100
Home Health Care Services	$20	20%
Durable Medical Equipment	10%	20%
Rehabilitation services (PT/OT/ST)[2]	$20	$60
Chiropractic[3]	Not Covered	$15
Other Benefits[5]	In network	In network
Dental check-up (preventive/diagnostic)	Covered in full	Covered in full
Dental basic	20%	30%
Dental major	50%	50%
Dental ortho	50%	50%
Vision exam (1 exam per 12 months)	Covered in full DW	Covered in full DW
Vision hardware	Covered in full	Covered in full
Pharmacy[6]	In network	In network
Pharmacy deductible	None	None
Preferred generic drugs	$5	$15
Preferred brand drugs	$20	$50
Non-preferred drugs	$30	$80
Specialty drugs	Preferred Specialty: 10% up to $250 Non-Preferred Specialty: 10% up to $250	Preferred Specialty: 20% up to $250 Non-Preferred Specialty: 20% up to $250

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. and/or Aetna Life Insurance Company (Aetna). Each insurer has sole financial responsibility for its own products.

Refer to pages 21 and 22 for footnotes.

Medical plans

HMO 1–100 (continued)

Plan Names	HMO Gold CA $35/55 250 Ded HMO Deductible Gold CA $35/55 250 Ded Aetna Value Network HMO Gold CA $35/55 250 Ded HMO Basic Gold CA $35/55 250 Ded AWH Southern CA HMO Gold CA $35/55 250 Ded	HMO Gold CA $25/50 500 Ded HMO Deductible Gold CA $25/50 500 Ded Aetna Value Network HMO Gold CA $25/50 500 Ded HMO Basic Gold CA $25/50 500 Ded AWH Southern CA HMO Gold CA $25/50 500 Ded
	In network	**In network**
Deductible (individual/family)	$250/$500	$500/$1,000
Out-of-pocket limit (individual/family)	$7,800/$15,600	$7,800/$15,600
Deductible/out-of-pocket limit accumulation	Embedded [1]	Embedded [1]
Primary care physician office visit	$35 DW	$25 DW
Specialist office visit	$55 DW	$50 DW
Mental Health/Chemical Dependency office visits	$35 DW	$50 DW
Walk-in clinics[4]	$35 DW	$25 DW
Diagnostic testing: Lab	$35 DW	$25 DW
Diagnostic testing: X-ray	$55 DW	$60 DW
Imaging CT/PET scans MRIs	$250 AD	$300 DW
Inpatient hospital facility	$600 per day to a maximum of $3,000 per admission AD	20% AD
Outpatient surgery	$300 AD	Freestanding facility: 10% AD /Hospital: 20% AD
Emergency room	$250 AD	$500 AD
Ambulance	$250 AD	20% AD
Urgent care	$35 DW	$50 DW
Home Health Care Services	$30 DW	20% AD
Durable Medical Equipment	20% DW	20% AD
Rehabilitation services (PT/OT/ST)[2]	$35 DW	$25 DW
Chiropractic[3]	Not Covered	$15 DW
Other Benefits[5]	In network	In network
Dental check-up (preventive/diagnostic)	Covered in full DW	Covered in full AD
Dental basic	20% DW	30% AD
Dental major	50% DW	50% AD
Dental ortho	50% DW	50% AD
Vision exam (1 exam per 12 months)	Covered in full DW	Covered in full DW
Vision hardware	Covered in full DW	Covered in full DW
Pharmacy[6]	In network	In network
Pharmacy deductible	None	None
Preferred generic drugs	$15	$15
Preferred brand drugs	$40	$50
Non-preferred drugs	$70	$80
Specialty drugs	Preferred Specialty: 20% up to $250 Non-Preferred Specialty: 20% up to $250	Preferred Specialty: 20% up to $250 Non-Preferred Specialty: 20% up to $250

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Medical plans

HMO 1–100 (continued)

Plan Names	HMO Silver CA $55/90 2250 Ded HMO Deductible Silver CA $55/90 2250 Ded Aetna Value Network HMO Silver CA $55/90 2250 Ded HMO Basic Silver CA $55/90 2250 Ded AWH Southern CA HMO Silver CA $55/90 2250 Ded	HMO Silver CA $50/75 2550 Ded HMO Deductible Silver CA $50/75 2550 Ded Aetna Value Network HMO Silver CA $50/75 2550 Ded HMO Basic Silver CA $50/75 2550 Ded AWH Southern CA HMO Silver CA $50/75 2550 Ded
	In network	**In network**
Deductible (individual/family)	$2,250/$4,500	$2,550/$5,100
Out-of-pocket limit (individual/family)	$8,200/$16,400	$7,850/$15,700
Deductible/out-of-pocket limit accumulation	Embedded [1]	Embedded [1]
Primary care physician office visit	$55 DW	$50 DW
Specialist office visit	$90 DW	$75 DW
Mental Health/Chemical Dependency office visits	$55 DW	$75 DW
Walk-in clinics[4]	$55 DW	$50 DW
Diagnostic testing: Lab	$55 DW	$50 DW
Diagnostic testing: X-ray	$90 DW	$75 DW
Imaging CT/PET scans MRIs	$300 AD	$250 DW
Inpatient hospital facility	30% AD	$250 per day to a maximum of $1,000 per admission AD
Outpatient surgery	30% AD	Freestanding facility: $300 DW /Hospital: $400 DW
Emergency room	30% AD	50% AD
Ambulance	30% AD	50% AD
Urgent care	$55 DW	$100 DW
Home Health Care Services	$45 DW	50% AD
Durable Medical Equipment	30% AD	50% AD
Rehabilitation services (PT/OT/ST)[2]	$55 DW	$75 DW
Chiropractic[3]	Not Covered	$15 DW
Other Benefits[5]	In network	In network
Dental check-up (preventive/diagnostic)	Covered in full DW	Covered in full AD
Dental basic	20% DW	30% AD
Dental major	50% DW	50% AD
Dental ortho	50% DW	50% AD
Vision exam (1 exam per 12 months)	Covered in full DW	Covered in full DW
Vision hardware	Covered in full DW	Covered in full DW
Pharmacy[6]	In network	In network
Pharmacy deductible	$300 Individual / $600 Family	$150 Individual / $300 Family
Preferred generic drugs	$17 DW	$25 DW
Preferred brand drugs	$80 AD	$100 AD
Non-preferred drugs	$110 AD	$150 AD
Specialty drugs	Preferred Specialty: 30% up to $250 AD Non-Preferred Specialty: 30% up to $250 AD	Preferred Specialty: 50% up to $250 AD Non-Preferred Specialty: 50% up to $250 AD

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Refer to pages 21 and 22 for footnotes.

Medical plans

HMO 1–100 (continued)

Plan Names	HMO Bronze CA $75/$125 7900 Ded HMO Deductible Bronze CA $75/$125 7900 Ded Aetna Value Network HMO Bronze CA $75/$125 7900 Ded HMO Basic Bronze CA $75/$125 7900 Ded AWH Southern CA HMO Bronze CA $75/$125 7900 Ded	HMO Basic Bronze CA $65/95 6300 Ded
	In network	**In network**
Deductible (individual/family)	$7,900/$15,800	$6,300/$12,600
Out-of-pocket limit (individual/family)	$7,900/$15,800	$8,200/$16,400
Deductible/out-of-pocket limit accumulation	Embedded [1]	Embedded [1]
Primary care physician office visit	$75 DW	$65 ded waiv/visits 1-3, $65 after ded visits 4+
Specialist office visit	$125 DW	$95 ded waiv/visits 1-3, $95 aft ded/visits 4+
Mental Health/Chemical Dependency office visits	$125 DW	$65 ded waiv/visits 1-3, $65 after ded visits 4+
Walk-in clinics[4]	$75 DW	$65 ded waiv/visits 1-3, $65 after ded visits 4+
Diagnostic testing: Lab	$125 DW	$40 DW
Diagnostic testing: X-ray	$125 DW	40% AD
Imaging CT/PET scans MRIs	$400 DW	40% AD
Inpatient hospital facility	Covered in full AD	40% AD
Outpatient surgery	Covered in full AD	40% AD
Emergency room	Covered in full AD	40% AD
Ambulance	0% AD	40% AD
Urgent care	$125 DW	$65 ded waiv/visits 1-3, $65 after ded visits 4+
Home Health Care Services	0% AD	40% AD
Durable Medical Equipment	0% AD	40% AD
Rehabilitation services (PT/OT/ST)[2]	$125 DW	$65 DW
Chiropractic[3]	$15 DW	Not Covered
Other Benefits[5]	In network	In network
Dental check-up (preventive/diagnostic)	Covered in full AD	Covered in full DW
Dental basic	Covered in full AD	20% DW
Dental major	Covered in full AD	50% DW
Dental ortho	Covered in full AD	50% DW
Vision exam (1 exam per 12 months)	Covered in full DW	Covered in full DW
Vision hardware	Covered in full DW	Covered in full DW
Pharmacy[6]	In network	In network
Pharmacy deductible	Integrated with Medical Deductible	$500 Individual / $1,000 Family
Preferred generic drugs	$35 DW	$18 AD
Preferred brand drugs	Covered in full AD	40% up to $500 AD
Non-preferred drugs	Covered in full AD	40% up to $500 AD
Specialty drugs	Preferred Specialty: Covered in full AD Non-Preferred Specialty: Covered in full AD	Preferred Specialty: 40% up to $500 AD Non-Preferred Specialty: 40% up to $500 AD

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Refer to pages 21 and 22 for footnotes.

Medical plans

Elect Choice Open Access 1–100

Plan Names	OA Elect Choice EPO Silver CA 60 2000 Ded AWH Southern CA OA Elect Choice EPO Silver CA 60 2000 Ded
	In network
Deductible (individual/family)	$2,000/$4,000
Out-of-pocket limit (individual/family)	$8,150/$16,300
Deductible/out-of-pocket limit accumulation	Embedded [1]
Primary care physician office visit	$40 DW
Specialist office visit	$75 DW
Mental Health/Chemical Dependency office visits	$75 DW
Walk-in clinics[4]	Designated Walk-in Clinics: Covered in full DW All Other Network Providers: $40 DW
Diagnostic testing: Lab	$55 DW
Diagnostic testing: X-ray	40% AD
Imaging CT/PET scans MRIs	40% AD
Inpatient hospital facility	40% AD
Outpatient surgery	40% AD
Emergency room	40% AD
Ambulance	40% AD
Urgent care	$50 DW
Home Health Care Services	40% AD
Durable Medical Equipment	40% AD
Rehabilitation services (PT/OT/ST)[2]	40% AD
Chiropractic[3]	40% AD
Other Benefits[5]	In network
Dental check-up (aka preventive/diagnostic)	Covered in full AD
Dental basic	30% AD
Dental major	50% AD
Dental ortho	50% AD
Vision exam (1 exam per 12 months)	Covered in full DW
Vision hardware	Covered in full DW
Pharmacy[6]	In network
Pharmacy deductible	$250 Individual / $500 Family
Preferred generic drugs	$20 DW
Preferred brand drugs	$80 AD
Non-preferred drugs	$100 AD
Specialty drugs	Preferred Specialty: 40% up to $250 AD Non-Preferred Specialty: 40% up to $250 AD

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. and/or Aetna Life Insurance Company (Aetna). Each insurer has sole financial responsibility for its own products.

Refer to pages 21 and 22 for footnotes.

Medical plans

Managed Choice Open Access 1–100

Plan Names	OA Managed Choice POS Platinum CA 90/50 0 Ded Savings Plus OA Managed Choice POS Platinum CA 90/50 0 Ded AWH Southern CA OA Managed Choice POS Platinum CA 90/50 0 Ded		OA Managed Choice POS Gold CA 80/50 350 Ded Savings Plus OA Managed Choice POS Gold CA 80/50 350 Ded AWH Southern CA OA Managed Choice POS Gold CA 80/50 350 Ded	
	In network	**Out of network**	**In network**	**Out of network**
Deductible (individual/family)	$0/$0	$1,000/$2,000	$350/$700	$700/$1,400
Out-of-pocket limit (individual/family)	$4,500/$9,000	$9,000/$18,000	$7,800/$15,600	$15,600/$31,200
Deductible/out-of-pocket limit accumulation	Embedded[1]		Embedded[1]	
Primary care physician office visit	$15	50% AD	$25 DW	50% AD
Specialist office visit	$30	50% AD	$50 DW	50% AD
Mental Health/Chemical Dependency office visits	$15	50% AD	$25 DW	50% AD
Walk-in clinics[4]	Designated Walk-in Clinics: Covered in full All Other Network Providers: $15	Not Covered	Designated Walk-in Clinics: Covered in full DW All Other Network Providers: $25 DW	Not Covered
Diagnostic testing: Lab	$15	50% AD	$25 DW	50% AD
Diagnostic testing: X-ray	$30	50% AD	$65 DW	50% AD
Imaging CT/PET scans MRIs	10%	50% AD	20% DW	50% AD
Inpatient hospital facility	10%	50% AD	20% AD	50% AD
Outpatient surgery	10%	50% AD	20% DW	50% AD
Emergency room	$200	Paid as In-Network	20% AD	Paid as In-Network
Ambulance	$150	Paid as In-Network	20% AD	Paid as In-Network
Urgent care	$15	50% AD	$25 DW	50% AD
Home Health Care Services	10%	50% AD	20% DW	50% AD
Durable Medical Equipment	10%	50% AD	20% DW	50% AD
Rehabilitation services (PT/OT/ST)[2]	$15	50% AD	$25 DW	50% AD
Chiropractic[3]	Not Covered	Not Covered	Not Covered	Not Covered
Other Benefits[5]	In network	Out of network	In network	Out of network
Dental check-up (aka preventive/diagnostic)	Covered in full	30% AD	Covered in full DW	30% AD
Dental basic	20%	50% AD	20% DW	50% AD
Dental major	50%	50% AD	50% DW	50% AD
Dental ortho	50%	50% AD	50% DW	50% AD
Vision exam (1 exam per 12 months)	Covered in full	Not Covered	Covered in full DW	Not Covered
Vision hardware	Covered in full	Not covered	Covered in full DW	Not covered
Pharmacy[6]	In network	Out of network	In network	Out of network
Pharmacy deductible	None	None	None	None
Preferred generic drugs	$10	Not Covered	$15	Not Covered
Preferred brand drugs	$25	Not Covered	$50	Not Covered
Non-preferred drugs	$40	Not Covered	$80	Not Covered
Specialty drugs	Preferred Specialty: 10% up to $250 Non-Preferred Specialty: 10% up to $250	Preferred Specialty: Not Covered Non-Preferred Specialty: Not Covered	Preferred Specialty: 20% up to $250 Non-Preferred Specialty: 20% up to $250	Preferred Specialty: Not Covered Non-Preferred Specialty: Not Covered

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. and/or Aetna Life Insurance Company (Aetna). Each insurer has sole financial responsibility for its own products.

Refer to pages 21 and 22 for footnotes.

Medical plans

Managed Choice Open Access 1–100 (continued)

Plan Names	OA Managed Choice POS Gold CA 80/50 750 Ded Savings Plus OA Managed Choice POS Gold CA 80/50 750 Ded AWH Southern CA OA Managed Choice POS Gold CA 80/50 750 Ded		OA Managed Choice POS Gold CA 80/50 1250 Ded Savings Plus OA Managed Choice POS Gold CA 80/50 1250 Ded AWH Southern CA OA Managed Choice POS Gold CA 80/50 1250 Ded	
	In network	**Out of network**	**In network**	**Out of network**
Deductible (individual/family)	$750/$1,500	$1,500/$3,000	$1,250/$2,500	$2,500/$5,000
Out-of-pocket limit (individual/family)	$7,500/$15,000	$15,000/$30,000	$7,200/$14,400	$14,400/$28,800
Deductible/out-of-pocket limit accumulation	Embedded[1]		Embedded[1]	
Primary care physician office visit	$20 DW	50% AD	$30 DW	50% AD
Specialist office visit	$50 DW	50% AD	$50 DW	50% AD
Mental Health/Chemical Dependency office visits	$50 DW	50% AD	$50 DW	50% AD
Walk-in clinics[4]	Designated Walk-in Clinics: Covered in full DW All Other Network Providers: $20 DW	Not Covered	Designated Walk-in Clinics: Covered in full DW All Other Network Providers: $30 DW	Not Covered
Diagnostic testing: Lab	$50 DW	50% AD	$30 DW	50% AD
Diagnostic testing: X-ray	20% DW	50% AD	20% AD	50% AD
Imaging CT/PET scans MRIs	20% AD	50% AD	20% AD	50% AD
Inpatient hospital facility	20% AD	50% AD	20% AD	50% AD
Outpatient surgery	20% AD	50% AD	20% AD	50% AD
Emergency room	20% AD	Paid as In-Network	$100 plus 20% AD	Paid as In-Network
Ambulance	20% AD	Paid as In-Network	20% AD	Paid as In-Network
Urgent care	$50 DW	50% AD	$100 DW	50% AD
Home Health Care Services	20% AD	50% AD	20% AD	50% AD
Durable Medical Equipment	20% AD	50% AD	20% AD	50% AD
Rehabilitation services (PT/OT/ST)[2]	20% AD	50% AD	20% AD	50% AD
Chiropractic[3]	20% AD	50% AD	20% AD	50% AD
Other Benefits[5]	In network	Out of network	In network	Out of network
Dental check-up (aka preventive/diagnostic)	Covered in full AD	30% AD	Covered in full AD	30% AD
Dental basic	30% AD	50% AD	30% AD	50% AD
Dental major	50% AD	50% AD	50% AD	50% AD
Dental ortho	50% AD	50% AD	50% AD	50% AD
Vision exam (1 exam per 12 months)	Covered in full DW	Not Covered	Covered in full DW	50% AD
Vision hardware	Covered in full DW	Not covered	Covered in full DW	Not covered
Pharmacy[6]	In network	Out of network	In network	Out of network
Pharmacy deductible	$300 Individual / $600 Family	None	$300 Individual / $600 Family	None
Preferred generic drugs	$15 DW	Not Covered	$15 DW	Not Covered
Preferred brand drugs	$55 AD	Not Covered	$55 AD	Not Covered
Non-preferred drugs	$80 AD	Not Covered	$80 AD	Not Covered
Specialty drugs	Preferred Specialty: 20% up to $250 AD Non-Preferred Specialty: 20% up to $250 AD	Preferred Specialty: Not Covered Non-Preferred Specialty: Not Covered	Preferred Specialty: 20% up to $250 AD Non-Preferred Specialty: 20% up to $250 AD	Preferred Specialty: Not Covered Non-Preferred Specialty: Not Covered

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. and/or Aetna Life Insurance Company (Aetna). Each insurer has sole financial responsibility for its own products.

Refer to pages 21 and 22 for footnotes.

Medical plans

Managed Choice Open Access 1–100 (continued)

Plan Names	OA Managed Choice POS Gold CA 80/50 1500 Ded Savings Plus OA Managed Choice POS Gold CA 80/50 1500 Ded AWH Southern CA OA Managed Choice POS Gold CA 80/50 1500 Ded		OA Managed Choice POS Silver CA 60/50 2000 Ded Savings Plus OA Managed Choice POS Silver CA 60/50 2000 Ded AWH Southern CA OA Managed Choice POS Silver CA 60/50 2000 Ded	
	In network	**Out of network**	**In network**	**Out of network**
Deductible (individual/family)	$1,500/$3,000	$3,000/$6,000	$2,000/$4,000	$4,000/$8,000
Out-of-pocket limit (individual/family)	$4,150/$8,300	$8,300/$16,600	$8,150/$16,300	$16,300/$32,600
Deductible/out-of-pocket limit accumulation	Embedded[1]		Embedded[1]	
Primary care physician office visit	$40 DW	50% AD	$40 DW	50% AD
Specialist office visit	$40 DW	50% AD	$75 DW	50% AD
Mental Health/Chemical Dependency office visits	$40 DW	50% AD	$75 DW	50% AD
Walk-in clinics[4]	Designated Walk-in Clinics: Covered in full DW All Other Network Providers: $40 DW	Not Covered	Designated Walk-in Clinics: Covered in full DW All Other Network Providers: $40 DW	Not Covered
Diagnostic testing: Lab	20% AD	50% AD	$55 DW	50% AD
Diagnostic testing: X-ray	20% AD	50% AD	40% AD	50% AD
Imaging CT/PET scans MRIs	20% AD	50% AD	40% AD	50% AD
Inpatient hospital facility	$100 per admission AD; then 20%	50% AD	40% AD	50% AD
Outpatient surgery	20% AD	50% AD	40% AD	50% AD
Emergency room	20% AD	Paid as In-Network	40% AD	Paid as In-Network
Ambulance	20% AD	Paid as In-Network	40% AD	Paid as In-Network
Urgent care	$40 DW	50% AD	$50 DW	50% AD
Home Health Care Services	20% AD	50% AD	40% AD	50% AD
Durable Medical Equipment	20% AD	50% AD	40% AD	50% AD
Rehabilitation services (PT/OT/ST)[2]	20% AD	50% AD	40% AD	50% AD
Chiropractic[3]	20% AD	50% AD	40% AD	50% AD
Other Benefits[5]	In network	Out of network	In network	Out of network
Dental check-up (aka preventive/diagnostic)	Covered in full AD	30% AD	Covered in full AD	30% AD
Dental basic	30% AD	50% AD	30% AD	50% AD
Dental major	50% AD	50% AD	50% AD	50% AD
Dental ortho	50% AD	50% AD	50% AD	50% AD
Vision exam (1 exam per 12 months)	Covered in full AD	50% AD	Covered in full DW	Not Covered
Vision hardware	Covered in full AD	Not covered	Covered in full DW	Not covered
Pharmacy[6]	In network	Out of network	In network	Out of network
Pharmacy deductible	$300 Individual / $600 Family	None	$250 Individual / $500 Family	None
Preferred generic drugs	$15 DW	Not Covered	$20 DW	Not Covered
Preferred brand drugs	$55 AD	Not Covered	$80 AD	Not Covered
Non-preferred drugs	$80 AD	Not Covered	$100 AD	Not Covered
Specialty drugs	Preferred Specialty: 20% up to $250 AD Non-Preferred Specialty: 20% up to $250 AD	Preferred Specialty: Not Covered Non-Preferred Specialty: Not Covered	Preferred Specialty: 40% up to $250 AD Non-Preferred Specialty: 40% up to $250 AD	Preferred Specialty: Not Covered Non-Preferred Specialty: Not Covered

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Refer to pages 21 and 22 for footnotes.

Medical plans

Managed Choice Open Access 1–100 (continued)

Plan Names	OA Managed Choice POS Silver CA Plan 70/50 2250 Ded Savings Plus OA Managed Choice POS Silver CA Plan 70/50 2250 Ded AWH Southern CA OA Managed Choice POS Silver CA Plan 70/50 2250 Ded		AWH Southern CA OA Managed Choice POS Silver CA 60/50 2550 Ded Savings Plus OA Managed Choice POS Silver CA 60/50 2550 Ded OA Managed Choice POS Silver CA 60/50 2550 Ded	
	In network	**Out of network**	**In network**	**Out of network**
Deductible (individual/family)	$2,250/$4,500	$4,500/$9,000	$2,550/$5,100	$5,100/$10,200
Out-of-pocket limit (individual/family)	$8,200/$16,400	$16,400/$32,800	$7,900/$15,800	$15,800/$31,600
Deductible/out-of-pocket limit accumulation	Embedded[1]		Embedded[1]	
Primary care physician office visit	$50 DW	50% AD	$60 DW	50% AD
Specialist office visit	$85 DW	50% AD	$80 AD	50% AD
Mental Health/Chemical Dependency office visits	$50 DW	50% AD	$80 AD	50% AD
Walk-in clinics[4]	Designated Walk-in Clinics: Covered in full DW All Other Network Providers: $50 DW	Not Covered	Designated Walk-in Clinics: Covered in full DW All Other Network Providers: $60 DW	Not Covered
Diagnostic testing: Lab	$50 DW	50% AD	$75 DW	50% AD
Diagnostic testing: X-ray	$85 DW	50% AD	40% DW	50% AD
Imaging CT/PET scans MRIs	30% AD	50% AD	40% AD	50% AD
Inpatient hospital facility	30% AD	50% AD	40% AD	50% AD
Outpatient surgery	30% AD	50% AD	40% AD	50% AD
Emergency room	30% AD	Paid as In-Network	40% AD	Paid as In-Network
Ambulance	30% AD	Paid as In-Network	40% AD	Paid as In-Network
Urgent care	$50 DW	50% AD	$100 DW	50% AD
Home Health Care Services	30% DW	50% AD	40% AD	50% AD
Durable Medical Equipment	30% DW	50% AD	40% AD	50% AD
Rehabilitation services (PT/OT/ST)[2]	$50 DW	50% AD	40% AD	50% AD
Chiropractic[3]	Not Covered	Not Covered	40% AD	50% AD
Other Benefits[5]	In network	Out of network	In network	Out of network
Dental check-up (aka preventive/diagnostic)	Covered in full DW	30% AD	Covered in full AD	30% AD
Dental basic	20% DW	50% AD	30% AD	50% AD
Dental major	50% DW	50% AD	50% AD	50% AD
Dental ortho	50% DW	50% AD	50% AD	50% AD
Vision exam (1 exam per 12 months)	Covered in full DW	Not Covered	Covered in full DW	Not Covered
Vision hardware	Covered in full DW	Not covered	Covered in full DW	Not covered
Pharmacy[6]	In network	Out of network	In network	Out of network
Pharmacy deductible	$300 Individual / $600 Family	None	Integrated with Medical Deductible	None
Preferred generic drugs	$17 DW	Not Covered	$10 DW	Not Covered
Preferred brand drugs	$70 AD	Not Covered	$60 AD	Not Covered
Non-preferred drugs	$100 AD	Not Covered	$90 AD	Not Covered
Specialty drugs	Preferred Specialty: 30% up to $250 AD Non-Preferred Specialty: 30% up to $250 AD	Preferred Specialty: Not Covered Non-Preferred Specialty: Not Covered	Preferred Specialty: 30% up to $250 AD Non-Preferred Specialty: 30% up to $250 AD	Preferred Specialty: Not Covered Non-Preferred Specialty: Not Covered

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Refer to pages 21 and 22 for footnotes.

Medical plans

Managed Choice Open Access 1–100 (continued)

Plan Names	OA Managed Choice POS Bronze CA Plan 60/50 6300 Ded Savings Plus OA Managed Choice POS Bronze CA Plan 60/50 6300 Ded AWH Southern CA OA Managed Choice POS Bronze CA Plan 60/50 6300 Ded		OA Managed Choice POS Bronze CA 50/50 8300 Ded Savings Plus OA Managed Choice POS Bronze CA 50/50 8300 Ded AWH Southern CA OA Managed Choice POS Bronze CA 50/50 8300 Ded	
	In network	**Out of network**	**In network**	**Out of network**
Deductible (individual/family)	$6,300/$12,600	$12,600/$25,200	$8,300/$16,600	$16,600/$33,200
Out-of-pocket limit (individual/family)	$8,200/$16,400	$16,400/$32,800	$8,550/$17,100	$17,100/$34,200
Deductible/out-of-pocket limit accumulation	Embedded[1]		Embedded[1]	
Primary care physician office visit	$65 ded waiv/visits 1-3,$65 after ded visits 4+	50% AD	$85 ded waived/visit 1, $0 after ded visits 2+	50% AD
Specialist office visit	$95 ded waiv/visits 1-3, $95 aft ded/visits 4+	50% AD	$95 AD	50% AD
Mental Health/Chemical Dependency office visits	$65 ded waiv/visits 1-3, $65 after ded visits 4+	50% AD	$95 AD	50% AD
Walk-in clinics[4]	Designated Walk-in Clinics: Covered in full DW All Other Network Providers: $65 ded waiv/visits 1-3, $65 after ded visits 4+	Not Covered	Designated Walk-in Clinics: Covered in full DW All Other Network Providers: $85 ded waived/visit 1, $0 after ded visits 2+	Not Covered
Diagnostic testing: Lab	$40 DW	50% AD	$85 DW	50% AD
Diagnostic testing: X-ray	40% AD	50% AD	50% AD	50% AD
Imaging CT/PET scans MRIs	40% AD	50% AD	50% AD	50% AD
Inpatient hospital facility	40% AD	50% AD	50% AD	50% AD
Outpatient surgery	40% AD	50% AD	50% AD	50% AD
Emergency room	40% AD	Paid as In-Network	50% AD	Paid as In-Network
Ambulance	40% AD	Paid as In-Network	50% AD	Paid as In-Network
Urgent care	$65 ded waiv/visits 1-3, $65 after ded visits 4+	50% AD	$100 DW	50% AD
Home Health Care Services	40% AD	50% AD	50% AD	50% AD
Durable Medical Equipment	40% AD	50% AD	50% AD	50% AD
Rehabilitation services (PT/OT/ST)[2]	$65 DW	50% AD	50% AD	50% AD
Chiropractic[3]	Not Covered	Not Covered	50% AD	50% AD
Other Benefits[5]	In network	Out of network	In network	Out of network
Dental check-up (aka preventive/diagnostic)	Covered in full DW	30% AD	Covered in full AD	30% AD
Dental basic	20% DW	50% AD	30% AD	50% AD
Dental major	50% DW	50% AD	50% AD	50% AD
Dental ortho	50% DW	50% AD	50% AD	50% AD
Vision exam (1 exam per 12 months)	Covered in full DW	Not Covered	Covered in full DW	Not Covered
Vision hardware	Covered in full DW	Not covered	Covered in full DW	Not covered
Pharmacy[6]	In network	Out of network	In network	Out of network
Pharmacy deductible	$500 Individual / $1,000 Family	None	Integrated with Medical Deductible	None
Preferred generic drugs	$18 AD	Not Covered	$30 DW	Not Covered
Preferred brand drugs	40% up to $500 AD	Not Covered	$100 AD	Not Covered
Non-preferred drugs	40% up to $500 AD	Not Covered	$150 AD	Not Covered
Specialty drugs	Preferred Specialty: 40% up to $500 AD Non-Preferred Specialty: 40% up to $500 AD	Preferred Specialty: Not Covered Non-Preferred Specialty: Not Covered	Preferred Specialty: 50% up to $500 AD Non-Preferred Specialty: 50% up to $500 AD	Preferred Specialty: Not Covered Non-Preferred Specialty: Not Covered

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. and/or Aetna Life Insurance Company (Aetna). Each insurer has sole financial responsibility for its own products.

Refer to pages 21 and 22 for footnotes.

Medical plans

Managed Choice Open Access 1–100 (continued)

Plan Names	OA Managed Choice POS Bronze HDHP CA 100 7000 Ded HSA Savings Plus OA Managed Choice POS Bronze HDHP CA 100 7000 Ded HSA AWH Southern CA OA Managed Choice POS Bronze HDHP CA 100 7000 Ded HSA	
	In network	**Out of network**
Deductible (individual/family)	$7,000/$14,000	$14,000/$28,000
Out-of-pocket limit (individual/family)	$7,000/$14,000	$14,000/$28,000
Deductible/out-of-pocket limit accumulation	Embedded[1]	
Primary care physician office visit	Covered in full AD	Covered in full AD
Specialist office visit	Covered in full AD	Covered in full AD
Mental Health/Chemical Dependency office visits	Covered in full AD	Covered in full AD
Walk-in clinics[4]	Designated Walk-in Clinics: Covered in full AD All Other Network Providers: Covered in full AD	Not Covered
Diagnostic testing: Lab	Covered in full AD	Covered in full AD
Diagnostic testing: X-ray	Covered in full AD	Covered in full AD
Imaging CT/PET scans MRIs	Covered in full AD	Covered in full AD
Inpatient hospital facility	Covered in full AD	Covered in full AD
Outpatient surgery	Covered in full AD	Covered in full AD
Emergency room	Covered in full AD	Paid as In-Network
Ambulance	Covered in full AD	Paid as In-Network
Urgent care	Covered in full AD	Covered in full AD
Home Health Care Services	Covered in full AD	Covered in full AD
Durable Medical Equipment	Covered in full AD	Covered in full AD
Rehabilitation services (PT/OT/ST)[2]	Covered in full AD	Covered in full AD
Chiropractic[3]	Not Covered	Not Covered
Other Benefits[5]	In network	Out of network
Dental check-up (aka preventive/diagnostic)	Covered in full DW	Covered in full AD
Dental basic	20% DW	Covered in full AD
Dental major	50% DW	Covered in full AD
Dental ortho	50% DW	Covered in full AD
Vision exam (1 exam per 12 months)	Covered in full DW	Not Covered
Vision hardware	Covered in full DW	Not covered
Pharmacy[6]	In network	Out of network
Pharmacy deductible	Integrated with Medical Deductible	None
Preferred generic drugs	Covered in full AD	Not Covered
Preferred brand drugs	Covered in full AD	Not Covered
Non-preferred drugs	Covered in full AD	Not Covered
Specialty drugs	Preferred Specialty: Covered in full AD Non-Preferred Specialty: Covered in full AD	Preferred Specialty: Not Covered Non-Preferred Specialty: Not Covered

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Refer to pages 21 and 22 for footnotes.

Medical plans

PPO Medical 1–100

Plan Names	Open Choice PPO Gold CA 80/50 1000 Ded[6]	
	In network	**Out of network**
Deductible (individual/family)	$1,000/$2,000	$2,000/$4,000
Out-of-pocket limit (individual/family)	$7,000/$14,000	$14,000/$28,000
Deductible/out-of-pocket limit accumulation	Embedded [1]	
Primary care physician office visit	$20 DW	50% AD
Specialist office visit	$50 DW	50% AD
Mental Health/Chemical Dependency office visits	$50 DW	50% AD
Walk-in clinics[4]	Designated Walk-in Clinics: Covered in full DW All Other Network Providers: $20 DW	Not Covered
Diagnostic testing: Lab	$20 DW	50% AD
Diagnostic testing: X-ray	20% DW	50% AD
Imaging CT/PET scans MRIs	20% AD	50% AD
Inpatient hospital facility	20% AD	50% AD
Outpatient surgery	20% AD	50% AD
Emergency room	20% AD	Paid as In-Network
Ambulance	20% AD	Paid as In-Network
Urgent care	$50 DW	50% AD
Home Health Care Services	20% AD	50% AD
Durable Medical Equipment	20% AD	50% AD
Rehabilitation services (PT/OT/ST)[2]	20% AD	50% AD
Chiropractic[3]	20% AD	50% AD
Other Benefits[5]	In network	Out of network
Dental check-up (aka preventive/diagnostic)	Covered in full AD	30% AD
Dental basic	30% AD	50% AD
Dental major	50% AD	50% AD
Dental ortho	50% AD	50% AD
Vision exam (1 exam per 12 months)	Covered in full DW	Not Covered
Vision hardware	Covered in full DW	Not covered
Pharmacy[6]	In network	Out of network
Pharmacy deductible	$300 Individual / $600 Family	None
Preferred generic drugs	$15 DW	Not Covered
Preferred brand drugs	$55 AD	Not Covered
Non-preferred drugs	$80 AD	Not Covered
Specialty drugs	Preferred Specialty: 50% up to $250 AD Non-Preferred Specialty: 50% up to $250 AD	Preferred Specialty: Not Covered Non-Preferred Specialty: Not Covered

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. and/or Aetna Life Insurance Company (Aetna). Each insurer has sole financial responsibility for its own products.

Refer to pages 21 and 22 for footnotes.

Medical footnotes

"AD" indicates after deductible and "DW" indicates deductible waived.

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® web site at **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.

[1]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.

[2]Rehabilitation services
Coverage is limited to **Unlimited** visits per calendar year for PT/OT/ST combined. Benefit limits are not shared between rehabilitation and habilitation services.

[3]Chiropractic/subluxation
Services have a limit of **20** visits per calendar year. Benefit limits are not shared between rehabilitation and habilitation services.

[4]Walk-in clinics
Walk-in clinics are freestanding health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be walk-in clinics.

[5]Vision and Dental services
These 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.– Important Notes: This plan will cover **1** set of frames and **1** set of contact lenses or eyeglass lenses per calendar year age 0-19.

[6]Pharmacy
The drug formulary includes Precertification, Step therapy and Quantity limits. Choose generics applies / Choose generics applies with dispense as written (DAW) override. Members must obtain all specialty medication fills through the Aetna Specialty Pharmacy network. Performance enhancing drugs are excluded. Fertility drugs are excluded. Pharmacy copays stated above are for up to a 30 day supply at Retail. Mail order delivery (MOD) available for 31-90 day supply at 2 times the retail copay.

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 our 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.

Medical footnotes (continued)

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

HMO & EPO - Professional Services:
N/A / Facility Services: N/A

Your provider sets his or her own rate to charge you. It may be higher – sometimes much higher – than what your Aetna plan "recognizes." Your provider 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 **aetna.com**. Type "network care" in the search box. You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Refer to the 'Find a Doctor' link on **aetna.com** for a listing of network providers under the heading "Small Group Under 51 Employees". If you are already a member, sign on to your member website.

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

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 or its affiliate(s) receives rebates from drug manufacturers. Rebates may not reduce the amount a member pays the pharmacy for covered prescriptions. Choose Generic: For PPO based plans the cost difference penalty for choose generics does not apply to the members accumulators. For HMO based plans the cost difference penalty does apply to the members accumulators. Information is subject to change. For more information about your pharmacy plan, refer to your plan's website.

Dental plans

Contributory non-voluntary dental 2–9

Plan Names	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	
	Fixed copay 58	DMO member 0/10/40	PPO max 100/80/50	Fixed copay 58	PPO 100/80/50
Office visit copay	$5	$5	N/A	$5	N/A
Annual deductible per member (does not apply to diagnostic & preventive services)	None	None	$50; 3X family maximum	None	$50; 3X family maximum
Annual maximum benefit	Unlimited	Unlimited	$2,000	Unlimited	$1,000
Diagnostic Services					
Oral exams					
Periodic oral exam	No charge	0%	100%	No charge	100%
Comprehensive oral exam	No charge	0%	100%	No charge	100%
Problem-focused oral exam	No charge	0%	100%	No charge	100%
X-rays					
Bitewing – single film	No charge	0%	100%	No charge	100%
Complete series	No charge	0%	100%	No charge	100%
Preventive Services					
Cleaning	No charge	0%	100%	No charge	100%
Sealants – per tooth	$5	0%	100%	$5	100%
Fluoride application – child	No charge	0%	100%	No charge	100%
Space maintainers – fixed	$60	0%	100%	$60	100%
Basic Services					
Amalgam filling – 2 surfaces	No charge	10%	80%	No charge	80%
Resin filling – 2 surfaces, anterior	No charge	10%	80%	No charge	80%
Oral surgery					
Extraction – exposed root or erupted tooth	No charge	10%	80%	No charge	80%
Extraction of impacted tooth – soft tissue	$46	10%	80%	$46	80%
Major Services*					
Complete upper denture	$275	40%	50%	$275	50%
Partial upper denture (Resin base)	$275	40%	50%	$275	50%
Crown – porcelain with noble metal[1]	$210	40%	50%	$210	50%
Pontic – porcelain with noble metal[1]	$210	40%	50%	$210	50%
Oral surgery					
Removal of impacted tooth – partially bony	$58	40%	50%	$58	50%
Endodontic services					
Bicuspid root canal therapy	$85	10%	50%	$85	80%
Molar root canal therapy	$240	40%	50%	$240	50%
Periodontic services					
Scaling & root planing – per quadrant	$55	10%	50%	$55	80%
Osseous surgery – per quadrant	$300	40%	50%	$300	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 25 for footnotes.

Dental plans

Contributory non-voluntary dental 2–9 (continued)

Plan Names	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						
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%
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 25 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 and Freedom-of-Choice Plus.

[1]There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures: Applies to DMO in DMO Plus and Freedom-of-Choice Plus.

Fixed dollar amounts including the office visit copay on DMO plans are member responsibility.

Most oral surgery, endodontic and periodontic services are covered as Basic Services on the DMO plans and PPO in Freedom-of-Choice Plus, PPO 1500, PPO 1500 Active and PPO 2000.

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 1000, PPO 1000 Active, PPO 1500 and PPO 1500 Active to the prevailing fees at the 80th percentile and the 90th percentile on PPO 2000.

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.

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 Names	Voluntary DMO Plus (Plan 58)	Voluntary PPO 1000 Active		Voluntary PPO 1500
	Fixed copay DMO 58	Preferred 100/80/50	Non-preferred 80/60/40	PPO 1500 100/80/50
Office visit copay	$10	N/A	N/A	N/A
Annual deductible per member (does not apply to diagnostic & preventive services)	None	$75; 3X family maximum	$75; 3X family maximum	$75; 3X family maximum
Annual maximum benefit	Unlimited	$1,000	$1,000	$1,500
Diagnostic Services				
Oral Exams				
Periodic oral exam	No charge	100%	80%	100%
Comprehensive oral exam	No charge	100%	80%	100%
Problem-focused oral exam	No charge	100%	80%	100%
X-rays				
Bitewing – single film	No charge	100%	80%	100%
Complete series	No charge	100%	80%	100%
Preventive Services				
Cleaning	No charge	100%	80%	100%
Sealants – per tooth	$5	100%	80%	100%
Fluoride application – child	No charge	100%	80%	100%
Space maintainers – fixed	$60	100%	80%	100%
Basic Services				
Amalgam filling – 2 surfaces	No charge	80%	60%	80%
Resin filling – 2 surfaces, anterior	No charge	80%	60%	80%
Oral surgery				
Extraction – exposed root or erupted tooth	No charge	80%	60%	80%
Extraction of impacted tooth – soft tissue	$46	80%	60%	80%
Major Services*				
Complete upper denture	$275	50%	40%	50%
Partial upper denture (Resin base)	$275	50%	40%	50%
Crown – porcelain with noble metal[1]	$210	50%	40%	50%
Pontic – porcelain with noble metal[1]	$210	50%	40%	50%
Oral surgery				
Removal of impacted tooth – partially bony	$58	50%	40%	50%
Endodontic services				
Bicuspid root canal therapy	$85	50%	40%	80%
Molar root canal therapy	$240	50%	40%	50%
Periodontic services				
Scaling & root planing – per quadrant	$55	50%	40%	80%
Osseous surgery – per quadrant	$300	50%	40%	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 28 for footnotes.

Dental plans

Voluntary dental 3–9 (continued)

Plan Names	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 member 0/10/40	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%	0%	100%
Comprehensive oral exam	100%	80%	0%	100%
Problem-focused oral exam	100%	80%	0%	100%
X-rays				
Bitewing – single film	100%	80%	0%	100%
Complete series	100%	80%	0%	100%
Preventive Services				
Cleaning	100%	80%	0%	100%
Sealants – per tooth	100%	80%	0%	100%
Fluoride application – child	100%	80%	0%	100%
Space maintainers – fixed	100%	80%	0%	100%
Basic Services				
Amalgam filling – 2 surfaces	80%	60%	10%	80%
Resin filling – 2 surfaces, anterior	80%	60%	10%	80%
Oral surgery				
Extraction – exposed root or erupted tooth	80%	60%	10%	80%
Extraction of impacted tooth – soft tissue	80%	60%	10%	80%
Major Services*				
Complete upper denture	50%	40%	40%	50%
Partial upper denture (Resin base)	50%	40%	40%	50%
Crown – porcelain with noble metal[1]	50%	40%	40%	50%
Pontic – porcelain with noble metal[1]	50%	40%	40%	50%
Oral surgery				
Removal of impacted tooth – partially bony	50%	40%	40%	50%
Endodontic services				
Bicuspid root canal therapy	80%	60%	10%	50%
Molar root canal therapy	50%	40%	40%	50%
Periodontic services				
Scaling & root planing – per quadrant	80%	60%	10%	50%
Osseous surgery – per quadrant	50%	40%	40%	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 28 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.

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

Fixed dollar amounts on DMO in Voluntary DMO Plus and 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 1500, Voluntary PPO 1500 Active and the DMO in Voluntary Freedom-of-Choice Coinsurance plan.

Out-of-network plan payments are limited by geographic area on the PPO in Voluntary PPO Active 1000 and 1500 and Voluntary PPO 1500 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.

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 Names	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 member 0/0/40	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	0%	No charge	No charge	No charge
Comprehensive oral exam	No charge	No charge	0%	No charge	No charge	No charge
Problem-focused oral exam	No charge	No charge	0%	No charge	No charge	No charge
X-rays						
Bitewing – single film	No charge	No charge	0%	No charge	No charge	No charge
Complete series	No charge	No charge	0%	No charge	No charge	No charge
Preventive Services						
Adult cleaning	No charge	No charge	0%	No charge	No charge	$8
Child cleaning	No charge	No charge	0%	No charge	No charge	$7
Sealants – per tooth	$5	No charge	0%	No charge	No charge	$8
Fluoride application – child	No charge	No charge	0%	No charge	No charge	No charge
Space maintainers – fixed	$60	No charge	0%	No charge	No charge	$80
Basic Services						
Amalgam filling – 2 surfaces	No charge	No charge	0%	No charge	No charge	$24
Resin filling – 2 surfaces, anterior	No charge	No charge	0%	No charge	No charge	$35
Endodontic services						
Bicuspid root canal therapy	$85	No charge	0%	No charge	No charge	$180
Periodontic services						
Scaling & root planing – per quadrant	$55	$25	0%	$35	$35	$56
Oral surgery						
Extraction – exposed root or erupted tooth	No charge	No charge	0%	No charge	No charge	$15
Extraction of impacted tooth – soft tissue	$46	No charge	0%	No charge	No charge	$60
Major Services*						
Complete upper denture	$275	$185	40%	$200	$200	$300
Partial upper denture (Resin base)	$275	$185	40%	$200	$200	$300
Crown – porcelain with noble metal[1]	$210	$150	40%	$180	$180	$315
Pontic – porcelain with noble metal[1]	$210	$150	40%	$180	$180	$315
Oral surgery						
Removal of impacted tooth – partially bony	$58	$45	40%	$45	$45	$72
Endodontic services						
Molar root canal therapy	$240	$125	40%	$146	$146	$303
Periodontic services						
Osseous surgery – per quadrant	$300	$140	40%	$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 35 for footnotes.

Dental plans

Voluntary and contributory dental 10–100 (continued)

Plan Names	Option 4A Freedom-of-Choice Monthly Selection Between DMO and PPO		Option 5A Freedom-of-Choice Active Monthly Selection Between DMO and PPO		
	DMO member 0/0/40	PPO 100/80/50	DMO member 0/0/40	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	0%	100%	0%	100%	100%
Comprehensive oral exam	0%	100%	0%	100%	100%
Problem-focused oral exam	0%	100%	0%	100%	100%
X-rays					
Bitewing – single film	0%	100%	0%	100%	100%
Complete series	0%	100%	0%	100%	100%
Preventive Services					
Adult cleaning	0%	100%	0%	100%	100%
Child cleaning	0%	100%	0%	100%	100%
Sealants – per tooth	0%	100%	0%	100%	100%
Fluoride application – child	0%	100%	0%	100%	100%
Space maintainers – fixed	0%	100%	0%	100%	100%
Basic Services					
Amalgam filling – 2 surfaces	0%	80%	0%	90%	80%
Resin filling – 2 surfaces, anterior	0%	80%	0%	90%	80%
Endodontic services					
Bicuspid root canal therapy	0%	80%	0%	90%	80%
Periodontic services					
Scaling & root planing – per quadrant	0%	80%	0%	90%	80%
Oral surgery					
Extraction – exposed root or erupted tooth	0%	80%	0%	90%	80%
Extraction of impacted tooth – soft tissue	0%	80%	0%	90%	80%
Major Services*					
Complete upper denture	40%	50%	40%	60%	50%
Partial upper denture (Resin base)	40%	50%	40%	60%	50%
Crown – porcelain with noble metal[1]	40%	50%	40%	60%	50%
Pontic – porcelain with noble metal[1]	40%	50%	40%	60%	50%
Oral surgery					
Removal of impacted tooth – partially bony	40%	80%	40%	90%	80%
Endodontic services					
Molar root canal therapy	40%	80%	40%	90%	80%
Periodontic services					
Osseous surgery – per quadrant	40%	80%	40%	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 35 for footnotes.

Dental plans

Voluntary and contributory dental 10–100 (continued)

Plan Names	Option 5B 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%
Oral surgery					
Removal of impacted tooth – partially bony	$45	90%	80%	80%	70%
Endodontic services					
Molar root canal therapy	$146	90%	80%	80%	70%
Periodontic services					
Osseous surgery – per quadrant	$140	90%	80%	80%	70%
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 35 for footnotes.

Dental plans

Voluntary and contributory dental 10–100 (continued)

Plan Names	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%
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 35 for footnotes.

Dental plans

Voluntary and contributory dental 10–100 (continued)

Plan Names	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%
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 35 for footnotes.

Dental plans

Voluntary and contributory dental 10–100 (continued)

Plan Names	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%
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 35 for footnotes.

Voluntary and contributory dental plan footnotes

*Coverage waiting period applies to all Voluntary PPO and 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 and 5B.

Fixed dollar amounts on the DMO in plan options 1A, 1B, 2A, 3A, 3B, 3C, 4A, 5A and 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 and 12B. All oral surgery, endodontic and periodontic services are covered as major services on the PPO in plan option 9A.

Plan options 9A, 10A and 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 and 12A to the prevailing fees at the 80th percentile and the 90th percentile in plan option 5B, 8A, 8B, 8C and 12B.

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

All 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 Names	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 reimbursement	$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 $120 allowance plus $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	$84 reimbursement	$130 plan allowance	$104 reimbursement	$115 plan allowance	$92 reimbursement
Medically necessary contact lenses	$0 copay	$200 reimbursement	$0 copay	$200 reimbursement	$0 copay	$200 reimbursement

Vision plans

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

Discounts may not be available in all states

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 102,000 providers* nationwide — whether it's your trusted neighborhood eye doctor or your favorite retail store including LensCrafters®, Pearle Vision®, Target Optical®, CVS Optical® and more. Plus you can use your benefits at five online retailers, including **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 **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 in-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.

*EyeMed provider data as of August, 2019.

**Standard text messaging and other rates from your wireless carrier may apply.

Limitations and 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 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. 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 network provider is coordinating care, the network provider will obtain the precertification. Precertification requirements may vary. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

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 **aetna.com**, or the Aetna Medication Formulary Guide. Aetna or its affiliate(s) receives rebates from drug manufacturers. Rebates may not reduce the amount a member pays the pharmacy for covered prescriptions. Information is subject to change. For more information about your pharmacy plan, refer to your plan's website. 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.

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.

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, 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. 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 aetna.com.

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