

B1





PLAN DESIGN & BENEFITS PROVIDED BY AETNA LIFE INSURANCE COMPANY

| PLAN FEATURES | IN-NETWORK | OUT-OF-NETWORK |
|--------------------------------|------------------|--------------------|
| Deductible (per calendar year) | \$750 Individual | \$1,000 Individual |
| | \$1,875 Family | \$2,500 Family |

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

Unless otherwise indicated, the deductible must be met prior to benefits being payable.

Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible.

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

| Deductible amount. | | | |
|---------------------------------------|--------------------|--------------------|--|
| Member Coinsurance | 10% | 30% | |
| Applies to all expenses unless otherw | ise stated. | | |
| Payment Limit (per calendar year) | \$4,000 Individual | \$6,000 Individual | |
| | \$10.000 Family | \$15.000 Family | |

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

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

Pharmacy expenses apply towards the Payment Limit.

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

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

Lifetime Maximum

Unlimited except where otherwise indicated.

| Payment for Non-Preferred | Not Applicable | Professional: 140% of Medicare | |
|---------------------------|----------------|--------------------------------|--|
| | | Facility: 140% of Medicare | |

We cover the cost of care differently based on whether health care providers, such as doctors and hospitals, are "in network" or "out of network." We want to help you understand how much we will pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this out-of-network care. As an example, you may choose a doctor in our network. You may choose to visit an out-of-network doctor. If you choose a doctor who is out of network, your health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital. When you choose out-of-network care, we will limit the amount it will pay. This limit is called the "recognized" or "allowed" amount. When you choose out-of-network care, we "recognize" an amount based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks. Your out-of-network doctor sets the rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes" or "allows." Your doctor may bill you for the dollar amount that we don't recognize. You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the recognized charge counts toward your deductible or maximum out-of-pocket. To learn more about how we pay out-of-network benefits visit our website. You can avoid these extra costs by getting your care from our broad network of health care providers. 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 us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.

Primary Care Physician Selection

Optional

Not Applicable





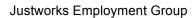
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Certification Requirements -

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

| expense is \$400 per occurrence. | | |
|--------------------------------------|--|---|
| Referral Requirement | None | None |
| PREVENTIVE CARE | IN-NETWORK | OUT-OF-NETWORK |
| Routine Adult Physical Exams/ | Covered 100%; deductible waived | 30%; after deductible |
| Immunizations | | |
| | 65, 1 exam per calendar year age 65 and | |
| Routine Well Child | Covered 100%; deductible waived | Covered 100%; deductible waived |
| Exams/Immunizations | | |
| | 3 exams in the second 12 months of life, | 3 exams in the third 12 months of life, 1 |
| exam per calendar year thereafter to | | |
| Routine Gynecological Care | Covered 100%; deductible waived | 30%; after deductible |
| Exams | | |
| 2 exams per calendar year. Includes | | |
| Routine Mammograms | Covered 100%; deductible waived | 30%; after deductible |
| Women's Health | Covered 100%; deductible waived | 30%; after deductible |
| | iabetes, HPV (Human- Papillomavirus) DI | |
| | d screening for human immunodeficiency | |
| | breastfeeding support, supplies and cour | |
| | procedures, patient education and counse | |
| Routine Digital Rectal Exam | Covered 100%; deductible waived | 30%; after deductible |
| Prostate-specific Antigen Test | Covered 100%; deductible waived | 30%; after deductible |
| Colorectal Cancer Screening | Covered 100%; deductible waived | Covered under Routine Adult Exams |
| Recommended: For all members age | | |
| Routine Eye Exams | Covered 100%; deductible waived | 30%; after deductible |
| 1 routine exam per 12 months. | | |
| Routine Hearing Screening | Covered 100%; deductible waived | 30%; after deductible |
| PHYSICIAN SERVICES | IN-NETWORK | OUT-OF-NETWORK |
| Office Visits to PCP | \$20 copay; deductible waived | 30%; after deductible |
| | eral physician, family practitioner or pedia | |
| Specialist Office Visits | \$30 copay; deductible waived | 30%; after deductible |
| Audiometric Hearing Exam | Not Covered | Not Covered |
| Pre-Natal Maternity | Covered 100%; deductible waived | Covered according to standard claim |
| | | practice. |
| Walk-in Clinics | \$20 copay; deductible waived | 30%; after deductible |
| | nding health care facilities. They are an a | |
| | gency illnesses and injuries and the admi | |
| | n services or the ongoing care provided b | |
| | of a hospital, shall be considered a Walk- | |
| Allergy Testing | Member cost sharing is based on the | Member cost sharing is based on the |
| | type of service performed and the | type of service performed and the |
| | place of service where it is rendered | place of service where it is rendered |





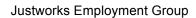
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| Allergy Injections | Member cost sharing is based on the type of service performed and the | Member cost sharing is based on the type of service performed and the |
|---|---|---|
| | place of service where it is rendered | place of service where it is rendered |
| DIAGNOSTIC PROCEDURES | IN-NETWORK | OUT-OF-NETWORK |
| Diagnostic X-ray | 10%; after deductible | 30%; after deductible |
| | fice visit and billed by the physician, exp | |
| applicable physician's office visit members | | enses are covered subject to the |
| Diagnostic Laboratory | 10%; after deductible | 30%; after deductible |
| | fice visit and billed by the physician, exp | |
| applicable physician's office visit members | | chaca are dovered adaptor to the |
| Diagnostic Outpatient Complex | 10%; after deductible | 30%; after deductible |
| Imaging | 1070, ditor doddotiolo | 5070, artor addadtible |
| EMERGENCY MEDICAL CARE | IN-NETWORK | OUT-OF-NETWORK |
| Urgent Care Provider | \$75 copay; deductible waived | 30%; after deductible |
| Non-Urgent Use of Urgent Care | Not Covered | Not Covered |
| Provider | | |
| Emergency Room | \$150 copay; deductible waived | Same as in-network care |
| Copay waived if admitted | • • • | |
| Non-Emergency Care in an | Not Covered | Not Covered |
| Emergency Room | | |
| Emergency Use of Ambulance | 10%; after deductible | Same as in-network care |
| Non-Emergency Use of Ambulance | Not Covered | Not Covered |
| HOSPITAL CARE | IN-NETWORK | OUT-OF-NETWORK |
| Inpatient Coverage | 10%; after deductible | 30%; after deductible |
| The member cost sharing applies to al | covered benefits incurred during a mem | nber's inpatient stay. |
| Inpatient Maternity Coverage | 10%; after deductible | 30%; after deductible |
| (includes delivery and postpartum | | |
| care) | | |
| | covered benefits incurred during a mem | |
| Outpatient Hospital Expenses | 10%; after deductible | 30%; after deductible |
| | covered benefits incurred during a mem | |
| Outpatient Surgery | 10%; after deductible | 30%; after deductible |
| | l covered benefits incurred during a mem | |
| Outpatient Surgery - Freestanding | 10%; after deductible | 30%; after deductible |
| Facility | | |
| | covered benefits incurred during a mem | |
| MENTAL HEALTH SERVICES | IN-NETWORK | OUT-OF-NETWORK |
| Inpatient | 10%; after deductible | 30%; after deductible |
| The member cost sharing applies to al | covered benefits incurred during a mem | |
| Outpatient | \$30 copay; deductible waived | 30%; after deductible |
| | covered benefits incurred during a mem | |
| Crisis Intervention Services | \$30 copay; deductible waived | 30%; after deductible |
| ALCOHOL/DRUG ABUSE SERVICES | IN-NETWORK | OUT-OF-NETWORK |
| Inpatient | 10%; after deductible | 30%; after deductible |
| Member cost sharing is based on the t | ype of service performed and the place of | of service where it is rendered |



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| Residential Treatment Facility | 10%; after deductible | 30%; after deductible |
|---|---|---|
| Outpatient | \$30 copay; deductible waived | 30%; after deductible |
| | covered benefits incurred during a mem | |
| OTHER SERVICES | IN-NETWORK | OUT-OF-NETWORK |
| Convalescent Facility | 10%; after deductible | 30%; after deductible |
| Limited to 60 days per calendar year. | 10 70, after deductible | 50 %, after deductible |
| | covered benefits incurred during a mem | her's innatient stay |
| Home Health Care | Covered 100%; deductible waived | 25%; deductible waived |
| Limited to 120 days per calendar year. | Covered 100%, deductible waived | 2070, academble warved |
| | e visit. Each visit up to 4 hours by a hom | e health care aide is one visit |
| Hospice Care - Inpatient | 10%; after deductible | 30%; after deductible |
| | covered benefits incurred during a mem | |
| Hospice Care - Outpatient | 10%; after deductible | 30%; after deductible |
| | covered benefits incurred during a mem | |
| Private Duty Nursing - Outpatient | 10%; after deductible | 30%; after deductible |
| Limited to 70 eight hour shifts per caler | | |
| | up to 8 hours will be deemed to be one p | rivate duty nursing shift. |
| Outpatient Short-Term | \$30 copay; deductible waived | 30%; after deductible |
| Rehabilitation | ************************************** | , |
| | ational Therapy, limited to 60 visits per c | alendar vear, unlimited for early |
| intervention services from birth to age | | |
| Autism Behavioral Therapy | Refer to MBH Outpatient Mental | Refer to MBH Outpatient Mental |
| | Health | Health |
| Covered same as any other Outpatient | : Mental Health benefit | |
| Autism Applied Behavior Analysis | Refer to MBH Outpatient Mental | Refer to MBH Outpatient Mental |
| | Health | Health |
| Covered same as any other Outpatient | Mental Health benefit with no visit limits | or age restrictions up to 680 hours per a |
| calendar year. | | |
| Autism Physical Therapy | \$30 copay; deductible waived | 30%; after deductible |
| Autism Occupational Therapy | \$30 copay; deductible waived | 30%; after deductible |
| Autism Speech Therapy | \$30 copay; deductible waived | 30%; after deductible |
| Spinal Manipulation Therapy | \$30 copay; deductible waived | 30%; after deductible |
| Hearing Aids | Not Covered | Not Covered |
| Durable Medical Equipment | 50%; after deductible | 50%; after deductible |
| Diabetic Supplies | Covered same as PCP office visit | Covered same as any other medical |
| | cost sharing | expense. |
| Fertility Drugs (oral and injectable) | 10%; after deductible | 30%; after deductible |
| Physician charges included (oral and in | njectable fertility drugs obtained at a pha | rmacy are covered under the Rx plan). |
| Contraceptive drugs and devices | Covered 100%; deductible waived | Covered same as any other expense. |
| not obtainable at a pharmacy | | |
| Generic FDA-approved Women's | Covered 100%; deductible waived | 30%; after deductible |
| Contraceptives | | |
| Transplants | 10%; after deductible | 30%; after deductible |
| | Preferred coverage is provided at an | Non-Preferred coverage is provided |
| | IOE contracted facility only. | at a Non-IOE facility. |
| | | |





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| Bariatric Surgery | 10%; after deductible | 30%; after deductible |
|---|---|---------------------------------------|
| | I covered benefits incurred during a mem | |
| FAMILY PLANNING | IN-NETWORK | OUT-OF-NETWORK |
| Infertility Treatment | Member cost sharing is based on the | Member cost sharing is based on the |
| | type of service performed and the | type of service performed and the |
| | place of service where it is rendered | place of service where it is rendered |
| Diagnosis and treatment of the underly | | |
| Comprehensive Infertility Services | Member cost sharing is based on the | Member cost sharing is based on the |
| | type of service performed and the | type of service performed and the |
| | place of service where it is rendered | place of service where it is rendered |
| Coverage includes Artificial Inseminati | | |
| Advanced Reproductive | Not Covered | Not Covered |
| Technology (ART) | | |
| | ation (IVF), zygote intrafallopian transfer | |
| | rs, intracytoplasmic sperm injection (ICSI | |
| Vasectomy | Member cost sharing is based on the | Member cost sharing is based on the |
| | type of service performed and the | type of service performed and the |
| | place of service where it is rendered | place of service where it is rendered |
| Tubal Ligation | Covered 100%; deductible waived | Member cost sharing is based on the |
| | | type of service performed and the |
| | | place of service where it is rendered |
| PHARMACY | IN-NETWORK | OUT-OF-NETWORK |
| Pharmacy Plan Type | Aetna Value Open Formulary | |
| Retail | \$10 copay for formulary generic | 30% of submitted cost; after |
| | drugs, \$30 copay for formulary | applicable copay |
| | brand-name drugs, and \$50 copay for | |
| | non-formulary brand-name and | |
| | generic drugs up to a 30 day supply | |
| | at participating pharmacies. | |
| Mail Order | \$20 copay for formulary generic | Not Applicable |
| | drugs, \$60 copay for formulary | |
| | brand-name drugs, and \$100 copay | |
| | for non-formulary brand-name and | |
| | generic drugs. | |
| | Up to a 31-90 day supply from Aetna | |
| | Rx Home Delivery®. | |
| Aetna Value Specialty Drugs | \$10 copay for formulary generic | Not Applicable |
| | drugs, \$30 copay for formulary | |
| | brand-name drugs, and \$50 copay for | |
| | non-formulary brand-name and | |
| | generic drugs up to a 30 day supply | |
| | at participating pharmacies. | |
| | at participating pharmacies. | |
| Value Specialty Drug List | at participating pharmacies. | |

First prescription fill at any retail drug facility. Subsequent fills must be through our preferred Aetna Specialty Pharmacy network.





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Plan Includes: Diabetic supplies and medication covered at PCP cost sharing and Contraceptive drugs and devices obtainable from a pharmacy.

Performance Enhancing Drugs limited to 4 tablets per month.

Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).

Value Pre-certification included

Value Step Therapy included

One transition fill allowed within 90 days of member's effective date

Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.

GENERAL PROVISIONS

Dependents Eligibility

Spouse, children from birth to age 26 regardless of student status.

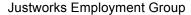
Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

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

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

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

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





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- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- · Custodial care.
- Dental care and dental X-rays.
- · Donor egg retrieval.
- · Durable medical Equipment
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids
- · Home births
- · Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- · Non-medically necessary services or supplies.
- · Orthotics except diabetic orthotics.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- · Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling or prescription drugs.
- · Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Treatment of behavioral disorders.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

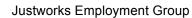
Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary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

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

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

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

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





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