



ALEX LEE, INC.
 Effective Date: January 1, 2020
 Aetna Choice® POS II – ASC
 Plus Option

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	\$1,000 Individual \$2,000 Family	\$3,000 Individual \$6,000 Family
<p>All covered expenses accumulate simultaneously toward both the preferred and 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.</p>		
Member Coinsurance	20%	50%
<p>Applies to all expenses unless otherwise stated.</p>		
Payment Limit (per calendar year)	\$3,000 Individual \$6,000 Family	\$9,000 Individual \$18,000 Family
<p>All covered expenses accumulate simultaneously toward both the preferred and non-preferred 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. Pharmacy expenses do not apply towards 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.</p>		
Lifetime Maximum	Unlimited except where otherwise indicated.	
Primary Care Physician Selection	Optional	Not Applicable
<p>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 \$500 per occurrence.</p>		
Referral Requirement	None	None
<p>Network Designations- In order to be covered at the preferred in-network benefit level you must use a designated provider for care. If you receive care from a non-designated provider your care may be paid at the out-of-network benefit level or may not be covered at all.</p>		
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members age 22 and older.	Covered 100%; deductible waived	50%; after deductible
Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 22.	Covered 100%; deductible waived	50%; after deductible
Routine Gynecological Care Exams 1 exam and pap smear per calendar year, includes related fees.	Covered 100%; deductible waived	50%; after deductible
Routine Mammograms	Covered 100%; deductible waived	50%; after deductible



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Women's Health	Covered 100%; deductible waived	50%; after deductible
Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		
Routine Digital Rectal Exam	Covered 100%; deductible waived	50%; after deductible
For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered under Routine Adult Exams
For all members age 50 and over.		
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office Visits to Non-Specialist	\$30 copay; deductible waived. Copay waived if no office visit billed.	50%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	20%; after deductible	50%; after deductible
Teladoc™	\$0 copay	Not Applicable
Go to www.Teladoc.com (or call 800-TEL-ADOC) to create your Teladoc account, complete your medical history disclosure, and request a consult.		
Hearing Exams	20%; after deductible	50%; after deductible
1 routine exam per 24 months.		
Pre-Natal Maternity	Covered 100%; deductible waived	Covered according to standard claim practice.
Walk-in Clinics	\$30 copay; deductible waived	50%; after deductible
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.		
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray	20%; after deductible	50%; after deductible
(other than Complex Imaging Services) If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic Laboratory	20%; after deductible	50%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic Complex Imaging	20% after \$150 copay; after deductible	50%; after deductible
EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK



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Urgent Care Provider	20% after \$50 copay; deductible waived	Same as in-network care
Non-Urgent Use of Urgent Care Provider	20% after \$50 copay; deductible waived	Same as in-network care
Emergency Room	20% after \$150 copay; deductible waived	Same as in-network care
Copay waived if admitted		
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	20%; 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	20%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	20%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	20%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	20%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	20%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	20%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	20%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%; deductible waived	50%; after deductible
SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	20%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	20%; after deductible	50%; after deductible
Substance Abuse Office Visits	20%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%; deductible waived	50%; after deductible
OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility	20%; after deductible	50%; after deductible
Limited to 60 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	20%; after deductible	50%; after deductible
Limited to 240 visits per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.		



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Hospice Care - Inpatient	20%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	20%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing	20%; after deductible	50%; after deductible
Limited to 120 eight hour shifts per calendar year. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.		
Outpatient Physical Therapy	\$20 copay; deductible waived	50%; after deductible
Outpatient Short-Term Rehabilitation	20%; after deductible	50%; after deductible
Includes speech and occupational therapies, limited to 60 visits per calendar year.		
Spinal Manipulation Therapy	20%; after deductible	50%; after deductible
Limited to 60 visits per calendar year.		
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Combined with outpatient mental health visits		
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health Other Services	Refer to MBH Outpatient Mental Health Other Services
Autism Physical Therapy	\$20 copay; deductible waived	50%; after deductible
Autism Occupational Therapy	20%; after deductible	50%; after deductible
Autism Speech Therapy	20%; after deductible	50%; after deductible
Durable Medical Equipment	20%; after deductible	50%; after deductible
Diabetic Supplies	Covered 100%; deductible waived	50%; after deductible
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.
Infusion Therapy Administered in the home or physician's office	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Vision Eyewear	Not Covered	Not Covered
Transplants (IOE= Institute of Excellence)	20%; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed

Diagnosis and treatment of the underlying medical condition only.



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Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART) Vasectomy	Not Covered	Not Covered
	Your cost sharing is based on the type of service and where it is performed	50%; after deductible
Tubal Ligation	Covered 100%; deductible waived	Your cost sharing is based on the type of service and where it is performed
PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	Aetna Value Open Formulary	
Value Drugs Tier 1A		
	Retail	\$3 copay
	Mail Order	\$6 copay
		Not Covered
		Not Applicable
Preferred Generic Drugs		
	Retail	\$10 copay
	Mail Order	\$15 copay
		Not Covered
		Not Applicable
Preferred Brand-Name Drugs		
	Retail	25%
		Minimum \$30, Maximum \$60
	Mail Order	25%
		Minimum \$60, Maximum \$120
		Not Covered
		Not Applicable
Non-Preferred Generic and Brand-Name Drugs		
	Retail	35%
		Minimum \$60, Maximum \$120
	Mail Order	35%
		Minimum \$120, Maximum \$240
		Not Covered
		Not Applicable
Value Specialty Drugs		
Preferred Specialty	35%	Not Applicable
	Minimum \$150, Maximum \$300	
Non-Preferred Specialty	35%	Not Applicable
	Minimum \$150, Maximum \$300	
Pharmacy Day Supply and Requirements		
	Retail	Up to a 30 day supply from Aetna National Network Percentage copays will not be doubled
Mandatory Maintenance Choice		After two retail fills, members are required to fill a 90-day supply of maintenance drugs at Aetna Rx Home Delivery® or CVS/pharmacy. Otherwise, the member will be responsible for 100 percent of the cost-share.
Value Specialty		Up to a 30 day supply from Aetna Specialty Pharmacy Network. All prescription fills must be through our preferred specialty pharmacy network.
Preventive Medications - Deductible is waived for certain preventive medications. A full list of these drugs is available on Navigator or from your employer.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.		



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A limited list of over-the-counter medications are covered when filled with a prescription.

Value Pre-certification included

Value Step Therapy included

Seasonal Vaccinations covered 100% in-network

Preventive Vaccinations covered 100% in-network

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

Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

Prescription Drug Annual Out of \$2,500 Individual

Pocket Maximum

\$5,000 Family

Medical expenses do not apply towards the Prescription Drug Payment Limit.

Only those pharmacy out-of-pocket expenses resulting from the application of coinsurance percentage and copays may be used to satisfy the Prescription Drug Payment Limit. The family Prescription Drug 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 Prescription Drug Payment Limit amount.

GENERAL PROVISIONS

Dependents Eligibility

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

*Working spouses eligible for medical benefits from their own employer will no longer be eligible to enroll in an Alex Lee medical plan. If your spouse is not offered health benefits from their employer, or is not employed, you may enroll your spouse in an Alex Lee medical plan for 2019. If you and your spouse are BOTH employed at an Alex Lee company, you can cover both you and your spouse in an Alex Lee medical plan.

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. 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.

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

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Home births



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- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and 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/enhancement, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

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 traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862**.

Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com**.
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