

How You Pay for Covered Services (1) (2)	Traditional Choice Plus		Savings Plus HSA		Basic Plus	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	
<b>Annual Deductible</b> (You pay 100% of cost until deductible is met, unless a co-pay applies)	Individual deductible applies for each family member unless two or more family members reach the family deductible first		<b>Associates covering a dependent must meet the entire family deductible before medical and pharmacy benefits pay coinsurance</b>		Individual deductible applies for each family member unless two or more family members reach the family deductible first	
<b>Per Person/Family</b>	\$900 / \$2,000	\$1,400 / \$3,000	\$1,800 / \$4,200	\$3,000 / \$6,500	\$2,000 / 4,000	\$4,000 / \$8,000
<b>Annual Out-of-Pocket Limit</b> (Includes deductible. Does not include out-of-network amounts over the recognized charge.) In-network & out-of-network limits are separate	\$3,000 / \$6,000	\$6,000 / \$12,000	<b>Associates covering a dependent must meet the entire family out-of-pocket maximum before it is applied for any covered member</b>		\$6,000 / \$12,000	\$9,000 / \$18,000
<b>Per Person/Family</b>			\$3,900 / \$7,050	\$7,800 / \$15,600		
<b>Office Visit</b> (for illness or injury) – PCP / Specialist Charges for other eligible medical services during the visit are subject to deductible & coinsurance	\$25/\$45 co-pay no deductible	40% after deductible	20% after deductible	40% after deductible	\$25/\$50 co-pay no deductible	50% after deductible
	20% after deductible	40% after deductible	20% after deductible	40% after deductible	30% after deductible	50% after deductible
<b>Mental Health Benefits</b> Outpatient Inpatient	\$25 co-pay no deductible	40% after deductible	20% after deductible	40% after deductible	\$25 co-pay no deductible	50% after deductible
	20% after deductible	40% after deductible	20% after deductible	40% after deductible	30% after deductible	50% after deductible
<b>Inpatient Hospital/Emergency Room Hospital-based providers</b>	20% after deductible You also pay: \$200 ER co-pay (ER copay waived if admitted)	Inpatient: 40% after deductible ER: 20% after deductible You also pay: \$200 ER co-pay (ER copay waived if admitted)	20% after deductible	Inpatient: 40% after deductible ER: 20% after deductible	Inpatient: 30% after deductible ER: \$250 co-pay	Inpatient: 50% after deductible ER: \$250 co-pay
<b>Urgent Care Centers</b>	\$45 co-pay no deductible	40% after deductible	20% after deductible	40% after deductible	30% after deductible	50% after deductible
<b>Physical, Speech and Occupational Therapy (3)</b>	20% after deductible	40% after deductible	20% after deductible	40% after deductible	30% after deductible	50% after deductible
<b>Chiropractor</b>	You pay: \$45 co-pay, no deductible (maximum Plan benefit of \$2,500 per calendar year)	40% after deductible up to a maximum benefit of \$2,500 per calendar year	20% after deductible (maximum Plan benefit of \$2,500 per calendar year)	40% after deductible up to a maximum benefit of \$2,500 per calendar year	30% after deductible	50% after deductible
<b>X-Ray / Lab</b>	20% after deductible	40% after deductible	20% after deductible	40% after deductible	30% after deductible	50% after deductible

		Traditional Choice Plus		Savings Plus HSA		Basic Plus
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
Preventive Care (4)		0% no deductible	40% after deductible	0% no deductible	40% after deductible	0% no deductible
Prescription Drugs (CVS)		No Rx Deductible/ Separate Rx Out-of-Pocket Maximum \$3,750/\$7,500		Combined with Medical Deductible and Out-of-Pocket Maximum		No Rx Deductible / Out-of-Pocket Maximum combined with Medical
Preventive Medications		ACA preventive medications will be covered at 100%		ACA and certain other preventive medications will be covered at 100%, no deductible. For all other prescriptions, the chart below will apply once your deductible under the SavingsPlus HSA Plan has been satisfied.		ACA preventive medications will be covered at 100%
<b>Plan payment based on cost of generic when available (5) – see also footnotes (6) (7) regarding prior authorization and long-term medications after first 3 fills</b>						
Retail – Up to a 30-day supply	Generic	30% of the prescription drug's total cost Minimum: \$15, Maximum: \$60		30% of the prescription drug's total cost Minimum: \$15, Maximum: \$60		\$10, no deductible
	Preferred	30% of the prescription drug's total cost Minimum: \$45, Maximum: \$120		30% of the prescription drug's total cost Minimum: \$45, Maximum: \$120		30% of the prescription drug's total cost Minimum: \$45, Maximum: \$120
	Non-Preferred	50% of the prescription drug's total cost Minimum: \$70, Maximum: \$180		50% of the prescription drug's total cost Minimum: \$70, Maximum: \$180		50% of the prescription drug's total cost Minimum: \$70, Maximum: \$180
Mail Order network pharmacy – Up to a 90-day supply	Generic	30% of the prescription drug's total cost Minimum: \$30, Maximum: \$120		30% of the prescription drug's total cost Minimum: \$30, Maximum: \$120		\$25, no deductible
	Preferred	30% of the prescription drug's total cost Minimum: \$90 Maximum: \$240		30% of the prescription drug's total cost Minimum: \$90 Maximum: \$240		30% of the prescription drug's total cost Minimum: \$90 Maximum: \$240
	Non-Preferred	50% of the prescription drug's total cost Minimum: \$175, Maximum: \$450		50% of the prescription drug's total cost Minimum: \$175, Maximum: \$450		50% of the prescription drug's total cost Minimum: \$175, Maximum: \$450
Exclusive Specialty (8) (9)	Generic	\$0 through PrudentRx (30% if you opt-out)		\$0 after deductible through PrudentRx (30% after deductible if you opt-out)		\$0 through PrudentRx (30% if you opt-out)
	Preferred					
	Non-Preferred					

See footnotes (1-10) on the next page

- 1) Shows co-insurance amount you pay (the Plan pays the difference, e.g. when you pay 20%, the Plan pays 80% of the applicable cost) or flat co-pays that you pay (as applicable). Prescription drug shows co-insurance and min/max amounts that you pay. **The Basic Plus plan provides in-network coverage only**, unless a true medical emergency.
- 2) Shows co-insurance amount you pay (the Plan pays the difference, e.g. when you pay 40%, the Plan pays 60% of the applicable cost; you also pay what is not covered out-of-network) or flat co-pays that you pay (as applicable). Eligible expenses when you use out-of-network providers (Traditional Choice Plus and SavingsPlus plans only) are covered at 250% of the Medicare allowed rate. The Medicare allowed rate is the charge that the Center for Medicare/Medicaid Services (CMS) establishes as the eligible cost for services. **When you use out-of-network providers, you will continue to pay your portion of coinsurance (after you meet the deductible) plus any amount above what is covered.**
- 3) Subject to medical review after 25 visits.
- 4) Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:
  - evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
  - immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
  - with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
  - with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration, including the expanded women's preventive services, which includes, among other items, breast feeding support, supplies and counseling.
- 5) If you purchase a brand name medication when a generic equivalent is available, you will pay your **generic co-payment plus the cost difference between the brand (preferred or non-preferred) name and generic medication**. The difference will not count towards your out-of-pocket maximum.
- 6) Some drugs are subject to prior authorization rules. Your doctor may be required to provide additional information before prescriptions for these medications can be filled.
- 7) Long-term (maintenance) drugs are subject to higher member cost-share if not purchased at a CVS retail pharmacy or CVS Mail Order after the first three fills. This higher cost share does not count towards the deductible or out-of-pocket maximum (as applicable).
- 8) If you are eligible for and use a third-party copay assistance program or drug manufacturer discount copay card when you fill your prescription through CVS Specialty®, your out-of-pocket costs may be reduced for a 30-day supply of your specialty medication. Any savings or rebates you receive from the drug manufacturer do not count toward your annual deductible and/or out-of-pocket maximum. Only the amount you pay out-of-pocket will apply to the deductible and/or out-of-pocket maximum.
- 9) Prescriptions plans include the PrudentRx solution for specialty medications. This program is designed to lower your out-of-pocket costs by assisting you with enrollment in drug manufacturer discount copay cards/assistance programs. Once enrolled in the PrudentRx solution, if you are enrolled in the Traditional Choice Plus and Basic Plus plan options, your out-of-pocket cost will be \$0 for eligible medications. If you are enrolled in the Savings Plus HSA, your out-of-pocket cost will be \$0 after deductible for eligible medications. If you opt out, you will be responsible for the 30% coinsurance and the amount may not apply toward your deductible and/or out-of-pocket maximum.

## Special features if you enroll in a Broadridge medical plan option:

- CVS MinuteClinic services will be provided at no cost share. For the SavingsPlus plan, your deductible must first be met before services are provided at no cost share. Go to <https://www.cvs.com/minuteclinic/services> to review available services.
- On-demand access to Teladoc for general, dermatology, and behavioral health needs <http://www.Teladoc.com/Aetna> (separate cost share schedule applies, details on [Broadridgebenefits.com](http://Broadridgebenefits.com))
- Free access to 2<sup>nd</sup> MD, offering second opinion services, recommendations for in-network care and health education resources: [2<sup>nd</sup>.MD/Aetna](http://2nd.MD/Aetna) or via the 2nd.MD app.
- Access to MSK Direct, offering cancer care and support through Memorial Sloan Kettering Cancer Center (MSK), including expedited appointments for on-site care at MSK, second opinion diagnosis and treatment plans (available remotely), and screening and prevention resources. Care delivered through MSK Direct will be submitted through your Aetna insurance and you will be responsible for the applicable in-network deductible and coinsurance for any clinical care you receive.
- Free access to Livongo, a program for associates and covered dependents who are diagnosed with diabetes. [www.join.livongo.com/Broadridge/hi](http://www.join.livongo.com/Broadridge/hi) (Code: BROADRIDGE). You get:
  - Connected Blood Glucose Meter
  - Personalized insights
  - Support from Expert Coaches
  - Unlimited Strips

## Traditional Passive PPO and Savings Passive PPO

The Passive PPO Options are only available to associates who reside outside of the Aetna Choice Plus managed care service areas or who are traveling out of the country. Passive benefits are not available for the BasicPlus plan option. Under the Aetna Passive PPO options, out-of-network benefits are paid at a higher level than the standard managed plan benefits (the Plan pays 80% coinsurance vs. 60%). The deductible and out-of-pocket maximums are the same as the network benefit levels.

To determine your Plan eligibility, log on to [Broadridgebenefits.com](http://Broadridgebenefits.com). You can also contact the Broadridge Benefits Service Center at **1-877-631-0059** for assistance.