REED AUTOMOTIVE GROUP, INC.
Proposed Effective Date: 01-01-2026
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PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK DESIGNATED PROVIDERS
Benefit limitations - Some service or supplies have limits on them per year. There might be a maximum number of visits or days, or a dollar limit per year. In such cases, the benefit year begins on January 1 (unless otherwise noted). Refer to your plan documents to learn more.	
Deductible (per calendar year)	$3,000 per Individual $6,000 per Family
You must first meet the deductible before the plan begins paying benefits, unless otherwise noted. The amount you pay (cost sharing) for some medical services does not count toward your deductible. Prescription drug costs do not count toward the deductible. Refer to your plan documents for details. Your family will have one deductible. You will meet it when the expenses of several family members add up to the family deductible. No one person will have to pay more than the individual deductible.	
Member coinsurance	Covered 100%
Applies to all expenses except as noted.	
Out-of-pocket limit (per calendar year)	$3,000 per Individual $6,000 per Family
Your pharmacy expenses count toward your out-of-pocket limit. In-network expenses include coinsurance/copays and deductibles. Your family will have one out-of-pocket limit. You will meet it when the expenses of several family members add up to the family out-of-pocket limit. No one person will have to pay more than the individual out-of-pocket limit amount.	
Lifetime maximum	
Unlimited except where otherwise indicated.	
Primary care physician selection	Encouraged
Referral requirement	Not required
Telehealth consultations - You can access covered services for telehealth visits from different kinds of providers in your network. Log on to **Aetna.com** to see a list of telehealth providers. You'll also find more about your options, including cost share amounts.	
Virtual care consultations - You can access covered services for virtual care visits from different kinds of providers in your network. Log on to **Aetna.com** to see a list of virtual care providers. You'll also find more about your options, including cost share amounts. **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.	
CVS VIRTUAL CARE	**IN-NETWORK**
CVS Health Virtual Primary Care (VPC) - preventive care consultations	Covered 100%; no deductible
Includes screening and counseling services through CVS Health Virtual Primary Care for members age 18 and older; refer to Aetna.com for more information.	
CVS Health Virtual Primary Care (VPC) - consultations	Covered 100%; no deductible
Includes basic medical service consultations through CVS Health Virtual Primary Care for members age 18 and older; refer to Aetna.com for additional information.	
CVS Health Virtual Care (VC) - general medicine	Covered 100%; no deductible
CVS Health Virtual Care (VC) - mental health	Covered 100%; no deductible

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PREVENTIVE CARE	IN-NETWORK DESIGNATED PROVIDERS
Routine adult physical exams/ immunizations	Covered 100%; no deductible
1 exam every 12 months until age 65, then 1 exam every 12 months age 65 and older	
Routine well child exams	Covered 100%; no deductible
• 7 exams in the first 12 months • 3 exams from age 13 months to 24 months • 3 exams from age 25 months to 36 months • 1 exam every 12 months thereafter until age 22	
Childhood immunizations	Covered 100%; no deductible
Child to age 5	
Routine gynecological care exams	Covered 100%; no deductible
1 exam and pap smear per year, includes related fees.	
Routine mammogram	Covered 100%; no deductible
Recommended: One per year for members age 40 and over	
Women's health	Covered 100%; no 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.	
Pre-natal maternity	Covered 100%; no deductible
Routine digital rectal exam	Covered 100%; no deductible
Recommended: For members age 40 and over	
Prostate-specific antigen test	Covered 100%; no deductible
Recommended: For members age 40 and over	
Colorectal cancer screening	Covered 100%; no deductible
Recommended: For members age 45 and over	
Routine eye exams	Not Covered
Routine hearing screening	Covered 100%; no deductible
Newborn hearing screening	Payable same as any other covered expense
Includes screening and hearing aids for each impaired ear for children under 1 year of age.	
PHYSICIAN SERVICES	**IN-NETWORK DESIGNATED PROVIDERS**
Office visits to primary care physician (PCP)	Covered 100%; no deductible
Includes services of an internist, general physician, family practitioner or pediatrician.	
Telehealth consultation with non-specialist	Covered 100%; no deductible
Specialist office visits	Covered 100%; no deductible
Telehealth consultation with specialist	Covered 100%; no deductible
Hearing exams	Not Covered
Walk-in clinics	Covered 100%; no deductible **Designated Walk-in clinics** Covered 100%; no deductible
Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services. Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices.	

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Allergy testing	Your cost sharing amount depends on the type of service and where you receive it.
Allergy injections	Your cost sharing amount depends on the type of service and where you receive it. Covered 100% when an office visit charge is not applicable.
DIAGNOSTIC PROCEDURES	**IN-NETWORK DESIGNATED PROVIDERS**
Diagnostic X-ray (Other than complex imaging services)	Covered 100%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	
Diagnostic laboratory	Covered 100%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	
Diagnostic complex imaging	Covered 100%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	
EMERGENCY MEDICAL CARE	**IN-NETWORK DESIGNATED PROVIDERS**
Urgent care provider	Covered 100%; no deductible
Non-urgent use of urgent care provider	Not Covered
Emergency room	Covered 100%; no deductible
Non-emergency care in an emergency room	Not Covered
Emergency use of ambulance	Covered 100%; no deductible
Non-emergency use of ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK DESIGNATED PROVIDERS**
Inpatient coverage	Covered 100%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Inpatient maternity coverage (includes delivery and postpartum care)	Covered 100%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Outpatient hospital	Covered 100%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	
Outpatient surgery - hospital	Covered 100%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	
Outpatient surgery - freestanding facility	Covered 100%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	
MENTAL HEALTH SERVICES	**IN-NETWORK DESIGNATED PROVIDERS**
Inpatient	Covered 100%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Mental health office visits	Covered 100%; no deductible
Mental health telehealth consultations	Covered 100%; no deductible
Other mental health services	Covered 100%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	

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SUBSTANCE ABUSE	IN-NETWORK DESIGNATED PROVIDERS
Inpatient	Covered 100%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Residential treatment facility	Covered 100%; after deductible
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Substance abuse office visits	Covered 100%; no deductible
Substance abuse telehealth consultations	Covered 100%; no deductible
Other substance abuse services	Covered 100%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	
THERAPY SERVICES	**IN-NETWORK DESIGNATED PROVIDERS**
Chiropractic care	$20 copay; no deductible
Outpatient rehabilitative physical and occupational therapy	Covered 100%; no deductible
Limited to 20 visits per year	
Outpatient rehabilitative speech therapy	Covered 100%; no deductible
Habilitative physical therapy	Covered 100%; no deductible
Habilitative occupational therapy	Covered 100%; no deductible
Habilitative speech therapy	Covered 100%; no deductible
Autism related physical therapy	Covered 100%; no deductible
Autism related occupational therapy	Covered 100%; no deductible
Autism related speech therapy	Covered 100%; no deductible
Autism related behavioral therapy	Covered 100%; no deductible
These benefits are combined with outpatient mental health visits	
Autism related applied behavior analysis	Covered 100%; after deductible
Your benefits for these services are the same as any other outpatient mental health other services benefit	
OTHER SERVICES	**IN-NETWORK DESIGNATED PROVIDERS**
Skilled nursing facility	Covered 100%; after deductible
Limited to 60 days per year When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Home health care	Covered 100%; after deductible
Limited to 60 visits per year Home health care services include private duty nursing Limited to three visits per day by staff from a home health care agency. One visit equals a period of four hours or less.	
Hospice care - inpatient	Covered 100%; after deductible
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Hospice care - outpatient	Covered 100%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	
Private duty nursing	Covered as part of home health care
We count each period of up to 8 hours as one private duty nursing shift.	

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Durable medical equipment	Covered 100%; after deductible
Diabetic supplies	
• If not covered under the prescription drug benefit	You pay your PCP visit cost sharing amount
• If covered under the prescription drug benefit	You pay your applicable prescription drug cost sharing amount
Infusion therapy - home/office	Covered 100%; no deductible
Infusion therapy - outpatient hospital/freestanding facility	Covered 100%; after deductible
Gene-based, Cellular, and other Innovative Therapies (GCIT™)	Your cost sharing amount depends on the type of service and where you receive it. $50 copay: after deductible for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.
Hearing aids 1 hearing aid per ear every 4 years to age 18	Covered 100%; after deductible
Transplants	Covered 100%; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.
Bariatric surgery	Not Covered
Acupuncture Limited to 10 visits per year	Covered 100%; no deductible
FAMILY PLANNING	**IN-NETWORK DESIGNATED PROVIDERS**
Basic Infertility Not covered for Artificial Insemination	Your cost sharing amount depends on the type of service and where you receive it.
Advanced Reproductive Technology (ART)	Not Covered
Fertility preservation	Not Covered
Vasectomy	Not Covered
Tubal ligation	Not Covered

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PHARMACY	IN-NETWORK
Pharmacy plan type	Advanced Control Plan - Aetna
Prescription drug out-of-pocket limit	Prescription drug expenses apply to your medical out-of-pocket limit.
Preferred generic drugs	
Retail	$15 copay
Mail order	$15 copay
Preferred brand-name drugs	
Retail	$50 copay
Mail order	$50 copay
Non-preferred generic and brand-name drugs	
Retail	$95 copay
Mail order	$95 copay
Pharmacy day supply and requirements	
Retail	You can get up to a 34-day supply from Aetna National Network
Mandatory maintenance choice	Maintenance drugs are prescriptions commonly used to treat conditions that require regular, daily use of medicines. If you take a maintenance drug, you can get two retail fills. Then you must fill a 102-day supply of the maintenance drug at CVS Caremark® Mail Service Pharmacy, a designated network pharmacy, or a CVS Pharmacy®. If you do not, you will need to pay 100% of the drug cost.
Opt Out	You must notify us if you want to continue to fill the medicine at a network retail pharmacy. Just call the number on the member ID card.
Specialty	You can get up to a 30-day supply of specialty drugs You must fill all specialty drugs through our preferred specialty pharmacy network. Advanced Control Formulary Aetna Insured List

Your prescription drug plan also includes:
- Diabetic supplies
- $25 copay maximum per fill per 30 day supply for formulary insulin drugs
- A limited list of over-the-counter medications when filled with a prescription

The following are covered 100% in-network:
- Oral chemotherapy drugs
- Seasonal vaccinations
- Preventive vaccinations
- Affordable Care Act (ACA) eligible preventive medications

Refer to **Aetna.com** for a complete list of eligible prescription drugs.

Precertification requirements

Some covered prescription drugs need approval from us before we will cover the drug. If you are currently taking one of these drugs when you switch to this plan, you may get one fill of your prescription within the first 90 days of starting the plan.

Some covered prescription drugs require step therapy before we cover them. With step therapy, you must first try one or more drugs before we will pay for drugs that require step therapy. If you are currently taking one of these drugs when you switch to this plan. you may get one fill of your prescription within the first 90 days of starting this plan.

To get the most up-to-date precertification requirements and a list of drugs that require step therapy, see your plan documents or go online to your member website.

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Choose generics - Sometimes you or your provider may ask for a brand-name prescription drug when a generic is available. If so, you will pay the brand-name copay plus the difference between the generic price and the brand-name price.

GENERAL PROVISIONS

Dependents who are eligible to be on your plan	Spouse, children from birth to age 26. Student status of children does not matter.

Plans are provided by: Aetna Health Inc. 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.
• 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.
• 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.

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

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Translation of this material into another language may be available. Please call Member Services at the number on the back of your ID card.

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.

For more information about Aetna plans, refer to **www.aetna.com.**
Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.

*****This plan document provides you with an overview of some of your benefits and your cost share obligations. This information is for illustrative purposes ONLY. This document is not an official document and may differ from your Certificate of Coverage (COC), which is your official document. Refer to your COC for your coverage and services and any obligations on your part.**