Schedule of Benefits

Employer:	**City of Portland**
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For: Value Based Plan - Choice POS II

Important Notice About Your Medical Plan

Designated and Non-Designated Network Providers
This Plan provides preferred benefit coverage and access to certain covered services and supplies through a network of health care providers and facilities that are unique to your Plan. The network has been divided into two groups. The two groups of **network providers** are called **designated network providers** and **non-designated network providers** in this Plan. This Plan is designed to lower your out-of-pocket costs when you use these **designated** and **non-designated network providers**. Your cost sharing will be lower when you use the **designated network providers**. Both groups of **network providers** are identified in the printed **directory** and the on-line version of the **directory** via DocFind at www.aetna.com. Please be sure to look at the appropriate **directory** that applies to your Plan, since different **Aetna** plans use different networks of providers. Your Plan includes different benefit levels based upon the type of **network provider** that you use (designated or non-designated) or if you choose to see an **out-of-network** provider.

Important Note:

If you live in an area with a designated network, for maximum savings, you must select a **designated network provider** for care. If you select a **non-designated network provider** for your care, your out-of-pocket expenses will be higher than if you selected a **designated network provider** or certain benefits may not be covered under this Plan. *Carefully read the details on cost-sharing provided later in this Schedule of Benefits.*

Aetna Choice POS II Medical Plan

PLAN FEATURES	NETWORK BENEFIT LEVEL		OUT-OF-NETWORK BENEFIT LEVEL
	Designated Network Provider	*Non-Designated Network Provider*	*Out-of-Network Provider*

Deductibles and Maximum Out of Pocket limits are not combined between designated network providers and non-designated network providers, unless specifically stated otherwise. Refer to the Deductible Provisions and Maximum Out of Pocket limits sections, which appear in this Schedule of Benefits.

Calendar Year Deductible*			
Individual Deductible*	$400	$1,000	$1,000
Family Deductible*	$800	$2,000	$2,000

*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.

Plan Maximum Out of Pocket Limit includes plan **deductible** and **copayments**.

Plan Maximum Out of Pocket Limit excludes **precertification** penalties.

Individual Maximum Out of Pocket Limit:

- For **designated network provider** expenses: $1,500.
- For **non-designated out-of-network provider** expenses: $2,500.
- For **out-of-network** expenses: $2,500.

Family Maximum Out of Pocket Limit:

- For **designated network provider** expenses: $3,000.
- For **non-designated out-of-network provider** expenses: $5,000.
- For **out-of-network** expenses: $5,000.

Lifetime Maximum Benefit per person	Unlimited	Unlimited	Unlimited

Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles and the remaining payment percentage. You are responsible for full payment of any non-covered expenses you incur.

All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network, unless specifically stated otherwise.

PLAN FEATURES	**NETWORK BENEFIT LEVEL**		**OUT-OF-NETWORK BENEFIT LEVEL**
	Designated Network Provider	*Non-Designated Network Provider*	*Out-of-Network Provider*
Preventive Care Benefits			
Routine Physical Exams Office Visits	100% per visit No **copay** or **deductible** applies.	70% per visit after Calendar Year **deductible**	Not Covered

Covered Persons through age 21: Maximum Age & Visit Limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents. *For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card*	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents. *For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card*	Not Covered.
Preventive Care Immunizations *Performed in a facility or* ***physician's*** *office*	100% per visit No **copay** or **deductible** applies. Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. *For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.*	70% per visit after Calendar Year **deductible** Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. *For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.*	Not Covered

Screening & Counseling Services ***Office Visits*** ***Obesity and/or Healthy Diet*** ***Misuse of Alcohol and/or Drugs & Use of Tobacco Products*** ***Sexually Transmitted Infections*** ***Genetic Risk for Breast and Ovarian Cancer***	100% per visit No **copay** or **deductible** applies.	70% per visit after Calendar Year **deductible**	No Coverage
Obesity and/or Healthy Diet Maximum Visits per not applicable *(This maximum applies only to Covered Persons ages 22 & older.)*	Unlimited visits*	Unlimited visits*	No Coverage
***Note:** Each session of up to 60 minutes is equal to one visit.*			
Misuse of Alcohol and/or Drugs Maximum Visits per not applicable	Unlimited visits*	Unlimited visits*	No Coverage
***Note:** Each session of up to 60 minutes is equal to one visit.*			
Use of Tobacco Products Maximum Visits per not applicable	Unlimited visits*	Unlimited visits*	No Coverage
***Note:** Each session of up to 60 minutes is equal to one visit.*			
Sexually Transmitted Infections Benefit Maximums Maximum Visits per not applicable	Unlimited visits*	Unlimited visits*	Not Covered
***Note:** Each session of up to 30 minutes is equal to one visit.*			

Well Woman Preventive Visits *Office Visits* Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administrations	100% per visit No Calendar Year **deductible** applies.	100% per visit No Calendar Year **deductible** applies.	Not Covered
Hearing Exam Up to age 20	$20 exam **copay** then the plan pays 100% No Calendar Year **deductible** applies.	$20 exam **copay** then the plan pays 100% No Calendar Year **deductible** applies.	70% per exam after Calendar Year **deductible**
Maximum exams per 24 month period	1 exam	1 exam	1 exam
Hearing Supply Up to age 18	90% after Calendar Year **deductible**	90% after Calendar Year **deductible** (The applicable Calendar Year **deductible** and **Maximum Out of Pocket Limit** is based on the designated network provider and **Maximum Out of Pocket Limit.)**	70% after Calendar Year **deductible**
Hearing Supply Maximum per 36 month period	$2,800	$2,800	$2,800
Routine Cancer Screening *Outpatient*	100% per exam No Calendar Year **deductible** applies.	100% per exam No Calendar Year **deductible** applies.	Not Covered

Maximums	Subject to any age; family history and frequency guidelines as set forth in the most current: • evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician*** *or Member Services by logging onto the* ***Aetna*** *website www.aetna.com, or calling the number on the back of your ID card.*	Subject to any age; family history and frequency guidelines as set forth in the most current: • evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician*** *or Member Services by logging onto the* ***Aetna*** *website www.aetna.com, or calling the number on the back of your ID card.*	Not Covered
Lung Cancer Screening	100% per exam No Calendar Year **deductible** applies.	100% per exam No Calendar Year **deductible** applies.	70% per visit after Calendar Year deductible
Lung Cancer Screening Maximum	One screening every 12 months*	One screening every 12 months*	One screening every 12 months*

Important Note:** ***Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing section of your Schedule of Benefits.

PLAN FEATURES	**NETWORK**		**OUT-OF-NETWORK**
Routine Cancer Screenings			
Routine Mammography	100% per test	100% per test	Not Covered
First 2 tests per Calendar Year	No Calendar Year **deductible** applies.	No Calendar Year **deductible** applies.	
	90% per test	90% per test	Not Covered
Additional tests in the Calendar Year	No Calendar Year **deductible** applies	No Calendar Year **deductible** applies	
Prenatal Care Office Visits	100% per visit No **copay** or **deductible** applies.	100% per visit No **copay** or **deductible** applies.	70% per visit after Calendar Year **deductible**

Important Note: Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.			
Comprehensive Lactation Support and Counseling Services			
Lactation Counseling Services *Facility or Office Visits*	100% per visit. No **copay** or **deductible** applies.	100% per visit. No **copay** or **deductible** applies.	Not Covered
Lactation Counseling Services Maximum Visits either in a group or individual setting	6* visits per 12 months	6* visits per 12 months	Not Applicable
***Important Note**: Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.			
Breast Pumps & Supplies	100% per item. No **deductible** applies.	100% per item. No **deductible** applies	No Coverage
Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet for limitations on breast pumps and supplies.			
Family Planning Services			
Female Contraceptive Counseling Services - Office Visits.	100% per visit. No **copay** or **deductible** applies.	100% per visit. No **copay** or **deductible** applies.	Not Covered
Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits per 12 months	2* visits per 12 months	Not Applicable
*Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.			
Family Planning Services - Female Contraceptives			
Female Contraceptive Generic **Prescription Drugs** and Devices provided, administered, or removed, by a **Physician** during an Office Visits.	100% per item No **copay** or **deductible** applies.	100% per item No **copay** or **deductible** applies.	Not Covered

PLAN FEATURES	NETWORK BENEFIT LEVEL		OUT-OF-NETWORK BENEFIT LEVEL
	Designated Network Provider	*Non-Designated Network Provider*	*Out-of-Network Provider*
Family Planning – Other Voluntary Termination of Pregnancy			
Outpatient	90% per visit after Calendar Year **deductible**	90% per visit after Calendar Year **deductible** (The applicable Calendar Year **deductible** and **Maximum Out of Pocket Limit** is based on the designated network provider **deductible** and **Maximum Out of Pocket Limit.**)	70% per visit after Calendar Year **deductible**
Voluntary Sterilization for Males			
Outpatient	90% per visit after Calendar Year **deductible**	90% per visit after Calendar Year **deductible** (The applicable Calendar Year **deductible** and **Maximum Out of Pocket Limit** is based on the designated network provider **deductible** and **Maximum Out of Pocket Limit.**)	70% per visit after Calendar Year **deductible**
Family Planning - Female Voluntary Sterilization			
Inpatient	100% per visit No **copay** or **deductible** applies.	100% per visit No **copay** or **deductible** applies.	70% per visit after Calendar Year **deductible**
Outpatient	100% per visit No **copay** or **deductible** applies.	100% per visit No **copay** or **deductible** applies.	70% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK BENEFIT LEVEL		OUT-OF-NETWORK BENEFIT LEVEL
	Designated Network Provider	*Non-Designated Network Provider*	*Out-of-Network Provider*
Vision Care			
Eye Examinations including refraction	100% per exam No Calendar Year **deductible** applies.	100% per exam No Calendar Year **deductible** applies.	70% per exam after Calendar Year **deductible**
Maximum Benefit per 2 Calendar Year period	1 exam	1 exam	1 exam

PLAN FEATURES	NETWORK BENEFIT LEVEL		OUT-OF-NETWORK BENEFIT LEVEL
	Designated Network Provider	*Non-Designated Network Provider*	*Out-of-Network Provider*
Physician Services			
Office Visits to Primary Care Physician Office visits (non-surgical) to non-specialist	100% per exam No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**	70% per visit after Calendar Year **deductible**
Specialist Office Visits	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**
Physician Office Visits-Surgery			
Physician	100% per exam No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**	70% per visit after Calendar Year **deductible**
Specialist	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**

Walk-In Clinic Visit (Non-Emergency)			
*Preventive Care Services** Immunizations	100% per visit No **copay** or **deductible** applies. For details, contact your **physician**, log onto the **Aetna** website www.aetna.com, or call the number on the back of your ID card.	100% per visit No **copay** or **deductible** applies. For details, contact your **physician**, log onto the **Aetna** website www.aetna.com, or call the number on the back of your ID card.	Not Covered
Individual Screening and Counseling Services for Tobacco Use	100% per visit No **copay** or **deductible** applies.	100% per visit No **copay** or **deductible** applies.	Not Covered
Maximum Benefit per visit - Individual Screening and Counseling Services for Tobacco Use	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Not Applicable
Individual Screening and Counseling Services for Obesity	100% per visit No **copay** or **deductible** applies.	100% per visit No **copay** or **deductible** applies.	Not Covered
Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Not Applicable
***Important Note**: Not all preventive care services are available at all **Walk-In Clinics**. The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your **physician**.			
All Other Services	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**

Physician Services for Inpatient Facility and Hospital Visits	90% per visit after Calendar Year **deductible**	90% per visit after Calendar Year **deductible** (The applicable Calendar Year **deductible** and **Maximum Out of Pocket Limit** is based on the designated network provider **deductible** and **Maximum Out of Pocket Limit.**)	70% per visit after Calendar Year **deductible**
Administration of Anesthesia	90% per procedure after Calendar Year **deductible**	90% per procedure after Calendar Year **deductible** (The applicable Calendar Year **deductible** and **Maximum Out of Pocket Limit** is based on the designated network provider **deductible and Maximum Out of Pocket Limit.**)	70% per procedure after Calendar Year **deductible**
Allergy Injections	90% per visit after Calendar Year **deductible**	90% per visit after Calendar Year **deductible** (The applicable Calendar Year **deductible** and **Maximum Out of Pocket Limit** is based on the designated network provider **deductible and Maximum Out of Pocket Limit.**)	70% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK BENEFIT LEVEL		OUT-OF-NETWORK BENEFIT LEVEL
	Designated Network Provider	*Non-Designated Network Provider*	*Out-of-Network Provider*
Emergency Medical Services			
Hospital Emergency Facility and Physician	$100 **copay** per visit then the plan pays 100% No Calendar Year **deductible** applies.	$100 **copay** per visit then the plan pays 100% No Calendar Year **deductible** applies.	Paid the same as the Network level of benefits. See Important Note Below
Important Note: Please note that as these providers are not **network providers** and do not have a contract with **Aetna**, the provider may not accept payment of your cost share (your **deductible** and **payment percentage)**, as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or **physician** bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.			
Non-Emergency Care in a Hospital Emergency Room	Not covered	Not covered	Not covered
Important Notice: A separate **hospital** emergency room **deductible** or **copay** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your **deductible** or **copay** is waived. Covered expenses that are applied to the emergency room **deductible** or **copay** cannot be applied to any other **deductible** or **copay** under your plan. Likewise, covered expenses that are applied to any of your plan's other **deductibles** or **copays** cannot be applied to the emergency room **deductible** or **copay**.			
Urgent Care Services			
Urgent Medical Care *(at a non-hospital free standing facility)*	$20 **copay** per visit then the plan pays 100% No Calendar Year **deductible** applies.	$20 **copay** per visit then the plan pays 100% No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**
Urgent Medical Care *(from other than a non-hospital free standing facility)*	Refer to *Emergency Medical Services* and *Physician Services* above.	Refer to *Emergency Medical Services* and *Physician Services* above.	Refer to *Emergency Medical Services* and *Physician Services* above.

Important Notice:
A separate **urgent care copay** or **deductible** applies for each visit to an **urgent care provider** for **urgent care**.

Covered expenses that are applied to the **urgent care copay/deductible** cannot be applied to any other **copay/deductible** under your plan. Likewise, covered expenses that are applied to your plan's other **copays/deductibles** cannot be applied to the **urgent care copay/deductible**.

PLAN FEATURES	NETWORK BENEFIT LEVEL		OUT-OF-NETWORK BENEFIT LEVEL
	Designated Network Provider	*Non-Designated Network Provider*	*Out-of-Network Provider*
Outpatient Diagnostic and Preoperative Testing			
Complex Imaging Services			
Complex Imaging	90% per test after Calendar Year **deductible**	90% per test after Calendar Year **deductible** (The applicable Calendar Year **deductible** and **Maximum Out of Pocket Limit** is based on the designated network provider **deductible** and **Maximum Out of Pocket Limit**.)	70% per test after Calendar Year **deductible**
Diagnostic Laboratory Testing			
Diagnostic Laboratory Testing	90% per procedure after Calendar Year **deductible**	90% per procedure after Calendar Year **deductible** (The applicable Calendar Year **deductible** and **Maximum Out of Pocket Limit** is based on the designated network provider **deductible** and **Maximum Out of Pocket Limit**.)	70% per procedure after Calendar Year **deductible**
Diagnostic X-Rays (except Complex Imaging Services)			
Diagnostic X-Rays	90% per procedure after Calendar Year **deductible**	90% per procedure after Calendar Year **deductible** (The applicable Calendar Year **deductible** and **Maximum Out of Pocket Limit** is based on the designated network provider **deductible** and **Maximum Out of Pocket Limit**.)	70% per procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK BENEFIT LEVEL		OUT-OF-NETWORK BENEFIT LEVEL
	Designated Network Provider	*Non-Designated Network Provider*	*Out-of-Network Provider*
Outpatient Surgery			
Outpatient Surgery	90% per visit/surgical procedure after Calendar Year **deductible**	90% per visit/surgical procedure after Calendar Year **deductible** **(**The applicable Calendar Year **deductible** and **Maximum out of Pocket Limit** is based on the designated network provider **deductible** and **Maximum Out of Pocket Limit**.)	70% per visit/surgical procedure after Calendar Year **deductible**
Outpatient Surgery, and applicable if inpatient for hip/knee replacements, herniated disk surgery, spine surgery, upper GI endoscopy, spinal injections for pain, shoulder/knee arthroscopy and sinus surgery	90% per visit/surgical procedure after Calendar Year **deductible**	70% per visit/surgical procedure after Calendar Year **deductible**	70% per visit/surgical procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK BENEFIT LEVEL		OUT-OF-NETWORK BENEFIT LEVEL
	Designated Network Provider	*Non-Designated Network Provider*	*Out-of-Network Provider*
Inpatient Facility Expenses			
Birthing Center	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Hospital Facility Expenses Room and Board (including maternity)	90% per admission after Calendar Year **deductible**	90% per admission after Calendar Year **deductible** (The applicable Calendar Year **deductible** and **Maximum Out of Pocket Limit** is based on the designated network provider **deductible** and **Maximum Out of Pocket Limit**.)	70% per admission after Calendar Year **deductible**
Other than Room and Board	90% per admission after Calendar Year **deductible**	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Skilled Nursing Inpatient Facility	90% per admission after Calendar Year **deductible**	90% per admission after Calendar Year **deductible** (The applicable Calendar Year **deductible** and **Maximum Out of Pocket Limit** is based on the designated network provider **deductible** and **Maximum Out of Pocket Limit.**)	70% per admission after Calendar Year **deductible**
Specialty Benefits			
Home Health Care (Outpatient)	90% per visit after Calendar Year **deductible**	90% per visit after Calendar Year **deductible** (The applicable Calendar Year **deductible** and **Maximum Out of Pocket Limit** is based on the designated network provider **deductible** and **Maximum Out of Pocket Limit.**)	70% per visit after Calendar Year **deductible**
Maximum Visits per Calendar Year	90 visits	90 visits	90 visits

Skilled Nursing Care (Outpatient)	90% per visit after Calendar Year **deductible**	90% per visit after Calendar Year **deductible** (The applicable Calendar Year **deductible** and **Maximum Out of Pocket Limit** is based on the designated network provider **deductible** and **Maximum Out of Pocket Limit.**)	70% per visit after Calendar Year **deductible**
Hospice Benefits			
Hospice Care - Facility Expenses (Room & Board)	100% per admission No Calendar Year **deductible** applies	100% per admission No Calendar Year **deductible** applies	70% per admission after Calendar Year **deductible**
Hospice Care - Other Expenses during a stay	100% per admission No Calendar Year **deductible** applies	100% per admission No Calendar Year **deductible** applies	70% per admission after Calendar Year **deductible**
Maximum Benefit per lifetime	Unlimited days	Unlimited days	Unlimited days
Hospice Outpatient Visits	100% per visit No Calendar Year **deductible** applies	100% per visit No Calendar Year **deductible** applies	70% per visit after Calendar Year **deductible**

PLAN FEATURES	**NETWORK BENEFIT LEVEL** *Designated Network Provider*	*Non-Designated Network Provider*	**OUT-OF-NETWORK BENEFIT LEVEL** *Out-of-Network Provider*
Infertility Treatment			
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided.

Comprehensive Infertility Expenses	$20 per visit copay then the plan pays 100% No Calendar Year **deductible** applies	$20 per visit copay then the plan pays 100% No Calendar Year **deductible** applies	70% after Calendar Year **deductible**
Advanced Reproductive Technology (ART) Expenses	$20 per visit copay then the plan pays 100% No Calendar Year **deductible** applies	$20 per visit copay then the plan pays 100% No Calendar Year **deductible** applies	70% after Calendar Year **deductible**
Combined Maximum per Lifetime for Comprehensive Infertility and Advanced Reproductive Technology (ART) Expenses	$20,000	$20,000	$20,000

PLAN FEATURES	NETWORK BENEFIT LEVEL		OUT-OF-NETWORK BENEFIT LEVEL
	Designated Network Provider	*Non-Designated Network Provider*	*Out-of-Network Provider*
Inpatient Treatment of Mental Disorders			
MENTAL DISORDERS *Hospital Facility Expenses*			
Room and Board	90% per admission after Calendar Year **deductible**	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Other than Room and Board	90% per admission after Calendar Year **deductible**	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Physician Services	90% per admission after Calendar Year **deductible**	90% per admission after Calendar Year **deductible** (The applicable Calendar Year **deductible** and **Maximum Out of Pocket Limit** is based on the **designated network provider deductible** and **Maximum Out of Pocket Limit**.)	70% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses	90% per admission after Calendar Year **deductible**	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	90% after Calendar Year **deductible**	90% after Calendar Year **deductible** (The applicable Calendar Year **deductible** and **Maximum Out of Pocket Limit** is based on the designated network provider **deductible** and **Maximum Out of Pocket Limit**.)	70% after Calendar Year **deductible**

Outpatient Treatment of Mental Disorders			
Outpatient Services	100% per visit No Calendar Year **deductible** applies	100% per visit No Calendar Year **deductible** applies	70% per visit after Calendar Year **deductible**

PLAN FEATURES	**NETWORK BENEFIT LEVEL**		**OUT-OF-NETWORK BENEFIT LEVEL**
	Designated Network Provider	*Non-Designated Network Provider*	*Out-of-Network Provider*
Inpatient Treatment of Substance Abuse			
Hospital Facility Expenses			
Room and Board	90% per admission after Calendar Year **deductible**	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Other than Room and Board	90% per admission after Calendar Year **deductible**	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Physician Services	90% per admission after Calendar Year **deductible**	90% per admission after Calendar Year **deductible** (The applicable Calendar Year **deductible** and **Maximum Out of Pocket Limit** is based on the designated network provider **deductible** and **Maximum Out of Pocket Limit**.)	70% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses	90% per admission after Calendar Year **deductible**	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	90% per visit after Calendar Year **deductible**	90% per admission after Calendar Year **deductible** (The applicable Calendar Year **deductible** and **Maximum Out of Pocket Limit** is based on the designated network provider deductible and **Maximum Out of Pocket Limit**.)	70% per visit after Calendar Year **deductible**

Outpatient Treatment of Substance Abuse			
Outpatient Treatment	100% per visit No Calendar Year **deductible** applies	100% per visit No Calendar Year **deductible** applies	70% per visit after Calendar Year **deductible**

PLAN FEATURES	**NETWORK BENEFIT LEVEL**		**OUT-OF-NETWORK BENEFIT LEVEL**
	Designated Network Provider	*Non-Designated Network Provider*	*Out-of-Network Provider*
Obesity Treatment Non Surgical			
Outpatient Obesity Treatment (non surgical)	90% per visit after Calendar Year **deductible**	70% per visit after Calendar Year **deductible**	70% per visit after Calendar Year **deductible**

PLAN FEATURES	**NETWORK BENEFIT LEVEL**		**OUT-OF-NETWORK BENEFIT LEVEL**
	Designated Network Provider	*Non-Designated Network Provider*	*Out-of-Network Provider*
Obesity Treatment Surgical			
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Unlimited	Unlimited

PLAN FEATURES	**NETWORK BENEFIT LEVEL**		**OUT-OF-NETWORK BENEFIT LEVEL**
	Designated Network Provider (IOE Facility)	*Non-Designated Network Provider (Non-IOE Facility)*	*Out-of-Network Provider*
Transplant Services Facility and Non-Facility Expenses			
Transplant Facility Expenses	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Transplant Physician Services (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided

PLAN FEATURES	NETWORK BENEFIT LEVEL *Designated Network Provider*	*Non-Designated Network Provider*	OUT-OF-NETWORK BENEFIT LEVEL *Out-of-Network Provider*
Other Covered Health Expenses			
Acupuncture in lieu of anesthesia	$10 per visit copay then the plan pays 100% No Calendar Year **deductible** applies.	$10 per visit copay then the plan pays 100% No Calendar Year **deductible** applies.	$10 per visit copay then the plan pays 100% No Calendar Year **deductible** applies.
Maximum visits per Calendar Year	12 visits	12 visits	12 visits
Maximum per visit	$70	$70	$70
Ground, Air or Water Ambulance	90% after Calendar Year **deductible**	90% after Calendar Year **deductible** (The applicable Calendar Year **deductible** and **Maximum Out of Pocket Limit** is based on the designated network provider **deductible** and **Maximum Out of Pocket Limit.)**	90% after Calendar Year **deductible**
Diabetic Equipment, Supplies and Education	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Durable Medical and Surgical Equipment	90% after Calendar Year **deductible**	90% after Calendar Year **deductible** (The applicable Calendar Year **deductible** and **Maximum Out of Pocket Limit** is based on the designated provider deductible and **Maximum Out of Pocket Limit.)**	70% after Calendar Year **deductible**
Clinical Trial Therapies (Experimental or Investigational Treatment)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Routine Patient Costs	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Jaw Joint Disorder Treatment	90% per visit after Calendar Year **deductible**	90% per visit after Calendar Year **deductible** (The applicable Calendar Year **deductible** and **Maximum Out of Pocket Limit** is based on the designated network provider **deductible** and **Maximum Out of Pocket Limit**.)	70% after Calendar Year **deductible**
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Prosthetic Devices	90% per item after Calendar Year **deductible**	90% per item after Calendar Year **deductible** (The applicable Calendar Year **deductible** and **Maximum Out of Pocket Limit** is based on the designated network provider **deductible** and **Maximum Out of Pocket Limit**.)	70% per item after Calendar Year **deductible** (excludes limbs) 80% per item for limb replacement No Calendar Year **deductible** applies

PLAN FEATURES	**NETWORK BENEFIT LEVEL** *Designated Network Provider*	*Non-Designated Network Provider*	**OUT-OF-NETWORK BENEFIT LEVEL** *Out-of-Network Provider*
Outpatient Therapies			
Chemotherapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Infusion Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Radiation Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	**NETWORK BENEFIT LEVEL**		**OUT-OF-NETWORK BENEFIT LEVEL**
	Designated Network Provider	*Non-Designated Network Provider*	*Out-of-Network Provider*
Short Term Outpatient Rehabilitation Therapies			
Outpatient Physical and Occupational Therapy only	$10 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	$10 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	70% per visit after Calendar Year **deductible**

PLAN FEATURES	**NETWORK BENEFIT LEVEL**		**OUT-OF-NETWORK BENEFIT LEVEL**
	Designated Network Provider	*Non-Designated Network Provider*	*Out-of-Network Provider*
Short Term Outpatient Rehabilitation Therapies			
Speech Therapy only	$10 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	$10 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	70% per visit after Calendar Year **deductible**
Children's Early Intervention Services	$10 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	$10 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**
Maximum Limit per Calendar Year	$3,200	$3,200	$3,200

PLAN FEATURES	NETWORK BENEFIT LEVEL *Designated Network Provider*	*Non-Designated Network Provider*	OUT-OF-NETWORK BENEFIT LEVEL *Out-of-Network Provider*
Spinal Manipulation			
	$10 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	$10 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	$10 per visit **deductible** then the plan pays 100% No Calendar Year **deductible** applies.
Spinal Manipulation Maximum visits per Calendar Year	25 visits	25 visits	25 visits
Massage Therapy			
	$10 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	$10 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	$10 per visit **deductible** then the plan pays 100% No Calendar Year **deductible** applies.
Maximum **visits** per Calendar Year	12 visits	12 visits	12 visits
Maximum per visit	$70	$70	$70
Inherited Metabolic Disease Formula (Amino Acid-Based Elemental Infant Formula)			
	100% per visit No Calendar Year **deductible** applies.	100% per visit No Calendar Year **deductible** applies.	100% per visit No Calendar Year **deductible** applies.

Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Preferred Generic Prescription Drugs		
For each initial 30 day supply filled at a retail **pharmacy**	$10	$10
For all fills of at least a 31 day supply and up to a 90 day supply filled at a **mail order pharmacy**	$15	Not Applicable

Preferred Brand-Name Prescription Drugs		
For each 30 day supply (retail)	$30	$30
For more than a 30 day supply but less than a 91 day supply (mail order)	$45	Not Applicable

Non-Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	$10	$10
For more than a 30 day supply but less than a 91 day supply (mail order)	$15	Not Applicable

Non-Preferred Brand-Name Prescription Drugs		
For each initial 30 day supply filled at a retail **pharmacy**	$60	$60
For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order **pharmacy**	$90	Not Applicable

Copay and Deductible Waiver

Waiver for Risk-Reducing Breast Cancer Prescription Drugs

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** will not apply to risk-reducing breast cancer generic **prescription drugs** when obtained at a **network pharmacy**. This means that such risk-reducing breast cancer generic **prescription drugs** will be paid at 100%.

Deductible and copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs

The **prescription drug deductible** and the per **prescription copayment/coinsurance** will not apply to the treatment regimens for tobacco cessation **prescription drugs** and OTC drugs when obtained at a **network pharmacy**. This means that such **prescription drugs** and OTC drugs will be paid at 100%.

Waiver for Prescription Drug Contraceptives

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** will not apply to contraceptive methods that are:

- **generic prescription drugs**; contraceptive devices; or
- FDA-approved female generic emergency contraceptives,

when obtained at a **network pharmacy**. This means that such contraceptive methods will be paid at 100%.

Refer to the *Pharmacy Plan Features* for information on coverage for FDA-Approved female over-the-counter contraceptives (Non-Emergency).

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** continue to apply:

- When the contraceptive methods listed above are obtained at an out-of-network pharmacy
- For contraceptive methods that are:
  - **brand-name prescription drugs** and devices and
  - FDA-approved female brand-name emergency contraceptives,

  that have a generic equivalent, or generic alternative available within the same **therapeutic drug class** obtained at an **out-of-network pharmacy** or **network pharmacy** unless you are granted a medical exception.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
FDA-Approved Female Generic Over-the-Counter Contraceptives For each 30 day supply filled at a retail **pharmacy**	100% per supply No **copay** or **deductible** applies.	Not covered.
FDA-Approved Female Generic Emergency Over-the-Counter Contraceptives	100% per supply No **copay** or **deductible** applies.	Not covered.

Important Note:
This Plan does not cover all over-the-counter (OTC) contraceptives. For a current listing, contact Member Services by logging on the Aetna website at www.aetna.com or calling the toll-free number on the back of the ID card.

Preventive Care Drugs and Supplements Preventive care drugs and supplements filled at a **pharmacy** with a **prescription**: Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact your physician or Member Services by logging onto the Aetna website www.aetna.com or calling the number on the back of your ID card.	100% per item. No **copay** or **deductible** applies.	Not Covered.

Important Note:
Refer to the Booklet and the *Preventive Care* section for a complete description of the preventive care drugs and supplements covered under this Plan and for any limitations that apply to these benefits.

Tobacco Cessation Prescription and Over-the-Counter Drugs		
Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** for each 90 day supply. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.	100% per supply No **copay** or **deductible** applies.	Not covered.

Coinsurance

	NETWORK	OUT-OF-NETWORK
Prescription Drug Plan Coinsurance	100% of the **negotiated charge**	100% of the **recognized charge**

The **prescription drug** plan **coinsurance** is the percentage of **prescription drug covered expenses** that the plan pays after any applicable **deductibles** and **copays** have been met.

Precertification and **step therapy** for certain **prescription drugs** is required. If **precertification** is not obtained, the **prescription drug** will not be covered.

Expense Provisions

The following provisions apply to your health expense plan.
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

Covered expenses applied to the **out-of-network provider deductibles** will not be applied to satisfy the **designated network provider** and **non-designated network provider deductibles**. **Covered expenses** applied to the **designated network provider** and **non-designated network provider deductibles** will not be applied to satisfy the **out-of-network provider deductibles**.

All **covered expenses** accumulate toward the **designated network provider** and **non-designated network provider and out-of-network provider deductibles** except for those **covered expenses** identified earlier in this *Schedule of Benefits.*

Covered expenses that are subject to the **deductibles** include covered expenses provided under the Medical or **Prescription drug** Plans, as applicable.

You and each of your covered dependents have separate Calendar Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Calendar Year **deductibles**.

Designated Network Provider Calendar Year Deductibles

Individual
This is an amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from a **designated network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**, the plan will begin to pay benefits for **covered expenses** that you incur from a **designated network provider** for the rest of the Calendar Year.

Family Deductible Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles,** these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

> The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Non-Designated Network Provider Calendar Year Deductible

Individual
This is an amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from a **non-designated network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**, the plan will begin to pay benefits for **covered expenses** that you incur from a **non-designated network provider** for the rest of the Calendar Year.

Family Deductible Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles**, these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

> The combined expenses that you and each of your covered dependents incur toward the individual Calendar Year **deductibles** must reach the family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Out-of-Network Provider Calendar Year Deductible

Individual
This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from an **out-of-network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**; this Plan will begin to pay benefits for **covered expenses** that you incur from an **out-of-network provider** for the rest of the Calendar Year.

Family Deductible Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles**, these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

> The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Copayments and Benefit Deductible Provisions

Copayment, Copay
This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

Payment Provisions

Payment Percentage
This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "Plan Payment Percentage". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

Maximum Out-of-Pocket Limit
The **Maximum Out-of-Pocket Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. This Plan has an individual **Maximum Out-of-Pocket Limit**. As to the individual **Maximum Out-of-Pocket Limit**, each of you must meet your **Maximum Out-of-Pocket Limit** separately and they cannot be combined and applied towards one limit.

Certain **covered expenses** do not apply toward the **Maximum Out-of-Pocket Limit**. See list below.

Designated Network Provider Maximum Out-of-Pocket Limit
The following **Maximum Out-of-Pocket Limits** apply to **designated network provider** benefits.

Individual
Once the amount of eligible **network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

Family Maximum Out-of-Pocket Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **network provider Maximum Out-of-Pocket Limit**, these expenses will also count toward a family **network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **network provider Maximum Out-of-Pocket Limit** for the rest of the Calendar Year, the following must happen:

The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **network provider Maximum Out-of-Pocket Limit** amount in a Calendar Year.

Non-Designated Network Provider Maximum Out of Pocket Limits

The following **Maximum Out-of-Pocket Limits** apply to **non-designated network provider** benefits.

Individual
Once the amount of eligible **network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

Family Maximum Out-of-Pocket Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **network provider Maximum Out-of-Pocket Limit**, these expenses will also count toward a family **network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **network provider Maximum Out-of-Pocket Limit** for the rest of the Calendar Year, the following must happen:

The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **network provider Maximum Out-of-Pocket Limit** amount in a Calendar Year.

Out-of Network Provider Maximum Out-of-Pocket Limit
The following **Maximum Out-of-Pocket Limits** apply to **out-of-network provider** benefits.

Individual
Once the amount of eligible **out-of-network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

Family Maximum Out-of-Pocket Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **out-of-network provider Maximum Out-of-Pocket Limit**, these expenses will also count toward a family **out-of-network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **out-of-network provider Maximum Out-of-Pocket Limit** for the rest of the Calendar Year, the following must happen:

> The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **out-of-network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **out-of-network provider Maximum Out-of-Pocket Limit** amount in a Calendar Year.

The **Maximum Out-of-Pocket Limit** applies to designated network, non-designated network, and out -of-network benefits. You have separate **Maximum Out-of-Pocket Limits** for designated network, non-designated network, and out-of-network benefits. **Maximum Out-of-Pocket Limit** amounts paid by you for designated network, non-designated network, and out -of-network **covered expenses** apply to each limit separately and may not be combined and applied toward one limit.

Covered expenses that are subject to the **Maximum Out-of-Pocket Limit** include **prescription drug** expenses provided under the Medical or **Prescription drug** Plans, as applicable.

Expenses That Do Not Apply to Your Out-of-Pocket Limit
Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room;
- and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

Precertification Benefit Reduction

The Booklet contains a complete description of the **precertification** program. Refer to the "Understanding Precertification" section for a list of services and supplies that require **precertification**.

Failure to precertify your **covered expenses** when required will result in a benefits reduction as follows:

- A $500 benefit reduction will be applied separately to each type of expense.

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.