

Schedule of Benefits

Employer: Pima County
MSA: 863646
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Schedule: 1B
Summary Plan Description: 1

For: Aetna Choice POS II - High Deductible Health Plan (HDHP)

This *Schedule of Benefits* shows what the Aetna medical benefits plan covers and how benefits are paid for that coverage. The *Summary Plan Description* describes the same, as well as your rights and obligations under the plan. Always keep your *Schedule of Benefits* with your *Summary Plan Description*, as this *Schedule* is part of your *Summary Plan Description* and they act as one package to explain your benefits plan.

Aetna Choice POS II Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Plan Year Deductible*		
Individual Deductible*	\$2,000	\$4,000
Family Deductible*	\$4,000	\$8,000

*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 **network** expenses: \$3,000.
- For **out-of-network** expenses: \$8,000.

Family Maximum Out of Pocket Limit:

- For **network** expenses: \$6,000.
- For **out-of-network** expenses: \$16,000.

Lifetime Maximum Benefit per person	Unlimited	Unlimited
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Payment Percentage (Coinsurance) listed in the Schedule below reflects the Plan Coinsurance. This is the amount the Plan pays. You are responsible to pay any deductibles and the remaining coinsurance. You are responsible for full payment of any non-covered expenses you incur.

All Covered Expenses Are Subject To The Plan 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	OUT-OF-NETWORK
Preventive Care Benefits		
Routine Physical Exams		
Office Visits	100% per visit	Not Covered
	No copay or deductible applies.	
<i>Covered Persons through age 21: Maximum Age & Visit Limits</i>	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.	Not Covered.
	<i>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</i>	
<i>Covered Persons ages 22 but less than 65: Maximum Visits per 12 consecutive months</i>	1 visit	Not Covered.
<i>Covered Persons age 65 and over: Maximum Visits per 12 consecutive months</i>	1 visit	Not Covered.

Preventive Care Immunizations

Performed in a facility or physician's office

100% per visit

Not Covered

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.

Screening & Counseling Services

100% per visit

No Coverage

No copay or deductible applies.

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

Obesity and/or Healthy Diet

Maximum Visits per 12 consecutive months
(This maximum applies only to Covered Persons ages 22 & older.)

26 visits *(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*]*

No Coverage

***Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

Misuse of Alcohol and/or Drugs

Maximum Visits per 12 consecutive months

5 visits*

No Coverage

***Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

Use of Tobacco Products

Maximum Visits per 12 consecutive months 8 visits* No Coverage

***Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

Sexually Transmitted Infections Benefit Maximums

Maximum Visits per Plan Year 2 visits* Not Covered

***Note: In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.**

**Well Woman Preventive Visits
Office Visits**

100% per visit Not Covered

Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administrations No **copay** or **deductible** applies.

Well Woman Preventive Visits

Maximum Visits per Plan Year 1 visit Not Covered

Hearing Exam

90% per exam Not Covered

No **copay** or **deductible** applies.

Maximum exams per 12 month period

1 exam

Not Covered

12654

Hearing Aids

90% per item after Plan Year **deductible**

70% per item after Plan Year **deductible**

Hearing Supply Maximum per 3 year period

\$5,000

\$5,000

**Routine Cancer Screening
Outpatient**

100% per exam

Not Covered

No **copay** or **deductible** applies.

Maximums	<p>Subject to any age; family history and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> 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. <p><i>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.</i></p>	Not Covered
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<i>Lung Cancer Screening Maximum</i>	One screening every 12 months*	Not Covered
<p>*Important Note: Lung cancer screenings in excess of the maximum as shown above are covered under the <i>Outpatient Diagnostic and Preoperative Testing</i> section of your <i>Schedule of Benefits</i>.</p>		

Prenatal Care Office Visits	100% per visit	70% per visit after Plan Year deductible
<p>No copay or deductible applies.</p> <p>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.</p>		

Comprehensive Lactation Support and Counseling Services		
Lactation Counseling Services Facility or Office Visits	100% per visit	70% per visit after Plan Year deductible
<p>No copay or deductible applies.</p>		

Lactation Counseling Services Maximum Visits either in a group or individual setting	6* visits per 12 months	Not Applicable
<p>*Important Note: Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the <i>Physician Services</i> office visit section of the <i>Schedule of Benefits</i>.</p>		

Breast Pumps & Supplies	100% per item	70% per item after Plan Year deductible
<p>No copay or deductible applies</p> <p>Important Note: Refer to the <i>Comprehensive Lactation Support and Counseling Services</i> section of the Summary Plan Description for limitations on breast pumps and supplies.</p>		

Family Planning Services		
Female Contraceptive Counseling Services -Office Visits.	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	Not Applicable
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*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.	Not Covered.

Family Planning - Other		
Voluntary Sterilization for Males		
Outpatient	90% per visit after Plan Year deductible.	70% per visit after Plan Year deductible.

Family Planning - Female Voluntary Sterilization		
Inpatient	100% per visit No copay or deductible applies.	70% per visit after Plan Year deductible
Outpatient	100% per visit No copay or deductible applies.	70% per visit after Plan Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Vision Care		
Eye Examinations including refraction	100% per exam No copay or deductible applies.	Not Covered
Maximum Benefit per 12 consecutive month period	1 exam	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Physician Services		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-specialist	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
Specialist Office Visits	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
Physician Office Visits-Surgery	90% per visit after Plan Year deductible	70% per visit after Plan 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.	Not Covered
Individual Screening and Counseling Services for Tobacco Use	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 <i>Preventive Care Benefit</i> 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.	Not Covered
Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity	Refer to the <i>Preventive Care Benefit</i> 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	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible

Physician Services for Inpatient Facility and Hospital Visits	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
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Administration of Anesthesia	90% per procedure after Plan Year deductible	70% per procedure after Plan Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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Emergency Medical Services		
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Hospital Emergency Facility and Physician	90% per visit after Plan Year deductible	90% per visit after Plan Year deductible
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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
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Urgent Care Services		
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Urgent Medical Care <i>(at a non-hospital free standing facility)</i>	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
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Urgent Medical Care <i>(from other than a non-hospital free standing facility)</i>	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.
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Non-Urgent Use of Urgent Care Provider <i>(at an Emergency Room or a non-hospital free standing facility)</i>	Not covered	Not covered
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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Outpatient Diagnostic and Preoperative Testing		
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Complex Imaging Services		
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Complex Imaging	90% per test after Plan Year deductible	70% per test after Plan Year deductible
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Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	90% per procedure after Plan Year deductible	70% per procedure after Plan Year deductible

Diagnostic X-Rays (except Complex Imaging Services)		
Diagnostic X-Rays	90% per procedure after Plan Year deductible	70% per procedure after Plan Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
Outpatient Surgery	90% per visit/surgical procedure after Plan Year deductible	70% per visit/surgical procedure after Plan Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
Birth 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.

Hospital Facility Expenses	90% per admission after Plan Year deductible	70% per admission after Plan Year deductible
Room and Board (including maternity)		
Other than Room and Board	90% per admission after Plan Year deductible	70% per admission after Plan Year deductible

Skilled Nursing Inpatient Facility	90% per admission after Plan Year deductible	70% per admission after Plan Year deductible
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Maximum Days per Plan Year	60 days	60 days
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits		
Home Health Care (Outpatient)	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible

Maximum Visits per Plan Year	60 visits	60 visits
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Skilled Nursing Care (Outpatient)	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
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Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board)	90% per admission after Plan Year deductible	70% per admission after Plan Year deductible
Hospice Care - Other Expenses <i>during a stay</i>	90% per admission after Plan Year deductible	70% per admission after Plan Year deductible
Maximum Benefit per lifetime	Unlimited days	Unlimited days

Hospice Outpatient Visits	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Mental Disorders		

MENTAL DISORDERS		
Hospital Facility Expenses		
Room and Board	90% per admission after Plan Year deductible	70% per admission after Plan Year deductible
Other than Room and Board	90% per admission after Plan Year deductible	70% per admission after Plan Year deductible
Physician Services	90% per admission after Plan Year deductible	70% per admission after Plan Year deductible

Inpatient Residential Treatment Facility Expenses	90% per admission after Plan Year deductible	70% per admission after Plan Year deductible
Inpatient Residential Treatment Facility Expenses Physician Services	90% after Plan Year deductible	70% after Plan Year deductible

Outpatient Treatment of Mental Disorders

Outpatient Services	90% per visit after the Plan Year deductible	70% per visit after the Plan Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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Inpatient Treatment of Substance Abuse

Hospital Facility Expenses

Room and Board	90% per admission after Plan Year deductible	70% per admission after Plan Year deductible
Other than Room and Board	90% per admission after Plan Year deductible	70% per admission after Plan Year deductible
Physician Services	90% per admission after Plan Year deductible	70% per admission after Plan Year deductible

<i>Inpatient Residential Treatment Facility Expenses</i>	90% per admission after Plan Year deductible	70% per admission after Plan Year deductible
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<i>Inpatient Residential Treatment Facility Expenses Physician Services</i>	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
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Outpatient Treatment of Substance Abuse

<i>Outpatient Treatment</i>	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
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PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
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Transplant Services Facility and Non-Facility Expenses

<i>Transplant Facility Expenses</i>	90% per admission after Plan Year deductible	70% per admission after Plan Year deductible	70% per admission after Plan Year deductible
<i>Transplant Physician Services</i> (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	OUT-OF-NETWORK
<i>Other Covered Health Expenses</i>		
<i>Acupuncture in lieu of anesthesia</i>	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.
<i>Ground, Air or Water Ambulance</i>	90% after Plan Year deductible	90% after Plan Year deductible
<i>Diabetic Equipment, Supplies and Education</i>	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.
<i>Durable Medical and Surgical Equipment</i>	90% per item after the Plan Year deductible	70% per item after the Plan Year deductible
<i>Clinical Trial Therapies</i> (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.
<i>Routine Patient Costs</i>	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.
Non-Surgical Treatment of Temporomandibular Joint (TMJ) Dysfunction Maximum Benefit per Plan Year	\$3,000	\$3,000
<i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i>	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.
<i>Prosthetic Devices</i>	90% per item after Plan Year deductible	70% per item after Plan Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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.
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.
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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Cardiac Rehabilitation	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
Cardiac Rehabilitation Maximum sessions per 12 week period	36 sessions	36 sessions
Pulmonary Rehabilitation	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
Pulmonary Rehabilitation Maximum	36 hours or a 12 week period	36 hours or a 12 week period

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Outpatient Physical and Occupational Therapy only	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
Combined Physical and Occupational Therapy Maximum visits per Plan Year	40 visits	40 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Speech Therapy only	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible

Speech Therapy Maximum visits per Plan Year	20 visits	20 visits
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Autism Spectrum Disorder</i>		
<i>Autism – Physical Therapy, Occupational Therapy, and Speech Therapy</i>	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
<i>Autism – Behavioral Therapy</i>	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
<i>Autism – Applied Behavior Analysis</i>	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Spinal Manipulation</i>		
	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible

Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Generic Prescription Drugs		
For each 30 day supply filled at a retail pharmacy	10% of the negotiated charge	10% of the recognized charge
For all fills of a 90 day supply filled at a mail order pharmacy or a CVS/pharmacy	10% of the negotiated charge	Not Applicable
Brand-Name Prescription Drugs		
For each 30 day supply filled at a retail pharmacy	10% of the negotiated charge	10% of the recognized charge
For all fills of a 90 day supply filled at a mail order pharmacy or a CVS/pharmacy	10% of the negotiated charge	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 first two 90-day 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%. Your **prescription drug deductible** and any **prescription copayment/coinsurance** will apply after those two regimens have been exhausted.

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:	100% per item. No copay or deductible applies.	Not covered.
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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.

Important Note:

Refer to the Summary Plan Description 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. 100% per supply Not covered.
 No **copay** or **deductible** applies.

Maximums:
 Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below.

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.

Coinsurance

	NETWORK	OUT-OF-NETWORK
Prescription Drug Plan Coinsurance	100% of the negotiated charge	70% 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 SUMMARY PLAN DESCRIPTION.

Deductible Provisions

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

All **covered expenses** accumulate toward the **network provider** and **out-of-network provider deductibles** except for those **covered expenses** identified later 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 Plan Year **deductibles**. This Plan has individual and family Plan Year **deductibles**.

For purposes of Plan Year deductible provision below, an individual means an employee enrolled for self only coverage with no dependent coverage and a family means an employee enrolled with one or more dependents. The family **deductible** can be met by one family member, or a combination of family members.

Network Provider Plan Year Deductible

Individual

This is the amount of **covered expenses** that you incur each Plan Year from a **network provider** for which no benefits will be paid. After **covered expenses** reach this individual Plan Year **deductible**, this Plan will begin to pay benefits for **covered expenses** that you incur from a **network provider** for the rest of the Plan Year.

Family

This is the amount of **covered expenses** that you and your covered dependents incur each Plan Year from a **network provider** for which no benefits will be paid. After **covered expenses** reach this family Plan Year **deductible**, this Plan will begin to pay benefits for **covered expenses** that you and your covered dependents incur from a **network provider** for the rest of the Plan Year.

Out-of-Network Provider Plan Year Deductible

Individual

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

Family

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

Deductible Waiver Provision for Preventive Prescription Drug Expenses

No **deductible** will apply to preventive covered **prescription drug** expenses for those **prescription drugs** used to treat the prevention of conditions relating to:

- Hypertension;
- Heart disease;
- Diabetic complications;
- Asthmatic episodes;
- Conditions resulting from osteoporosis;

- Stroke;
- Various pediatric conditions, such as vitamins and fluoride deficiency, and maternal and fetal problems during pregnancy

The preventive **prescription drug** list is available from your employer in printed form. Member Services can answer any questions you have about this preventive **prescription drug** list.

Copayments and Benefit Deductible Provisions

Copayment, Copay – Prescription Drugs

This is a specified percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network pharmacy**. It represents a portion of the applicable expense.

Payment Provisions

Coinsurance

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.

For purposes of the following coinsurance provisions, an individual means an employee enrolled for self only coverage with no dependents coverage and a family means an employee enrolled with one or more dependents.

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 Plan Year. This Plan has an individual and family **Maximum Out-of-Pocket Limit**.

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

The **Maximum Out-of-Pocket Limit** applies to **network provider and out-of-network provider** benefits.

You have a separate **Maximum Out-of-Pocket Limit** for **network provider and out-of-network provider** benefits.

You are not able to combine **network provider and out-of-network provider covered expenses** and apply them toward one limit.

Network Provider Maximum Out-of-Pocket Limit

Individual

Once the amount of eligible **network provider** expenses you have paid during the Plan 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 Plan Year for that person.

Family

The Family **Maximum Out-of-Pocket Limit** can be met by a combination of family members or by any single individual within the family. Once the amount of eligible **network provider** expenses paid during the Plan Year meets this family **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Plan Year for all covered family members.

Out-of Network Provider Maximum Out-of-Pocket Limit

Individual

Once the amount of eligible **out-of-network provider** expenses you have paid during the Plan 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 Plan Year for that person.

Family

The Family **Maximum Out-of-Pocket Limit** can be met by a combination of family members or by any single individual within the family. Once the amount of eligible **out-of-network provider** expenses paid during the Plan Year meets this family **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Plan Year for all covered family members.

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;
- Expenses incurred for non-urgent use of an **urgent care provider**; 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 Summary Plan Description 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 reduced **coinsurance** of 50% will apply separately to the eligible expenses incurred for each type of service or supply.

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 Summary Plan Description and should be kept with your Summary Plan Description.