Schedule of Benefits

Employer: **Pima County**

ASA: 863646

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For: Aetna Choice POS II

This *Schedule of Benefits* shows what the Aetna medical benefits plan covers and how benefits are paid for that coverage. The *Booklet* describes the same, as well as your rights and obligations under the plan. Always keep your *Schedule of Benefits* with your *Booklet*, as this *Schedule* is part of your *Booklet* 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*	$1,000	$2,000
Family Deductible*	$2,000	$4,000

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

Plan Payment Limit excludes plan **deductible, copayments and precertification** penalties

Individual Payment Limit:

- For **network** expenses: $2,000.
- For **out-of-network** expenses: $4,000.

Family Payment Limit:

- For **network** expenses: 4,000.
- For **out-of-network** expenses: 8,000.

Lifetime Maximum Benefit per person	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 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 No **copay** or **deductible** applies.	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 Health Resources and Services Administration. *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.
Covered Persons ages 22 but less than 65: Maximum Visits per 12 consecutive months	1 visit	Not Covered.
Covered Persons age 65 and over: Maximum Visits per 12 consecutive months	1 visit	Not Covered.
Preventive Care Immunizations *Performed in a facility or* ***physician's*** *office*	100% per visit No **copay** or **deductible** applies.	Not Covered
Screening & Counseling Services - Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products	100% per visit No **copay** or **deductible** applies.	No Coverage

Obesity 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
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.		
Well Woman Preventive Visits ***Office Visits***	100% per visit No **copay** or **deductible** applies.	Not Covered
Well Woman Preventive Visits Maximum Visits per Plan Year	1 visit	Not Covered
Hearing Exam	100% per exam No **copay** or **deductible** applies.	Not Covered
Hearing Aids	80% per item after Plan Year **deductible**	60% per item after Plan Year **deductible**
Hearing Supply Maximum per 3 year period	$5,000	$5,000
Routine Cancer Screening ***Outpatient***	100% per exam No **copay** or **deductible** applies.	Not Covered

Maximums	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. *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

Prenatal Care		
Office Visits	100% per visit No **copay** or **deductible** applies.	60% per visit after Plan 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.	60% per visit after Plan Year **deductible**

Lactation Counseling Services Maximum Visits either in a group or individual setting	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 **copay** or **deductible** applies.	60% per item after Plan Year **deductible**
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.	Not Covered.

Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	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 - Other		
Voluntary Termination of Pregnancy Outpatient	80% per visit after Plan Year **deductible.**	60% per visit after Plan Year **deductible.**
Voluntary Sterilization for Males Outpatient	80% per visit after Plan Year **deductible.**	60% per visit after Plan Year **deductible.**

Family Planning - Female Voluntary Sterilization		
Inpatient	100% per visit No **copay** or **deductible** applies.	60% per visit after Plan Year **deductible**
Outpatient	100% per visit No **copay** or **deductible** applies.	60% per visit after Plan Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Family Planning Services - Female Contraceptives		
Female Contraceptive Generic Prescription Drugs (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided)	100% per prescription or refill No **copay** or **deductible** applies.	Not covered.
Female Contraceptive Devices (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided)	100% per prescription or refill No **copay** or **deductible** applies.	Not covered.

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

Physician Services *<11SECTION025>*		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-**specialist**	$25 visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	60% per visit after Plan Year **deductible**

Specialist Office Visits	$45 visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	60% per visit after Plan Year **deductible**

Physician Office Visits-Surgery		
Physician	$25 visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	60% per visit after Plan Year **deductible**
Specialist	$45 visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	60% 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.	60% per visit after Plan Year **deductible**
Individual Screening and Counseling Services for Tobacco Use	100% per visit No **copay** or **deductible** applies.	60% per visit after Plan Year **deductible**
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
Individual Screening and Counseling Services for Obesity	100% per visit No **copay** or **deductible** applies.	Plan Year per visit after Plan Year **deductible**
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

***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**.

Stress Management Services*		
Individual Screening and Counseling Services	100% per visit No **copay** or **deductible** applies.	60% per visit after Plan Year **deductible**

***Important Note**:
Not all stress management 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	$25 visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	60% per visit after Plan Year **deductible**
Physician Services for Inpatient Facility and Hospital Visits	80% per visit after Plan Year **deductible**	60% per visit after Plan Year **deductible**
Administration of Anesthesia	80% per procedure after Plan Year **deductible**	60% per procedure after Plan Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Emergency Medical Services		
Hospital Emergency Facility and Physician	$125 **copay** per visit then the plan pays 100% No Plan Year **deductible** applies.	$125 **deductible/copay** per visit then the plan pays 100% No Plan Year **deductible** applies. 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

Important Notice:
A separate **hospital** emergency room **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 **copay** is waived.

Urgent Care Services		
Urgent Medical Care *(at a non-hospital free standing facility)*	$35 **copay** per visit then the plan pays 100% No Plan Year **deductible** applies.	60% per visit after Plan 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.
Non-Urgent Use of Urgent Care Provider *(at an Emergency Room or a non-hospital free standing facility)*	Not covered	Not covered

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	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		
Complex Imaging Services		
Complex Imaging	80% per test after Plan Year **deductible**	60% per test after Plan Year **deductible**
Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	100% per procedure No Plan Year **deductible** applies.	60% per procedure after Plan Year **deductible**
Diagnostic X-Rays (except Complex Imaging Services)		
Diagnostic X-Rays	100% per procedure No Plan Year **deductible** applies.	60% per procedure after Plan Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
Outpatient Surgery	80% per visit/surgical procedure after Plan Year **deductible**	60% per visit/surgical procedure after Plan Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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.
Hospital Facility Expenses		
Room and Board (including maternity)	80% per admission after Plan Year **deductible**	60% per admission after Plan Year **deductible**
Other than Room and Board	80% per admission after Plan Year **deductible**	60% per admission after Plan Year **deductible**
Skilled Nursing Inpatient Facility	80% per admission after Plan Year **deductible**	60% per admission after Plan Year **deductible**
Maximum Days per Plan Year	60 days	60 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits		
Home Health Care (Outpatient)	80% per visit after the Plan Year **deductible**	60% per visit after the Plan Year **deductible**
Maximum Visits per Plan Year	60 visits	60 visits
Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board)	80% per admission after Plan Year **deductible**	60% per admission after Plan Year **deductible**
Hospice Care - Other Expenses during a stay	80% per admission after Plan Year **deductible**	60% per admission after Plan Year **deductible**
Maximum Benefit per lifetime	Unlimited days	Unlimited days
Hospice Outpatient Visits	80% per visit after Plan Year **deductible**	60% per visit after Plan Year **deductible**

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	80% per admission after Plan Year **deductible**	60% per admission after Plan Year **deductible**
Other than Room and Board	80% per admission after Plan Year **deductible**	60% per admission after Plan Year **deductible**
Physician Services	80% per admission after Plan Year **deductible**	60% per admission after Plan Year **deductible**
Inpatient Residential Treatment Facility Expenses	80% per admission after Plan Year **deductible**	60% per admission after Plan Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	80% after Plan Year **deductible**	60% after Plan Year **deductible**
Outpatient Treatment Of Mental Disorders		
Outpatient Services	$25 per visit **copay** then the plan pays 100% No Plan Year **deductible** applies	60% per visit after the Plan Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Substance Abuse		
Hospital Facility Expenses		
Room and Board	80% per admission after Plan Year **deductible**	60% per admission after Plan Year **deductible**
Other than Room and Board	80% per admission after Plan Year **deductible**	60% per admission after Plan Year **deductible**
Physician Services	80% per admission after Plan Year **deductible**	60% per admission after Plan Year **deductible**
Inpatient Residential Treatment Facility Expenses	80% per admission after Plan Year **deductible**	60% per admission after Plan Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	80% per visit after Plan Year **deductible**	60% per visit after Plan Year **deductible**
Outpatient Treatment of Substance Abuse		
Outpatient Treatment	$25 per visit **copay** then the plan pays 100% No Plan Year **deductible** applies	60% per visit after Plan Year **deductible**

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
Transplant Services Facility and Non-Facility Expenses			
Transplant Facility Expenses	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.
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	OUT-OF-NETWORK
Other Covered Health Expenses		
Acupuncture in lieu of anesthesia	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.

Ground, Air or Water Ambulance	80% after Plan Year **deductible**	80% after Plan 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.
Durable Medical and Surgical Equipment	80% per item after the Plan Year **deductible**	60% per item after the Plan Year **deductible**
Maximum Benefit per Plan Year	$5,000	$5,000
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.
Non-Surgical Treatment of Temporomandibular Joint (TMJ) Dysfunction Maximum Benefit per Plan Year	$3,000	$3,000
Prosthetic Devices	80% per item after Plan Year **deductible**	60% 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		
Speech Therapy only	$25 per visit **copay** then the plan pays 100% No Plan Year **deductible** applies	60% per visit after Plan Year **deductible**
Speech Therapy Maximum visits per Plan Year	20 visits	20 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Outpatient Physical and Occupational Therapy only	$25 per visit **copay** then the plan pays 100% No Plan Year **deductible** applies	60% 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
Spinal Manipulation		
	$25 per visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	60% per visit after Plan Year **deductible**

Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Preferred Generic Prescription Drugs		
For each 31 day supply (retail)	$10	$10
For more than a 31 day supply but less than a 91 day supply (mail order)	$20	Not Applicable

Preferred Brand-Name Prescription Drugs		
For each 31 day supply (retail)	$30	$30
For more than a 31 day supply but less than a 91 day supply (mail order)	$60	Not Applicable

Non-Preferred Generic Prescription Drugs		
For each 31 day supply (retail)	$10	$10
For more than a 31 day supply but less than a 91 day supply (mail order)	$20	Not Applicable

Non-Preferred Brand-Name Prescription Drugs		
For each 31 day supply (retail)	$50	$50
For more than a 31 day supply but less than a 91 day supply (mail order)	$100	Not Applicable

Copay and Deductible Waiver

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;
- FDA-approved female generic emergency contraceptives, when obtained at a **network pharmacy**.

This means that such contraceptive methods will be paid at 100%.

With respect to those plans that provide **out-of-network pharmacy** benefits under the Prescription Drug Plan, the per **prescription copay/deductible** and any applicable **prescription drug** calendar year **deductible** continue to apply.

The per **prescription copay/deductible** and any **prescription drug** calendar year **deductible** continue to apply:

- For contraceptive methods that are:
  - **brand-name prescription drugs** and brand name devices and
  - FDA-approved female brand-name emergency contraceptives,

  that have a generic equivalent, or generic alternative available within the same **therapeutic drug class** unless you are granted a medical exception.

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 **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*.

You and each of your covered dependents have separate Plan Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined, meaning, for example, expenses for yourself cannot be applied to one of your dependents' individual deductibles or vice versa. This Plan has individual and family Plan Year **deductibles**.

Network Provider Plan Year Deductible

Individual
This is the amount of **covered expenses** that you and each of your covered dependents incur each Plan Year from a **network provider** for which no benefits will be paid. This individual Plan Year **deductible** applies separately to you and each of your covered dependents. 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 Deductible Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Plan Year **deductibles,** these expenses will also count toward a family **deductible** limit.

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

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

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

Out-of-Network Provider Plan Year Deductible

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

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

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

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

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

Certain **covered expenses** do not apply toward the **Payment Limit**. See list below.

Network Provider Payment Limit

Individual
Once the amount of eligible **network provider** expenses you or your covered dependents have paid during the Plan Year meets the individual **Payment 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 Payment Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Plan Year **network provider Payment Limit,** these expenses will also count toward a family **network provider Payment Limit**.

To satisfy this family **network provider Payment Limit** for the rest of the Plan Year, the following must happen:

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

Out-of Network Provider Payment Limit

Individual
Once the amount of eligible **out-of-network provider** expenses you or your covered dependents have paid during the Plan Year meets the individual **Payment 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 Payment Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Plan Year **out-of-network provider Payment Limit,** these expenses will also count toward a family **out-of-network provider Payment Limit**.

To satisfy this family **out-of-network provider Payment Limit** for the rest of the Plan Year, the following must happen:

> The family **Payment Limit** is a cumulative **Payment Limit** for all family members. The family **out-of-network provider Payment 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 Payment Limit** amount in a Plan Year.

The **Payment Limit** applies to both network and out -of-network benefits. You have separate **Payment Limit** for in-network and out-of-network benefits. **Payment Limit** amounts paid by you for in-network and out -of-network **covered expenses** apply to each limit separately and may not be combined and applied toward one limit.

Expenses That Do Not Apply to Your Payment Limit
Certain covered expenses do not apply toward your plan payment limit. These include:

- Expenses applied toward a **deductible**;
- Charges over the **recognized charge**;
- Expenses applied toward a **copayment**;
- Expenses incurred for outpatient **prescription drugs**;
- 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 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 reduced payment percentage 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 Booklet and should be kept with your Booklet.