Schedule of Benefits

employer: Pima County

MSA: 863646

issue date: July 20, 2017

effective date: July 1, 2021

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 and CVS Caremark pharmacy benefits plans cover and how benefits are paid for these coverages. 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

<table>
<thead>
<tr>
<th>Plan Year Deductible*</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Deductible*</td>
<td>$2,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>Family Deductible*</td>
<td>$4,000</td>
<td>$8,000</td>
</tr>
</tbody>
</table>

*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

| Lifetime Maximum Benefit per person | Unlimited | Unlimited |

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.

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive Care Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Routine Physical Exams</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Office Visits</em></td>
<td>100% per visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>No copay or deductible applies.</td>
<td></td>
</tr>
</tbody>
</table>

| Covered Persons through age 21:            | 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. |
| Maximum Age & Visit Limits                 |                                                                |                |

For details, contact your **physician** or Member Services by logging onto the Aetna website [www.aetna.com](http://www.aetna.com), or calling the number on the back of your ID card

| Covered Persons ages 22 but less than 65:  | 1 visit            | Not Covered. |
| Maximum Visits per 12 consecutive months   |                                                                |                |

| Covered Persons age 65 and over:           | 1 visit            | Not Covered. |
| Maximum Visits per 12 consecutive months    |                                                                |                |
### 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.

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity and/or Healthy Diet</td>
<td></td>
</tr>
<tr>
<td>Misuse of Alcohol and/or Drugs &amp; Use of Tobacco Products</td>
<td></td>
</tr>
<tr>
<td>Sexually Transmitted Infections</td>
<td></td>
</tr>
<tr>
<td>Genetic Risk for Breast and Ovarian Cancer</td>
<td></td>
</tr>
</tbody>
</table>

### Obesity and/or Healthy Diet

Maximum Visits per 12 consecutive months  
(This maximum applies 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.*
<table>
<thead>
<tr>
<th>Use of Tobacco Products</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Visits per 12 consecutive months</td>
</tr>
<tr>
<td>*Note: <em>In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexually Transmitted Infections Benefit Maximums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Visits per Plan Year</td>
</tr>
<tr>
<td>*Note: <em>In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Well Woman Preventive Visits Office Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administrations</td>
</tr>
<tr>
<td>100% per visit</td>
</tr>
<tr>
<td>No copay or deductible applies.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Well Woman Preventive Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Visits per Plan Year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventive Care Heart Screenings</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT Calcium Scorings and Cardiovascular Stress Test</td>
</tr>
<tr>
<td>100% per visit</td>
</tr>
<tr>
<td>No copay or deductible applies.</td>
</tr>
<tr>
<td>Maximum Visits per Plan Year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hearing Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>90% per exam</td>
</tr>
<tr>
<td>No copay or deductible applies.</td>
</tr>
<tr>
<td>Maximum exams per 12 month period</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hearing Aids</th>
</tr>
</thead>
<tbody>
<tr>
<td>90% per item after Plan Year deductible</td>
</tr>
<tr>
<td>Hearing Supply Maximum per 3 year period</td>
</tr>
<tr>
<td>Routine Cancer Screening</td>
</tr>
<tr>
<td>--------------------------</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maximums</th>
<th>Subject to any age; family history and frequency guidelines as set forth in the most current:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• 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</td>
</tr>
<tr>
<td></td>
<td>• the comprehensive guidelines supported by the Health Resources and Services Administration.</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Lung Cancer, Ovarian Cancer, and Skin Cancer Screening Maximum</th>
<th>One screening every 12 months*</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Important Note: <strong>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.</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prenatal Care Office Visits</th>
<th>100% per visit</th>
<th>70% per visit after Plan Year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No copay or deductible applies.</td>
</tr>
</tbody>
</table>

**Important Note:** Refer to the Physician Services and Pregnancy Expenses sections of the Booklet for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.

<table>
<thead>
<tr>
<th>Comprehensive Lactation Support and Counseling Services</th>
<th>100% per visit</th>
<th>70% per visit after Plan Year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lactation Counseling Services Facility or Office Visits</td>
<td></td>
<td>No copay or deductible applies.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lactation Counseling Services Maximum Visits either in a group or individual setting</th>
<th>6* visits per 12 months</th>
<th>Not Applicable</th>
</tr>
</thead>
</table>

**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**.

<table>
<thead>
<tr>
<th>Breast Pumps &amp; Supplies</th>
<th>100% per item</th>
<th>70% per item after Plan Year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No copay or deductible applies</td>
</tr>
</tbody>
</table>
**Important Note:** Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Summary Plan Description for limitations on breast pumps and supplies.

<table>
<thead>
<tr>
<th>Family Planning Services</th>
<th>100% per visit.</th>
<th>Not Covered.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Contraceptive Counseling Services - Office Visits.</td>
<td>No copay or deductible applies.</td>
<td></td>
</tr>
</tbody>
</table>

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.*

<table>
<thead>
<tr>
<th>Family Planning Services - Female Contraceptives</th>
<th>100% per item</th>
<th>Not Covered.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Contraceptive Generic Prescription Drugs and Devices provided, administered, or removed, by a Physician during an Office Visits.</td>
<td>No copay or deductible applies.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Planning - Other</th>
<th>90% per visit after Plan Year deductible.</th>
<th>70% per visit after Plan Year deductible.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary Sterilization for Males</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Planning - Female Voluntary Sterilization</th>
<th>100% per visit</th>
<th>70% per visit after Plan Year deductible.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>No copay or deductible applies.</td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>100% per visit</td>
<td>70% per visit after Plan Year deductible.</td>
</tr>
<tr>
<td>No copay or deductible applies.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender Dysphoria Treatment</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Eligible Health Services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## PLAN FEATURES

### Vision Care

<table>
<thead>
<tr>
<th><strong>Eye Examinations</strong> including refraction</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% per exam</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>No copay or deductible applies.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Maximum Benefit per 12 consecutive month period

| 1 exam | Not Covered |

## PLAN FEATURES

### Physician Services

**Telemedicine Consultations**

*The plan may utilize one or more telemedicine vendors. To obtain information regarding potential cost share when utilizing a telemedicine vendor, contact member services at the number on your ID card.*

<table>
<thead>
<tr>
<th><strong>Office Visits to Primary Care Physician</strong></th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits (non-surgical) to non-specialist</td>
<td>90% per visit after Plan Year deductible</td>
<td>70% per visit after Plan Year deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Specialist Office Visits</strong></th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>90% per visit after Plan Year deductible</td>
<td>70% per visit after Plan Year deductible</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Physician Office Visits-Surgery</strong></th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>90% per visit after Plan Year deductible</td>
<td>70% per visit after Plan Year deductible</td>
<td></td>
</tr>
</tbody>
</table>

### 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.

**Individual Screening and Counseling Services for Tobacco Use**

100% per visit

No copay or deductible applies.

**Individual Screening and Counseling Services for Obesity**

100% per visit

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

**Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity**

Not Applicable
No **copay** or **deductible** applies.

| 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 | 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**.

<table>
<thead>
<tr>
<th>All Other Services</th>
<th>90% per visit after Plan Year deductible</th>
<th>70% per visit after Plan Year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Services for Inpatient Facility and Hospital Visits</strong></td>
<td>90% per visit after Plan Year deductible</td>
<td>70% per visit after Plan Year deductible</td>
</tr>
<tr>
<td><strong>Administration of Anesthesia</strong></td>
<td>90% per procedure after Plan Year deductible</td>
<td>70% per procedure after Plan Year deductible</td>
</tr>
</tbody>
</table>

**PLAN FEATURES**

<table>
<thead>
<tr>
<th>Emergency Medical Services</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Emergency Facility and Physician</strong></td>
<td>90% per visit after Plan Year deductible</td>
<td>90% per visit after Plan Year deductible</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Non-Emergency Care in a Hospital Emergency Room</th>
<th>Not covered</th>
<th>Not covered</th>
</tr>
</thead>
</table>

**Urgent Care Services**

<table>
<thead>
<tr>
<th>Urgent Medical Care (at a non-hospital free standing facility)</th>
<th>90% per visit after Plan Year deductible</th>
<th>70% per visit after Plan Year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent Medical Care (from other than a non-hospital free standing facility)</strong></td>
<td>Refer to <em>Emergency Medical Services and Physician Services</em> above.</td>
<td>Refer to <em>Emergency Medical Services and Physician Services</em> above.</td>
</tr>
<tr>
<td>Non-Urgent Use of Urgent Care Provider</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>------------</td>
<td>------------</td>
</tr>
<tr>
<td><em>(at an Emergency Room or a non-hospital free standing facility)</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PLAN FEATURES | NETWORK | OUT-OF-NETWORK

#### Outpatient Diagnostic and Preoperative Testing

<table>
<thead>
<tr>
<th>Complex Imaging Services</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex Imaging</td>
<td>90% per test after Plan Year deductible</td>
<td>70% per test after Plan Year deductible</td>
</tr>
</tbody>
</table>

#### Diagnostic Laboratory Testing

<table>
<thead>
<tr>
<th>Diagnostic Laboratory Testing</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Laboratory Testing</td>
<td>90% per procedure after Plan Year deductible</td>
<td>70% per procedure after Plan Year deductible</td>
</tr>
</tbody>
</table>

#### Diagnostic X-Rays (except Complex Imaging Services)

<table>
<thead>
<tr>
<th>Diagnostic X-Rays</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic X-Rays</td>
<td>90% per procedure after Plan Year deductible</td>
<td>70% per procedure after Plan Year deductible</td>
</tr>
</tbody>
</table>

### PLAN FEATURES | NETWORK | OUT-OF-NETWORK

#### Outpatient Surgery

<table>
<thead>
<tr>
<th>Outpatient Surgery</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgery</td>
<td>90% per visit/surgical procedure after Plan Year deductible</td>
<td>70% per visit/surgical procedure after Plan Year deductible</td>
</tr>
</tbody>
</table>

### PLAN FEATURES | NETWORK | OUT-OF-NETWORK

#### Inpatient Facility Expenses

<table>
<thead>
<tr>
<th>Birthing Center</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Birthing Center</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
</tbody>
</table>

#### Hospital Facility Expenses

<table>
<thead>
<tr>
<th>Room and Board (including maternity)</th>
<th>90% per admission after Plan Year deductible</th>
<th>70% per admission after Plan Year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other than Room and Board</td>
<td>90% per admission after Plan Year deductible</td>
<td>70% per admission after Plan Year deductible</td>
</tr>
</tbody>
</table>

#### Skilled Nursing Inpatient Facility

<table>
<thead>
<tr>
<th>Skilled Nursing Inpatient Facility</th>
<th>90% per admission after Plan Year deductible</th>
<th>70% per admission after Plan Year deductible</th>
</tr>
</thead>
</table>

| Maximum Days per Plan Year | 60 days | 60 days |
### PLAN FEATURES

<table>
<thead>
<tr>
<th>Specialty Benefits</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home Health Care (Outpatient)</strong></td>
<td>90% per visit after Plan Year deductible</td>
<td>70% per visit after Plan Year deductible</td>
</tr>
<tr>
<td>Maximum Visits per Plan Year</td>
<td>60 visits</td>
<td>60 visits</td>
</tr>
<tr>
<td><strong>Skilled Nursing Care (Outpatient)</strong></td>
<td>90% per visit after Plan Year deductible</td>
<td>70% per visit after Plan Year deductible</td>
</tr>
</tbody>
</table>

### 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 during a stay | 90% per admission after Plan Year deductible | 70% per admission after Plan Year deductible |
| Maximum Benefit per lifetime | Unlimited days | Unlimited days |

### PLAN FEATURES

<table>
<thead>
<tr>
<th>Bariatric Surgery Facility and Non-Facility Expenses</th>
<th>NETWORK (IOQ Facility)</th>
<th>NETWORK (Non-IOQ Facility)</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bariatric Surgery Facility Expenses</strong></td>
<td>90% per admission after Plan Year deductible</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Bariatric Physician Services</strong> (including office visits)</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided</td>
<td>Not covered</td>
</tr>
<tr>
<td>Maximum Benefit per lifetime</td>
<td>One surgery per person per lifetime</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### PLAN FEATURES

<table>
<thead>
<tr>
<th>Infertility Treatment</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic Infertility Expenses</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td>PLAN FEATURES</td>
<td>NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>---------------</td>
<td>---------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Inpatient Treatment of Mental Disorders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MENTAL DISORDERS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Facility Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and Board</td>
<td>90% per admission after Plan Year deductible</td>
<td>70% per admission after Plan Year deductible</td>
</tr>
<tr>
<td>Other than Room and Board</td>
<td>90% per admission after Plan Year deductible</td>
<td>70% per admission after Plan Year deductible</td>
</tr>
<tr>
<td>Physician Services</td>
<td>90% per admission after Plan Year deductible</td>
<td>70% per admission after Plan Year deductible</td>
</tr>
<tr>
<td><strong>Inpatient Residential Treatment Facility Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Facility Expenses Physician Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>90% per admission after Plan Year deductible</td>
<td>70% per admission after Plan Year deductible</td>
</tr>
<tr>
<td></td>
<td>90% after Plan Year <strong>deductible</strong></td>
<td>70% after Plan Year <strong>deductible</strong></td>
</tr>
<tr>
<td><strong>Outpatient Treatment of Mental Disorders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>90% per visit after Plan Year deductible</td>
<td>70% per visit after Plan Year deductible</td>
</tr>
<tr>
<td><strong>PLAN FEATURES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Treatment of Substance Abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Facility Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and Board</td>
<td>90% per admission after Plan Year deductible</td>
<td>70% per admission after Plan Year deductible</td>
</tr>
<tr>
<td>Other than Room and Board</td>
<td>90% per admission after Plan Year deductible</td>
<td>70% per admission after Plan Year deductible</td>
</tr>
<tr>
<td>Physician Services</td>
<td>90% per admission after Plan Year deductible</td>
<td>70% per admission after Plan Year deductible</td>
</tr>
<tr>
<td><strong>Inpatient Residential Treatment Facility Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Facility Expenses Physician Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>90% per admission after Plan Year deductible</td>
<td>70% per admission after Plan Year deductible</td>
</tr>
<tr>
<td></td>
<td>90% per visit after Plan Year deductible</td>
<td>70% per visit after Plan Year deductible</td>
</tr>
</tbody>
</table>
## Outpatient Treatment of Substance Abuse

<table>
<thead>
<tr>
<th>Outpatient Treatment</th>
<th>NETWORK (IOE Facility)</th>
<th>NETWORK (Non-IOE Facility)</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>90% per visit after Plan Year deductible</td>
<td>70% per visit after Plan Year deductible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## PLAN FEATURES

### Transplant Services Facility and Non-Facility Expenses

<table>
<thead>
<tr>
<th>Category</th>
<th>NETWORK (IOE Facility)</th>
<th>NETWORK (Non-IOE Facility)</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplant Facility Expenses</td>
<td>90% per admission after Plan Year deductible</td>
<td>70% per admission after Plan Year deductible</td>
<td>70% per admission after Plan Year deductible</td>
</tr>
<tr>
<td>Transplant Physician Services</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided</td>
</tr>
<tr>
<td>(including office visits)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PLAN FEATURES

#### Other Covered Health Expenses

<table>
<thead>
<tr>
<th>Category</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture in lieu of anesthesia</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td>Ground, Air or Water Ambulance</td>
<td>90% after Plan Year deductible</td>
<td>90% after Plan Year deductible</td>
</tr>
<tr>
<td>Diabetic Equipment, Supplies and Education</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td>Durable Medical and Surgical Equipment</td>
<td>90% per item after the Plan Year deductible</td>
<td>70% per item after the Plan Year deductible</td>
</tr>
<tr>
<td>Clinical Trial Therapies (Experimental or Investigational Treatment)</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td>Routine Patient Costs</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td>Jaw Joint Disorder Treatment</td>
<td>90% per visit after Plan Year deductible</td>
<td>70% per visit after Plan Year deductible</td>
</tr>
<tr>
<td>Non-Surgical Treatment of Temporomandibular Joint (TMJ) Dysfunction</td>
<td>Maximum Benefit per Plan Year</td>
<td>$3,000</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td><strong>Prosthetic Devices</strong></td>
<td>90% per item after Plan Year deductible</td>
<td>70% per item after Plan Year deductible</td>
</tr>
<tr>
<td><strong>PLAN FEATURES</strong></td>
<td><strong>NETWORK</strong></td>
<td><strong>OUT-OF-NETWORK</strong></td>
</tr>
<tr>
<td><strong>Outpatient Therapies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chemotherapy</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td><strong>Gene-based, cellular and other innovative therapies (GCIT)</strong></td>
<td>(GCIT-designated facility/provider)</td>
<td>(Including providers who are otherwise part of Aetna's network but are not GCIT-designated facilities/providers)</td>
</tr>
<tr>
<td>Description</td>
<td>Services and supplies</td>
<td>Covered based on type of service and where it is received</td>
</tr>
<tr>
<td><strong>Infusion Therapy</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td><strong>Radiation Therapy</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td><strong>PLAN FEATURES</strong></td>
<td><strong>NETWORK</strong></td>
<td><strong>OUT-OF-NETWORK</strong></td>
</tr>
<tr>
<td><strong>Short Term Outpatient Rehabilitation Therapies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cardiac Rehabilitation</strong></td>
<td>90% per visit after Plan Year deductible</td>
<td>70% per visit after Plan Year deductible</td>
</tr>
<tr>
<td>Cardiac Rehabilitation Maximum sessions per 12 week period</td>
<td>36 sessions</td>
<td>36 sessions</td>
</tr>
<tr>
<td><strong>Pulmonary Rehabilitation</strong></td>
<td><strong>90% per visit after Plan Year deductible</strong></td>
<td><strong>70% per visit after Plan Year deductible</strong></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Pulmonary Rehabilitation Maximum</td>
<td>36 hours or a 12 week period</td>
<td>36 hours or a 12 week period</td>
</tr>
</tbody>
</table>

**PLAN FEATURES**

**NETWORK**

**OUT-OF-NETWORK**

**Short Term Outpatient Rehabilitation Therapies**

Short-term rehabilitation services (outpatient physical, occupational therapies) combined with Habilitation therapy services (outpatient physical, occupational therapies)

- 90% (of the negotiated charge) per visit after Plan Year deductible
- 70% (of the recognized charge) per visit after Plan Year deductible

Short-term rehabilitation services (outpatient speech therapy) combined with Habilitation therapy services (outpatient speech therapy)

- 90% (of the negotiated charge) per visit after Plan Year deductible
- 70% (of the recognized charge) per visit after Plan Year deductible

Outpatient physical and occupational therapies combined with habilitation therapy services (outpatient physical, occupational therapies) maximum

- Maximum visits per Plan Year 40 visits
- Maximum visits per Plan Year 40 visits

Outpatient speech therapy combined with habilitation therapy services (outpatient speech therapy) maximum

- Maximum visits per Plan Year 20 visits
- Maximum visits per Plan Year 20 visits

**PLAN FEATURES**

**Autism Spectrum Disorder**

**Autism – Physical Therapy, Occupational Therapy, and Speech Therapy**

- 90% per visit after Plan Year deductible
- 70% per visit after Plan Year deductible

**Autism – Behavioral Therapy**

- 90% per visit after Plan Year deductible
- 70% per visit after Plan Year deductible

**Autism – Applied Behavior Analysis**

- 90% per visit after Plan Year deductible
- 70% per visit after Plan Year deductible

**PLAN FEATURES**

**Spinal Manipulation**

- 90% per visit after Plan Year deductible
- 70% per visit after Plan Year deductible

Spinal Manipulation Maximum visits per Plan Year

- 40 visits
- 40 visits
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 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.

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 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.
<table>
<thead>
<tr>
<th>DRUG CATEGORY</th>
<th>RETAIL PHARMACY</th>
<th>MAIL ORDER</th>
<th>CVS MAINTENANCE CHOICE PROGRAM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>You Pay</td>
<td>You Pay</td>
<td>You Pay</td>
</tr>
<tr>
<td>Generic</td>
<td>10% Charge After Deductible</td>
<td>10% Charge After Deductible</td>
<td>10% Charge After Deductible</td>
</tr>
<tr>
<td>Brand (preferred)</td>
<td>10% Charge After Deductible</td>
<td>10% Charge After Deductible</td>
<td>10% Charge After Deductible</td>
</tr>
<tr>
<td>Brand (non-preferred)</td>
<td>10% Charge After Deductible</td>
<td>10% Charge After Deductible</td>
<td>10% Charge After Deductible</td>
</tr>
<tr>
<td>Specialty- CVS Retail Pharmacy or CVS Specialty Pharmacy</td>
<td>10% Charge After Deductible (CVS Retail Pharmacy Only)</td>
<td>10% Charge After Deductible</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Out-of-network</td>
<td></td>
<td></td>
<td>30% after deductible</td>
</tr>
<tr>
<td>Day Supply Limit</td>
<td>Retail Pharmacy</td>
<td>Mail Order</td>
<td></td>
</tr>
<tr>
<td>The maximum amount you can receive per prescribed order</td>
<td>30-day supply, except that Maintenance Choice Program allows for 90-day supply</td>
<td>90-day supply</td>
<td></td>
</tr>
<tr>
<td>Specialty</td>
<td>30-day supply</td>
<td>30-day supply</td>
<td></td>
</tr>
<tr>
<td>Refill Limit</td>
<td>Retail Pharmacy</td>
<td>Mail Order</td>
<td></td>
</tr>
<tr>
<td>The maximum amount you can receive per refill order</td>
<td>30-day supply, except that Maintenance Choice Program allows for 90-day supply</td>
<td>90-day supply</td>
<td></td>
</tr>
<tr>
<td>Use For:</td>
<td>Short-term medications or immediate prescription drug needs except that Retail 90 Program/Maintenance Choice Program allows for 90-day supply</td>
<td>Long-term, maintenance, and injectable medications</td>
<td></td>
</tr>
</tbody>
</table>
OUT-OF-POCKET EXPENSES AND MAXIMUMS
Benefit Plan(s) HDHP 2000

DEDUCTIBLE
A deductible is the amount you must pay under the Plan for covered expenses each Plan Year before the Plan begins to pay benefits. No prescription drug benefits (other than certain preventative expenses as required by law) are payable under the Plan until you satisfy the annual deductible. The amount of the deductible you must pay under the Plan is outlined on the schedule above.

CO-INSURANCE
A co-insurance payment is the percentage you pay toward your prescription drug expenses after the deductible, if any, is satisfied. Some prescription drug expenses are paid by the Plan at 90%, which means that your co-insurance obligation is 10% of the cost of the prescription drug, up to the out-of-pocket maximum, as described in the following section. The co-insurance payment required under the Plan is set forth on the schedule of benefits.

ANNUAL OUT-OF-POCKET MAXIMUMS
The annual out-of-pocket maximum limits the amount you or your family must pay for covered prescription drugs during the Plan Year. The amount of the out-of-pocket maximum applicable under the Plan is set forth in the Medical Schedule of Benefits. Once you reach the applicable limit under the Plan, the Plan will pay 100% of your covered prescription drug expenses for the rest of the Plan year. The out-of-pocket maximum does not include:

- The difference in cost between generic and brand name drugs;
- The difference in cost between Participating Network Provider and non-Participating Network Provider.

COVERAGE FOR PREVENTIVE CARE MEDICATIONS
Certain preventive care medications (specifically, evidenced-based items that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force) are required by law to be covered under the Plan. You will not be required to pay a deductible, co-payment or co-insurance payment when you obtain such preventive care medications from a Participating Network Pharmacy. Because the Plan’s coverage of these preventive care medications is based on the recommendations of the United States Preventive Services Task Force, the particular medications that are subject to coverage will change over time as the recommendations of the United States Preventive Services Task Force change.