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 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

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

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 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 American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents. *For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card*	Not Covered.
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. Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. *For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.*	Not Covered
Screening & Counseling Services ***Office Visits*** ***Obesity and/or Healthy Diet*** ***Misuse of Alcohol and/or Drugs & Use of Tobacco Products*** ***Sexually Transmitted Infections*** ***Genetic Risk for Breast and Ovarian Cancer***	100% per visit No **copay** or **deductible** applies.	No Coverage
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 No **copay** or **deductible** applies.	Not Covered
Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administrations		
Well Woman Preventive Visits Maximum Visits per Plan Year	1 visit	Not Covered
Preventive Care Heart Screenings CT Calcium Scorings and Cardiovascular Stress Test	100% per visit No **copay** or **deductible** applies.	Not Covered
Maximum Visits per Plan Year	1 visit	Not Covered
Hearing Exam	90% per exam No **copay** or **deductible** applies.	Not Covered
Maximum exams per 12 month period	1 exam	Not Covered
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 No **copay** or **deductible** applies.	Not Covered
Maximums	Subject to any age; family history and frequency guidelines as set forth in the most current: • evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician*** *or Member Services by logging onto the* ***Aetna*** *website www.aetna.com, or calling the number on the back of your ID card.*	Not Covered
Lung Cancer, Ovarian Cancer, and Skin CancerScreening Maximum	One screening every 12 months*	Not Covered
***Important Note:** Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing section of your Schedule of Benefits.*		
Prenatal Care ***Office Visits***	100% per visit No **copay** or **deductible** applies.	70% per visit after Plan Year **deductible**
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.		
Comprehensive Lactation Support and Counseling Services		
Lactation Counseling Services *Facility or Office Visits*	100% per visit No **copay** or **deductible** applies.	70% 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	70% per item after Plan Year **deductible**

Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Summary Plan Description 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 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**
Gender Dysphoria Treatment		
Eligible Health Services	Payable in accordance with the type of expense incurred and the place where service is provided.	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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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.*		
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 *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Not Applicable
Individual Screening and Counseling Services for Obesity	100% per visit	Not Covered

	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**.

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**
Administration of Anesthesia	90% per procedure after Plan Year **deductible**	70% per procedure after Plan Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Emergency Medical Services		
Hospital Emergency Facility and Physician	90% per visit after Plan Year **deductible**	90% per visit after Plan Year **deductible** 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
Urgent Care Services		
Urgent Medical Care *(at a non-hospital free standing facility)*	90% per visit after Plan Year **deductible**	70% 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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		
Complex Imaging Services		
Complex Imaging	90% per test after Plan Year **deductible**	70% per test after Plan Year **deductible**
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		
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	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**
Maximum Days per Plan Year	60 days	60 days

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
Skilled Nursing Care (Outpatient)	90% per visit after Plan Year **deductible**	70% per visit after Plan Year **deductible**
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
Hospice Outpatient Visits	90% per visit after Plan Year **deductible**	70% per visit after Plan Year **deductible**

PLAN FEATURES	NETWORK (IOQ Facility)	NETWORK (Non-IOQ Facility)	OUT-OF-NETWORK
Bariatric Surgery Facility and Non-Facility Expenses			
Bariatric Surgery Facility Expenses	90% per admission after Plan Year **deductible**	Not covered	Not covered
Bariatric 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	Not covered
Maximum Benefit per lifetime	One surgery per person per lifetime	Not covered	Not covered

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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**
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% per visit after Plan Year **deductible**	70% per visit after Plan Year **deductible**

Outpatient Treatment of Substance Abuse		
Outpatient Treatment	90% per visit after Plan Year **deductible**	70% 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	90% per admission after Plan Year **deductible**	70% per admission after Plan Year **deductible**	70% per admission after Plan Year **deductible**
Transplant Physician Services (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided

PLAN FEATURES	NETWORK	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	90% after Plan Year **deductible**	90% 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	90% per item after the Plan Year **deductible**	70% per item after the Plan Year **deductible**
Clinical Trial Therapies (Experimental or Investigational Treatment)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Routine Patient Costs	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Jaw Joint Disorder Treatment	90% per visit after Plan Year **deductible**	70% per visit after Plan Year **deductible**

Non-Surgical Treatment of Temporomandibular Joint (TMJ) Dysfunction Maximum Benefit per Plan Year	$3,000	$3,000
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.
Prosthetic Devices	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		
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	40 visits
Outpatient speech therapy combined with habilitation therapy services (outpatient speech therapy) maximum		
Maximum visits per Plan Year	20 visits	20 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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	NETWORK	OUT-OF-NETWORK
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.

PHARMACY SCHEDULE OF BENEFITS

Benefit Plan(s) – HDHP 2000 Plan

DRUG CATEGORY	RETAIL PHARMACY	MAIL ORDER	CVS MAINTENANCE CHOICE PROGRAM
	You Pay	**You Pay**	**You Pay**
Generic	10% Charge After Deductible	10% Charge After Deductible	10% Charge After Deductible
Brand (preferred)	10% Charge After Deductible	10% Charge After Deductible	10% Charge After Deductible
Brand (non-preferred)	10% Charge After Deductible	10% Charge After Deductible	10% Charge After Deductible
Specialty- CVS Retail Pharmacy or CVS Specialty Pharmacy	10% Charge After Deductible (CVS Retail Pharmacy Only)	10% Charge After Deductible	Not Applicable

Out-of-network	30% after deductible	
Day Supply Limit	**Retail Pharmacy**	**Mail Order**
The maximum amount you can receive per prescribed order	30-day supply, except that Maintenance Choice Program allows for 90-day supply	90-day supply
Specialty	30-day supply	30-day supply
Refill Limit	**Retail Pharmacy**	**Mail Order**
The maximum amount you can receive per refill order	30-day supply, except that Maintenance Choice Program allows for 90-day supply	90-day supply
Use For:	Short-term medications or immediate prescription drug needs except that Retail 90 Program/Maintenance Choice Program allows for 90-day supply	Long-term, maintenance, and injectable medications

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.