

# Schedule of Benefits

**Employer:** Pima County  
**ASA:** 863646  
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**Schedule:** 2A  
**Booklet Base:** 2

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

This *Schedule of Benefits* shows what the Aetna medical benefits plan covers and how benefits are paid for that coverage. The *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
<b>Plan Year Deductible*</b>		
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**.

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

**Individual Payment Limit:**

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

**Family Payment Limit:**

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

<b>Lifetime Maximum Benefit per person</b>	Unlimited	Unlimited
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*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
<b><i>Preventive Care Benefits</i></b>		
<b><i>Routine Physical Exams</i></b>		
<b><i>Office Visits</i></b>	100% per visit  No copay or deductible applies.	Not Covered
<b><i>Covered Persons through age 21: Maximum Age &amp; Visit Limits</i></b>	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.  <i>For details, contact your <b>physician</b> log onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or call the number on the back of your ID card.</i>	Not Covered.
<b><i>Covered Persons ages 22 but less than 65: Maximum Visits per 12 consecutive months</i></b>	1 visit	Not Covered.
<b><i>Covered Persons age 65 and over: Maximum Visits per 12 consecutive months</i></b>	1 visit	Not Covered.
<b><i>Preventive Care Immunizations</i></b>		
<b><i>Performed in a facility or <b>physician's</b> office</i></b>	100% per visit  No copay or deductible applies.	Not Covered
<b><i>Screening &amp; Counseling Services - Obesity, Misuse of Alcohol and/or Drugs &amp; Use of Tobacco Products</i></b>	100% per visit  No copay or deductible applies.	No Coverage

<i>Obesity</i> 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
<i>Misuse of Alcohol and/ or Drugs</i> Maximum Visits per 12 consecutive months	5 visits*	No Coverage
<b>*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.</b>		
<i>Use of Tobacco Products</i> Maximum Visits per 12 consecutive months	8 visits*	No Coverage
<b>*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.</b>		
<b>Well Woman Preventive Visits</b> <b>Office Visits</b>	100% per visit  No Plan Year deductible applies.	Not Covered
<b>Well Woman Preventive Visits</b> Maximum Visits per Plan Year	1 visit	Not Covered
<b>Hearing Exam</b>	100% per exam  No Plan Year deductible applies.	Not Covered
<b>Hearing Aids</b>	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
<b>Routine Cancer Screening</b> <b>Outpatient</b>	100% per exam  No Plan Year 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.  <i>For details, contact your <b>physician</b>, [log onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a>,] or call the number on the back of your ID card.]</i>	Not Covered
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<b><i>Prenatal Care</i></b> <b><i>Office Visits</i></b>	100% per visit  No <b>copay</b> or <b>deductible</b> applies.	70% per visit after Plan Year <b>deductible</b> .
<b>Important Note:</b> 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.		

<b><i>Comprehensive Lactation Support and Counseling Services</i></b> <b>Lactation Counseling Services</b> <i>Facility or Office Visits</i>	100% per visit  No <b>copay</b> or <b>deductible</b> applies.	70% per visit after Plan Year <b>deductible</b>
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Lactation Counseling Services Maximum Visits either in a group or individual setting	6* visits per <b>12 months</b>	Not Applicable
<b>*Important Note:</b> Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the <i>Physician Services</i> office visit section of the <i>Schedule of Benefits</i> .		

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

<b><i>Family Planning Services</i></b> Female Contraceptive Counseling Services -Office Visits.	100% per visit. No <b>copay</b> or <b>deductible</b> applies.	Not Covered.
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Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits per 12 months	Not Applicable
<b>*Important Note:</b> Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the <i>Physician Services</i> office visit section of the <i>Schedule of Benefits</i> .		

<b><i>Family Planning - Other</i></b> Voluntary Termination of Pregnancy Outpatient	90% per visit after Plan Year deductible.	70% per visit after Plan Year deductible.
Voluntary Sterilization for Males Outpatient	90% per visit after Plan Year deductible.	70% per visit after Plan Year deductible.

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Family Planning Services - Female Contraceptives</i></b> <b><i>Female Contraceptive Generic Prescription Drugs</i></b> (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 Plan Year deductible applies.	Not covered.
<b><i>Female Contraceptive Devices</i></b> (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 Plan Year deductible applies.	Not covered.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Vision Care</i></b> <b><i>Eye Examinations</i></b> including refraction	100% per exam  No Plan Year deductible applies.	Not Covered
Maximum Benefit per 12 consecutive month period	1 exam	Not covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Physician Services</i></b> <11.SECTION025> <b><i>Office Visits to Primary Care Physician</i></b> Office visits (non-surgical) to non-specialist	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible

<b><i>Specialist Office Visits</i></b>	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
<b><i>Physician Office Visits-Surgery</i></b>	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
<b><i>Walk-In Clinic Visit (Non-Emergency)</i></b>		
<b><i>Preventive Care Services*</i></b>		
Immunizations	100% per visit  No copay or deductible applies.  For details, contact your <b>physician</b> , log onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a> , or call the number on the back of your ID card.	70% per visit after Plan Year deductible
Individual Screening and Counseling Services for Tobacco Use	100% per visit  No copay or deductible applies.	70% per visit after Plan Year deductible
Maximum Benefit per visit - Individual Screening and Counseling Services for Tobacco Use	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services
Individual Screening and Counseling Services for Obesity	100% per visit  No copay or deductible applies.	70% per visit after Plan Year deductible
Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services
<b>*Important Note:</b> Not all preventive care services are available at all <b>Walk-In Clinics</b> . The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your <b>physician</b> .		
<b><i>Stress Management Services*</i></b>		
Individual Screening and Counseling Services	100% per visit  No copay or deductible applies.	70% per visit after Plan Year deductible
<b>*Important Note:</b> Not all stress management services are available at all <b>Walk-In Clinics</b> . The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your <b>physician</b> .		
<b><i>All Other Services</i></b>	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible

<b><i>Physician Services for Inpatient Facility and Hospital Visits</i></b>	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
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<b><i>Administration of Anesthesia</i></b>	90% per procedure after Plan Year deductible	70% per procedure after Plan Year deductible
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<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
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<b><i>Emergency Medical Services</i></b>		
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<b><i>Hospital Emergency Facility and Physician</i></b>	90% per visit after the Plan Year deductible	90% per visit after the Plan Year deductible
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See Important Note Below

**Important Note:** Please note that as these providers are not **network providers** and do not have a contract with **Aetna**, the provider may not accept payment of your cost share (your **deductible** and **payment percentage**), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or **physician** bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.

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

<b><i>Diagnostic X-Rays (except Complex Imaging Services)</i></b>		
<b><i>Diagnostic X-Rays</i></b>	90% per procedure after Plan Year deductible	70% per procedure after Plan Year deductible

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

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Inpatient Facility Expenses</i></b>		
<b><i>Birth Center</i></b>	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.

<b><i>Hospital Facility Expenses</i></b>	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

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

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

<b>Hospice Outpatient Visits</b>	90% per visit after Plan Year <b>deductible</b>	70% per visit after Plan Year <b>deductible</b>
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<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Infertility Treatment</b>		
<b>Basic Infertility Expenses</b> 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.

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient Treatment of Mental Disorders</b>		

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

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

***Outpatient Treatment Of Mental Disorders***

<b><i>Outpatient Services</i></b>	90% per visit after the Plan Year deductible	70% per visit after the Plan Year deductible
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**PLAN FEATURES NETWORK OUT-OF-NETWORK**

***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

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

<b><i>Outpatient Treatment</i></b>	90% per visit after the Plan Year deductible	70% per visit after the Plan Year deductible
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**PLAN FEATURES NETWORK (IOE Facility) NETWORK (Non-IOE Facility) OUT-OF-NETWORK**

***Transplant Services Facility and Non-Facility Expenses***

<b><i>Transplant Facility Expenses</i></b>	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.
<b><i>Transplant Physician Services</i></b> (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
<b><i>Other Covered Health Expenses</i></b>		
<b><i>Acupuncture in lieu of anesthesia</i></b>	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.
<b><i>Ground, Air or Water Ambulance</i></b>	90% after Plan Year <b>deductible</b>	90% after Plan Year <b>deductible</b>
<b><i>Diabetic Equipment, Supplies and Education</i></b>	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.
<b><i>Durable Medical and Surgical Equipment</i></b>	90% per item after the Plan Year <b>deductible</b>	70% per item after the Plan Year <b>deductible</b>
<b><i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i></b>	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
<b><i>Prosthetic Devices</i></b>	90% per item after Plan Year <b>deductible</b>	70% per item after Plan Year <b>deductible</b>
<b>PLAN FEATURES</b>		
<b>NETWORK</b>		
<b>OUT-OF-NETWORK</b>		
<b><i>Outpatient Therapies</i></b>		
<b><i>Chemotherapy</i></b>	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.
<b><i>Infusion Therapy</i></b>	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.
<b><i>Radiation Therapy</i></b>	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
<b>Short Term Outpatient Rehabilitation Therapies</b>		
<i>Speech Therapy only</i>	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible

Speech Therapy Maximum visits per Plan Year	20 visits	20 visits
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Short Term Outpatient Rehabilitation Therapies</b>		
<i>Outpatient Physical and Occupational Therapy only</i>	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible

Combined Physical and Occupational Therapy Maximum visits per Plan Year	40 visits	40 visits
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Spinal Manipulation</b>		
	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible

## Pharmacy Benefit

### Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
<b>Generic Prescription Drugs</b>		
For each 31 day supply (retail)	10% of the <b>negotiated charge</b> after Plan Year deductible	30% of the <b>recognized charge</b> after Plan Year deductible
For more than a 31 day supply but less than a 91 day supply (mail order)	10% of the <b>negotiated charge</b> after Plan Year deductible	Not Applicable

<b>Brand-Name Prescription Drugs</b>		
For each 31 day supply (retail)	10% of the <b>negotiated charge</b> after Plan Year deductible	30% of the <b>recognized charge</b> after Plan Year deductible
For more than a 31 day supply but less than a 91 day supply (mail order)	10% of the <b>negotiated charge</b> after Plan Year deductible	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	90% of the <b>negotiated charge</b>	70% of the <b>recognized charge</b>

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*.

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

You and each of your covered dependents have separate Plan Year **deductibles**. This Plan has individual and family Plan Year **deductibles**.

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

### **Network Provider Plan Year Deductible**

#### **Individual**

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

#### **Family**

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

### **Out-of-Network Provider Plan Year Deductible**

#### **Individual**

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

#### **Family**

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

### **Deductible Waiver Provision for Preventive Prescription Drug Expenses**

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

- Hypertension;
- Heart disease;
- Diabetic complications;
- Asthmatic episodes;
- Conditions resulting from osteoporosis;
- Stroke;
- Various pediatric conditions, such as vitamins and fluoride deficiency, and maternal and fetal problems during pregnancy

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

## **Copayments and Benefit Deductible Provisions**

### **Copayment, Copay – Prescription Drugs**

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

## **Payment Provisions**

### **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.

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.

### **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 and family **Payment Limit**.

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

The **Payment Limit** applies to **network provider and out-of-network provider** benefits.

You have a separate **Payment 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 Payment Limit**

### **Individual**

Once the amount of eligible **network provider** expenses you 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**

The Family **Payment 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 **Payment 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 Payment Limit**

### **Individual**

Once the amount of eligible **out-of-network provider** expenses you 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

The Family **Payment 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 **Payment 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 **Payment Limit** include **prescription drug** expenses provided under the Medical or **Prescription drug** Plans, as applicable.

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:

- 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 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.