

Schedule of Benefits

Employer: Millard Public Schools
 MSA: 737381
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 Schedule: 2A
 Booklet Base: 2

For: Aetna Whole Health CHI Health Accountable Care Network - Choice POS II High Deductible Health Plan

Aetna Choice POS II Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	\$3,100	\$6,200
Family Deductible*	\$6,200	\$12,400

*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 Maximum Out of Pocket Limit:

- For **network** expenses: \$3,100.
- For **out-of-network** expenses: \$11,200.

Family Maximum Out of Pocket Limit:

- For **network** expenses: \$6,200.
- For **out-of-network** expenses: \$22,400.

Lifetime Maximum Benefit per person	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 Calendar 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.	80% per visit after Calendar Year deductible
<i>Covered Persons through age 21: Maximum Age & Visit Limits</i>	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents. <i>For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.</i>	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. <i>For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.</i>
<i>Covered Persons ages 22 but less than 65: Maximum Visits per Calendar Year</i>	1 visit	1 visit
<i>Covered Persons age 65 and over: Maximum Visits per Calendar Year</i>	1 visit	1 visit

Preventive Care Immunizations <i>Performed in a facility or physician's office</i>	100% per visit No copay or deductible applies.	80% per visit after Calendar Year deductible
	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.	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.
	<i>For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.</i>	<i>For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.</i>

Screening & Counseling Services	100% per visit	80% per visits after Calendar Year deductible
Office Visits Obesity and/or Healthy Diet	No copay or deductible applies.	
Misuse of Alcohol and/or Drugs & Use of Tobacco Products		
Sexually Transmitted Infections		
Genetic Risk for Breast and Ovarian Cancer		

Obesity and/or Healthy Diet Maximum Visits per 12 consecutive months <i>(This maximum applies only to Covered Persons ages 22 & older.)</i>	26 visits <i>(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)*</i>	26 visits <i>(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)*</i>
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***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 *	5 visits *
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***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* 8 visits*

***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 Calendar Year 2 visits* 2 visits*

***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 80% per visit after Calendar Year deductible

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

Well Woman Preventive Visits

Maximum Visits per Calendar Year 1 visit 1 visit

Routine Cancer Screening Outpatient

100% per visit 80% per visit after Calendar Year deductible

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

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.*

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.*

<i>Lung Cancer Screening Maximum</i>	One screening every 12 months*	One screening every 12 months*
*Important Note: <i>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.</i>		

Prenatal Care Office Visits	100% per visit	80% per visit after Calendar Year deductible
No copay or deductible applies.		
Important Note: Refer to the Physician Services and Pregnancy Related 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	80% per visit after Calendar Year deductible
No copay or deductible applies.		

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 <i>Physician Services</i> office visit section of the <i>Schedule of Benefits</i> .		

Breast Pumps & Supplies	100% per item	80% per item after Calendar Year deductible
No copay or deductible applies		
Important Note: Refer to the <i>Comprehensive Lactation Support and Counseling Services</i> section of the Booklet for limitations on breast pumps and supplies.		

Family Planning Services Female Contraceptive Counseling Services -Office Visits	100% per visit.	80% per visit after Calendar Year deductible
No copay or deductible applies.		

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 <i>Physician Services</i> office visit section of the <i>Schedule of Benefits</i> .		

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.	80% per item after Calendar Year deductible
No copay or deductible applies.		

Family Planning - Other		
Voluntary Sterilization for Males		
Outpatient	100% per visit after Calendar Year deductible.	80% per visit after Calendar Year deductible.
Family Planning - Female Voluntary Sterilization		
Inpatient	100% per visit No copay or deductible applies.	80% per visit after Calendar Year deductible
Outpatient	100% per visit No copay or deductible applies.	80% per visit after Calendar Year deductible
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Physician Services		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-specialist	100% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
Specialist Office Visits	100% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
Physician Office Visits-Surgery	100% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
Walk-In Clinic Visit (Non-Emergency)		
Preventive Care Services*		
Immunizations	100% per visit No copay or deductible applies. For details, contact your physician , log onto the Aetna website www.aetna.com , or call the number on the back of your ID card.	Not Covered
Individual Screening and Counseling Services for Tobacco Use	100% per visit No copay or deductible applies.	Not Covered
Maximum Benefit per visit - Individual Screening and Counseling Services for Tobacco Use	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Not Applicable

Individual Screening and Counseling Services for Obesity	100% per visit No copay or deductible applies.	Not Covered
Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Not Applicable
*Important Note: Not all preventive care services are available at all Walk-In Clinics . The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your physician .		
<i>All Other Services</i>	100% per visit after Calendar Year deductible	Not Covered

<i>Physician Services for Inpatient Facility and Hospital Visits</i>	100% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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<i>Administration of Anesthesia</i>	100% per procedure after Calendar Year deductible	80% per procedure after Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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<i>Emergency Medical Services</i>		
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<i>Hospital Emergency Facility and Physician</i>	100% per visit after the Calendar Year deductible	Paid the same as the Network level of benefits. See Important Note Below
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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.

<i>Non-Emergency Care in a Hospital Emergency Room</i>	Not covered	Not covered
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<i>Urgent Care Services</i>		
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<i>Urgent Medical Care (at a non-hospital free standing facility)</i>	100% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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Urgent Medical Care <i>(from other than a non-hospital free standing facility)</i>	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.
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Non-Urgent Use of Urgent Care Provider <i>(at an Emergency Room or a non-hospital free standing facility)</i>	Not covered	Not covered
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		

Complex Imaging Services		
Complex Imaging	100% per test after Calendar Year deductible	80% per test after Calendar Year deductible

Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	100% per procedure after Calendar Year deductible	80% per procedure after Calendar Year deductible

Diagnostic X-Rays (except Complex Imaging Services)		
Diagnostic X-Rays	100% per procedure after Calendar Year deductible	80% per procedure after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
Outpatient Surgery	100% per visit/surgical procedure after Calendar Year deductible	80% per visit/surgical procedure after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
Birth Center	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Hospital Facility Expenses	100% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Room and Board (including maternity)		
Other than Room and Board	100% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible

<i>Skilled Nursing Inpatient Facility</i>	100% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Maximum Days per Calendar Year	120 days	120 days
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Specialty Benefits</i>		
<i>Home Health Care (Outpatient)</i>	100% per visit after the Calendar Year deductible	80% per visit after the Calendar Year deductible
Maximum Visits per Calendar Year	60 visits	60 visits
<i>Skilled Nursing Care (Outpatient)</i>	100% per visit after the Calendar Year deductible	80% per visit after the Calendar Year deductible
<i>Hospice Benefits</i>		
<i>Hospice Care - Facility Expenses (Room & Board)</i>	100% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
<i>Hospice Care - Other Expenses during a stay</i>	100% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Maximum Benefit per lifetime	Unlimited days	Unlimited days
<i>Hospice Outpatient Visits</i>	100% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Infertility Treatment</i>		
<i>Basic Infertility Expenses</i> 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
<i>Inpatient Treatment of Mental Disorders</i>		
<i>MENTAL DISORDERS</i>		
<i>Hospital Facility Expenses</i>		
Room and Board	100% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Other than Room and Board	100% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Physician Services	100% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible

<i>Inpatient Residential Treatment Facility Expenses</i>	100% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
<i>Inpatient Residential Treatment Facility Expenses Physician Services</i>	100% after Calendar Year deductible	80% after Calendar Year deductible

Outpatient Treatment Of Mental Disorders

<i>Outpatient Services</i>	100% per visit after the Calendar Year deductible	80% per visit after the Calendar Year deductible
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PLAN FEATURES NETWORK OUT-OF-NETWORK

Inpatient Treatment of Substance Abuse

Hospital Facility Expenses

Room and Board	100% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Other than Room and Board	100% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Physician Services	100% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible

<i>Inpatient Residential Treatment Facility Expenses</i>	100% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
<i>Inpatient Residential Treatment Facility Expenses Physician Services</i>	100% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

Outpatient Treatment of Substance Abuse

<i>Outpatient Treatment</i>	100% per visit after Calendar Year deductible	80% per visit after Calendar 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

<i>Transplant Facility Expenses</i>	100% per admission after Calendar Year deductible	Not Covered	Not Covered
<i>Transplant Physician Services</i> (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided	Not Covered	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Other Covered Health Expenses</i>		
<i>Acupuncture in lieu of anesthesia</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Ground, Air or Water Ambulance</i>	100% after Calendar Year deductible	100% after Calendar Year deductible
<i>Durable Medical and Surgical Equipment</i>	100% per item after the Calendar Year deductible	80% per item after the Calendar Year deductible
<i>Clinical Trial Therapies</i> (Experimental or Investigational Treatment)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Routine Patient Costs</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Jaw Joint Disorder Treatment</i>	100% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Prosthetic Devices</i>	100% per item after Calendar Year deductible	80% per item after Calendar Year deductible
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Outpatient Therapies</i>		
<i>Chemotherapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Infusion Therapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

<i>Radiation Therapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Short Term Outpatient Rehabilitation Therapies</i>		
<i>Outpatient Physical, Occupational and Speech Therapy combined</i>	100% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year	60 visits	60 visits
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Spinal Manipulation</i>		
	100% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

Spinal Manipulation Maximum visits per Calendar Year	36 visits	36 visits
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Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
<i>Preferred Generic and Non-Preferred Generic Prescription Drugs</i>		
For each 30 day supply filled at a retail pharmacy	Deductible then Coinsurance	Deductible then Coinsurance
For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order pharmacy	Deductible then Coinsurance	Not Applicable

<i>Preferred Brand-Name Prescription Drugs</i>		
For each 30 day supply filled at a retail pharmacy	Deductible then Coinsurance	Deductible then Coinsurance
For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order pharmacy	Deductible then Coinsurance	Not Applicable

Non-Preferred Brand-Name Prescription Drugs

For each 30 day supply filled at a retail pharmacy	Deductible then Coinsurance	Deductible then Coinsurance
For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order pharmacy	Deductible then Coinsurance	Not Applicable

Coinsurance

	NETWORK	OUT-OF-NETWORK
Prescription Drug Plan Coinsurance	100% of the negotiated charge	80% of the recognized charge

The **prescription drug plan coinsurance** is the percentage of **prescription drug covered expenses** that the plan pays after any applicable **deductibles** and **copays** have been met.

Copay and Deductible Waiver

Waiver for Risk-Reducing Breast Cancer Prescription Drugs

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** will not apply to risk-reducing breast cancer generic **prescription drugs** when obtained at a **network pharmacy**. This means that such risk-reducing breast cancer generic **prescription drugs** will be paid at 100%.

Deductible and copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs

The **prescription drug deductible** and the per **prescription copayment/coinsurance** will not apply to the first two 90-day treatment regimens for tobacco cessation **prescription drugs** and OTC drugs when obtained at a **network pharmacy**. This means that such **prescription drugs** and OTC drugs will be paid at 100%. Your **prescription drug deductible** and any **prescription copayment/coinsurance** will apply after those two regimens have been exhausted.

Waiver for Prescription Drug Contraceptives

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** will not apply to contraceptive methods that are:

- **generic prescription drugs**; contraceptive devices; or
- FDA-approved female generic emergency contraceptives,

when obtained at a **network pharmacy**. This means that such contraceptive methods will be paid at 100%.

Refer to the *Pharmacy Plan Features* for information on coverage for FDA-Approved female over-the-counter contraceptives (Non-Emergency).

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** continue to apply:

- When the contraceptive methods listed above are obtained at an out-of-network pharmacy
- For contraceptive methods that are:
 - **brand-name prescription drugs** and devices and
 - FDA-approved female brand-name emergency contraceptives,

that have a generic equivalent, or generic alternative available within the same **therapeutic drug class** obtained at an **out-of-network pharmacy** or **network pharmacy** unless you are granted a medical exception.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
FDA-Approved Female Generic Over-the-Counter Contraceptives For each 30 day supply filled at a retail pharmacy	100% per supply No copay or deductible applies.	Not covered.
FDA-Approved Female Generic Emergency Over-the-Counter Contraceptives	100% per supply No copay or deductible applies.	Not covered.

Important Note:

This Plan does not cover all over-the-counter (OTC) contraceptives. For a current listing, contact Member Services by logging on the Aetna website at www.aetna.com or calling the toll-free number on the back of the ID card.

Preventive Care Drugs and Supplements

Preventive care drugs and supplements filled at a pharmacy with a prescription :	100% per item. No copay or deductible applies.	Not Covered.
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Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact your physician or Member Services by logging onto the Aetna website www.aetna.com or calling the number on the back of your ID card.

Important Note:

Refer to the **Booklet** and the **Preventive Care** section for a complete description of the preventive care drugs and supplements covered under this Plan and for any limitations that apply to these benefits.

Tobacco Cessation Prescription and Over-the-Counter Drugs

Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** for each 90 day supply.

100% per supply

Not covered.

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

Maximums:

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

Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.

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 be applied to satisfy the **network provider deductibles**. **Covered expenses** applied to the **network provider deductibles** will 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 Calendar Year **deductibles**. This Plan has individual and family Calendar Year **deductibles**.

For purposes of Calendar 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 Calendar Year Deductible

Individual

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

Family

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

Out-of-Network Provider Calendar Year Deductible

Individual

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

Family

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

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.

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 Calendar 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. **Covered expenses** applied to the out-of-network **Maximum Out-of-Pocket Limit** will be applied to satisfy the in-network **Maximum Out-of-Pocket Limit** and **covered expenses** applied to the in-network **Maximum Out-of-Pocket Limit** will be applied to satisfy the out-of-network **Maximum Out-of-Pocket Limit**.

Network Provider Maximum Out-of-Pocket Limit

Individual

Once the amount of eligible **network provider** expenses you have paid during the Calendar 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 Calendar 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 Calendar 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 Calendar 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 Calendar 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 Calendar 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 Calendar 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 Calendar Year for all covered family members.

Covered expenses that are subject to the **Maximum Out-of-Pocket Limit** include **prescription drug** expenses provided under the Medical or **Prescription drug** Plans, as applicable.

Expenses That Do Not Apply to Your Out-of-Pocket Limit

Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an **urgent care provider**; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

Precertification Benefit Reduction

The 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 \$400 benefit reduction will be applied separately to each type of expense.

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.